STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 07/09/2019 through 07/11/2019. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000	The statements made on this Plan of Correction (PoC) are not an admission to and do not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all Federal and State regulations, the facility has taken or will take the actions set forth in the following PoC. This PoC constitutes the facility's allegation of compliance such that all alleged deficiencies cited during the survey have been or will be corrected by the compliance date indicated.	
F 000	INITIAL COMMENTS An unannounced {Medicare/Medicaid} standard/licensure survey was conducted 07/09/19 through 07/11/19. Two complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 155 certified bed facility was 113 at the time of the survey. The survey sample consisted of 50 current Resident reviews and 7 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	F550 1. Resident #46 was referred to Occupational Therapy and an assessment completed specific to resident's ability to activate call-bell/light system. Resident unable to activate using touch-pad; a hand splint was ordered to provide resident with enhanced ability to activate standard unit. 2. All residents have the potential to be affected. 3. Unit Managers/designee will audit ten (10) LTC residents daily x5 days, then weekly x4 weeks, to ensure that any decline in activation of the call	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 7-31-19

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.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, facility document review and clinical record review, it was determined that facility staff failed to maintain a resident's dignity for one of 57 residents in the survey sample, Resident # 46. The facility staff failed to provide an appropriate call bell for Resident #46. To activate the call bell Resident #46 was observed placing the cord in her mouth so she could grasp it with her left hand and then pushed it against her chin to activate the bell. When asked how she felt about this process, Resident #46 stated, "It makes me	F 550	2. All residents have the potential to be affected. 3. Unit Managers/designee will audit ten (10) LTC residents daily x5 days, then weekly x4 weeks, to ensure that any decline in activation of the call bell/light system is identified and resolved in a timely manner. New admissions to the facility will be evaluated upon arrival with regards to ability to activate the call bell/light system. Licensed nurses & CNAs will be re-educated on reporting functional decline in residents' status with regards to the use of call lights. 4. Director of Nursing/designee will report the results of audits at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

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F 550	Continued From page 2 angry." The findings include: Resident #46 was admitted to the facility on 7/8/2017 with a readmission on 7/2/2019. Resident #46's diagnoses included but were not limited to Parkinson's disease (1), multiple sclerosis (2), and atherosclerotic heart disease (3). 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)." Resident #46's comprehensive care plan dated 7/08/2017 documented, "Keep call lights and personal belongings w/in (within) reach" and "Reinforce need to call for assistance." On 7/10/19 at 3:00 p.m., Resident #46 was observed in her room in a wheelchair. The call bell was lying across her lap. Resident #46 was asked to ring the call bell to ensure the resident was able to access the device effectively. Resident #46 stated her right arm is, "almost completely" paralyzed and the left arm is very weak with limited movement in the fingers. She demonstrated the use of the call bell by grasping the call bell cord with her fingers on her left hand	F 550		

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F 550	Continued From page 3 and bringing the cord to her mouth. Placing the cord in her mouth, she maneuvered her left hand to the end of the call bell to grasp it and pushed it against her chin to activate the bell. When asked how she felt about this process, Resident #46 stated, "It makes me angry." On 7/11/19 at 08:04 a.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 was asked what the staff do with residents who have limited or decreased range of motion to ensure access to and use of the call bell. CNA #2 stated, "For instance, one patient who is paralyzed we have call light that patient can touch with any part of their hand and it cuts it on." When asked if she has witnessed Resident #46 access and activate her call light, CNA #2 stated, "I have never seen her struggle to activate the call bell, for her I never see a problem, I do not see how she is pressing it though." CNA #2 was informed of the observation of Resident #46 accessing the call bell on 7/10/19. CNA #2 stated, "It is not a dignified way to activate the call bell by putting it in the mouth. Maybe the touch pad call light would be a better option for her; I will tell my supervisor that she needs a touch pad." On 7/11/19 at 8:16 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked what the staff do with residents who have limited or decreased range of motion to ensure access to and use of the call bell. RN #2 stated, "I don't have any residents who cannot press the light, but usually we put the light on the strong side so they can use it." After being informed of the observation of Resident #46 accessing the call bell on 7/10/19, RN#2 stated, "This is new, I have seen the call light in her	F 550		

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F 550	Continued From page 4 hand." RN #2 was asked if he has ever witnessed Resident #46 access and activate her call light. RN #2 stated, "No." RN#2 stated, "Not a dignified manner to access call light to put in mouth." The facility's resident's rights entitled "Your Resident Rights" documented in part, "A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality." The facility policy, "Call Light" documented in part, "Purpose: To use a light and/or sound system to alert staff to patient needs. Equipment: Bedside call light with cord. NOTE: Adaptive call light equipment is available for those patients who cannot use standard call light cord." On 07/11/19 at approximately 12:05 p.m., ASM # 1 (administrative staff member), administrator, ASM # 2, the administrative director of nursing and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit. References: 1. Parkinson's disease A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 2. multiple sclerosis A nervous system disease that affects your brain	F 550		

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F 550	Continued From page 5 and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html. 3. atherosclerosis A disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium, and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the flow of oxygen-rich blood to your body. This information was obtained from the website: https://medlineplus.gov/atherosclerosis.html.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview and facility document review, it was determined that the facility staff failed to ensure reasonable accommodation of resident needs for three of 57 residents in the survey sample, Residents #61, #93, and #46.	F 558	F558 1. Residents #46, 61 & 93 did not have their call-light cords within reach during survey. Upon notification by the surveyor, this was resolve for all three residents.. Resident #46 was referred to Occupational Therapy and an assessment completed specific to resident's ability to activate call-bell/light system. Resident unable to activate using touch-pad; a hand splint was ordered to provide resident with enhanced ability to activate standard unit. 2. All residents have the potential to be affected.	

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F 558	Continued From page 6 1. The facility staff failed to place the Resident #61's call bell within reach after getting the resident up in her wheelchair. 2. The facility staff failed to ensure Resident #93's call bell was within the resident's reach while the resident was in bed on 7/9/19. 3. The facility staff failed to provide an appropriate call bell for Resident #46 and failed to ensure that the call bell was within the resident's reach while the resident was in bed on 7/10/19. The findings include: 1. The facility staff failed to place the Resident #61's call bell within reach after getting the resident up in her wheelchair. Resident #61 was admitted to the facility on 10/26/19 with diagnoses that included but were not limited to: high blood pressure, shortness of breath, gastroesophageal reflux disease [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. (1)], history of falls, and osteoporosis [abnormal loss of bony tissue, causing fragile bones that fracture easily (2)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/17/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive	F 558	3. Unit Managers/designee will conduct random audits of each unit and resident rooms, daily x5 days then weekly x4 weeks, to ensure residents have their call light within reach, with appropriate intervention initiated as needed. Director of Nursing (DON) will also conduct random audits to ensure compliance. Licensed nurses & CNAs re-educated on expectation that call-light cords are within reach of the residents at all times. 4. Unit Managers and DON will report the results of audits at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

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F 558	Continued From page 7	F 558		

decisions. Resident #61 was coded as requiring extensive assistance of one staff member for all of her activities of daily living.

Observation was made of Resident #61 on 7/10/19 at 9:18 a.m. The CNA (certified nursing assistant) had just gotten the resident up in her wheelchair. The CNA put the wheelchair legs on the wheelchair. Put the resident's oxygen on the resident. Gathered her dirty linens and left the room. The call bell was observed on the floor between the wheelchair and the bed, and was not in reach of the resident. The CNA did not return to the room for approximately 15 minutes.

The comprehensive care plan dated, 12/3/18, and revised on 1/17/19, documented in part, "Focus: AT risk for falls due to history of falls, impaired balance/pro (problem) coordination, unsteady gait." The "Interventions" documented in part, "Reinforce need to call for assistance."

An interview was conducted with CNA # 7 on 7/10/19 at 9:48 a.m. When asked where the call bell should be placed, CNA #7 stated, "Within reach." CNA #7 was asked if a call bell is in reach if it is on the floor between the resident's wheelchair and the bed, CNA #7 stated, "No."

An interview was conducted with LPN (licensed practical nurse) #1, on 7/11/19 at 9:51 a.m. When asked where the call bell should be placed, LPN #1 stated, "Within reach of the resident." When asked if it is on the floor, is that within reach, LPN #1 stated, "No."

The facility policy, "Call Light" documented in part, "Purpose: To use a light and/or sound system to alert staff to patient needs. Equipment:

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F 558	Continued From page 8 Bedside call light with cord. NOTE: Adaptive call light equipment is available for those patients who cannot use standard call light cord...6. Always position all light conveniently for use and within reach." Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 424. 2. The facility staff failed to ensure Resident #93's call bell was within the resident's reach while the resident was in bed on 7/9/19. Resident #93 was admitted to the facility on 9/6/06. Resident #93's diagnoses included but were not limited to pain, chronic kidney disease and dementia. Resident #93's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/14/19, coded the resident's cognition as severely impaired. Section G coded Resident #93 as requiring extensive assistance of one staff with bed mobility and transfers. Resident #93's comprehensive care plan dated 12/4/17 documented, "Encourage patient to call for assistance..."	F 558		

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F 558	Continued From page 9 On 7/9/19 at 11:37 a.m., Resident #93 was observed lying in bed. The resident's call bell was observed on the floor approximately one and a half feet from the bed. There was no clip on the call bell to ensure the device could be attached to the resident's bed. On 7/9/19 at 4:43 p.m., Resident #93 was observed lying in bed. The call bell was lying on the bed. Resident #93 was asked to ring the call bell to ensure the resident understood how to use the device. Resident #93 rang the call bell when asked. When asked if she uses the call bell, Resident #93 stated she does. On 7/10/19 at 3:02 p.m., an interview was conducted with CNA (certified nursing assistant) #1. CNA #1 was asked how staff ensures a resident's call bell is kept within reach when a resident is in bed. CNA #1 stated, "Clip the call bell somewhere on the bed or the sheet." When asked if every call bell should have a clip, CNA #1 stated, "Yes." When asked why, CNA #1 stated, "So that it will not fall on the floor." CNA #1 confirmed Resident #93 does use the call bell and confirmed the resident would not be able to reach or obtain the call bell if it was on the floor approximately one and a half feet away from the bed. On 7/10/19 at 5:49 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to provide an	F 558		

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F 558	Continued From page 10 appropriate call bell for Resident #46 and failed to ensure that the call bell was within the resident's reach while the resident was in bed on 7/10/19. Resident #46 was admitted to the facility on 7/8/2017. Resident #46's diagnoses included but were not limited to Parkinson's disease1, multiple sclerosis2, and atherosclerotic heart disease3. 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)." Resident #46's comprehensive care plan dated 7/08/2017 documented, "Keep call lights and personal belongings w/in (within) reach" and "Reinforce need to call for assistance." On 7/10/19 at 09:55 a.m., Resident #46 was observed lying in bed. The resident's call bell was observed draped across the back of the mattress in the bed beside the upper portion of the resident's left upper arm. When asked if she was able to use her call bell, Resident #46 stated that it was in the bed somewhere and she would have to hunt for it. Resident #46 stated her right arm is, "almost completely" paralyzed and the left arm is very weak with limited movement in the fingers due to her medical condition.	F 558		

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F 558	Continued From page 11 On 7/10/19 at 3:00 p.m., Resident #46 was observed in room in a wheelchair. The call bell was lying across her lap. Resident #46 was asked to ring the call bell to ensure the resident was able to access the device effectively. Resident #46 again stated her right arm is "almost completely" paralyzed and the left arm is very weak with limited movement in the fingers. She demonstrated the use of the call bell by grasping the call bell cord with her fingers and bringing the cord to her mouth. Placing the cord in her mouth, she maneuvered her left hand to the end of the call bell to grasp it and pushed it against her chin to activate the bell. When asked how she felt about this process she stated, "It makes me angry." On 7/11/19 at 08:04 a.m., an interview was conducted with CNA (certified nursing assistant) #2. CNA #2 was asked how staff ensures a resident has access to the call bell. CNA #2 stated, "We put it where the patient can reach." CNA #2 was asked what staff do with residents who have limited or decreased range of motion to ensure access to the call bell. CNA #2 stated, "For instance, one patient who is paralyzed we have call light that patient can touch with any part of their hand and it cuts it on." When asked specifically about resident #46's ability to access her call light, CNA #2 stated, "We give her call light and she holds it with her hand. She can push the call light and dial phone to call her daughter. Resident (name of Resident #46), has call light on her lap and in bed she has it beside her. They are supposed to put it in front of her, I place it in the middle of her lap and she can reach it." CNA #2 was asked if she has witnessed Resident #46 accessing and activating her call light. CNA #2 stated, "I have never seen her	F 558		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 558	Continued From page 12	F 558		

struggle to activate the call bell, for her I never see a problem, I do not see how she is pressing it though." CNA #2 was informed of the above observation noted by surveyor on 7/10/19 at 3:00 p.m. CNA #2 stated, "It is not a dignified way to activate the call bell by putting it in the mouth. Maybe the touch pad call light would be a better option for her; I will tell my supervisor that she needs a touch pad."

On 7/11/19 at 8:16 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 was asked how staff ensures a resident has access to the call bell. RN #2 stated, "The process is we try to keep the call light as close as possible, it has to be close to them so they are able to press when needed." RN #2 was asked what staff do with residents who have limited or decreased range of motion to ensure access to the call bell. RN #2 stated, "I don't have any residents who cannot press the light but usually we put light on the strong side so they can use it." When asked specifically about Resident #46, RN #2 stated, "She has used the call light multiple times last week, did not have any difficulty." After being informed of the observation of Resident # 46 accessing the call bell on 7/10/19, RN # 2 stated, "This is new, I have seen the call light in her hand." RN #2 was asked if he has ever witnessed Resident #46 access and activate her call light. RN #2 stated, "No." RN#2 stated, "Not a dignified manner to access call light to put in mouth."

On 07/11/19 at approximately 12:05 p.m., ASM # 1 (administrative staff member), administrator, ASM # 2, the administrative director of nursing and ASM # 3, quality assurance consultant, were made aware of the findings.

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 558	Continued From page 13 No further information was provided prior to exit. References: 1. Parkinson's disease A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. 2. Multiple Sclerosis A nervous system disease that affects your brain and spinal cord. It damages the myelin sheath, the material that surrounds and protects your nerve cells. This damage slows down or blocks messages between your brain and your body, leading to the symptoms of MS. They can include visual disturbances, muscle weakness, trouble with coordination and balance, sensations such as numbness, prickling, or "pins and needles" and thinking and memory problems. This information was obtained from the website: https://medlineplus.gov/multiplesclerosis.html. 3. Atherosclerosis A disease in which plaque builds up inside your arteries. Plaque is a sticky substance made up of fat, cholesterol, calcium, and other substances found in the blood. Over time, plaque hardens and narrows your arteries. That limits the flow of oxygen-rich blood to your body. This information was obtained from the website: https://medlineplus.gov/atherosclerosis.html.	F 558		
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to-	F 577	F577 1. An orange & white binder entitled "Survey Results and Plans of Correction for Past 3 Years" has	

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 577	Continued From page 14 (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, it was determined that the facility staff failed to ensure the survey results were readily accessible to residents and failed to post notice of the survey results. The census in the 155 certified bed facility was 113 at the time of the survey. The findings include: On 7/10/19 at 11:00 a.m., a group interview was conducted with five cognitively intact residents. The residents (Resident #50, and non sampled	F 577	been placed in the lobby area of the facility, that is now readily accessible to all residents and/or their representatives to review 24/7. 2. All residents have the potential to be affected. 3. Administrative and Management Staff were educated on the requirement specific to accessibility to survey results and plans of correction. Administrator or designee in their absence will monitor daily to determine ongoing compliance with this requirement at all times. 4. Results of this ongoing monitoring and related audits will be presented at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance date: August 13, 2019	

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 577	Continued From page 15 group Residents #132, 114, 44, and 83) stated they were not aware of the location of the survey results. On 7/10/19 at 11:27 a.m. and 3:02 p.m., observations of the facility were conducted. No posting regarding the survey results was observed. The survey results were observed in a binder labeled, "VIRGINIA DEPARTMENT OF HEALTH INSPECTION REPORTS." The binder was located on a desk behind the reception desk in the front lobby. On 7/10/19 at 4:06 p.m., an interview was conducted with OSM (other staff member) #11 (the general clerk behind the reception desk during the day) and OSM #12 (the business office coordinator behind the reception desk during the evening). OSM #11 and OSM #12 were asked if residents are permitted to go behind the reception desk. OSM #11 and OSM #12 both stated, "No." On 7/10/19 at 5:49 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern. On 7/11/19 at 9:47 a.m., ASM #3 stated the facility did not have a policy regarding survey results and the facility staff follows the regulations. No further information was presented prior to exit.	F 577		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or	F 578	F578 1. New evaluations were conducted by the Social Workers for Residents #64, #66, #93 & #94 to determine	

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 578	Continued From page 16 discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.	F 578	any change in advance directives and, when/if applicable, to obtain related documents, e.g., DNR, Power of Attorney, etc. 2. All residents have the potential to be affected. 3. Social Workers were re-educated regarding requirement to periodically review decisions regarding advance directives for LTC residents. Social Workers will audit all current LTC residents to identify any additional residents that require an overdue, periodic review of advance directives, initiating the necessary action to complete in a timely manner if any identified. Social Workers will randomly audit LTC residents to ensure compliance with periodic review of advance directives. 4. Results of all audits will be presented by the Social Workers at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

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F 578	Continued From page 17 This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical record review, it was determined that the facility staff failed to conduct follow-up reviews of advance directives for four of 57 residents in the survey sample, Residents #64, #66, #93 and #94. The facility staff failed to periodically review Resident #64's, #66's, #93's and #94's (or their representative's) decisions regarding advance directives. The findings include: 1. The facility staff failed to review periodically Resident #64's (or the representative's) decisions regarding advance directives. Resident #64 was admitted to the facility on 5/26/16. Resident #64's diagnoses included but were not limited to cough, chronic pain and major depressive disorder. Resident #64's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/26/19, coded the resident as being cognitively intact. Review of Resident #64's clinical record revealed a social service assessment dated 12/29/17. The assessment addressed advance directives and documented the resident and/or representative did not have advanced care planning (including advance directives) in place and did not want information on advance directives. Further review of Resident #64's clinical record failed to reveal a periodic review regarding advance directives since the 12/29/17 social	F 578		

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F 578	Continued From page 18 service assessment. Resident #64's comprehensive care plan dated 11/17/17 failed to document information regarding advance directives. On 7/10/19 at 1:49 p.m., an interview was conducted with OSM (other staff member) #2 and OSM #3 (both social workers). OSM #2 and OSM #3 was asked about the facility process regarding advance directives. OSM #2 stated a social service assessment is completed upon admission and advance directives is a part of the assessment. OSM #2 stated the social workers ask residents and/or representatives if they have advance directives in place. OSM #2 stated if residents have advance directives in place then the social workers ask for a copy and the copy is placed in the clinical record. OSM #2 stated if residents do not have advance directives upon admission then the social workers offer to provide information regarding this. When asked if periodic reviews and follow up of advance directives are conducted, OSM #2 stated periodic reviews are conducted at the quarterly care plan meetings. At this time, OSM #2 and OSM #3 were asked to provide evidence that Resident #64's advance directives had been periodically reviewed since 12/29/17. On 7/10/19 at 5:25 p.m., an interview was conducted with Resident #64. Resident #64 stated the facility staff has periodically reviewed and updated her code status (whether or not to be resuscitated) but confirmed the facility staff has not periodically reviewed full advance directives including the decision to appoint a power of attorney or create a living will.	F 578		

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F 578	Continued From page 19 On 7/10/19 at 5:31 p.m., OSM #2 and OSM #3 confirmed they had no further information to provide. On 7/10/19 at 5:49 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern. The facility document regarding advance directives failed to document information regarding periodic reviews. No further information was presented prior to exit. 2. The facility staff failed to periodically review Resident #66's (or the representative's) decisions regarding advance directives. Resident #66 was admitted to the facility on 8/18/15. Resident #66's diagnoses included but were not limited to heart disease and chronic pain. Resident #66's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 5/26/19, coded the resident's cognition as severely impaired. Review of Resident #66's clinical record revealed a social service assessment dated 12/29/17. The assessment addressed advance directives and documented the resident and/or representative did not have advanced care planning (including advance directives) in place and did not want information on advance directives. Further review of Resident #66's clinical record failed to reveal a periodic review regarding advance directives since the 12/29/17 social	F 578		

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F 578	Continued From page 20 service assessment. Resident #66's comprehensive care plan dated 11/5/18 failed to document information regarding advance directives. On 7/10/19 at 1:49 p.m., an interview was conducted with OSM (other staff member) #2 and OSM #3 (both social workers). OSM #2 and OSM #3 was asked to explain the facility process regarding advance directives. OSM #2 stated a social service assessment is completed upon admission and advance directives is a part of the assessment. OSM #2 stated the social workers ask residents and/or representatives if they have advance directives in place. OSM #2 stated if residents have advance directives in place then the social workers ask for a copy and the copy is placed in the clinical record. OSM #2 stated if residents do not have advance directives upon admission then the social workers offer to provide information regarding this. When asked if periodic reviews of advance directives are conducted, OSM #2 stated periodic reviews are conducted at the quarterly care plan meetings. At this time, OSM #2 and OSM #3 were asked to provide evidence that Resident #66's advance directives had been periodically reviewed since 12/29/17. On 7/10/19 at 5:31 p.m., OSM #2 and OSM #3 confirmed they had no further information to provide. On 7/10/19 at 5:49 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern.	F 578		

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F 578	Continued From page 21 No further information was presented prior to exit. 3. The facility staff failed to review periodically Resident #93's (or the representative's) decisions regarding advance directives. Resident #93 was admitted to the facility on 9/6/06. Resident #93's diagnoses included but were not limited to pain, chronic kidney disease and dementia. Resident #93's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/14/19, coded the resident's cognition as severely impaired. Review of Resident #93's clinical record revealed a social service assessment dated 12/12/17. The assessment addressed advance directives and documented the resident and/or representative did not have advanced care planning (including advance directives) in place and did not want information on advance directives. Further review of Resident #93's clinical record failed to reveal a periodic review regarding advance directives since the 12/12/17 social service assessment. Resident #93's comprehensive care plan dated 12/4/17 failed to document information regarding advance directives. On 7/10/19 at 1:49 p.m., an interview was conducted with OSM (other staff member) #2 and OSM #3 (both social workers). OSM #2 and OSM #3 was asked to explain the facility process regarding advance directives. OSM #2 stated a social service assessment is completed upon	F 578		

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F 578	Continued From page 22 admission and advance directives is a part of the assessment. OSM #2 stated the social workers ask residents and/or representatives if they have advance directives in place. OSM #2 stated if residents have advance directives in place then the social workers ask for a copy and the copy is placed in the clinical record. OSM #2 stated if residents do not have advance directives upon admission then the social workers offer to provide information regarding this. When asked if periodic reviews of advance directives are conducted, OSM #2 stated periodic reviews are conducted at the quarterly care plan meetings. At this time, OSM #2 and OSM #3 were asked to provide evidence that Resident #93's advance directives had been periodically reviewed since 12/12/17. On 7/10/19 at 5:31 p.m., OSM #2 and OSM #3 confirmed they had no further information to provide. On 7/10/19 at 5:49 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern. No further information was presented prior to exit. 4. The facility staff failed to review periodically Resident #94's (or the resident's representative) decisions regarding advance directives. Resident #94 was admitted to the facility on 01/30/2018 with a readmission on 12/05/2018. Resident #94's diagnoses included but were not limited to type 2 diabetes mellitus (1), atrial fibrillation (2), and dependence on renal dialysis (3). Resident #94's most recent MDS (minimum	F 578		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 23	F 578		

data set), a quarterly assessment with an ARD (assessment reference date) of 6/15/19, coded the resident's cognition as cognitively intact.

Review of Resident #94's clinical record revealed a social service assessment dated 2/13/18. The assessment addressed advance directives and documented the resident and/or representative did not want information on advance directives.

Further review of Resident #94's clinical record failed to reveal a periodic review regarding advance directives since the 2/13/18 social service assessment.

On 7/10/19 at 1:49 p.m., an interview was conducted with OSM (other staff member) #2 and OSM #3 (both social workers). When asked if periodic reviews of advance directives are conducted, OSM #2 stated periodic reviews are conducted at the quarterly care plan meetings. At this time, OSM #2 and OSM #3 were asked to provide evidence that Resident #94's advance directives had been periodically reviewed since 2/13/18.

On 7/10/19 at 4:00 p.m., OSM #3 submitted a copy of Resident #94's DDNR (durable do not resuscitate) and Virginia Physician Orders for Scope of Treatment dated 2/27/18. No evidence of periodic review was noted for advanced directives.

On 07/11/19 at approximately 12:05 p.m., ASM # 1 (administrative staff member), administrator, ASM # 2, the administrative director of nursing and ASM # 3, quality assurance consultant, were made aware of the findings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 24 No further information was provided prior to exit. 1. diabetes mellitus A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 2. atrial fibrillation A problem with the speed or rhythm of the heartbeat. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/atrialfibrillation.html. 3. hemodialysis Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.	F 578		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent	F 584	F584 1. The identified issue of handles on the nightstand drawers in room 219, 222, 223 and 227 has been resolved. The identified issue of broken floor tiles in room 218 has been resolved. 2. All residents have the potential to be affected. 3. Staff across departments were re-educated on the policy and procedure for creating work orders on the TELS computer system in a timely manner for any identified	

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F 584	Continued From page 25 possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to provide a homelike environment in five of 18 rooms on the Arcadia (dementia) unit, (rooms 219, 222, 223, 227 and 218). 1. The pull handles for the night stands in rooms 219, 222, 223 and 227 were either missing or	F 584	repair issues toward timely resolution. An inspection was completed of all resident rooms to identify any new or outstanding repair issues, and of the TELS system to determine if all needed repairs were reflected until repair completed. Any missing work orders were added at that time. Regular, assigned room rounds by management staff will include identifying and addressing toward resolution any repair needs. 4. Results of completed room rounds will be shared and discussed at morning stand-up meeting, and results of all inspections and audits will be presented at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 584	Continued From page 26 hanging by one screw. 2. The facility staff failed to maintain the floor tiles in resident room 218 in good repair. The findings include: 1. On 7/9/19 at 11:28 a.m., observation was conducted of the Arcadia unit. In Room 219, a pull handle on the nightstand was fastened to the drawer with only one screw, and was observed hanging down by the one screw. In Room 222, a pull handle on the nightstand that was fastened to the drawer with only one screw, and was observed hanging down by the one screw. In Room 223, a pull handle on the nightstand was fastened to the drawer with one screw, and was observed hanging down by the one screw. In Room 227, there was no pull handle on the bottom drawer of the nightstand. A walk through the unit was conducted with Administrative staff member (ASM) #1, the administrator and OSM (other staff member) # 7, the director of environmental services, on 7/10/19 at 3:55 p.m. ASM #1 was shown the above rooms with the missing or hanging pull handles, and was asked if this was homelike. ASM #1 stated, "No, it's not." An interview was conducted with CNA (certified nursing assistant) # 2 on 7/11/19 at 8:56 a.m., regarding the process followed if she observes something broken, missing or in need of repair. CNA #2 stated, "We put it in (name of computer program) that goes to the maintenance department. If it's urgent we page them."	F 584		

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F 584	Continued From page 27 An interview was conducted with LPN (licensed practical nurse) #2, on 7/11/19 at 9:00 a.m. When asked about the process staff follows if they see something in need of repair, broken or missing. LPN #2 stated, "We put it in (name of computer program) or page maintenance to fix it right away." On 7/11/19 at 9:11 a.m., an interview was conducted with OSM #7. OSM #7 was asked how reports of broken things or things in need of repair are reported. OSM #7 stated, "We put it in (name of computer program)." When asked if his staff has access to put it in the computer, OSM #7 stated, "No, my staff tell me and I put it in (name of computer program) or tell maintenance myself." Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m. On 7/11/19 at 11:14 a.m., ASM #3 informed this surveyor the facility did not have a policy on maintenance repairs. On 7/11/19 at approximately 12:00 p.m., ASM #1 presented a package of papers that documented, "(Name of computer program) Work Orders." The policy documented in part, "Creating a Work Order: Click on new work order. What is required: title, room/area. What is requested: description, creator's name as reference number, priority level, once all info (information) is enter press create work order." No further information was provided prior to exit.	F 584		

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F 584	Continued From page 28 2. The facility staff failed to maintain the floor tiles in resident room 218 in good repair. On 07/09/19 at 4:15 p.m., and on 07/10/19 at 9:14 a.m., observations of resident room 218 revealed three floor tiles broken on far side of the room, to the left of the resident bed. The first tile with an opening measuring approximately four inches long and one and a half inches wide. The second tile with an opening measuring approximately three and a half inches long and one and a half inches wide, and the third tiles with an opening measuring approximately two and a half inches long and two and a half inches wide. On 07/10/19 at approximately 3:30 p.m., a telephone interview was conducted with OSM # 4, maintenance assistant. When asked to describe the process for identifying needed repairs in the facility, OSM # 4 stated, "If the staff finds things that are in need of repair they put the work order in the 'Tels', a computerized work order system, and I check it every day. We also do a walk through every morning to identify any problems." When asked if he was aware of the broken tiles in resident room 218, OSM # 4 stated no. On 07/11/19 at approximately 12:05 p.m., ASM # 1 (administrative staff member), administrator, ASM # 2, the administrative director of nursing and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit.	F 584		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and	F 607	F607 1. The allegation of abuse by resident #39 was reported to the State by the Administrator, albeit not within the	

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F 607	Continued From page 29 implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the abuse policies and procedures for one of 57 residents in the survey sample, Resident #39. The facility staff failed to implement the abuse policy and procedure to report Resident # 39's allegation of abuse verbalized to staff on 5/15/19, immediately and or within 2 hours to the State Agency. The allegation was not reported until 5/17/19. The findings include: The facility staff failed implement the facility's abuse policy after Resident # 39 made an allegation of abuse. Resident #39 was admitted to the facility on 07/26/2010 and a readmission on 06/03/2011 with diagnoses that included but were not limited to: dementia (1), anemia (2), and hypertension (3). Resident # 39's most recent MDS (minimum data set), a quarterly assessment with an ARD	F 607	required timeframe per current Federal regulations. However, timely actions including an investigation were initiated timely toward a determination and resolution for the well-being of the resident. 2. No other residents were affected. 3. Staff across departments were re-educated on the requirements to report any allegation or suspicion of abuse immediately to the facility Administrator, or Director of Nursing in their absence. Administrator will ensure that allegations of abuse are reported to the appropriate State entities consistent with current Federal regulations. 4. Facility Administrator will share information pertaining to FRIs at daily management meetings, and results of related audits at the monthly QAPI Committee meetings x 3 months for its review and recommendations. 5. Compliance date: August 13, 2019	

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F 607	Continued From page 30	F 607		

(assessment reference date) of 05/06/19, coded Resident # 39 as scoring a four on the staff assessment for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions.

The Facility Reported Incident (FRI) for Resident # 39, documented "Indeterminable" and "Report date: May 17, 2019." Under "Incident Type" it documented, "Allegation of abuse/mistreat." The FRI further documented, "Describe incident, including location and action taken: Resident stated to various staff members that two teenage girls came into her room at night, hit her and threw things all over her room before leaving. She said to the writer that it happened a couple of nights ago, to others 'a few days ago', and to one employee 'about two weeks ago'. Skin assessment by nurse only identified a rash on shoulder."

The facility's "Investigative Report" included a witness statement written by OSM (other staff member) # 7, director of environmental services dated "5-15-19." The witness statement documented, "Time 11:15 am (a.m.) [sic] Residents report to me that she got beat up by two young females, about two weeks ago. She stated they [sic] enter her room and beat her up. Slapped her in the face and kept hitting her. I reported it to the nurse on private hall. I her to follow up with the resident and talk to the administer and the DON (director of nursing)."

The facility's "Progress Notes" dated 5/15/19 for Resident # 39 documented, "Resident alert and responsive able to make her needs known. All scheduled medications administered and

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 607	Continued From page 31	F 607		

tolerated well. Assisted with ADL (activities of daily living) care as needed. Resident ate 75% for meals. Resident reported beeb beting [sic] by two teenage female two days ago in the night. Skin assessment was done and resident has a rash on the RUE (right upper extremity), NP (nurse practitioner) FE assessed the resident's skin and prescribed Nystatin cream. Reported the issue to (Name of Administrator), the administrator whom interviewed the resident. Resident is currently sitting on hallway next to nurse's station. No complain of pain voiced or noted. Nursing will keep monitor."

Review of the facility's facsimile confirmation receipt for the FRI dated May 17, 2019 documented, "DATE/TIME: 05/17 10:56. FAX NO (number)/NAME: (Fax Number for the State Office of Licensure and Certification)."

On 07/10/19 at 2:33 p.m., an interview was conducted with OSM (other staff member) # 7, director of housekeeping. OSM # 7 reviewed and confirmed the witness statement he wrote dated 5/15/19. When asked to elaborate on his witness statement, OSM # 7 stated, "The resident informed me of being abused. I told the nurse then, I followed up with the administrator and DON (director of nursing) on the same day the resident told me and they (administrator and DON) advised me to write up the statement."

On 07/10/19 at 4:05 p.m., an interview with ASM (administrative staff member) # 1, administrator regarding the FRI involving the allegation of abuse for Resident # 39. When asked to describe the facility's policy and procedure for reporting an allegation of abuse, ASM # 1 stated, "Within two hours of discovery." After reviewing

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 607	Continued From page 32 the facsimile of the FRI dated 05/17/19, the FRI and the witness statement by OSM (other staff member) # 7, director of housekeeping, ASM # 1 was asked if the allegation of abuse for Resident # 39 was reported to the state agency within two hours of receiving the allegation. ASM # 1 stated, "No." The facility's policy "Patient Protection. Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention" documented, "Reporting Allegations of Abuse. §42CFR 483.12 (c) (1): (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures." On 07/11/19 at approximately 12:05 p.m., ASM # 1 (administrative staff member), administrator, ASM # 2, the administrative director of nursing and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit.	F 607		

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F 607	Continued From page 33 References: (1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm. (2) Low iron. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/anemia.html . (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 607		
F 608 SS=C	Reporting of Reasonable Suspicion of a Crime CFR(s): 483.12(b)(5)(i)-(iii) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(5) Ensure reporting of crimes occurring in federally-funded long-term care facilities in accordance with section 1150B of the Act. The policies and procedures must include but are not limited to the following elements. (i) Annually notifying covered individuals, as defined at section 1150B(a)(3) of the Act, of that individual's obligation to comply with the following reporting requirements. (A) Each covered individual shall report to the State Agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility. (B) Each covered individual shall report	F 608	F608 1. Copies of the company-adopted document *Elder Justice Act: Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility* were posted during survey in the employee break room, at the two time clocks and in front of the HR office. 2. All residents had the potential to be affected. 3. Staff across all departments will be in-serviced on the requirements and expectations regarding reasonable suspicions of crimes within the facility. Administrator or their designee will conduct periodic inspections to ensure the document *Elder Justice Act: Reporting Reasonable Suspicion of a Crime in a Long-Term Care Facility* remains posted in the	

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F 608	Continued From page 34 immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury. (ii) Posting a conspicuous notice of employee rights, as defined at section 1150B(d)(3) of the Act. (iii) Prohibiting and preventing retaliation, as defined at section 1150B(d)(1) and (2) of the Act. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined that the facility staff failed to post notice of employee rights regarding the reporting of suspicious crimes. The findings include: On 7/11/19 at approximately 9:00 a.m., a tour of the facility was conducted to locate a posted notice of employee rights regarding the reporting of suspicious crimes. No notice could be located. On 7/11/19 at approximately 10:10 a.m., ASM (administrative staff member) #1, the administrator was made aware a posted notice of employee rights regarding the reporting of suspicious crimes could not be located. ASM #1 stated she would check throughout the facility for the posting. On 7/11/19 at 10:45 a.m., ASM #1 confirmed the notice was not posted and provided this surveyor with a copy of the "Elder Justice Act. Reporting Reasonable Suspicion of a Long-Term Care Facility." ASM #1 stated they had the policy but it was not posted.	F 608	employee break room, at the two time clocks and in front of the HR office at all times. 4. Administrator will report findings from these inspections at the monthly QAPI Committee meetings x3 months for its review and consideration. 5. Compliance date: August 13, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 608	Continued From page 35 The facility's policy "Patient Protection. Abuse, Neglect, Exploitation, Mistreatment & Misappropriation Prevention" documented, "(5) (B)(ii) Posting a conspicuous notice of employee rights, as defined at section 1150B (d)(3) of the Act ..." No further information was presented prior to exit.	F 608		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the	F 609	F609 1. The allegation of abuse by resident #39 was reported to the State by the Administrator, albeit not within the required timeframe per current Federal regulations. However, timely actions including an investigation were initiated timely toward a determination and resolution for the well-being of the resident. 2. No other residents were affected. 3. Staff across departments were re-educated on the requirements to report any allegation or suspicion of abuse immediately to the facility Administrator, or Director of Nursing in his absence. Administrator will ensure that allegations of abuse are reported to the appropriate State entities consistent with current Federal regulations. 4. Facility Administrator will share information pertaining to FRIs at daily management meetings, and results of related audits at the monthly QAPI Committee meetings x3 months for its review and consideration. 5. Compliance date: August 13, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 36	F 609		

incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to report an allegation of abuse immediately and or within 2 hours, for one of 57 residents in the survey sample, Resident #39. On 05/15/19, when Resident # 39 verbalized an allegation of abuse to facility staff, the facility staff failed to report the allegation of abuse immediately and or within 2 hours to the State Agency and other officials in accordance with State law through established procedures. The allegation was not reported until 5/17/19.

The findings include:

Resident #39 was admitted to the facility on 07/26/2010 and a readmission on 06/03/2011 with diagnoses that included but were not limited to: dementia (1), anemia (2), and hypertension (3).

Resident # 39's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 05/06/19, coded Resident # 39 as scoring a four on the staff assessment for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions. Resident # 39 was coded as requiring limited assistance of one staff member for activities of daily living.

The Facility Reported Incident (FRI) for Resident # 39, documented "Indeterminable" and "Report date: May 17, 2019." Under "Incident Type" it documented, "Allegation of abuse/mistreat." The

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 609	Continued From page 37 FRI further documented, "Describe incident, including location and action taken: Resident stated to various staff members that two teenage girls came into her room at night, hit her and threw things all over her room before leaving. She said to the writer that it happened a couple of nights ago, to others 'a few days ago', and to one employee 'about two weeks ago'. Skin assessment by nurse only identified a rash on shoulder." The facility's "Investigative Report" included a witness statement written by OSM (other staff member) # 7, director of environmental services dated "5-15-19." The witness statement documented, "Time 11:15 am (a.m.) [sic] Residents report to me that she got beat up by two young females, about two weeks ago. She stated they [sic] enter her room and beat her up. Slapped her in the face and kept hitting her. I reported it to the nurse on private hall. I her to follow up with the resident and talk to the administer and the DON (director of nursing)." The facility's "Progress Notes" dated 5/15/19 for Resident # 39 documented, "Resident alert and responsive able to make her needs known. All scheduled medications administered and tolerated well. Assisted with ADL (activities of daily living) care as needed. Resident ate 75% for meals. Resident reported beeb beting [sic] by two teenage female two days ago in the night. Skin assessment was done and resident has a rash on the RUE (right upper extremity), NP (nurse practitioner) FE assessed the resident's skin and prescribed Nystatine cream. Reported the issue to (Name of Administrator), the administrator whom interviewed the resident.	F 609		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 609	Continued From page 38 Resident is currently sitting on hallway next to nurse's station. No complain of pain voiced or noted. Nursing will keep monitor." Review of the facility's facsimile confirmation receipt for the FRI dated May 17, 2019 documented, "DATE/TIME: 05/17 10:56. FAX NO (number)/NAME: (Fax Number for the State Office of Licensure and Certification)." On 07/10/19 at 2:33 p.m., an interview was conducted with OSM (other staff member) # 7, director of housekeeping. OSM # 7 reviewed and confirmed the witness statement he wrote dated 5/15/19. When asked to elaborate on his witness statement, OSM # 7 stated, "The resident informed me of being abused. I told the nurse then, I followed up with the administrator and DON (director of nursing) on the same day the resident told me and they (administrator and DON) advised me to write up the statement." On 07/10/19 at 4:05 p.m., an interview with ASM (administrative staff member) # 1, administrator regarding the FRI involving the allegation of abuse for Resident # 39. When asked to describe the facility's policy and procedure for reporting an allegation of abuse, ASM # 1 stated, "Within two hours of discovery." After reviewing the facsimile of the FRI dated 05/17/19, the FRI and the witness statement by OSM (other staff member) # 7, director of housekeeping, ASM # 1 was asked if the allegation of abuse for Resident # 39 was reported to the state agency according to the policy and the regulatory requirements, ASM # 1 stated, "No." The facility's policy "Patient Protection. Abuse, Neglect, Exploitation, Mistreatment &	F 609		

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 609	Continued From page 39	F 609		

Misappropriation Prevention" documented, "Reporting Allegations of Abuse. §42CFR 483.12 (c) (1): (c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: (1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than two (2) hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures."

On 07/11/19 at approximately 12:05 p.m., ASM # 1 (administrative staff member), administrator, ASM # 2, director of nursing and ASM # 3, quality assurance consultant, were made aware of the findings.

No further information was provided prior to exit.

References:
(1) A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 609	Continued From page 40 . (3) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 609		
F 622 SS=E	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D) The health of individuals in the facility would otherwise be endangered; (E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or	F 622	F622 1. Resident #56 returned to the facility on 5/15/19. Resident #52 returned to the facility on 5/28/19. Resident #61 returned to the facility on 5/10/19. 2. All residents experiencing a facility-initiated transfer to the hospital have the potential to be affected. 3. Unit Managers/Shift Supervisors will audit facility-initiated discharges to the hospital, daily x 5 days and weekly x4 weeks, to ensure compliance with the requirement of information provided to the hospital, including a copy of the comprehensive plan of care, and completion of the internal document *Post Acute Care Transfer Document Checklist.* Licensed nurses on all shifts will be re-educated on the requirement of information provided to the hospital, to include a copy of the comprehensive plan of care, and completion of the internal document *Post Acute Care Transfer Document Checklist.* 4. Unit Managers will report the results of audits at the monthly QAPI Committee meetings x3 months for it review and recommendations. 5. Compliance Date: August 13, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 622	Continued From page 41 (F) The facility ceases to operate. (ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c)(1)(A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section.	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 622	Continued From page 42 (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to evidence the required information was provided to hospital staff for a facility-initiated transfer for four of 57 residents in the survey sample, Residents #56, #52, #61 and #70. The findings include: 1. The facility staff failed to evidence that comprehensive care plan goals were provided to hospital staff when Resident #56 was transferred to the hospital on 5/11/19. Resident #56 was admitted to the facility on 7/12/17. Resident #56's diagnoses included but were not limited to pneumonia, heart disease and asthma. Resident #56's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/20/19,	F 622		

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F 622	Continued From page 43 coded the resident's cognition as severely impaired. Review of Resident #56's clinical record revealed the resident was transferred to the hospital on 5/11/19 due to a low oxygen level. Further review of Resident #56's clinical record (including an acute care transfer form and nurses' notes) failed to reveal evidence that the resident's comprehensive care plan goals were provided to the hospital staff. On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked to describe the information that is provided to hospital staff when a resident is transferred to the hospital and how staff evidences that information was provided. LPN #1 stated the nurses provide a face sheet, medication list, progress notes for the last 72 hours, history and physical, labs [laboratory tests], an acute care transfer form, a copy of the care plan and the bed hold policy. LPN #1 stated the nurses have a checklist that they reference but do not physically use. LPN #1 stated due to previous in-services, the nurses have learned that they need to document that a copy of the care plan and the bed hold policy was provided. LPN #1 stated this information should be documented in nurses' notes. On 7/10/19 at 5:49 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern. The facility document titled, "INTERDISCIPLINARY CARE TRANSITIONS	F 622		

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F 622	Continued From page 44 CHECKLISTS" documented, "TRANSITION FROM SKILLED NURSING FACILITY TO ACUTE CARE: Complete Acute Care Transfer Documentation Checklist. Collect necessary documents including a Transfer/Discharge Record and copy of the patient's comprehensive care plan goals from (name of computer system) and place in envelope. Seal envelope. Remove top copy and place in patient's clinical record..." No further information was presented prior to exit. 2. The facility staff failed to provide the care plan goals to the hospital for a facility initiated transfer for Resident #52 on 5/27/19. Resident #52 was admitted to the facility on 5/22/16 with diagnoses that included but were not limited to: dementia, anxiety disorder, agitation, and glaucoma [a disease in which elevated pressure in the eye, due to obstruction of the outflow of aqueous humor, damages the optic nerve and causes visual defects (1)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/9/9, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating he is severely impaired to make daily cognitive decisions. The physician order dated, 5/27/19, documented, "Send resident to (Name of hospital) for psychiatric evaluation RE (regarding) pushed another resident to the floor." The nurse's note dated, 5/27/19 at 8:57 p.m.	F 622		

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 622	Continued From page 45	F 622		

documented in part, "Call placed to (name of doctor). New order received to send to (Name of hospital) for evaluation."

Review of the clinical record failed to evidence documentation of that the comprehensive care plan goals were sent with the resident to the hospital.

On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated due to previous in-services, the nurses have learned that they need to document that a copy of the care plan and the bed hold policy was provided. LPN #1 stated this information should be documented in nurses' notes.

Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m.

On 7/11/19 at 11:00 a.m., a request was made of ASM #2 for any documentation that the care plan goals were sent with the resident when he went to the hospital on 5/27/19. At 11:45 a.m., ASM #2 stated that if she didn't give this information to this surveyor, she didn't have it.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 247.

3. The facility staff failed to provide the care plan

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 622	Continued From page 46 goals to the hospital for a facility initiated transfer for Resident #61 on 5/10/19. Resident #61 was admitted to the facility on 10/26/19 with diagnoses that included but were not limited to: high blood pressure, shortness of breath, gastroesophageal reflux disease [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. (1)], history of falls, and osteoporosis [abnormal loss of bony tissue, causing fragile bones that fracture easily (2)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/17/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. The nurse's note dated, 5/10/19 at 12:49 a.m. documented in part, "At about 10 pm, a nurse paged the building saying 2nd floor nurses to come front desk, all 2nd floor nurses rushed to front desk area, upon getting there, PT (Patient) was observed sitting on the floor with her daughter holding her head. When asked what happened and the daughter said that pt (patient) was entering the building and fall hitting her head on the front desk counter resulting in head injury and was bleeding. And that EMS (emergency medical services) has been called and EMS came after about 5 min (minutes) and take the pt to the hospital. MD (medical doctor) was called and notified."	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 622	Continued From page 47 Review of the clinical record failed to evidence documentation evidencing the comprehensive care plan goals were sent with the resident to the hospital. On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated due to previous in-services, the nurses have learned that they need to document that a copy of the care plan and the bed hold policy was provided. LPN #1 stated this information should be documented in nurses' notes. Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m. On 7/11/19 at 11:00 a.m., a request was made of ASM #2 for any documentation that the care plan goals were sent with the resident when he went to the hospital on 5/27/19. At 11:45 a.m., ASM #2 stated that if she didn't give this information to this surveyor, she didn't have it. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 424. 4. The facility staff failed to provide the comprehensive care plan goals to the hospital for a facility initiated transfer for Resident #70 on	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 622	Continued From page 48 6/9/19. Resident #70 was admitted to the facility on 4/27/19. Resident #70's diagnoses included but were not limited to legal blindness, kidney disease and anxiety disorder. Resident #70's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/24/19, coded the resident's cognition as cognitively intact. The nurse note dated, 6/9/19 at 11:38 p.m. documented in part, "Patient is alert and oriented x 2. Nurse checked patients blood pressure around 6:00 p.m. is 104/46. Then nurse checked blood pressure around 8:10 p.m. is 72/37. Nurse elevated patient's legs to increase patient blood pressure. MD (medical director) called, message left. Supervisor aware of it. Supervisor notified. Order received from MD to call 911 and transfer patient to acute care hospital. Patient has been sent to Fairfax Hospital via 911. Report given to emergency room nurse and paramedic staff. Patient's sister notified for patient's condition and transfer to hospital Review of the clinical record failed to evidence documentation of the comprehensive care plan goals being sent with the resident to the hospital. On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated due to previous in-services, the nurses have learned that they need to document that a copy of the care plan and the bed hold policy was provided. LPN #1 stated this information should be documented in nurses' notes.	F 622		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 622	Continued From page 49 On 07/11/2019 at approximately 2:00 p.m., ASM #1 (administrative staff member) (the administrator), ASM #2 (the administrative director of nursing), and ASM #3 (the quality assurance consultant) were made aware of findings. No further information was presented prior to exit.	F 622		
F 623 SS=E	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of	F 623	F623 1. Residents #25 & #70 returned to the facility on 6/18/19. Resident #56 returned to the facility on 5/15/19. Resident #52 returned to the facility on 5/28/19. Resident #61 returned to the facility on 5/10/19. Resident #87 returned to the facility on 5/31/19. 2. All residents experiencing a facility-initiated transfer to the hospital have the potential to be affected. 3. Social Workers were re-educated on the requirement to provide written notification to residents or their representatives regarding all facility-initiated transfers/discharges. Social Workers have employed the use of the company-approved document *Notice of Discharge* that addresses the specific nature of a facility-initiated transfer/discharge. This document will be completed and provided to every resident or their representative at the time of the transfer/discharge, as well as a copy provided to the Local Ombudsman. Administrator/designee will monitor and audit facility-initiated transfers to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 623	Continued From page 50 this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge; (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402,	F 623	the hospital to ensure compliance with this requirement. 4. Administrator will present findings of these audits at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 623	Continued From page 51 codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide written notification of a facility-initiated transfer to the resident, resident representative and/or ombudsman for six of 57 residents in the survey sample, Residents #25, #56, #52, #61, #70 and #87. The findings include:	F 623		

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 623	Continued From page 52 1. The facility staff failed to provide written notification of transfer to Resident #25, the resident's representative and the ombudsman when the resident was transferred to the hospital on 6/16/19. Resident #25 was admitted to the facility on 2/19/19. Resident #25's diagnoses included but were not limited to diabetes, prostate cancer and urinary retention. Resident #25's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/25/19, coded the resident as being cognitively intact. Review of Resident #25's clinical record revealed the resident was transferred to the hospital on 6/16/19 for a non-responsive episode. Further review of Resident #25's clinical record failed to reveal evidence that the resident, the resident's representative and the ombudsman were provided written notification regarding the transfer. On 7/10/19 at 1:49 p.m., an interview was conducted with OSM (other staff member) #2 and OSM #3 (both social workers). OSM #2 and OSM #3 were asked if they provide written notification of hospital transfers to residents and/or their representatives. OSM #3 stated the social workers do not and she thought the nurses do. OSM #2 and OSM #3 were asked if they notify the ombudsman of resident hospital transfers. OSM #2 stated she sends faxes to the ombudsman twice a week. OSM #2 and OSM #3 were asked to provide evidence that the ombudsman was notified when Resident #25 was transferred to the hospital on 6/16/19.	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 53 On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses provide written notification of hospital transfers to residents and/or their representatives. LPN #1 stated, "No but we do put in our documentation that we were unable to manage symptoms in-house and the patient and rp (responsible party) were notified and understand." On 7/10/19 at 5:31 p.m., OSM #2 and OSM #3 confirmed they had no further information to provide. On 7/10/19 at 5:49 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern. The facility document titled, "INTERDISCIPLINARY CARE TRANSITIONS CHECKLISTS" documented, "TRANSITION FROM SKILLED NURSING FACILITY TO ACUTE CARE: Notify patient, family, and representative. Issue written notification per state specific guidelines; consult a representative from the legal department with questions. Notify ombudsman..." No further information was presented prior to exit. 2. The facility staff failed to provide written notification of transfers to Resident #56, the resident's representative and the ombudsman when the resident was transferred to the hospital on 2/7/19 and 5/11/19.	F 623		

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 623	Continued From page 54 Resident #56 was admitted to the facility on 7/12/17. Resident #56's diagnoses included but were not limited to pneumonia, heart disease and asthma. Resident #56's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/20/19, coded the resident's cognition as severely impaired. Review of Resident #56's clinical record revealed the resident was transferred to the hospital on 2/7/19 due to bloody urine and 5/11/19 due to a low oxygen level. Further review of Resident #56's clinical record failed to reveal evidence that the resident, the resident's representative and the ombudsman were provided written notification regarding the transfers. On 7/10/19 at 1:49 p.m., an interview was conducted with OSM (other staff member) #2 and OSM #3 (both social workers). OSM #2 and OSM #3 were asked if they provide written notification of hospital transfers to residents and/or their representatives. OSM #3 stated the social workers do not and she thought the nurses do. OSM #2 and OSM #3 were asked if they notify the ombudsman of resident hospital transfers. OSM #2 stated she sends faxes to the ombudsman twice a week. OSM #2 and OSM #3 were asked to provide evidence that the ombudsman was notified when Resident #56 was transferred to the hospital on 2/7/19 and 5/11/19. On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses provide written notification of hospital transfers to residents and/or their representatives. LPN #1 stated, "No	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 55	F 623		

but we do put in our documentation that we were unable to manage symptoms in-house and the patient and rp (responsible party) were notified and understand."

On 7/10/19 at 5:31 p.m., OSM #2 and OSM #3 confirmed they had no further information to provide.

On 7/10/19 at 5:49 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern.

No further information was presented prior to exit.
3. The facility staff failed to provide the resident and/or resident representative a written notice, of the reason for a facility initiated transfer to the hospital, for Resident #52 on 5/27/19.

Resident #52 was admitted to the facility on 5/22/16 with diagnoses that included but were not limited to: dementia, anxiety disorder, agitation, and glaucoma [a disease in which elevated pressure in the eye, due to obstruction of the outflow of aqueous humor, damages the optic nerve and causes visual defects (1)].

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 4/9/9, coded the resident as scoring a "6" on the BIMS (brief interview for mental status) score, indicating he is severely impaired to make daily cognitive decisions.

The physician order dated, 5/27/19, documented, "Send resident to (Name of hospital) for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 56 psychiatric evaluation RE (regarding) pushed another resident to the floor." The nurse's note dated, 5/27/19 at 8:57 p.m. documented in part, "Call placed to (name of doctor). New order received to send to (Name of hospital) for evaluation." Review of the clinical record failed to evidence that a written notification of the transfer was provided to the resident and/or resident representative. On 7/10/19 at 1:49 p.m., an interview was conducted with OSM (other staff member) #2 and OSM #3 (both social workers). OSM #2 and OSM #3 were asked if they provide written notification of hospital transfers to residents and/or their representatives. OSM #3 stated the social workers do not and she thought the nurses do. On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses provide written notification of hospital transfers to residents and/or their representatives. LPN #1 stated, "No but we do put in our documentation that we were unable to manage symptoms in-house and the patient and rp (responsible party) were notified and understand." Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m. On 7/11/19 at 11:00 a.m., a request was made of	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 57	F 623		

ASM #2 for any documentation that the resident and/or the resident representative was provided written notification when he went to the hospital on 5/27/19. At 11:45 a.m., ASM #2 stated that if she didn't give the information to this surveyor, she didn't have it.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 247.

4. The facility staff failed to provide the resident and/or resident representative a written notice, of the reason for a facility initiated transfer to the hospital, for Resident #61 on 5/10/19.

Resident #61 was admitted to the facility on 10/26/19 with diagnoses that included but were not limited to: high blood pressure, shortness of breath, gastroesophageal reflux disease [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. (1)], history of falls, and osteoporosis [abnormal loss of bony tissue, causing fragile bones that fracture easily (2)].

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/17/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #61 was coded as requiring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 623	Continued From page 58 extensive assistance on one staff member for all of her activities of daily living. The nurse's note dated, 5/10/19 at 12:49 a.m. documented in part, "At about 10 pm, a nurse paged the building saying 2nd floor nurses to come front desk, all 2nd floor nurses rushed to front desk area, upon getting there, PT (Patient) was observed sitting on the floor with her daughter holding her head. When asked what happened and the daughter said that pt (patient) was entering the building and fall hitting her head on the front desk counter resulting in head injury and was bleeding. And that EMS (emergency medical services) has been called and EMS came after about 5 min (minutes) and take the pt to the hospital. MD (medical doctor) was called and notified." Review of the clinical record failed to evidence that a written notification of the transfer was provided to the resident and/or resident representative. On 7/10/19 at 1:49 p.m., an interview was conducted with OSM (other staff member) #2 and OSM #3 (both social workers). OSM #2 and OSM #3 were asked if they provide written notification of hospital transfers to residents and/or their representatives. OSM #3 stated the social workers do not and she thought the nurses do. On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses provide written notification of hospital transfers to residents and/or their representatives. LPN #1 stated, "No but we do put in our documentation that we were	F 623		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 623	Continued From page 59	F 623		

unable to manage symptoms in-house and the patient and rp (responsible party) were notified and understand."

Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m.

On 7/11/19 at 11:00 a.m., a request was made of ASM #2 for any documentation that the resident and/or the resident representative was provided written notification when she went to the hospital on 5/10/19. At 11:45 a.m., ASM #2 stated that if she didn't give the information to this surveyor, she didn't have it.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 424.
5. Resident #70 was transferred to the hospital on 6/9/19. The facility staff failed to evidence that written notification regarding the transfer was provided to the resident, resident and/or the resident representative.

Resident #70 was admitted to the facility on 4/27/19. Resident #70's diagnoses included but were not limited to legal blindness, kidney disease and anxiety disorder. Resident #70's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/24/19, coded the resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 623	Continued From page 60 cognition as cognitively intact. Review of Resident #70's clinical record revealed the resident was transferred to the hospital on 6/9/19 for low blood pressure. Further review of Resident #70's clinical record failed to reveal documentation to evidence the resident and/or the resident representative received written notification regarding transfer to the hospital on 6/9/19. On 7/10/19 at 1:49 p.m., an interview was conducted with OSM (other staff member) #2 and OSM #3 (both social workers). OSM #2 and OSM #3 were asked if they provide written notification of hospital transfers to residents and/or their representatives. OSM #3 stated the social workers do not and she thought the nurses do. On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 was asked if nurses provide written notification of hospital transfers to residents and/or their representatives. LPN #1 stated, "No but we do put in our documentation that we were unable to manage symptoms in-house and the patient and RP (responsible party) were notified and understand." On 07/11/2019 at approximately 2:00 p.m., ASM #1 (administrative staff member) (the administrator), ASM #2 (the administrative director of nursing), and ASM #3 (the quality assurance consultant) were made aware of findings. No further information was presented prior to exit.	F 623		

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 623	Continued From page 61 6. The facility staff failed to provide written notice of transfer to Resident #87 or their responsible party at the time of transfer to the hospital. Resident #87 was admitted to the facility on 05/20/2019. Her diagnoses included hip fracture, general anxiety, and anemia (low levels of red blood cells). Resident #87's most recent Minimum Data Set (MDS) assessment was an Unscheduled Assessment with an Assessment Reference Date (ARD) of 06/19/2019. The Brief Interview for Mental Status (BIMS) scored Resident #87 at a 10, indicating moderate impairment. A review of Resident #87's record revealed a Progress Note dated 05/23/2019 at 7:21 p.m., that documented Resident #87 was transferred to the hospital on that date, 05/23/2019, following a fall. The progress note documented in part "Acute Care transfer form, care plan, labs [laboratory tests], and bed holding policy was send[sic] to ER [emergency room] and bed holding policy was discussed with Patient and RP (responsible party)." No documentation of a written notice of transfer was found. On 7/10/19 at 1:49 p.m., an interview was conducted with OSM (other staff member) #2 and OSM #3 (both social workers). OSM #2 and OSM #3 were asked if they provide written notification of hospital transfers to residents and/or their representatives. OSM #3 stated the social workers do not and she thought the nurses do. On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1.	F 623		

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F 623	Continued From page 62 LPN #1 was asked if nurses provide written notification of hospital transfers to residents and/or their representatives. LPN #1 stated, "No but we do put in our documentation that we were unable to manage symptoms in-house and the patient and rp (responsible party) were notified and understand." On 7/10/19 at 5:31 p.m., OSM #2 and OSM #3 confirmed they had no further information to provide. Administrative Staff Member (ASM) #1, the facility Administrator and ASM #2, the Director of Nursing, were informed of the findings on the morning of 07/11/2019. No further documentation was provided.	F 623		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and	F 625	F625 1. Residents #70 returned to the facility on 6/18/19. Resident #56 returned to the facility on 5/15/19. 2. All residents experiencing a facility-initiated transfer to the hospital have the potential to be affected. 3. Unit Managers/Shift Supervisors will audit facility-initiated discharges to the hospital, daily x 5 days and weekly x4 weeks, to ensure compliance with the requirement of information provided to the hospital, including a copy of the bed-hold policy, and completion of the internal document *Post Acute Care Transfer Document Checklist.* Licensed nurses on all shifts will be re-educated on the requirement of information provided to the hospital,	

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 625	Continued From page 63 (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide a written bed hold notice for a facility-initiated transfer for two of 57 residents in the survey sample, Residents #56 and #70. The findings include: 1. The facility staff failed to provide Resident #56 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 5/11/19. Resident #56 was admitted to the facility on 7/12/17. Resident #56's diagnoses included but were not limited to pneumonia, heart disease and asthma. Resident #56's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 5/20/19, coded the resident's cognition as severely impaired. Review of Resident #56's clinical record revealed the resident was transferred to the hospital on 5/11/19 due to a low oxygen level. Further review of Resident #56's clinical record (including an	F 625	to include a copy of the bed-hold policy, and completion of the internal document *Post Acute Care Transfer Document Checklist.* 4. Unit Managers or DON will report the results of audits at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

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F 625	Continued From page 64 acute care transfer form and nurses' notes) failed to reveal evidence that written notification of the bed hold policy was provided to the resident and/or the resident representative. On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated a copy of the bed hold policy is sent with residents when they are transferred to the hospital. LPN #1 stated due to previous in-services, the nurses have learned that they need to document the bed hold policy was provided. LPN #1 stated this information should be documented in nurses' notes. On 7/10/19 at 5:49 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the administrative director of nursing) and ASM #3 (the quality assurance consultant) were made aware of the above concern. The facility document titled, "INTERDISCIPLINARY CARE TRANSITIONS CHECKLISTS" documented, "TRANSITION FROM SKILLED NURSING FACILITY TO ACUTE CARE: Issue copy of bed hold policy to patient or patient representative..." No further information was presented prior to exit. 2. The facility staff failed to provide Resident #70 or the resident's representative written notification of the bed hold policy when the resident was discharged to the hospital on 6/9/19. Resident #70 was admitted to the facility on 4/27/19. Resident #70's diagnoses included but were not limited to legal blindness, kidney disease and anxiety disorder. Resident #70's	F 625		

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F 625	Continued From page 65 most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 4/24/19, coded the resident's cognition as cognitively intact. Review of Resident #70's clinical record revealed the resident was transferred to the hospital on 6/9/19 due to a low blood pressure. Further review of Resident #70's clinical record (including nurses' notes) failed to reveal evidence that written notification of the bed hold policy was provided to the resident and/or the resident representative. On 7/10/19 at 11:05 a.m., an interview was conducted with Resident #70. Resident #70 was asked if anyone had given her written notification of the bed hold policy when she was transferred to the hospital on 6/9/19. Resident #70 stated, "I don't recall receiving any paperwork regarding the bed hold policy." On 7/10/19 at 3:08 p.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated a copy of the bed hold policy is sent with residents when they are transferred to the hospital. LPN #1 stated due to previous in-services, the nurses have learned that they need to document the bed hold policy was provided. LPN #1 stated this information should be documented in nurses' notes. On 07/11/2019 at approximately 2:00 p.m., ASM #1 (administrative staff member) (the administrator), ASM #2 (the administrative director of nursing), and ASM #3 (the quality assurance consultant) were made aware of findings.	F 625		

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F 625	Continued From page 66 No further information was presented prior to exit.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments: The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to complete an accurate MDS (minimum data set) assessment for one of 57 residents in the survey sample, Resident #61. The findings included: The facility staff failed to code accurately Section C - Cognition, on the quarterly assessment, with an assessment reference date of 5/17/19. Resident #61 was admitted to the facility on 10/26/19 with diagnoses that included but were not limited to: high blood pressure, shortness of breath, gastro-esophageal reflux disease [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. (1)], history of falls, and osteoporosis [abnormal loss of bony tissue, causing fragile bones that fracture easily (2)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/17/19, coded the	F 641	F641 1. MDS Nurse opened a new MDS assessment with ARD 7/29/19 under assessment "significant correction to prior quarterly" for Resident #61, the Social Worker will complete an interview of resident and her section of the assessment. Once this has been completed MDS Nurse will complete the MDS Assessment. 2. All residents have the potential to be affected. 3. Facility MDS Nurse re-educated the Social Workers on requirements regarding the MDS-assessment process. Administrator will randomly audit social-services assessments x3 months, to determine accuracy and compliance with all requirements, addressing any identified discrepancies with the Social Workers toward resolution. 4. Administrator will present the results of these audits to the QAPI Committee meetings x 3 months for its review and consideration. 5. Compliance Date: August 13, 2019	

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F 641	Continued From page 67 resident in Section B - Hearing, Speech and Vision, as sometimes being understood and sometimes understanding others. In Section C - cognition, the resident interview was coded as not being completed due to the resident being rarely/never understood. The bottom of this section, C0500 BIMS (brief interview for mental status) score, documents, "Enter 99 if the resident was unable to complete the interview." The "Staff Interview for Mental Status" was completed and coded the resident with both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. An interview was conducted with RN (registered nurse) #3, the MDS coordinator, on 7/10/19 at 3:11 p.m. When asked who completes Section B of the MDS assessment, RN #3 stated that she does that section. When asked who completes Section C, RN #3 stated the social workers do that section. The above MDS assessment was reviewed with RN #3. RN #3 stated she wanted to talk to the social worker and get back with this surveyor. On 7/10/19 at 3:18 p.m., RN #3 and other staff member (OSM) #2, the social worker, returned. OSM #2 stated, "I attempt the interview every time. She was upset that day and wouldn't talk with me. She kept on saying, 'my heart is broken.' I re-attempted the interview and I got the same response." When asked if the resident should have been coded as rarely/never understood, OSM #2 stated, "No." When asked what reference the facility uses to complete the MDS assessments, RN #3 stated, "The RAI (resident assessment instrument) manual."	F 641		

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F 641	Continued From page 68 The RAI manual documented in part, "C0100: Should Brief Interview for Mental Status be Conducted? Code 1, yes; if the interview should be conducted because the resident is at least sometimes understood verbally, in writing, or using another method, and if an interpreter is needed, one is available...Coding Tips: Do not complete the Staff Assessment for Mental Status if the resident interview should have been conducted, but not done. Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 424.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must	F 656	F656 1. The oxygen-concentrator levels for Residents #85, #61 & #110 were 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 Supervisors will audit all residents on supplemental oxygen, 3x/week x5 weeks and weekly x4 weeks, to ensure settings	

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 656	Continued From page 69 describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to implement the comprehensive care plan for three of 57 residents in the survey sample, Residents #85, #110 and #61.	F 656	are consistent with physician order care plan for each resident. Licensed nurses on all shifts will be re-educated on the requirement to ensure O2 settings are consistent with physician orders and care plans for each resident. 4. Unit Managers or DON will report the results of audits at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

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MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 656	Continued From page 70 The findings include: 1. The facility staff failed to implement the comprehensive care plan for the use of oxygen for Resident #85. Resident #85 was admitted to the facility on 8/26/17. Resident #85's diagnoses included but were not limited to heart failure, high blood pressure and chronic pain. Resident #85's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/5/19, coded Resident #85 with no cognitive impairment. Section G coded Resident #85 as requiring extensive assistance with one to two staff members for activities of daily living. On 7/9/19 at approximately 11:45 a.m., Resident #85 was observed lying in bed watching television. Resident #85 was wearing oxygen that was being administered via nasal cannula connected to an oxygen concentrator. Resident #85's oxygen concentrator was observed with the flow meter ball sitting between 2 and 2.5 liters. This reading was observed at eye level by this surveyor. On 7/9/19 at approximately 12:45 p.m., Resident #85 was observed lying in bed watching television. Resident #85 was wearing oxygen that was being administered via nasal cannula connected to an oxygen concentrator. Resident #85's oxygen concentrator was observed with the flow meter ball sitting between 2 and 2.5 liters. This surveyor observed this reading at eye level. Review of Resident #85's clinical record revealed a physician order dated 12/5/17, which documented, "Oxygen at 2 lpm (liters per minute)	F 656		

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F 656	Continued From page 71 via nasal cannula continuously." Further review of Resident #85's care plan dated 12/5/17 documented, "Administer oxygen as ordered." On 7/11/19 at 8:48 a.m., an interview was conducted with RN #1 (registered nurse) (unit manager). RN #1 was asked what the purpose of the resident's care plan is. RN #1 stated that the care plan is what is used to let nursing staff know what the resident needs are. RN #1 was asked who is responsible for developing and implementing the care plan. RN #1 stated that the nursing team as a whole is responsible for developing and implementing the care plan for residents. RN #1 was asked how you ensure care plan interventions are in place. RN #1 stated that rounds are made to ensure that care planned interventions are in place. RN #1 was made aware of Resident #85's oxygen setting being incorrect. RN #1 stated that this is something that should've been noticed and corrected during room rounds. The facility document titled "Interdisciplinary Care Planning" documented, "The facility must develop and implement a comprehensive person-centered a care plan for each patient that includes measurable objectives and timeframes to meet a patient's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following: - In consultation with the patient and the patient's representative, - The patient's goals for admission and desired outcomes, The patient's preference and potential for future discharge, - Discharge plans in the comprehensive care plan,	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 72 as appropriate, - The services that are to be furnished to maintain the patient's highest practicable physical, mental, and psychosocial well-being, Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR (pre admission screening and annual resident review) recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the patient's medical record." On 07/11/2019 at approximately 2:00 p.m., ASM #1 (administrative staff member) (the administrator), ASM #2 (the administrative director of nursing), and ASM #3 (the quality assurance consultant) were made aware of findings. No further information was presented prior to exit. 2. The facility staff failed to implement the comprehensive care plan for the use of oxygen for Resident #110. Resident #110 was admitted to the facility on 6/14/19. Resident #110's diagnoses included but were not limited to high blood pressure, heart disease and high cholesterol. Resident #110's most recent MDS (minimum data set), a 14-day scheduled assessment with an ARD (assessment reference date) of 6/28/19, coded Resident #110 with severe cognitive impairments. Section G coded Resident #110 as requiring extensive assistance with one to two staff members for activities of daily living. On 7/9/19 at approximately 11:55 a.m., Resident #110 was observed lying in bed watching television. Resident #110 was wearing oxygen	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 656	Continued From page 73	F 656		

that was being administered via nasal cannula connected to an oxygen concentrator. Resident #110's oxygen concentrator was observed on with the flow meter ball sitting between 2 and 2.5 liters. This surveyor observed this reading at eye level.

On 7/9/19 at approximately 12:55 p.m., Resident #110 was observed lying in bed watching television. Resident #110 was wearing oxygen that was being administered via nasal cannula connected to an oxygen concentrator. Resident #110's oxygen concentrator was observed being on with the flow meter ball sitting between 2 and 2.5 liters. This surveyor observed this reading at eye level.

Review of Resident #110's clinical record revealed a physician order dated 6/15/19 which documented, "Oxygen at 2 lpm (liters per minute) via nasal cannula continuously."

Further review of Resident #110's care plan dated 6/15/19 documented, "Administer oxygen as per physician order."

On 7/11/19 at 8:48 a.m., an interview was conducted with RN #1 (registered nurse) (unit manager). RN #1 was asked what the purpose of the resident's care plan is. RN #1 stated that the care plan is what is used to let nursing staff know what the resident needs are. RN #1 was asked who is responsible for developing and implementing the care plan. RN #1 stated that the nursing team as a whole is responsible for developing and implementing the care plan for residents. RN #1 was asked how you ensure care plan interventions are in place. RN #1 stated that rounds are made to ensure that care planned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 656	Continued From page 74 interventions are in place. RN #1 was made aware of Resident #85's oxygen setting being incorrect. RN #1 stated that this is something that should've been noticed and corrected during room rounds. On 07/11/2019 at approximately 2:00 p.m., ASM #1 (administrative staff member) (the administrator), ASM #2 (the director of nursing), and ASM #3 (the quality assurance consultant) were made aware of findings. No further information was presented prior to exit. 3. The facility staff failed to implement the comprehensive care plan for the administration of oxygen to Resident #61. Resident #61 was admitted to the facility on 10/26/19 with diagnoses that included but were not limited to: high blood pressure, shortness of breath, gastroesophageal reflux disease [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. (1)], history of falls, and osteoporosis [abnormal loss of bony tissue, causing fragile bones that fracture easily) (2)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/17/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #61 was coded as requiring extensive assistance on one staff member for all of her activities of daily living. In Section O -	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 75 Special Treatments, Procedures, and Programs, coded the resident as using oxygen during the look back period. The comprehensive care plan dated, 12/3/18, documented in part, "Focus: Has/At risk for respiratory impairment related to chronic respiratory failure and SOB (shortness of breath)." The "Interventions" documented in part, "administer oxygen per MD (medical doctor) order." The physician order dated, 5/11/19, documented, "O2 (oxygen) at 4 lpm (liters per minute) via NC (nasal cannula) for SOB (shortness of breath)." Observation was made of Resident #61 on 7/9/19 at 3:44 p.m. The resident was sitting in her wheelchair with her oxygen on via the nasal cannula (a two-pronged tubing that inserts into the nose) connected to an oxygen concentrator. The oxygen concentrator was set at 4.5 liters per minute (LPM), the center of the black ball was sitting on the 4.5 LPM line. On 7/9/19 at 5:13 p.m., a second observation was made the oxygen was set at the same rate. On 7/10/19 at 9:18 a.m., an observation was made of Resident #61 the oxygen concentrator was set with the bottom of the ball sitting on the 4.0 line and the top of the ball resting just below the 4.5 line. An interview was conducted with LPN (licensed practical nurse) # 2 on 7/11/19 at 8:59 a.m. When asked the purpose of the care plan, LPN #2 stated, "It's how we take care of the patient and their needs. It has to be individualized for that patient." When asked if the oxygen isn't being administered per the physician order and the care plan documents to administer it per the physician	F 656		

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	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 656	Continued From page 76 order, is that then following the care plan, LPN #2 stated, "No." An interview was conducted with RN (registered nurse) #2 on 7/11/19 at 9:13 a.m. When asked the purpose of the care plan, RN #2 stated, "It is the nursing commitment of what we promise to do for these residents based on their needs." RN #2 was asked if the care plan documents to administer oxygen as ordered, and the oxygen is not at the physician prescribed flowrate, are the staff implementing and following the care plan, RN #2 stated, "No." Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined the facility staff failed to provide care and services per	F 658	F658 1. Upon notification by the surveyor, the identified physician order for Resident #75 was clarified. 2. All residents on insulin have the potential to be affected. 3. Unit Managers/designee will complete an audit of all residents currently on insulin, to determine any additional, physician orders requiring clarification with regards to coordination and accommodation with meal times.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 658	Continued From page 77 professional standards for one of 57 residents in the survey sample, Resident #75. The facility staff failed to clarify a physician's order for Resident #75's insulin to be given prior to meals. The findings include: Resident #75 was admitted to the facility on 5/29/19 with diagnoses that included but were not limited to: diabetes, dementia, and COPD [chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis (1)]. The most recent MDS (minimum data set), an admission assessment, with an assessment reference date of 6/5/19, coded the resident as scoring a "7" on the BIMS (brief interview for mental status) score, indicting the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring limited to extensive assistance of one staff member for her activities of daily living. Observation was made of LPN (licensed practical nurse) #2 on 7/10/19 at 10:06 a.m. LPN #2 proceeded to check Resident #75's blood sugar. The reading was 247. When asked if the resident gets any (insulin) coverage, LPN #2 stated, "Yes, she does." LPN #2 proceeded to the medication cart and drew up two units of Humalog insulin a [short acting insulin (2)]. LPN #2 then proceeded to the resident's room at 10:18 a.m. and administered the insulin to Resident #75 by injection. The physician order dated, 5/29/19, documented in part, "Humalog Solution 100 UNIT/ML	F 658	New Admissions on insulin will be clarified at time of admission to ensure coordination and accommodation with meal times. Licensed nurses will be re-educated regarding need and expectation to ensure that meals are available at time insulin is administrated. Unit Managers/designee will randomly audit residents on insulin daily x5 days then weekly x4 weeks, to determine compliance with need and expectation to have snacks readily available for residents on insulin. 4. Unit Managers will report the results of monitoring and audits at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 658	Continued From page 78	F 658		

(milliliters) inject as per sliding scale:
If (blood sugar) < (less than) 70 - call doctor
70 - 200 - give no insulin
201 - 250 = 2 units
251 - 300 = 4 units
301 - 350 = 6 units
351 - 400 = 8 units
401 - 450 = 10 units
if BS (blood sugar) > 450 call doctor
Subcutaneously before meals and at bedtime for DM (diabetes mellitus)."

The Medication Administration Record (MAR) for July 2019 documented the above physicians order. The times scheduled for the before meals and at bedtime were documented as: 6:00 a.m., 11:00 a.m. 4:00 p.m. and 9:00 p.m.

The comprehensive care plan dated, 5/30/19, documented in part, "Focus: The resident is on insulin r/t (related to) diabetes." The "Interventions" documented in part, "Educate resident/family care giver on administration of insulin. Monitor blood sugar, lab (laboratory tests) results as ordered by the physician."

The schedule of the meal cart delivery documented in part:
Breakfast - (Name of unit Resident #75 resides on) - 9:00 a.m.
Lunch - (Name of unit Resident #75 resides on) - 1:05 p.m.
Dinner - (Name of unit Resident #75 resides on) - 6:05 a.m.

Resident #75 was observed eating her lunch on 7/10/19 and took her first bite of food at 1:27 p.m. Resident #75 received her "before meals" insulin three hours prior to eating her meal and just one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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F 658	Continued From page 79	F 658		

hour and 18 minutes after being served the breakfast meal.

An interview was conducted with LPN #2 on 7/11/19 at 8:59 a.m. LPN #2 was asked when a medication prescribed as before meals should be administered. LPN #2 stated, "You follow the time on the orders and you can give it an hour before or an hour after the prescribed time." When asked what time Resident #75 ate her lunch, LPN #2 stated, "The trays come up around 1:00 p.m." LPN #2 was asked when the resident ate breakfast. LPN #2 stated they serve them around 9:00 a.m. LPN #2 was asked if the blood sugar reading she obtained was just an hour after Resident #75 had her breakfast. LPN #2 stated, "Yes, we need to contact the doctor to get the times changed."

An interview was conducted with RN (registered nurse) #2, the unit manager; on 7/11/19 at 9:13 a.m., RN #2 was asked when insulin prescribed for before meals should be administered. RN #2 stated, "Depending on the order, but before the resident actually eats. I go by the order." The above order for Humalog and the schedule of meal times was reviewed with RN #2. RN #2 stated, "That order needs to be clarified."

An interview was conducted with administrative staff member (ASM) #2, the administrative director of nursing, on 7/11/19 at 10:55 a.m. When asked what it means when an order documents to give before meals, ASM #2 stated, "It means before she eats."

According to Fundamentals of Nursing, 6th edition Potter and Perry, 2005, page 846, "A medication order is required for any medication to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 658	Continued From page 80 be administered by a nurse...If the medication order is incomplete, the nurse should inform the prescriber and ensure completeness before carrying out any medication order." Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m. On 7/11/19 at 11:14 a.m. ASM #3, the quality assurance consultant, stated the facility did not have a policy on clarifying physician orders. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124. (2) Humalog insulin a short acting insulin used to treat elevated blood sugars -Insulin lispro comes as a solution (liquid) and a suspension (liquid with particles that will settle on standing to inject subcutaneously (under the skin). Insulin lispro solution (Admelog, Humalog) is usually injected within15 minutes before a meal or immediately after a meal. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a697021.html (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 424.	F 658		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i)	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 81 § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to oxygen administration consistent with professional standards of practice, and the comprehensive person-centered care plan for 3 of 57 residents in the survey sample, Residents #85, #110 and #61. The findings include: 1. The facility staff failed to administer oxygen per the physician orders for Resident #85 Resident #85 was admitted to the facility on 8/26/17. Resident #85's diagnoses included but were not limited to heart failure, high blood pressure and chronic pain. Resident #85's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/5/19, coded Resident #85 with no cognitive impairment. Section G coded Resident #85 as requiring extensive assistance with one to two staff members for activities of daily living. On 7/9/19 at approximately 11:45 a.m., Resident #85 was observed wearing oxygen that was being administered via nasal cannula connected to an oxygen concentrator. Resident #85's oxygen	F 695	F695 1. The oxygen-concentrator levels for Residents #85, #61 & #110 were 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 Supervisors will audit all residents on supplemental oxygen, 3x/week x5 weeks and weekly x4 weeks, to ensure settings are consistent with physician order care plan for each resident. Licensed nurses on all shifts will be re-educated on the requirement to ensure O2 settings are consistent with physician orders and care plans for each resident. 4. Unit Managers or DON will report the results of audits at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 695	Continued From page 82 concentrator was observed on with the flow meter ball sitting between 2 and 2.5 liters. This surveyor observed this reading at eye level. On 7/9/19 at approximately 12:45 p.m., Resident #85 was wearing oxygen that was being administered via nasal cannula connected to an oxygen concentrator. Resident #85's oxygen concentrator was observed being on with the flow meter ball sitting between 2 and 2.5 liters. This surveyor observed this reading at eye level. Review of Resident #85's clinical record revealed a physician order dated 12/5/17 which documented, "Oxygen at 2 lpm (liters per minute) via nasal cannula continuously." Further review of Resident #85's care plan dated 12/5/17 documented, "Administer oxygen as ordered." On 7/11/19 at 8:48 a.m., an interview was conducted with RN #1 (registered nurse) (unit manager). RN #1 was asked the process for ensuring a resident's oxygen was on the correct setting. RN #1 stated, "You review the physician orders to see what the oxygen should be set at. You then go into the resident's room and get down at eye level in front of the oxygen concentrator to ensure the setting is correct. The ball should be located in the middle of the line on the setting that the physician has ordered. RN #1 was made aware that Resident #85's oxygen was being administered at the wrong rate. The user manual titled "Perfecto O2 Series" documented," Flowrate 1. Turn the flowrate knob to the setting prescribed by your physician or therapist.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 83 On 07/11/2019 at approximately 2:00 p.m., ASM #1 (administrative staff member) (the administrator), ASM #2 (the administrative director of nursing), and ASM #3 (the quality assurance consultant) were made aware of findings. No further information 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 included: Resident #110 was admitted to the facility on 6/14/19. Resident #110's diagnoses included but were not limited to high blood pressure, heart disease and high cholesterol. Resident #110's most recent MDS (minimum data set), a 14-day scheduled assessment with an ARD (assessment reference date) of 6/28/19, coded Resident #110 with severe cognitive impairments. Section G coded Resident #110 as requiring extensive assistance with one to two staff members for activities of daily living. On 7/9/19 at approximately 11:55 a.m., Resident #110 was observed wearing oxygen that was being administered via nasal cannula connected to an oxygen concentrator. Resident #110's oxygen concentrator was observed on with the flow meter ball sitting between 2 and 2.5 liters. This surveyor observed this reading at eye level. On 7/9/19 at approximately 12:55 p.m., Resident #110 was observed wearing oxygen that was being administered via nasal cannula connected	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 84	F 695		

to an oxygen concentrator. Resident #110's oxygen concentrator was observed being on with the flow meter ball sitting between 2 and 2.5 liters. This surveyor observed this reading at eye level.

Review of Resident #110's clinical record revealed a physician order dated 6/15/19 which documented, "Oxygen at 2 lpm (liters per minute) via nasal cannula continuously."

Further review of Resident #110's care plan dated 6/15/19 documented, "Administer oxygen as per physician order."

On 7/11/19 at 8:48 a.m., an interview was conducted with RN #1 (registered nurse) (unit manager). RN #1 was asked the process for ensuring a resident's oxygen was on the correct setting. RN #1 stated, "You review the physician orders to see what the oxygen should be set at. You then go into the resident's room and get down at eye level in front of the oxygen concentrator to ensure the setting is correct. The ball should be located in the middle of the line on the setting that the physician has ordered. RN #1 was made aware that Resident #110's oxygen was being administered at the wrong rate.

The user manual titled "Perfecto O2 Series" documented," Flowrate 1. Turn the flowrate knob to the setting prescribed by your physician or therapist.

On 07/11/2019 at approximately 2:00 p.m., ASM #1 (administrative staff member) (the administrator), ASM #2 (the administrative director of nursing), and ASM #3 (the quality assurance consultant) were made aware of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 85	F 695		

findings.

No further information was presented prior to exit.
3. The facility staff failed to administer oxygen per the physician orders for Resident #61.

Resident #61 was admitted to the facility on 10/26/19 with diagnoses that included but were not limited to: high blood pressure, shortness of breath, gastroesophageal reflux disease [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. (1)], history of falls, and osteoporosis [abnormal loss of bony tissue, causing fragile bones that fracture easily) (2)].

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/17/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #61 was coded as requiring extensive assistance on one staff member for all of her activities of daily living. In Section O - Special Treatments, Procedures, and Programs, coded the resident as using oxygen during the look back period.

Observation was made of Resident #61 on 7/9/19 at 3:44 p.m. The resident was sitting in her wheelchair with her oxygen on via the nasal cannula (a two pronged tubing that inserts into the nose), connected to an oxygen concentrator. The oxygen concentrator was set at 4.5 liters per minute (LPM), the center of the black ball was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 86 sitting on the 4.5 LPM line. On 7/9/19 at 5:13 p.m., a second observation was made the oxygen was set at the same rate. on 7/10/19 at 9:18 a.m., an observation was made of Resident #61 the oxygen concentrator was set with the bottom of the ball sitting on the 4.0 line and the top of the ball resting just below the 4.5 line. The physician order dated, 5/11/19, documented, "O2 (oxygen) at 4 lpm (liters per minute) via NC (nasal cannula) for SOB (shortness of breath)." The comprehensive care plan dated, 12/3/18, documented in part, "Focus: Has/At risk for respiratory impairment related to chronic respiratory failure and SOB." The "Interventions" documented in part, "administer oxygen per MD (medical doctor) order." An interview was conducted with LPN (licensed practical nurse) #2, on 7/11/19 at 8:56 a.m. When asked how to read an oxygen concentrator, LPN #2 stated, "The line has to go directly through the ball." An interview was conducted with RN (registered nurse) #2 on 7/11/19 at 9:13 a.m. RN #2 was asked how the nurses read an oxygen flowmeter. RN #2 stated, "First you get at eye level. Then you set the rate by putting the prescribed dose line through the middle of the ball." Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m. No further information was provided prior to exit.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to securely store controlled medications in two of three facility medication rooms, (first and second floor medication rooms). Refrigerated controlled medications were stored in containers not permanently affixed to the refrigerator in the first floor medication room. The Findings included:	F 761	F761 1. The refrigerator shelves on the nursing units, with the secured lockboxes attached to them for controlled medications, are attached to the frames of the refrigerator. 2. No residents were affected. 3. Unit Managers/designees will monitor and audit to ensure all controlled medications are kept in the lockboxes, all lockboxes are secured to a refrigerator shelf, and all of those shelves are attached to the inside frame of the refrigerator. 4. Unit Managers or DON will report the results of audits at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 88 An inspection of facility medication, storage rooms was conducted on the afternoon of 07/10/2019. At 5:33 p.m., the first floor medication room was inspected. During inspection, an observation was made of the secured lockbox inside the medication refrigerator used for storing controlled medications. The lockbox was clear plastic, and secured to the shelf of the refrigerator. However, the shelf itself was not attached to the frame of the refrigerator. This surveyor was able to lift the shelf out of the refrigerator. At 5:50 p.m., an inspection of the second floor medication room was conducted with Registered Nurse (RN) #2, the Unit Manager. During the inspection, an observation was made of the secured lockbox inside the medication refrigerator used for storing controlled medications. The lockbox was the same clear plastic, and secured to the shelf of the refrigerator. However, again the shelf itself was not attached to the frame of the refrigerator. This surveyor was able to lift the shelf out of the refrigerator. RN #2 stated that the shelf should be secured. Administrative Staff Member (ASM) #1, the facility Administrator, and ASM #2, the Administrative Director of Nursing, were informed of the findings on the morning of 07/11/2019. The Administrator stated, "We will have to fix that", but no further documentation was provided.	F 761		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements.	F 812	F812 1. All food items identified during survey as not being properly stored were discarded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 89 The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined that the facility staff failed to store and serve food in a sanitary manner. 1. The facility staff failed to document an open date on an open gallon of coleslaw dressing and Italian dressing in the walk-in refrigerator and available for use. In addition, the staff failed to ensure a quart carton of pre-thickened milk in the walk-in refrigerator was covered and not open to air. 2. The facility staff failed to ensure a flour scoop was not stored inside the flour bin. 3. The facility staff failed to ensure clean shallow pans were not wet nesting.	F 812	2. All residents have the potential to be affected. 3. All Food-Services Staff were re-educated by Food Services Director (FSD) on proper Food Storage & Labeling, Scoop Usage, Pan & Small-wares Drying, Cleaning of Mixer and Meat Slicer and Use of Hair Restraints. Related Policies and Procedures reviewed as well as posted for quick reference by staff. FSD or Assistant FSD will monitor and audit these practices to ensure compliance. These audits will be completed 3x/week for 4 weeks. 4. FSD or Assistant FSD will present results of all kitchen audits and inspections at the monthly QAPI Committee meetings x 3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 90 4. The facility staff failed to ensure a mixer and meat slicer that were ready for use, were cleaned and free from food debris. 5. The facility staff failed to cover facial hair while preparing and serving food. The findings include: 1. The facility staff failed to document an open date on an open gallon of coleslaw dressing and Italian dressing in the walk-in refrigerator and available for use. In addition, the staff failed to ensure a quart carton of pre-thickened milk in the walk-in refrigerator was covered and not open to air. On 07/09/19 at 11:15 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) # 8, assistant dietary manager. An observation of the walk-in refrigerator revealed a one-gallon container of coleslaw dressing and a gallon container of Italian dressing sitting on the middle shelf in the back of the walk-in refrigerator. Observation of the gallon container of coleslaw dressing and the Italian dressing revealed they were open and approximately two-thirds of the coleslaw dressing remained in the gallon container and approximately one-quarter of Italian dressing remained in the gallon container. Further observation of the gallon containers of coleslaw dressing and Italian dressing failed to evidence an open date. Further observation of the walk-in refrigerator revealed a one-quart carton of thickened milk sitting on the middle shelf on the right side of the walk-in refrigerator. Observation of the quart carton revealed the screw top was missing, exposing the milk to the open air and potential	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 91 contamination. Further observation revealed there was approximately half a quart of milk remaining in the carton. On 07/10/19 at 4:45 p.m., an interview was conducted with OSM # 10, dietary manager. When asked to describe the process of storing opened food OSM # 10 stated it should be dated when it is opened. When informed of the opened quart carton of thickened milk stated OSM # 10 that it should have been covered. 2. The facility staff failed to ensure a flour scoop was not stored inside the flour bin. Observation of the facility's dry storage room of the facility's kitchen revealed a twenty-two quart, clear plastic dry storage bin on the bottom self of a food storage-shelving unit. Observation of the dry storage bin revealed approximately six cups of flour in the bin. Further observation of the dry storage bin revealed a plastic scoop resting in the flour on the inside of the storage bin. On 07/10/19 at 4:45 p.m., an interview was conducted with OSM # 10, dietary manager. When informed of the scoop observed being stored in the flour OSM # 10 stated that it should have been stored separately from the flour and it could be an infection issue. The facility's policy "Food Storage" documented, "Guidelines. 6. Store flour, sugar and similar foods in air tight containers with the handle of scoops out of the food product." 3. The facility staff failed to ensure clean shallow pans were not wet nesting.	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 92 Observation of the of the drying rack next to the three compartment sink in the facility's kitchen revealed three, four inch deep shallow pans stacked together, each one inside the other. Further observation of the pans revealed they were stored wet. OSM # 8 stated that they should have been dried before being stacked together. On 07/10/19 at 4:45 p.m., an interview was conducted with OSM # 10, dietary manager. When informed of the wet nesting pans flour OSM # 10 stated that they should have been dried before being stacked together. The facility's policy "Cleaning Procedure - Pots and Pans" documented. "Guidelines. 7. Remove from sanitizing sink. Invert to drain. Air dry. Pans may be stacked once completely dry." 4. The facility staff failed to ensure a mixer and meat slicer that were ready for use, were cleaned and free from food debris. Observation of the mixer revealed it was sitting on a food preparation table covered with a plastic bag. When asked if the mixer was clean and ready for use, OSM # 8 stated yes. After OSM # 8 removed, the plastic bag from the mixer an observation of the mixer revealed food debris splattered on the neck of mixer, behind and above the mixing bowl. When asked if the mixer was clean OSM # 8 stated no. Observation of the meat slicer revealed it was sitting on a food preparation table covered with a plastic bag. When asked if the meat slicer was clean and ready for use, OSM # 8 stated yes. After, OSM # 8 removed the plastic bag from the	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 93	F 812		

meat slicer. An observation of the meat slicer revealed food debris on the meat grip, which was attached to the sled. This surveyor ran his fingers across the meat grip and it left a greasy residue on his fingers. OSM # 8 was asked to run her fingers across the meat grip and when asked if the meat slicer was clean, OSM # 8 stated no.

On 07/10/19 at 4:45 p.m., an interview was conducted with OSM # 10, dietary manager. When informed of food debris found on the mixer and meat slicer after being informed that they were clean and ready for use OSM # 10 stated that they should have been clean and that they clean them after every use.

The facility's policy "Cleaning Procedure - Mixer" documented, "Guidelines. 4. Scrub all stationary parts of the mixer using detergent solution. Give special attention to: underside of head, corners, cord, handles, underneath, rolled rims, switches, and walls around area."

The facility's policy "Cleaning Procedure - Slicer" documented, "Guidelines. 3. Dismantle slicer and take removable parts to ware washing area. Wash in hot water, rinse and sanitize."

5. The facility staff failed to cover facial hair while preparing and serving food.

On 07/09/19 at 11:58 a.m., food temperatures were taken in the facility's kitchen with OSM # 9, the cook, prior to the staff serving lunch. OSM # 9 had been observed preparing food items to be served, setting up the steam table and taking the temperatures of eleven different food items to be served with this surveyor. Observation of OSM #

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 94 9 revealed he had a mustache and it was not covered. On 07/11/19 at 11:45 a.m., an interview was conducted with OSM # 13, food service director. When informed of OSM # 9 not having his mustache covered while preparing and serving food OSM # 13 stated, 'Beard and mustaches should be covered, it's out policy." The facility's policy "Hair Restraints" documented, "1. Hair restraints are worn by anyone in the kitchen. 5. Hair restraints include: beard or facial hair coverings." On 07/11/19 at approximately 12:05 p.m., ASM # 1 (administrative staff member), administrator, ASM # 2, director of nursing and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit.	F 812		
F 814 SS=C	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined that the facility staff failed to maintain the dumpster area in a sanitary manner. The findings include: The facility staff failed to maintain the area around the dumpsters free of trash. Several large pieces of used, wet cardboard were observed	F 814	F814 1. The pieces of cardboard identified on the ground in front of one of the trash dumpsters were picked up and placed in the dumpster during survey. 2. No residents were affected. 3. Housekeeping and Dietary Staff were in-serviced on the requirement and regulation to dispose of garbage and refuse properly. Housekeeping Supervisor or their designee will inspect the dumpster area on a daily basis to ensure all garbage and trash are being disposed of properly, i.e., no trash or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 814	Continued From page 95 lying on the ground in front of one of the trash dumpsters and in front of the cardboard recycling dumpster. On 07/09/19 at approximately 12:00 p.m., an observation of the facility dumpsters was conducted with OSM (other staff member) # 8, assistant dietary manager. An observation revealed the facility had two trash dumpster's and one cardboard recycling dumpster located behind the facility. Observations of the area around the three dumpsters revealed several large pieces of used, wet cardboard lying on the ground in front of one of the trash dumpsters and in front of the cardboard recycling dumpster. When asked who was responsible for ensuring the dumpster area was kept clean OSM # 8 stated that it was the maintenance department. On 07/10/19 at approximately 3:30 p.m., a telephone interview was conducted with OSM # 4, maintenance assistant. When asked who was responsible for maintaining the dumpster area OSM # 4 stated that the maintenance department was and that the dumpster area should be checked daily. On 07/11/19 at approximately 2:30 p.m., ASM # 1 (administrative staff member), administrator, ASM # 2, director of nursing and ASM # 3, quality assurance consultant, were made aware of the findings. No further information was provided prior to exit.	F 814	garbage on the ground, initiating any needed corrective action in a timely manner. 4. Housekeeping Supervisor will report findings of these inspections at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 96 §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F 880	F880 1. Upon notification by surveyor, the oxygen tubing for Resident #61 was replaced. 2. All residents have the potential for to be affected. 3. Unit Managers/Shift Supervisors will conduct room rounds to determine any issues with oxygen tubing not being properly maintained in a sanitary manner. Licenses nurses and CNAs re-educated on the requirement to ensure oxygen tubing is maintained in a sanitary and safe manner at all times. Unit Managers/Shift Supervisor will conduct random audits of resident receiving supplemental oxygen to determine ongoing compliance with maintaining tubing in a sanitary and safe manner. 4. Unit Managers will report the results of audits at the monthly QAPI Committee meetings x3 months for its review and recommendations. 5. Compliance Date: August 13, 2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 07/11/2019

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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 97 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined the facility staff failed to administer oxygen in a sanitary manner for one of 57 residents in the survey sample, Resident #61. The facility staff failed to maintain infection control practices while administering oxygen to Resident #61. The findings include:	F 880		

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F 880	Continued From page 98 Resident #61 was admitted to the facility on 10/26/19 with diagnoses that included but were not limited to: high blood pressure, shortness of breath, gastroesophageal reflux disease [backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn. (1)], history of falls, and osteoporosis [abnormal loss of bony tissue, causing fragile bones that fracture easily (2)]. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 5/17/19, coded the resident as having both short and long-term memory difficulties. The resident was coded as being severely impaired to make daily cognitive decisions. Resident #61 was coded as requiring extensive assistance on one staff member for all of her activities of daily living. In Section O - Special Treatments, Procedures, and Programs, coded the resident as using oxygen during the look back period. An observation was made of Resident #61 on 7/10/19 at 9:18 a.m. The CNA (certified nursing assistant) had just gotten the resident up into her wheelchair. The oxygen tubing, with the nasal cannula, was observed on the floor behind the wheelchair. The CNA picked the oxygen tubing up off the floor and placed it on Resident #61. She then left the room. An interview was conducted with CNA #2 on 7/11/19 at 8:56 a.m. When asked about the process staff follows when oxygen tubing falls on	F 880		

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F 880	Continued From page 99 the floor, CNA #2 stated, "If it's on the floor we have to get another one or tell the nurse to get another one." An interview was conducted with LPN #2 on 7/11/19 at 8:59 a.m. When asked if is acceptable for a staff member to apply oxygen tubing to a resident that has been on the floor, LPN #2 stated, "No, it has to be changed immediately. That's an infection control issue." The facility policy, "Oxygen Administration" failed to evidence guidance as to what to do if the tubing is found on the floor. Administrative staff member (ASM) #1, the administrator, ASM #2, the administrative director of nursing, and ASM #3, the quality assurance consultant, were made aware of the above concern on 7/11/19 at 10:50 a.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 424.	F 880		
F 947 SS=E	Required In-Service Training for Nurse Aides CFR(s): 483.95(g)(1)-(4) §483.95(g) Required in-service training for nurse aides. In-service training must- §483.95(g)(1) Be sufficient to ensure the continuing competence of nurse aides, but must	F 947	F947 1. The required 12 hours of annual training will be completed by August 5, 2019, for the four (4) CNAs identified during the survey as being deficient in one or more areas of training. 2. All residents have the potential to be affected.	

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F 947	Continued From page 100 be no less than 12 hours per year. §483.95(g)(2) Include dementia management training and resident abuse prevention training. §483.95(g)(3) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment at § 483.70(e) and may address the special needs of residents as determined by the facility staff. §483.95(g)(4) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on staff interview and employee record review it was determined that the facility staff failed to ensure that four of six, CNA (certified nursing assistant) records reviewed received the required 12 hours of annual training's. The findings include: On 07/11/19, a review was conducted of the annual training's of six CNAs. This review revealed the following missing data: There was no evidence of 12 hours of annual training for CNA #3, CNA #4, CNA #5 and CNA #6. On 07/11/19 at 12:05 p.m., an interview was conducted with ASM (administrative staff member) # 2, the director of nursing, during the end of the day meeting with ASM # 1, administrator and ASM # 3, quality assurance consultant present. After reviewing, the facility training hour's sheets for CNAs # 3, #4, # 5 and #6, ASM # 2 was asked about the 12 hours of required training. ASM # 2 stated, "They're	F 947	3. The balance of CNA employee files will be reviewed, to determine any need for additional hours of required, annual training. Failure by any identified CNA to complete all required training by the compliance date will result in being removed from the work schedule until all required training has been completed. Human Resources Director (HRD) will communicate this requirement to newly-hired CNAs during initial orientation, will conduct a quarterly review of CNA files to determine in-service status and ensure that all required training and in-services are completed by the employees' anniversary date-of-hire. 4. Along with other employee-related reports and data, HRD will present findings and status of required annual training at the monthly QAPI Committee meetings for their review and recommendations. 5. Compliance date: August 13, 2019	

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F 947	Continued From page 101 (CNAs) are assigned mandatory training on the computer system and it is reviewed quarterly to make sure the training is done." No further information was provided.	F 947		

State of Virginia

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F 000	Initial Comments 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. The census in this 155 certified bed facility was 113 at the time of the survey. The survey sample consisted of 50 current Resident reviews and 7 closed record reviews.	F 000		
F 001	Non Compliance The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: 12 VAC 5 - 371 - 250 G Cross references to Federal deficiency 558 12 VAC 5 - 371 - 370 A, G Cross references to Federal Deficiency 584 12 VAC 5 - 371 - 250 A - 3 Cross references to Federal Deficiency 641 12 VAC 5 - 371 - 200 B 1 Cross references to Federal Deficiency 658 12 VAC 5 - 371 - 180 A Cross references to Federal Defciency 880 Management & Administration 12VAC5-371-110 B2,3,C cross reference to F609 Staff Developement and Inservice Training 12VAC5-371-260 F cross reference to F947 12 VAC 5-371-220 (D), Cross reference to F695 12 VAC 5-371-250 (G), Cross reference to F656	F 001	See PoC for F 558 on CMS-2567 See PoC for F 584 on CMS-2567 See PoC for F 641 on CMS-2567 See PoC for F 658 on CMS-2567 See PoC for F 880 on CMS-2567 See PoC for F 609 on CMS-2567 See PoC for F 947 on CMS-2567 See PoC for F 695 on CMS-2567 See PoC for F 656 on CMS-2567	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
	Administrator	July 31, 2019