(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495038

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PRINTED: 03/10/2021 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

08/25/2020

		IVIA	NASSAS, VA 20109	
(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) COMPLETIO DATE
E 000	Initial Comments	E 000		
F 000	An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted onsite on 08/25/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. INITIAL COMMENTS	F 000		
	An unannounced COVID-19 Focused Survey was conducted onsite on 08/25/2020. Corrections are required for compliance with F-880 of 42 CFR Part 483 Federal Long Term Care requirement(s).			
F 880	On 08/25/2020, the census in this 120 certified bed facility was 104. Of the 104 current residents, one resident and one staff member had tested positive for the COVID-19 virus. The survey sample consisted of five current resident reviews (Residents #1 through #5). Infection Prevention & Control	F 880		9/21/20
SS=E		1 000		3/21/20
	§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			
	Y DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE	(X6) DATE
Electror	nically Signed			09/05/20

(X2) MULTIPLE CONSTRUCTION

A. BUILDING

B. WING

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

program participation.

Event ID: B2B311

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

Facility ID: VA0003

If continuation sheet Page 1 of 27

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		NO ANTHONORMOUS COM	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
		495038	B. WING_		08	/25/2020
	PROVIDER OR SUPPLIE			STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109	DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 880	and communicable staff, volunteers, providing services arrangement bas conducted accord accepted national §483.80(a)(2) Wr procedures for the but are not limited (i) A system of surpossible communifications before persons in the fact (ii) When and to communicable direported; (iii) Standard and to be followed to (iv) When and how resident; includin (A) The type and depending upon involved, and (B) A requirement least restrictive procircumstances. (v) The circumstances. (v) The circumstances will transiculation (in the contact with resident will transiculation (vi) The hand hygology staff involved §483.80(a)(4) A sidentified under the contact will transiculation (vi) The hand hygology staff involved §483.80(a)(4) A sidentified under the contact will transiculation (vi) The hand hygology staff involved §483.80(a)(4) A sidentified under the contact will transiculation (vi) The hand hygology staff involved §483.80(a)(4) A sidentified under the contact will transiculation (vi) The hand hygology staff involved §483.80(a)(4) A sidentified under the contact will transiculation (vi) The hand hygology staff involved §483.80(a)(4) A sidentified under the contact will transiculate the contact will tr	le diseases for all residents, visitors, and other individuals sunder a contractual ed upon the facility assessment ding to §483.70(e) and following I standards; litten standards, policies, and e program, which must include, doctoriveillance designed to identify nicable diseases or they can spread to other	F 88	30		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The real residence of the second	LE CONSTRUCTION		E SURVEY PLETED
		495038	B. WING		08/2	25/2020
	PROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	§483.80(e) Linens. Personnel must ha transport linens so infection.  §483.80(f) Annual The facility will con IPCP and update to This REQUIREMED by:  Based on observations and determined that facility interview and determined that facility interview and determined that facility interview and #5, all of whore under contact precensure appropriate equipment], donning the rooms and pro Resident(s) #1, #2 were under contact.  The findings included the diagnoses that Alzheimer's disease obstructive pulmor The most recent Machine and proceed as being semake daily life decoded as requiring semake daily life decoded as requiring semake daily life decoded as requiring the most requiring semake daily life decoded as requiring semake daily life decoded as requiring the semantic s	andle, store, process, and as to prevent the spread of review. duct an annual review of its heir program, as necessary. NT is not met as evidenced ation, clinical record review, facility document review, it was cility staff failed to implement actices to prevent the spread disease for five of 27 residents ble, Residents #1, #2, #3, #4, in were identified as being fautions. The facility staff failed a PPE [personal protective and of gloves prior to entering viding feeding assistance to, , #3, #4, and #5, all of whom at precautions.	F 880	1. Both staff were provided educat regarding transmission based precand glove use during meals. 2. Any resident requiring assistance meals has the potential to be affect staff do not follow transmission bas precautions. 3. DON or designee will provide ed to staff to wear gloves while provid assistance with meals to residents transmission based precautions. 4. DON or designee will conduct observational rounding during mea ensure that staff are wearing glove providing assistance with meals to residents on transmission based precautions daily for five days, we three weeks and monthly for two means to the conduct of	e with ted if sed ucation ing on ls to s while	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION		TE SURVEY MPLETED
		495038	B. WING		08	/25/2020
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109			
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F 880	activities of daily li On 08/25/2020 at revealed Resident breakfast. Furthe [certified nursing a Resident # 1's bec Observation of CN protective equipm a face mask gogg observation failed gloves. Observat # 1's room revealed door that docume PRECAUTIONS hands, including bleaving the room. MUST ALSO: Put Discard gloves before room entry exit. Do not wear the care of more for disposable equipment or disposable equipment person. U.S. Dep Services. Centers Prevention."  A review of the corevealed one date risk for COVID-19 understand recon and control approsocial distancing, cognitive deficits. following interven 8/24/20. "Staff to supervise/Que/Er	9:12 a.m., an observation that 1 in their bed having robservation revealed CNA assistant] # 2 was seated at diside feeding the resident. NA# 2's PPE [personal ent] revealed they were wearing alles and gown. Further to evidence CNA# 2 wearing ion of the entrance to Resident ent a sign posted next to the inted, "STOP. CONTACT EVERYONE MUST: Clean their personal entering and when PROVIDERS AND STAFF on gloves before room entry. For entering and when PROVIDERS and gown before room the same gown and gloves for than one person. Use dedicated a inpment. Clean and disinfect ent before use on another partment of Health and Human is for Disease Control and imprehensive care plan and disinfect entering and the entering and the entering and the entering in the entering and the entering in the enteri	F 880			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING		08/25/2020		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE. DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 880	A review of the cli laboratory result of documented the result of the cliphysician's order Isolation every shadeling and the review of the nurclinical record from COVID-19 monitoridentified why this Precautions for Cexposed since be a review of the "Cexposed since be a review of the resident was non-and would take it a sign poster with a sign poster stated, "A gown in gloves." When a 1 with their break wearing a mask a gloves." When a wear all of the co "Because of the vertical the patient describe what was resident # 1's round the review of the vertical the review of the ve	nical record revealed a dated 7/22/20 which resident had tested negative for cOVID-19).  nical record revealed a dated 8/24/20 for "Contact ift for COVID-19 precautions."  rese's notes in Resident #1's m 8/18/20 to 8/24/20, revealed oring occurring, however none is resident required Contact OVID-19 (i.e. was the resident ing tested, etc.)  cOVID-19/Coronavirus Daily that was completed at least /18/20 to 8/24/20 revealed in the ion on many of them that the compliant with wearing a mask	F 88				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED			
		495038	B. WING _		08	/25/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		4	
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F 880	been wearing glove precautions, CNA  On 08/25/2020 at conducted with LF 2. When asked to worn by staff when that is under contagoggles, gown and asked why it was follow the approprentering a resident precautions, LPN spread of infection observation, LPN should've followed On 08/25/2020 at conducted with RI [assistant director coordinator. When following the direct posted on the contact preventage of the posted on the contact preventages. When asked the sign for contact precautions, CNA and the sign for contact precautions, CNA a	en asked if they should have ves if a resident is under contact	F 88				
	spread of infection	n." When asked if staff are  ng the use of PPE under contact					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 4	LE CONSTRUCTION		TE SURVEY MPLETED
		495038	B. WING		08	3/25/2020
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 8575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 880	precautions, RN # education and the about once a wee or any member of informed of the about that the staff [CNA gloves. RN # 1 w documentation of education/in-servi #2.  The facility's "IN-S FORM" dated "7/1 Residents face magerial PPE." Under it documented CN On 08/25/2020 at interview was con [assistant director coordinator. Whe under contact preresident who resident with the resident contact with the residents of organisms, sontact with the resident contact Precisions of organis direct resident contact Precisions. Glove equipment. Precautions: Glove precisions of the precision of the p	1 stated, "There's an initial n there's ongoing education k and spot checking by myself the leadership." When bove observation, RN # 1 stated [A #2] should have been wearing as asked to provide the most recent ce for the use of PPE for CNA [BERVICEATTENDANCE] [3/20" documented, "Topic: ask and social distancing & er "Print Name" and "Signature"	F 880			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second resemble to	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING		08	/25/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Standard Precaut are worn when proclothing, toileting, etc.) to residents Wear gloves whe intact skin or surfaresident (e.g. med gloves upon entry Gloves should als potentially contamnesistant organism as bedside tables bathroom fixtures suctions and oxygicare for residents having contact with contain high condition (fecal material or gloves is not a surfaces will be repleaving the reside with soap and waw will be used. After hygiene, staff shout touch potentially contained to the surfaces or items transfer of microcenvironments."  On 08/25/2020 at [administrative stawas informed of the surfaces:  [1] A brain disorder person's ability to	pions, clean, non-sterile gloves oviding direct care (changing, bathing, dressing changes, on Contact Precautions. 2. never touching the resident's aces and articles near the dical equipment, bed rails). Don into the room or cubicle. 3. so be worn when handling items hinated by MDROs [multi-drug ms]. This includes items such a over-bed tables, bed rails, a television and bed controls, gen tubing. 4. During providing a gloves will be changed after the infective material that may be entrations of microorganisms wound drainage). 5. Wearing bestitute for hand antisepsis. In moved and discarded before ent's room, hands will be washed the or waterless hand antiseptic that the resident's room to avoid contaminated environmental in the resident's room to avoid organisms to other residents or a carry out daily activities). This obtained from the website:	F 8	80			

A. BUILDING	9
495038 B. WING	08/25/2020
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER  STREET ADDRESS, C 8575 RIXLEW LANE MANASSAS, VA	CITY, STATE, ZIP CODE E
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COF	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)  (X5) COMPLETION DATE
F 880 Continued From page 8 https://www.nlm.nih.gov/medlineplus/alzheimersdi sease.html.  [2] Disease that makes it difficult to breath that can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.  2. Resident #2 was admitted to the facility with the diagnoses that included but not limited to liver disease, Alzheimer's disease [1], high blood pressure, and peripheral vascular disease [2]. The significant change MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 6/21/20 coded the resident as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive assistance for dressing and total care for all other areas of activities of daily living, including eating.  On 08/25/2020 at 9:16 a.m., observation revealed Resident # 2 in bed with their breakfast tray on the over the bed table. Further observation revealed CNA [certified nursing assistant] # 3 was seated at Resident # 2's bed side offering/ holding a cup of orange juice in front of Resident # 2. After several attempts Resident # 2 refused the juice, CNA # 3 placed the cup on the breakfast tray and got up from their chair. Observation of CNA # 3's PPE [personal protective equipment] revealed they were wearing a face mask, face shield, and gown. Further observation failed to evidence CNA # 3 wearing gloves. Observation of the entrance to Resident # 2's room revealed a sign posted next to the door that documented, "STOP. CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when	

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMPLETED			
		495038	B. WING _		08	3/25/2020
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	leaving the room. MUST ALSO: Put Discard gloves be before room entry exit. Do not wear the care of more or disposable equ reusable equipme person. U.S. Dep Services. Centers Prevention."  A review of Resid plan revealed one at risk for COVID understand recon and control appro social distancing, cognitive deficits. following interven 8/24/20. "Staff to supervise/Que/Er (Infection Control  A review of the cli laboratory result of documented the in "SARS-CoV-2" (Co A review of the cl physician's order Isolation every sh  Review of nurse's record from 8/18/ COVID-19 monito identified why this	PROVIDERS AND STAFF on gloves before room entry. Fore room exit. Put on gown in Discard gown before room the same gown and gloves for than one person. Use dedicated in the same gown and disinfect ent before use on another partment of Health and Human is for Disease Control and the ent #2's comprehensive care in the dated 7/16/20 for "Resident is 19 exposure due to inability to mended infection prevention aches (e.g. use of face mask, handwashing, etc.) related to "This care plan included the tions: "Contact Isolation" dated incourage/Assist resident with IC compliance" dated 7/16/20. Inical record revealed a dated 7/22/20 which resident had tested negative for COVID-19).  Inical record revealed a dated 8/24/20 for "Contact ift for COVID-19 precautions."  In notes in Resident #2's clinical 20 to 8/24/20 revealed oring occurring, however none is resident required Contact COVID-19 (i.e. was the resident coverage).	F 88			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495038	B. WING		08/25/2020		
	PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		E		
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F 880	A review of the "C Evaluation" form twice daily from 8 "comments" section resident was non-and would take it.  On 08/25/2020 at conducted with C PPE that should the room of a reswith a sign poster stated, "A gown, and gloves " Wh. Resident # 2 with yes. When asked wearing gloves work, CNA # 3 st was important to # 3 stated, "To provide the room of the properties of the	COVID-19/Coronavirus Daily that was completed at least /18/20 to 8/24/20 revealed in the on on many of them that the compliant with wearing a mask	F 880				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 38 8	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 880	coordinator. When following the direct posted on the contitute residents' doordebating between sign says." When were maintaining s stated, "To prevent asked if it possible droplets from a resassistance without yes. When asked it the sign for contact yes. When asked the contact precauresident's room, RI spread of infection educated regarding precautions, RN # education and ther about once a week or any member of informed of the about once a week or any member of informed of the about the staff should RN # 1 was asked the most recent ed of PPE for CNA #3  The facility's "IN-SI FORM" dated "7/13 Residents face ma [and] PPE." Under it documented CNA On 08/25/2020 at interview was conclassistant director coordinator. When	asked if staff should be cons and recommendations act precaution signs outside is, RN # 1 stated, "We are resident dignity and what the asked why staff and residents ocial distancing, RN # 1 contact with droplets." When to come into contact with the ident while providing feeding wearing gloves, RN # 1 stated if the staff should be following precautions, RN # 1 stated why it was important to follow tions when entering a N # 1 stated, "To prevent the "When asked if staff are githe use of PPE under contact 1 stated, "There's an initial at there's ongoing education and spot checking by myself the leadership." When ove observation RN # 1 stated do have been wearing gloves. To provide documentation of ucation/in-service for the use of the leadership. The service for the use of the leadership of the leadership. The stated documentation of ucation/in-service for the use of the leadership. The stated documentation of ucation/in-service for the use of the leadership. The stated documentation of ucation/in-service for the use of the leadership when the leadersh	F 880			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N 42	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
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F 880	resident who residunit], had tested p On 08/25/2020 at [administrative stawas informed of the last of	ded on the same unit, [name of cositive for COVID-19.  11:23 a.m., ASM aff member] # 1, administrator, ne above findings.  ation was provided prior to exit.  That seriously affects a carry out daily activities) This btained from the website: ih.gov/medlineplus/alzheimersdiesystem is the body's network of includes the arteries, veins and arry blood to and from the heart. The thick and stiff, a problem cosis. Blood clots can clog to blood flow to the heart or brain. The vessels can burst, causing e body.) This information was	F 880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	Market Market Land	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 880	limited assistance.  A review of the conrevealed one datedrisk for COVID-19 understand recommand control approasocial distancing, hogoritive deficits." following interventis supervise/Que/End (Infection Control) care plan for "(Resfor ADL assistance intervention, dated - COVID-19 precauton 08/25/2020 at State (Resident # 3 in bedobservation reveal assistant] # 2 was bedside feeding the CNA # 2's PPE [perevealed they were and gown. Further CNA # 2 wearing gentrance to Reside posted next to the CONTACT PRECACIE Clean their hands, when leaving the restance of the care dedicated or dispodisinfect reusable of the care dedi	inprehensive care plan d 7/16/20 for "Resident is at exposure due to inability to mended infection prevention ches (e.g. use of face mask, andwashing, etc.) related to This care plan included the on: "Staff to courage/Assist resident with IC compliance" dated 7/16/20. A ident) demonstrates the need "dated 12/23/19, included the 8/3/20 for "Contact Precaution"	F 88	30			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The same of the sa	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 880	Human Services. and Prevention."  A review of the cli laboratory result of the resident had to "SARS-CoV-2" (Complysician's order Isolation every should be served from 8/18/COVID-19 monitorial identified why this Precautions for Coexposed since be a review of the "Comments" sective and would take it to 10 08/25/2020 and 10 08/25/2020 an	centers for Disease Control  inical record revealed a dated 8/4/20 which documented ested negative for COVID-19).  inical record revealed a dated 8/24/20 for "Contact ift for COVID-19 precautions."  in notes in Resident #3's clinical 20 to 8/24/20 revealed oring occurring, however none is resident required Contact cOVID-19 (i.e. was the resident eing tested, etc.)  COVID-19/Coronavirus Daily that was completed at least in 18/20 to 8/24/20 revealed in the ion on many of them that the compliant with wearing a mask	F8	80			

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	S. Chinamatha	2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING			0:	8/25/2020
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	HAB CENTER		STREET ADDRES 8575 RIXLEW L MANASSAS, Y			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH	OVIDER'S PLAN OF CORRECTIVE ACTION SHO REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 880	describe what was Resident # 1's room gloves a gown a marked shield." When been wearing glove contact precautions.  On 08/25/2020 at 1 conducted with LP1 2. When asked to worn by staff when that is under contact goggles, gown and asked why it was in follow the appropriate entering a residency precautions LPN # spread of infection. observation LPN # should've followed  On 08/25/2020 at 1 conducted with RN [assistant director coordinator. When following the direct posted on the contact the residents' doors debating between r sign says." When were maintaining s stated, "To prevent asked if it possible droplets from a resassistance without yes. When asked if the sign for contact yes.	on the sign outside the door of in, CNA # 2 stated, "To wear ask and wear the goggles or a in asked if they should have as if the resident is under as CNA # 2 stated yes.  1:00 a.m., an interview was in licensed practical nurse] # describe what PPE should be entering a residence room at precautions LPN # 2 stated mask and gloves. When I important to wear gloves and atte contact precautions when are room under contact 2 stated, "To prevent the "When informed of the above 2 stated, "They [CNA #2] the sign and wore gloves."  1:10 a.m., an interview was [registered nurse] # 1, ADON of nursing] and infection control in asked if staff should be shown and recommendations and recommendations and recommendations and recommendations are precaution signs outside as, RN # 1 stated, "We are resident dignity and what the asked why staff and residents ocial distancing, RN # 1 contact with droplets." When to come into contact with the ident while providing feeding wearing gloves, RN # 1 stated if the staff should be following the precautions, RN # 1 stated why it was important to follow the staff should be following the precautions, RN # 1 stated why it was important to follow the staff should be following the precautions, RN # 1 stated why it was important to follow the staff should be followed the staff should be staff should be staff should	F 8	80			

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495038	B. WING _	3	01	3/25/2020
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 880	resident's room, R spread of infection educated regardin precautions, RN # education and the about once a weel or any member of informed of the ab that the staff shou RN # 1 was asked the most recent ed of PPE for CNA #2  The facility's "IN-SFORM" dated "7/1 Residents face ma [and] PPE." Unde it documented CN  On 08/25/2020 at interview was conclassistant director coordinator. Whe under contact precedent who resident who residently, had tested por On 08/25/2020 at [administrative stawas informed of the No further information of the contact precedent was informed on the contact precedent was informed of the contact precedent was informed was informed on the contact precedent was informed was informed of the contact precedent was informed was infor	IN # 1 stated, "To prevent the n." When asked if staff are g the use of PPE under contact 1 stated, "There's an initial in there's ongoing education is and spot checking by myself the leadership." When love observation RN # 1 stated id have been wearing gloves. It to provide documentation of ducation/in-service for the use 2.  SERVICEATTENDANCE 3/20" documented, "Topic: lask and social distancing & last and "Signature" A #2's name.  1:26 p.m., a telephone ducted with RN # 1, ADON of nursing and infection control in asked why Resident # 3 was cautions, RN # 1 stated that a led on the same unit, [name of lositive for COVID-19.  11:23 a.m., ASM aff member] # 1, administrator, the above findings.  ation was provided prior to exit.  function that occurs with certain is memory, thinking, language, thavior. This information was	F 88	30		

AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION  A. BUILDING  A. BUILDING		(X3) DATE SURVEY COMPLETED					
		495038	B. WING		08	/25/2020	
	PROVIDER OR SUPPLIER	EHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109			,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	can lead to shortney was obtained from https://www.nlm.ni  [3] A brain disorder recurring seizures. clusters of nerve consend out the wrong strange sensations strangely. They may or lose conscious obtained from the https://medlineplus.  4. Resident # 4 was diagnoses that incidementia [1], chrowledge and bipolar distered by the coded as being semake daily life decoded as requiring areas of activities which required total coded as requiring areas of activities which required total coded as seing semake daily life decoded as requiring areas of activities which required total coded as seing semake daily life decoded as requiring areas of activities which required total coded as seing semake daily life decoded as requiring areas of activities which required total code as seing semake daily life decoded as requiring areas of activities which required total code as seing semake daily life decoded as requiring areas of activities which required total code as seing semake daily life decoded as requiring areas of activities of the code as seing semake daily life decoded as requiring areas of activities of the code as seing semake daily life decoded as requiring areas of activities of the code as requiring areas of activities o	akes it difficult to breath that ess of breath. This information the website: h.gov/medlineplus/copd.html.  That causes people to have The seizures happen when ells, or neurons, in the brain g signals. People may have and emotions or behave ay have violent muscle spasms less. This information was website: s.gov/epilepsy.html.  as admitted to the facility with luded but not limited to hic kidney disease, psychosis order [3]. The most recent ata Set) was a quarterly in ARD (Assessment f 6/3/20. The resident was extensive to total care for all of daily living, including eating	F 880				

	OF CORRECTION	IDENTIFICATION NUMBER:	Die Verderteile etreswork	G		MPLETED	
		495038	B. WING		08	3/25/2020	
	PROVIDER OR SUPPLIER	HAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	room revealed a sign documented, "STO PRECAUTIONS EV hands, including be leaving the room. MUST ALSO: Put of Discard gloves before room entry. exit. Do not wear to the care of more thoor disposable equipmenters on the care of more thoor disposable equipmenters of the care of the clin laboratory disposable equipmenters of the clin laboratory result disposable equipmenters of the clin physician's order disposable equipmenters of the clin laboratory result	gn posted next to the door that P. CONTACT VERYONE MUST: Clean their efore entering and when PROVIDERS AND STAFF on gloves before room entry. Ore room exit. Put on gown Discard gown before room the same gown and gloves for an one person. Use dedicated oment. Clean and disinfect at before use on another urtment of Health and Human for Disease Control and the same gown to inability to mended infection prevention ches (e.g. use of face mask, andwashing, etc.) related to This care plan included the cons: "Contact Isolation" dated courage/Assist resident with IC compliance" dated 7/16/20. iical record revealed a lated 7/22/20 which sident had tested negative for	F 88				

	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	G		TE SURVEY MPLETED	
		495038	B. WING		08	3/25/2020	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 8575 RIXLEW LANE MANASSAS, VA 20109	E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	COVID-19 monitoridentified why this Precautions for C exposed since be A review of the "C Evaluation" form twice daily from 8 "comments" section resident was non-and would take it On 08/25/2020 at conducted with C PPE that should be the room of a resident # 4 with yes. When asked wearing gloves work wearing gloves work was important to # 3 stated, "To preconducted with LI 2. When asked tworn by staff when that is under continuous goggles, gown an asked why it was follow the appropentering a resident precautions LPN spread of infection observation LPN	oring occurring, however none resident required Contact OVID-19 (i.e. was the resident ing tested, etc.)  COVID-19/Coronavirus Daily that was completed at least /18/20 to 8/24/20 revealed in the on on some of them that the compliant with wearing a mask	F 88				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	N 19 .	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING		30	3/25/2020	
	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	HAB CENTER		STREET ADDRESS, CITY, STATE, 2 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	On 08/25/2020 at 1 conducted with RN [assistant director of coordinator. When following the directiposted on the contathe residents' doors debating between right sign says." When a were maintaining stated, "To prevent asked if it possible droplets from a resussistance without yes. When asked if the sign for contact yes. When asked if the contact precaut resident's room, RN spread of infection educated regarding precautions, RN # education and then about once a week or any member of the informed of the about the staff should RN # 1 was asked the most recent ed of PPE for CNA #3  The facility's "IN-SE FORM" dated "7/13 Residents face ma [and] PPE." Under it documented CNA	1:10 a.m., an interview was [registered nurse] # 1, ADON of nursing] and infection control asked if staff should be ons and recommendations act precaution signs outside s, RN # 1 stated, "We are esident dignity and what the asked why staff and residents ocial distancing, RN # 1 contact with droplets." When to come into contact with the ident while providing feeding wearing gloves, RN # 1 stated the staff should be following precautions, RN # 1 stated why it was important to follow ions when entering a N # 1 stated, "To prevent the the use of PPE under contact 1 stated, "There's an initial there's ongoing education and spot checking by myself he leadership." When eladership. When observation RN # 1 stated thave been wearing gloves. To provide documentation of ucation/in-service for the use of	F8	80			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	2 2	PLE CONSTRUCTION		TE SURVEY MPLETED
		495038	B. WING		08	3/25/2020
STATE OF THE PARTY	PROVIDER OR SUPPLIER  SAS HEALTH AND RE	EHAB CENTER	-8	STREET ADDRESS, CITY, STATE, ZIP COE 8575 RIXLEW LANE MANASSAS, VA 20109	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 880	interview was condigassistant director of coordinator. When under contact predicts are included unit, had tested point of the contact predicts and tested point of the contact predicts are included unit, had tested point of the contact predicts are included unit, had tested point of the contact predicts are included and the contact predicts are included unit, had tested point of the contact predicts are included unit, had tested point of the contact predicts are included unit, had tested point of the contact predicts are included unit, and the c	ducted with RN # 1, ADON of nursing] and infection control in asked why Resident # 4 was autions, RN # 1 stated that a ed on the same unit, [name of ositive for COVID-19.  11:23 a.m., ASM if member] # 1, administrator, e above findings.  Ition was provided prior to exit.  Imaged and can't filter blood as information was obtained from a gov/chronickidneydisease.htm  In swhen a person loses contact erson may have false beliefs in place, or who one is a hear things that are not there has information was obtained a gov/ency/article/001553.htm.  In that causes unusual shifts in vity levels, and the ability to any tasks. This information was	F 880			

	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	1 to 15	G		TE SURVEY MPLETED
		495038	B. WING _		08	8/25/2020
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 880	[2], adult failure to The most recent I quarterly assessing Reference Date) and coded as being somake daily life decoded as requiring areas of activities requiring extensive On 08/25/2020 at Resident # 5 reventage for the following breakfast. CNA [certified nurset Resident # 5's Observation of Clarotective equipment goggles, face man observation failed gloves. Observati	thrive, and bipolar disorder [3]. MDS (Minimum Data Set) was a nent with an ARD (Assessment of 6/16/20. The resident was everely impaired in ability to cisions. The resident was g extensive to total care for all of daily living, with eating	F 88			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION  G		TE SURVEY	
		495038	B. WING _		08	3/25/2020	
	PROVIDER OR SUPPLIER	HAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  8575 RIXLEW LANE  MANASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 880	and control approasocial distancing, hogonitive deficits." following intervention 8/24/20. "Staff to supervise/Que/Enc (Infection Control)  A review of the clin result dated 7/22/2 resident had tested (COVID-19).  A review of the clin physician's order disolation every shift record from 8/18/2 COVID-19 monitor identified why this precautions for CO exposed since being A review of the "CO exposed since being A review of the "CO exposed since being and would take it comments" section resident was non-cand would take it comments and would take it comments as a review of a resident was non-cand would take it comments and would take it comments as a resident was non-cand would take it comments as a resident was non-cand would take it comments as a resident was non-cand would take it comments as a resident was non-cand would take it comments.	ches (e.g. use of face mask, randwashing, etc.) related to This care plan included the cons: "Contact Isolation" dated courage/Assist resident with IC compliance" dated 7/16/20.  ical record revealed a lab 0 which documented the I negative for "SARS-CoV-2"  ical record revealed a ated 8/24/20 for "Contact to Tor COVID-19 precautions."  notes in Resident #5's clinical 0 to 8/24/20, revealed ing occurring, however none resident required Contact OVID-19 (i.e. was the resident not to the state of t	F 88				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING		80	3/25/2020	
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  8575 RIXLEW LANE  MANASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	gloves." When asl wear all of the corr "Because of the vir protect the patient describe what was Resident # 1's roor gloves a gown a marked shield." When been wearing glove contact precaution.  On 08/25/2020 at conducted with LP 2. When asked to worn by staff when that is under contagoggles, gown and asked why it was in follow the approprientering a residency precautions LPN # spread of infection observation LPN # should've followed  On 08/25/2020 at conducted with RN [assistant director coordinator. When following the direct posted on the contagonate of the	age 24 ad gown. I did not have ked why it was important to ect PPE, CNA # 2 stated, rus that's going on gloves and myself." When asked to on the sign outside the door of m CNA # 2 stated, "To wear ask and wear the goggles or an asked if they should have es if the resident were under s, CNA # 2 stated yes.  11:00 a.m., an interview was N [licensed practical nurse] # describe what PPE should be entering a residence room ct precautions LPN # 2 stated I mask and gloves. When I mportant to wear gloves and ate contact precautions when be room under contact e 2 stated, "To prevent the entering and wore gloves."  11:10 a.m., an interview was I [registered nurse] # 1, ADON of nursing] and infection control of asked if staff should be since and recommendations are resident dignity and what the asked why staff and residents are resident while providing feeding the pr	F 880				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING		08	/25/2020	
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  8575 RIXLEW LANE  MANASSAS, VA 20109				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 880	assistance without yes. When asked the sign for contact yes. When asked the contact precauresident's room, R spread of infection educated regardin precautions, RN # education and the about once a weel or any member of informed of the ab that the staff shou RN # 1 was asked the most recent ecof PPE for CNA #2  The facility's "IN-S FORM" dated "7/1 Residents face ma [and] PPE." Unde it documented CN  On 08/25/2020 at interview was conclassistant director coordinator. Whe under contact precresident who residunit], had tested por consistent of the contact of the contact precresident who residunity had tested por consistent of the contact of the contact precresident who residunity had tested por consistent of the contact precresident who residunity had tested por co	wearing gloves, RN # 1 stated if the staff should be following at precautions, RN # 1 stated why it was important to follow ations when entering a N # 1 stated, "To prevent the it." When asked if staff are g the use of PPE under contact 1 stated, "There's an initial in there's ongoing education and spot checking by myself the leadership." When ove observation RN # 1 stated and have been wearing gloves. It to provide documentation of ducation/in-service for the use 2.  ERVICEATTENDANCE 3/20" documented, "Topic: ask and social distancing & "Print Name" and "Signature" A #2's name.  1:26 p.m., a telephone ducted with RN # 1, ADON of nursing] and infection control in asked why Resident # 5 was cautions, RN # 1 stated that a led on the same unit, [name of ositive for COVID-19.  11:23 a.m., ASM ff member] # 1, administrator,	F8	80			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING		0	8/25/2020	
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  8575 RIXLEW LANE  MANASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	[1] A loss of brain f diseases. It affects judgment, and beh obtained from the white https://medlineplus  [2] A chronic disease regulate the amour information was obhttps://www.nlm.nit 001214.htm.  [3] A brain disorder mood, energy, activicarry out day-to-day obtained from the was activities.	unction that occurs with certain memory, thinking, language, avior. This information was website: .gov/ency/article/000739.htm. se in which the body cannot at of sugar in the blood. This stained from the website: h.gov/medlineplus/ency/article/ that causes unusual shifts in vity levels, and the ability to y tasks. This information was	FE	380			