STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	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 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.	E 000		
F 000	INITIAL COMMENTS 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). 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).	F 000		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §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	F 880		9/21/20

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

Electronically Signed | 09/05/2020

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 1 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: (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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 2 §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, clinical record review, staff interview and facility document review, it was determined that facility staff failed to implement infection control practices to prevent the spread of communicable disease for five of 27 residents in the survey sample, Residents #1, #2, #3, #4, and #5, all of whom were identified as being under contact precautions. The facility staff failed ensure appropriate PPE [personal protective equipment], donning of gloves prior to entering the rooms and providing feeding assistance to, Resident(s) #1, #2, #3, #4, and #5, all of whom were under contact precautions. The findings include: 1. Resident #1 was admitted to the facility with the diagnoses that included but not limited to Alzheimer's disease [1], heart failure, chronic obstructive pulmonary disease [2], and a stroke. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/23/20. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring total care for bathing and extensive assistance for all other areas of	F 880	1. Both staff were provided education regarding transmission based precautions and glove use during meals. 2. Any resident requiring assistance with meals has the potential to be affected if staff do not follow transmission based precautions. 3. DON or designee will provide education to staff to wear gloves while providing assistance with meals to residents on transmission based precautions. 4. DON or designee will conduct observational rounding during meals to ensure that staff are wearing gloves while providing assistance with meals to residents on transmission based precautions daily for five days, weekly for three weeks and monthly for two months.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 3 activities of daily living, including eating. On 08/25/2020 at 9:12 a.m., an observation revealed Resident # 1 in their bed having breakfast. Further observation revealed CNA [certified nursing assistant] # 2 was seated at Resident # 1's bedside feeding the resident. Observation of CNA # 2's PPE [personal protective equipment] revealed they were wearing a face mask goggles and gown. Further observation failed to evidence CNA # 2 wearing gloves. Observation of the entrance to Resident # 1'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 leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention." A review of the comprehensive care plan revealed one dated 7/16/20 for "Resident is at risk for COVID-19 exposure due to inability to understand recommended infection prevention and control approaches (e.g. use of face mask, social distancing, handwashing, etc.) related to cognitive deficits." This care plan included the following interventions: "Contact Isolation" dated 8/24/20. "Staff to supervise/Que/Encourage/Assist resident with IC (Infection Control) compliance" dated 7/16/20.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 4 A review of the clinical record revealed a laboratory result dated 7/22/20 which documented the resident had tested negative for "SARS-CoV-2" (COVID-19). A review of the clinical record revealed a physician's order dated 8/24/20 for "Contact Isolation every shift for COVID-19 precautions." Review of the nurse's notes in Resident #1's clinical record from 8/18/20 to 8/24/20, revealed COVID-19 monitoring occurring, however none identified why this resident required Contact Precautions for COVID-19 (i.e. was the resident exposed since being tested, etc.) A review of the "COVID-19/Coronavirus Daily Evaluation" form that was completed at least twice daily from 8/18/20 to 8/24/20 revealed in the "Comments" section on many of them that the resident was non-compliant with wearing a mask and would take it off. On 08/25/2020 at 10:52 a.m., an Interview was conducted with CNA # 2. When asked about the PPE that should be worn by staff when entering the room of a resident on contact precautions, with a sign posted outside of their room, CNA # 2 stated, "A gown mask face shield or goggles and gloves " When asked if they assisted Resident # 1 with their breakfast, CNA # 2 stated, "Yes. I was wearing a mask and gown. I did not have gloves." When asked why it was important to wear all of the correct PPE, CNA # 2 stated, "Because of the virus that's going on gloves protect the patient and myself." When asked to describe what was on the sign outside the door of Resident # 1's room, CNA # 2 stated, "To wear gloves a gown a mask and wear the goggles or a	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 5 face shield." When asked if they should have been wearing gloves if a resident is under contact precautions, CNA # 2 stated yes. On 08/25/2020 at 11:00 a.m., an interview was conducted with LPN [licensed practical nurse] # 2. When asked to describe what PPE should be worn by staff when entering a residence room that is under contact precautions, LPN # 2 stated goggles, gown and mask and gloves. When asked why it was important to wear gloves and follow the appropriate contact precautions when entering a residence room under contact precautions, LPN # 2 stated, "To prevent the spread of infection." When informed of the above observation, LPN # 2 stated, "They [CNA #2] should've followed the sign and wore gloves." On 08/25/2020 at 11:10 a.m., an interview was conducted with RN [registered nurse] # 1, ADON [assistant director of nursing] and infection control coordinator. When asked if staff should be following the directions and recommendations posted on the contact precaution signs outside the residents' doors, RN # 1 stated, "We are debating between resident dignity and what the sign says." When asked why staff and residents were maintaining social distancing, RN # 1 stated, "To prevent contact with droplets." When asked if it possible to come into contact with the droplets from a resident while providing feeding assistance without wearing gloves, RN # 1 stated yes. When asked if the staff should be following the sign for contact precautions, RN # 1 stated yes. When asked why it was important to follow the contact precautions when entering a resident's room, RN # 1 stated, "To prevent the spread of infection." When asked if staff are educated regarding the use of PPE under contact	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 6 precautions, RN # 1 stated, "There's an initial education and then there's ongoing education about once a week and spot checking by myself or any member of the leadership." When informed of the above observation, RN # 1 stated that the staff [CNA #2] should have been wearing gloves. RN # 1 was asked to provide documentation of the most recent education/in-service for the use of PPE for CNA #2. The facility's "IN-SERVICEATTENDANCE FORM" dated "7/13/20" documented, "Topic: Residents face mask and social distancing & [and] PPE." Under "Print Name" and "Signature" it documented CNA #2's name. On 08/25/2020 at 1:26 p.m., a telephone interview was conducted with RN # 1, ADON [assistant director of nursing] and infection control coordinator. When asked why Resident # 1 was under contact precautions, RN # 1 stated that a resident who resided on the same unit, [name of unit], had tested positive for COVID-19. The facility's policy "Contact Precautions" documented in part, "Policy: Contact Precautions are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, spread by direct or indirect contact with the resident or the resident's environment. In addition to Standard Precautions use Contact Precautions to prevent nosocomial spread of organisms that can be transmitted by direct resident contact (touching) with environmental surfaces or contaminated resident care equipment. Procedures for Contact Precautions: Glove Use for Contact Precautions. 1. In addition to wearing gloves as outlined under	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 7 Standard Precautions, clean, non-sterile gloves are worn when providing direct care (changing, clothing, toileting, bathing, dressing changes, etc.) to residents on Contact Precautions. 2. Wear gloves whenever touching the resident's intact skin or surfaces and articles near the resident (e.g. medical equipment, bed rails). Don gloves upon entry into the room or cubicle. 3. Gloves should also be worn when handling items potentially contaminated by MDROs [multi-drug resistant organisms]. This includes items such as bedside tables, over-bed tables, bed rails, bathroom fixtures, television and bed controls, suctions and oxygen tubing. 4. During providing care for residents, gloves will be changed after having contact with infective material that may contain high concentrations of microorganisms (fecal material or wound drainage). 5. Wearing gloves is not a substitute for hand antisepsis. Gloves will be removed and discarded before leaving the resident's room, hands will be washed with soap and water or waterless hand antiseptic will be used. After glove removal and hand hygiene, staff should ensure that hands do not touch potentially contaminated environmental surfaces or items in the resident's room to avoid transfer of microorganisms to other residents or environments." On 08/25/2020 at 11:23 a.m., ASM [administrative staff member] # 1, administrator, was informed of the above findings. No further information was provided prior to exit. References: [1] A brain disorder that seriously affects a person's ability to carry out daily activities). This information was obtained from the website:	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 8 https://www.nlm.nih.gov/medlineplus/alzheimersdisease.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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 9	F 880		

leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention."

A review of Resident #2's comprehensive care plan revealed one dated 7/16/20 for "Resident is at risk for COVID-19 exposure due to inability to understand recommended infection prevention and control approaches (e.g. use of face mask, social distancing, handwashing, etc.) related to cognitive deficits." This care plan included the following interventions: "Contact Isolation" dated 8/24/20. "Staff to supervise/Que/Encourage/Assist resident with IC (Infection Control) compliance" dated 7/16/20.

A review of the clinical record revealed a laboratory result dated 7/22/20 which documented the resident had tested negative for "SARS-CoV-2" (COVID-19).

A review of the clinical record revealed a physician's order dated 8/24/20 for "Contact Isolation every shift for COVID-19 precautions."

Review of nurse's notes in Resident #2's clinical record from 8/18/20 to 8/24/20 revealed COVID-19 monitoring occurring, however none identified why this resident required Contact Precautions for COVID-19 (i.e. was the resident exposed since being tested, etc.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 10 A review of the "COVID-19/Coronavirus Daily Evaluation" form that was completed at least twice daily from 8/18/20 to 8/24/20 revealed in the "comments" section on many of them that the resident was non-compliant with wearing a mask and would take it off. On 08/25/2020 at 10:56 a.m., an Interview was conducted with CNA # 3. When asked about the PPE that should be worn by staff when entering the room of a resident on contact precautions with a sign posted outside of their room, CNA # 3 stated, "A gown, 95 mask, face shield or goggles and gloves " When asked if they assisted Resident # 2 with their breakfast, CNA # 2 stated yes. When asked if they should have been wearing gloves when they were in Resident # 2's room, CNA # 3 stated yes. When asked why it was important to wear all of the correct PPE CNA # 3 stated, "To protect the patient and myself." On 08/25/2020 at 11:00 a.m., an interview was conducted with LPN [licensed practical nurse] # 2. When asked to describe what PPE should be worn by staff when entering a residence room that is under contact precautions LPN # 2 stated goggles, gown and mask and gloves. When asked why it was important to wear gloves and follow the appropriate contact precautions when entering a residence room under contact precautions, LPN # 2 stated, "To prevent the spread of infection." When informed of the above observation, LPN # 2 stated, "They [CNA#3] should've followed the sign and wore gloves." On 08/25/2020 at 11:10 a.m., an interview was conducted with RN [registered nurse] # 1, ADON [assistant director of nursing] and infection control	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11 coordinator. When asked if staff should be following the directions and recommendations posted on the contact precaution signs outside the residents' doors, RN # 1 stated, "We are debating between resident dignity and what the sign says." When asked why staff and residents were maintaining social distancing, RN # 1 stated, "To prevent contact with droplets." When asked if it possible to come into contact with the droplets from a resident while providing feeding assistance without wearing gloves, RN # 1 stated yes. When asked if the staff should be following the sign for contact precautions, RN # 1 stated yes. When asked why it was important to follow the contact precautions when entering a resident's room, RN # 1 stated, "To prevent the spread of infection." When asked if staff are educated regarding the use of PPE under contact precautions, RN # 1 stated, "There's an initial education and then there's ongoing education about once a week and spot checking by myself or any member of the leadership." When informed of the above observation RN # 1 stated that the staff should have been wearing gloves. RN # 1 was asked to provide documentation of the most recent education/in-service for the use of PPE for CNA #3. The facility's "IN-SERVICEATTENDANCE FORM" dated "7/13/20" documented, "Topic: Residents face mask and social distancing & [and] PPE." Under "Print Name" and "Signature" it documented CNA #3's name. On 08/25/2020 at 1:26 p.m., a telephone interview was conducted with RN # 1, ADON [assistant director of nursing] and infection control coordinator. When asked why Resident # 2 was under contact precautions, RN # 1 stated that a	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 resident who resided on the same unit, [name of unit], had tested positive for COVID-19. On 08/25/2020 at 11:23 a.m., ASM [administrative staff member] # 1, administrator, was informed of the above findings. No further information was provided prior to exit. References: [1] A brain disorder that seriously affects a person's ability to carry out daily activities) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/alzheimersdisease.html. [2] The vascular system is the body's network of blood vessels. It includes the arteries, veins and capillaries that carry blood to and from the heart. Arteries can become thick and stiff, a problem called atherosclerosis. Blood clots can clog vessels and block blood flow to the heart or brain. Weakened blood vessels can burst, causing bleeding inside the body.) This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/vasculardiseases.html. 3. Resident # 3 was admitted to the facility with the diagnoses that included but not limited dementia [1], chronic obstructive pulmonary disease [2], high blood pressure, and epilepsy [3]. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 8/2/20. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive care for all areas of activities of daily living, with eating requiring	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13 limited assistance. A review of the comprehensive care plan revealed one dated 7/16/20 for "Resident is at risk for COVID-19 exposure due to inability to understand recommended infection prevention and control approaches (e.g. use of face mask, social distancing, handwashing, etc.) related to cognitive deficits." This care plan included the following intervention: "Staff to supervise/Que/Encourage/Assist resident with IC (Infection Control) compliance" dated 7/16/20. A care plan for "(Resident) demonstrates the need for ADL assistance" dated 12/23/19, included the intervention, dated 8/3/20 for "Contact Precaution - COVID-19 precaution." On 08/25/2020 at 9:24 a.m., observation revealed Resident # 3 in bed having breakfast. Further observation revealed CNA [certified nursing assistant] # 2 was seated at Resident # 3's bedside feeding the resident. Observation of CNA # 2's PPE [personal protective equipment] revealed they were wearing a face mask, goggles and gown. Further observation failed to evidence CNA # 2 wearing gloves. Observation of the entrance to Resident # 3'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 leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. U.S. Department of Health and	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14 Human Services. Centers for Disease Control and Prevention." A review of the clinical record revealed a laboratory result dated 8/4/20 which documented the resident had tested negative for "SARS-CoV-2" (COVID-19). A review of the clinical record revealed a physician's order dated 8/24/20 for "Contact Isolation every shift for COVID-19 precautions." Review of nurse's notes in Resident #3's clinical record from 8/18/20 to 8/24/20 revealed COVID-19 monitoring occurring, however none identified why this resident required Contact Precautions for COVID-19 (i.e. was the resident exposed since being tested, etc.) A review of the "COVID-19/Coronavirus Daily Evaluation" form that was completed at least twice daily from 8/18/20 to 8/24/20 revealed in the "comments" section on many of them that the resident was non-compliant with wearing a mask and would take it off. On 08/25/2020 at 10:52 a.m., an Interview was conducted with CNA # 2. When asked about the PPE that should be worn by staff when entering the room of a resident on contact precautions with a sign posted outside of their room, CNA # 2 stated, "A gown mask face shield or goggles and gloves " When asked if they assisted Resident # 3 with their breakfast, CNA # 2 stated, "Yes. I was wearing a mask and gown. I did not have gloves." When asked why it was important to wear all of the correct PPE, CNA # 2 stated, "Because of the virus that's going on gloves protect the patient and myself." When asked to	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15 describe what was on the sign outside the door of Resident # 1's room, CNA # 2 stated, "To wear gloves a gown a mask and wear the goggles or a face shield." When asked if they should have been wearing gloves if the resident is under contact precautions CNA # 2 stated yes. On 08/25/2020 at 11:00 a.m., an interview was conducted with LPN [licensed practical nurse] # 2. When asked to describe what PPE should be worn by staff when entering a residence room that is under contact precautions LPN # 2 stated goggles, gown and mask and gloves. When I asked why it was important to wear gloves and follow the appropriate contact precautions when entering a residence room under contact precautions LPN # 2 stated, "To prevent the spread of infection." When informed of the above observation LPN # 2 stated, "They [CNA #2] should've followed the sign and wore gloves." On 08/25/2020 at 11:10 a.m., an interview was conducted with RN [registered nurse] # 1, ADON [assistant director of nursing] and infection control coordinator. When asked if staff should be following the directions and recommendations posted on the contact precaution signs outside the residents' doors, RN # 1 stated, "We are debating between resident dignity and what the sign says." When asked why staff and residents were maintaining social distancing, RN # 1 stated, "To prevent contact with droplets." When asked if it possible to come into contact with the droplets from a resident while providing feeding assistance without wearing gloves, RN # 1 stated yes. When asked if the staff should be following the sign for contact precautions, RN # 1 stated yes. When asked why it was important to follow the contact precautions when entering a	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16 resident's room, RN # 1 stated, "To prevent the spread of infection." When asked if staff are educated regarding the use of PPE under contact precautions, RN # 1 stated, "There's an initial education and then there's ongoing education about once a week and spot checking by myself or any member of the leadership." When informed of the above observation RN # 1 stated that the staff should have been wearing gloves. RN # 1 was asked to provide documentation of the most recent education/in-service for the use of PPE for CNA #2. The facility's "IN-SERVICEATTENDANCE FORM" dated "7/13/20" documented, "Topic: Residents face mask and social distancing & [and] PPE." Under "Print Name" and "Signature" it documented CNA #2's name. On 08/25/2020 at 1:26 p.m., a telephone interview was conducted with RN # 1, ADON [assistant director of nursing] and infection control coordinator. When asked why Resident # 3 was under contact precautions, RN # 1 stated that a resident who resided on the same unit, [name of unit], had tested positive for COVID-19. On 08/25/2020 at 11:23 a.m., ASM [administrative staff member] # 1, administrator, was informed of the above 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.	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17 [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. [3] A brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html. 4. Resident # 4 was admitted to the facility with diagnoses that included but not limited to dementia [1], chronic kidney disease, psychosis [2], and bipolar disorder [3]. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/3/20. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive to total care for all areas of activities of daily living, including eating which required total care. On 08/25/2020 at 9:28 a.m., observation revealed Resident # 4 in bed having breakfast. Further observation revealed CNA [certified nursing assistant] # 3 was seated at Resident # 4's bedside feeding the resident. Observation of CNA # 3's PPE [personal protective equipment] revealed they were wearing a face mask, faceshield, and gown. Further observation failed to evidence CNA # 3 wearing gloves. Observation of the entrance to Resident # 4's	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18 room revealed a sign posted next to the door that documented, "STOP. CONTACT PRECAUTIONS EVERYONE MUST: Clean their hands, including before entering and when leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention." A review of Resident #4's comprehensive care plan revealed one dated 7/16/20 for "Resident is at risk for COVID-19 exposure due to inability to understand recommended infection prevention and control approaches (e.g. use of face mask, social distancing, handwashing, etc.) related to cognitive deficits." This care plan included the following interventions: "Contact Isolation" dated 8/24/20. "Staff to supervise/Que/Encourage/Assist resident with IC (Infection Control) compliance" dated 7/16/20. A review of the clinical record revealed a laboratory result dated 7/22/20 which documented the resident had tested negative for "SARS-CoV-2" (COVID-19). A review of the clinical record revealed a physician's order dated 8/24/20 for "Contact Isolation every shift for COVID-19 precautions." Review of nurse's notes in Resident #4's clinical record from 8/18/20 to 8/24/20, revealed	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19 COVID-19 monitoring occurring, however none identified why this resident required Contact Precautions for COVID-19 (i.e. was the resident exposed since being tested, etc.) A review of the "COVID-19/Coronavirus Daily Evaluation" form that was completed at least twice daily from 8/18/20 to 8/24/20 revealed in the "comments" section on some of them that the resident was non-compliant with wearing a mask and would take it off. On 08/25/2020 at 10:56 a.m., an interview was conducted with CNA # 3. When asked about the PPE that should be worn by staff when entering the room of a resident on contact precautions with a sign posted outside of their room, CNA # 3 stated, "A gown, 95 mask, face shield or goggles and gloves " When asked if they assisted Resident # 4 with their breakfast, CNA # 3 stated yes. When asked if they should have been wearing gloves when they were in Resident # 4's room CNA # 3 stated yes. When asked why it was important to wear all of the correct PPE CNA # 3 stated, "To protect the patient and myself." On 08/25/2020 at 11:00 a.m., an interview was conducted with LPN [licensed practical nurse] # 2. When asked to describe what PPE should be worn by staff when entering a residence room that is under contact precautions LPN # 2 stated goggles, gown and mask and gloves. When I asked why it was important to wear gloves and follow the appropriate contact precautions when entering a residence room under contact precautions LPN # 2 stated, "To prevent the spread of infection." When informed of the above observation LPN # 2 stated, "They [CNA #3] should've followed the sign and wore gloves."	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20 On 08/25/2020 at 11:10 a.m., an interview was conducted with RN [registered nurse] # 1, ADON [assistant director of nursing] and infection control coordinator. When asked if staff should be following the directions and recommendations posted on the contact precaution signs outside the residents' doors, RN # 1 stated, "We are debating between resident dignity and what the sign says." When asked why staff and residents were maintaining social distancing, RN # 1 stated, "To prevent contact with droplets." When asked if it possible to come into contact with the droplets from a resident while providing feeding assistance without wearing gloves, RN # 1 stated yes. When asked if the staff should be following the sign for contact precautions, RN # 1 stated yes. When asked why it was important to follow the contact precautions when entering a resident's room, RN # 1 stated, "To prevent the spread of infection." When asked if staff are educated regarding the use of PPE under contact precautions, RN # 1 stated, "There's an initial education and then there's ongoing education about once a week and spot checking by myself or any member of the leadership." When informed of the above observation RN # 1 stated that the staff should have been wearing gloves. RN # 1 was asked to provide documentation of the most recent education/in-service for the use of PPE for CNA #3. The facility's "IN-SERVICEATTENDANCE FORM" dated "7/13/20" documented, "Topic: Residents face mask and social distancing & [and] PPE." Under "Print Name" and "Signature" it documented CNA #3's name. On 08/25/2020 at 1:26 p.m., a telephone	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21 interview was conducted with RN # 1, ADON [assistant director of nursing] and infection control coordinator. When asked why Resident # 4 was under contact precautions, RN # 1 stated that a resident who resided on the same unit, [name of unit], had tested positive for COVID-19. On 08/25/2020 at 11:23 a.m., ASM [administrative staff member] # 1, administrator, was informed of the above findings. No further information was provided prior to exit. References: [1] Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html. [2] Psychosis occurs when a person loses contact with reality. The person may have false beliefs about what is taking place, or who one is (delusions), see or hear things that are not there (hallucinations). This information was obtained from the website: https://medlineplus.gov/ency/article/001553.htm. [3] A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml. 5. Resident # 5 was admitted to the facility with diagnoses that included but not limited to dementia [1], chronic kidney disease, diabetes	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22 [2], adult failure to thrive, and bipolar disorder [3]. The most recent MDS (Minimum Data Set) was a quarterly assessment with an ARD (Assessment Reference Date) of 6/16/20. The resident was coded as being severely impaired in ability to make daily life decisions. The resident was coded as requiring extensive to total care for all areas of activities of daily living, with eating requiring extensive care. On 08/25/2020 at 9:35 a.m., an observation of Resident # 5 revealed they were in their bed having breakfast. Further observation revealed CNA [certified nursing assistant] # 2 was seated at Resident # 5's bedside feeding the resident. Observation of CNA # 2's PPE [personal protective equipment] revealed they were wearing goggles, face mask and gown. Further observation failed to evidence CNA # 2 wearing gloves. Observation of the entrance to Resident # 5'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 leaving the room. PROVIDERS AND STAFF MUST ALSO: Put on gloves before room entry. Discard gloves before room exit. Put on gown before room entry. Discard gown before room exit. Do not wear the same gown and gloves for the care of more than one person. Use dedicated or disposable equipment. Clean and disinfect reusable equipment before use on another person. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention." A review of the comprehensive care plan revealed one dated 7/16/20 for "Resident is at risk for COVID-19 exposure due to inability to understand recommended infection prevention	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23 and control approaches (e.g. use of face mask, social distancing, handwashing, etc.) related to cognitive deficits." This care plan included the following interventions: "Contact Isolation" dated 8/24/20. "Staff to supervise/Que/Encourage/Assist resident with IC (Infection Control) compliance" dated 7/16/20. A review of the clinical record revealed a lab result dated 7/22/20 which documented the resident had tested negative for "SARS-CoV-2" (COVID-19). A review of the clinical record revealed a physician's order dated 8/24/20 for "Contact Isolation every shift for COVID-19 precautions." Review of nurse's notes in Resident #5's clinical record from 8/18/20 to 8/24/20, revealed COVID-19 monitoring occurring, however none identified why this resident required Contact Precautions for COVID-19 (i.e. was the resident exposed since being tested, etc.) A review of the "COVID-19/Coronavirus Daily Evaluation" form that was completed at least twice daily from 8/18/20 to 8/24/20 revealed in the "comments" section on many of them that the resident was non-compliant with wearing a mask and would take it off. On 08/25/2020 at 10:52 a.m., an Interview was conducted with CNA # 2. When asked about the PPE that should be worn by staff when entering the room of a resident on contact precautions, with a sign posted outside of their room, CNA # 2 stated, "A gown mask face shield or goggles and gloves." When asked if they assisted Resident # 3 with their breakfast CNA # 2 stated, "Yes. I was	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24	F 880		

wearing a mask and gown. I did not have gloves." When asked why it was important to wear all of the correct PPE, CNA # 2 stated, "Because of the virus that's going on gloves protect the patient and myself." When asked to describe what was on the sign outside the door of Resident # 1's room CNA # 2 stated, "To wear gloves a gown a mask and wear the goggles or a face shield." When asked if they should have been wearing gloves if the resident were under contact precautions, CNA # 2 stated yes.

On 08/25/2020 at 11:00 a.m., an interview was conducted with LPN [licensed practical nurse] # 2. When asked to describe what PPE should be worn by staff when entering a residence room that is under contact precautions LPN # 2 stated goggles, gown and mask and gloves. When I asked why it was important to wear gloves and follow the appropriate contact precautions when entering a residence room under contact precautions LPN # 2 stated, "To prevent the spread of infection." When informed of the above observation LPN # 2 stated, "They [CNA #2] should've followed the sign and wore gloves."

On 08/25/2020 at 11:10 a.m., an interview was conducted with RN [registered nurse] # 1, ADON [assistant director of nursing] and infection control coordinator. When asked if staff should be following the directions and recommendations posted on the contact precaution signs outside the residents' doors, RN # 1 stated, "We are debating between resident dignity and what the sign says." When asked why staff and residents were maintaining social distancing, RN # 1 stated, "To prevent contact with droplets." When asked if it possible to come into contact with the droplets from a resident while providing feeding

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25	F 880		

assistance without wearing gloves, RN # 1 stated yes. When asked if the staff should be following the sign for contact precautions, RN # 1 stated yes. When asked why it was important to follow the contact precautions when entering a resident's room, RN # 1 stated, "To prevent the spread of infection." When asked if staff are educated regarding the use of PPE under contact precautions, RN # 1 stated, "There's an initial education and then there's ongoing education about once a week and spot checking by myself or any member of the leadership." When informed of the above observation RN # 1 stated that the staff should have been wearing gloves. RN # 1 was asked to provide documentation of the most recent education/in-service for the use of PPE for CNA #2.

The facility's "IN-SERVICEATTENDANCE FORM" dated "7/13/20" documented, "Topic: Residents face mask and social distancing & [and] PPE." Under "Print Name" and "Signature" it documented CNA #2's name.

On 08/25/2020 at 1:26 p.m., a telephone interview was conducted with RN # 1, ADON [assistant director of nursing] and infection control coordinator. When asked why Resident # 5 was under contact precautions, RN # 1 stated that a resident who resided on the same unit, [name of unit], had tested positive for COVID-19.

On 08/25/2020 at 11:23 a.m., ASM [administrative staff member] # 1, administrator, was informed of the above findings.

No further information was provided prior to exit.

References:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. BUILDING _____ B. WING _____	08/25/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 26 [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] 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. [3] A brain disorder that causes unusual shifts in mood, energy, activity levels, and the ability to carry out day-to-day tasks. This information was obtained from the website: https://www.nimh.nih.gov/health/topics/bipolar-disorder/index.shtml.	F 880		