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 _____	03/05/2021

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 survey was conducted 3/2/21 through 3/5/21. 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 Medicare/Medicaid standard survey was conducted 3/2/21 through 3/5/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. No complaint(s) was/were investigated during the survey. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 96 at the time of the survey. The survey sample consisted of 40 current resident reviews and six closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of	F 580		4/14/21

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

Electronically Signed | 03/18/2021

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

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F 580	Continued From page 1 treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to notify the physician of a change in peritoneal dialysis status for one of 46 residents in the	F 580	1. The physician for Resident #245 was notified that the resident did not complete dialysis on 2/28/2021 and 3/1/2021. 2. All residents who have a change in status or condition have the potential to be	

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F 580	Continued From page 2 survey sample, Resident #245. The facility staff failed to notify the physician when Resident #245 did not complete peritoneal dialysis on 2/28/21 and 3/1/21. The findings include: Resident #245 was admitted to the facility on 2/26/21 with diagnoses including, but not limited to infected leg wound and ESRD (end stage renal disease) (2). On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/5/21. Resident #245 was coded as moderately cognitively impaired, scoring seven out of 15 on the BIMS (brief interview for mental status). He was coded as receiving dialysis in the facility during the look back period. Resident #245 was observed lying on his back in bed, with his eyes closed, on the following dates and times: 3/02/21 at 12:18 p.m., 3/02/21 at 3:06 p.m., and 3/03/21 at 9:11 a.m. During each observation, supplies for the resident's peritoneal dialysis (1), including dialysis solutions and a machine, were visible in the room. A review of Resident #245's clinical record revealed the following physician's orders: "- Peritoneal Dialysis: 1. Low calcium (2.5mEq/L [milliequivalent/ liter]) with 1.5% Dextrose 6000 ml [milliliter] x 1 bags (yellow cap) 2. Low calcium (2.5mEq/L) with 2.5% Dextrose 6000 ml x 1 bags (GREEN cap) 3. Extraneal (icodextrin) 2000 ml x 1 bag (purple cap) UNTIL SOLUTION IS COMPLETE - Peritoneal Dialysis: 1. Low calcium (2.5mEq/L	F 580	affected if facility staff fail to notify their physician. Resident records will be reviewed for the previous 24 hours to verify that physicians were notified for any resident change in condition or status. Variances will be addressed. 3. The Director of Nursing, or designee, will provide education to licensed nursing staff on the requirement to notify the physician when a resident has a change in status or condition. 4. DON or designee will review 10 resident records daily (M-F) for five (5) days, weekly for three (3) weeks and monthly for two (2) months, for evidence of physician notification for changes in condition. Findings will be reviewed with the QAPI Committee.	

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F 580	Continued From page 3 [milliequivalent / per Liter]) with 1.5% Dextrose 6000 ml (milliliters) x 2 bags (yellow cap) 2. Extraneal (icodextrin) 2000 ml x 1 bag (purple cap) UNTIL SOLUTION IS COMPLETE - PD [peritoneal dialysis] Drain Time: 1900-0500 - Peritoneal dialysis: Call [name of local dialysis center] at [phone number for dialysis center] for any issues - PD Catheter Care q (each) shift." A review of Resident #245's progress notes revealed, in part the following: "2/28/2021 3:00 a.m. Health Status Note...writer went in patient's room and observed peritoneal dialysis machine stopped working. Writer tried to help patient to fix the machine, but patient denied and removed all the connectors and stated that he will start the machine at 12 noon. Patient denied any discomfort." This note was written by RN (registered nurse) #4. "3/1/2021 4:45 a.m. Health Status Note...PD machine was beeping around 0400 (4:00 a.m.) this morning. Patient called for assistance and writer went in to check what was going on. Patient did not allow writer to fix the problem and told writer that he did not want to continue with the therapy again. Patient asked writer to disconnect everything. Therapy was not completely done." This note was written by RN #4. A review of Resident #245's initial care plan, dated 2/27/21 and updated 3/4/21, revealed, in part: [Resident #245] needs dialysis (peritoneal r/t (related to) renal failure...Check and change	F 580		

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F 580	Continued From page 4 dressing daily at access site per MD (medical doctor) orders...labs [laboratory tests] as ordered. Report results to physician...Observe for and report to MD s/sx [signs and symptoms] of the following: bleeding, hemorrhage, bacteremia (infection in the blood), septic shock." On 3/4/21 at 8:05 a.m., RN (registered nurse) #4 was interviewed regarding her responsibilities with Resident #245's peritoneal dialysis. RN #4 stated since she works night shift, she is responsible for monitoring him through the night, and for taking him off the machine when he finishes in the morning. RN #4 stated, "He is already hooked up when I get here." When asked about the two mornings referenced in the above progress notes when Resident #245 did not complete the peritoneal dialysis, RN #4 stated that on both nights, the machine had been working well during the night. But on both mornings, when she had gone in to check the resident, she had discovered the machine beeping and no longer working to dialyze the resident. She stated that on 2/28/21, the resident would not allow her to troubleshoot and restart the machine. She stated that on 3/1/21, the resident again would not allow her to restart the machine. When asked if she notified they physician that the resident did not complete the dialysis, she stated she did not. RN #4 stated, "I know I was supposed to. I called the dialysis nurse, but I did not call the physician." On 3/4/21 at 9:22 a.m., ASM (administrative staff member) #2, the director of nursing, was interviewed, regarding the process staff should follow a resident's peritoneal dialysis is not completed. ASM #2 stated, "You have to notify the doctor." When asked why it would be	F 580		

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F 580	Continued From page 5 important to notify the doctor, ASM #2 stated, "Because we are trying to get all the fluid out. If it stops, that means the fluid may not have all drained out, and anything can happen." On 3/4/21 at 11:58 a.m., ASM #1, (the administrator) ASM #2, the director of nursing and ASM #3, the nurse consultant were notified of these concerns. No further information was provided prior to exit. (1) "Peritoneal dialysis is a treatment for kidney failure that uses the lining of your abdomen, or belly, to filter your blood inside your body. Health care providers call this lining the peritoneum." This information was provided by the website https://www.niddk.nih.gov/health-information/kidney-disease/kidney-failure/peritoneal-dialysis. (2) "End-stage kidney disease (ESKD) is the last stage of long-term (chronic) kidney disease. This is when your kidneys can no longer support your body's needs. End-stage kidney disease is also called end-stage renal disease (ESRD)." This information is taken from the website https://medlineplus.gov/ency/article/000500.htm.	F 580		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial	F 656		4/14/21

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F 656	Continued From page 6 needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interviews, facility document review and clinical record review, it was determined the facility staff failed to develop and / or implement the comprehensive care plan for two of forty six residents, Resident #53 and	F 656	1. Comprehensive care plans were developed and implemented for Resident #53 and Resident #61 to reflect the use of an incentive spirometer. 2. All residents are at risk if facility staff	

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F 656	Continued From page 7 Resident #61. The facility staff failed to develop and implement a comprehensive care plan to address the use of an incentive spirometer for Residents #53 and # 61. The findings include: 1. Resident #53 was admitted to the facility on 2/22/20 with diagnoses that included but were not limited to: bipolar (mental disorder characterized by periods of mania and depression) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and angina (severe pain in the chest accompanied by a choking feeling) (3). The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 1/24/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact. A review of the MDS Section G-functional status coded the resident as requiring limited assistance for bed mobility, hygiene, bathing, dressing; supervision for eating / locomotion and as independent in walking. Observations of resident #53's room and bedside table on 3/2/21 at 11:15 AM, 3/2/21 at 1:00 PM and 3/3/21, revealed an uncovered incentive spirometer. A review of Resident #53's physician orders failed to evidence any order for the use of an incentive spirometer. A review of the physical therapy notes dated 1/22/21 at 3:22 PM, documented in part, "Diaphragmatic breathing exercises to improve	F 656	fail to develop and implement a comprehensive care plan that reflects their care needs. Resident care plans will be reviewed to ensure a person-specific comprehensive care plan has been developed and implemented to meet their care needs and variances will be addressed. 3. The Director of Nursing or designee will educate licensed nursing staff and interdisciplinary team members on the requirement to develop and implement a comprehensive care plan to reflect resident care needs. 4. DON or designee will review comprehensive care plans for 5 different residents daily (M-F) for five (5) days, weekly for three (3) weeks, and monthly for two (2) months, to ensure each resident has a care plan that has been developed and implemented to reflect resident care needs. Findings will be reviewed with the QAPI Committee.	

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F 656	Continued From page 8 lung capacity followed by use of incentive spirometer. Oxygen saturation was 97% at room air post incentive spirometer use. Instructed resident in using the incentive spirometer to improve lung capacity with good carry over noted." A review of Resident #53's comprehensive care plan failed to address or evidence any documentation for the use of an incentive spirometer. An interview was conducted on 3/3/21 at 2:00 PM with Resident #53. When asked if he used his incentive spirometer, Resident #53 stated, "Oh yes! It makes such a difference. I use it four times a day. Therapy helped me get it. When I use it, my oxygen levels get to 97% or 98%, when I do not it is 91%. I can't believe how much better I breathe when I use it." An interview was conducted on 3/03/21 at 2:05 PM with OSM (other staff member) #1, the rehabilitation director regarding Resident #53's incentive spirometer. OSM #1 stated, "We discussed this with nursing after assessing the resident for the incentive spirometer. Nursing gets the order and gives it to the patient (Resident #53) then." An interview was conducted on 3/3/21 at 2:30 PM with LPN (licensed practical nurse) #3. When asked if orders were obtained for Resident #53's incentive spirometer, LPN #3 stated, "No, incentive spirometers don't require a physician order, they are a nursing intervention." When asked if Resident #53 used his spirometer, LPN #3 stated, "Yes, he does use it." When asked about the purpose of the comprehensive care	F 656		

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F 656	Continued From page 9 plan, LPN #3 stated, "To provide a guide for the resident's care." When asked if an incentive spirometer should be on the care plan, LPN #3 stated, "Yes, it should be on the care plan." An interview was conducted on 3/3/21 at 4:10 PM with LPN #2, the unit manager, regarding the purpose of the comprehensive care plan. LPN #2 stated, "The plan drives the care of the residents with problems, goals and interventions." When asked about the comprehensive care plan and residents using an incentive spirometer, LPN #2 stated, "The care plan should be developed as the incentive spirometer is a device to tell staff how and why it is indicated for use." When asked if there was a care plan for incentive spirometer for Resident #53, LPN #2 stated, "No there is no care plan." When asked if there were orders for the incentive spirometer for Resident #53, LPN #2 stated, "No, there are not orders, but we consider the incentive spirometer a nursing intervention and do not need a physician order." On 3/4/21 at 8:59 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director or nursing and ASM #3, the nurse consultant were informed of the above concerns. No further information was provided prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 71. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 160. 3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 34. 2. The facility staff failed to develop a comprehensive care plan for Resident #61's use	F 656		

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F 656	Continued From page 10 of an incentive spirometer. [1] Resident # 61 was admitted to the facility with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [2]. Resident # 61's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/26/2021, coded Resident # 61 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired of cognition for making daily decisions. On 03/02/21 at approximately 2:45 p.m., 5:09 p.m., and 03/03/21 at approximately 8:25 a.m., observations of Resident #61's room revealed an incentive spirometer on the bedside table uncovered. The physician's order for Resident # 61 dated "1/8/2021" documented, "Incentive Spirometer x 10 HR [ten times per hour] while awake. Frequency: every shift. Schedule Type: Everyday." The comprehensive care plan for Resident # 61 dated 02/17/2021 failed to evidence the use of an incentive spirometer. On 03/02/2021 at approximately 2:45 p.m., in an interview with Resident # 61 regarding the use of the incentive spirometer, Resident # 61 stated, "I use it several times a week On 03/03/2021 at approximately 3:30 p.m., an interview was conducted with LPN [licensed practical nurse] # 5. When asked to describe the purpose of a comprehensive care plan, LPN # 5 stated that it describes the proper treatment and	F 656		

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F 656	Continued From page 11 care of a resident. When asked if a resident's use of an incentive spirometer should be addressed on their care plan LPN # 5 stated yes. On 03/03/2021 at approximately 4:00 p.m. LPN #2, unit manager, was asked to review Resident # 61's comprehensive care plan dated 02/17/2021, for the use of an incentive spirometer. At approximately 4:05 p.m., LPN # 2 stated that the comprehensive care plan did not address Resident # 61's incentive spirometer use. The facility's policy "Comprehensive Care-Planning Process" documented in part, "6. Duties and responsibilities of the Care Planning/Interdisciplinary Team include, but are not limited to: b. Reviewing the care plan to assure that: i. They reflect the resident's medical and nursing assessments; iii. They are oriented toward preventing declines in functioning and/or functional levels." On 03/03/2021 at 5:25 p.m., ASM # 1 [administrative staff member], administrator, was made aware of the findings. No further information was provided prior to exit. References: [1] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.	F 656		

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

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F 656	Continued From page 12 [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.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it	F 657	1. Comprehensive care plans were reviewed and revised to reflect the use of	4/14/21

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

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F 657	Continued From page 13 was determined that the facility staff failed to review and revise the comprehensive care plan for three of 46 residents in the survey sample, Residents #90, #65 and #194. The facility staff failed to review and revise the comprehensive care plans for Resident #90, Resident #65 and Resident #194 to address the residents' use of bed rails. The findings include: 1. Resident #90 was admitted to the facility on 2/10/21. Resident #90's diagnoses included but were not limited to muscle weakness, dementia and difficulty swallowing. Resident #90's admission MDS (minimum data set) assessment, with an ARD (assessment reference date) of 2/15/21, coded the resident's cognition as severely impaired. On 3/2/21 at 4:33 p.m., Resident #90 was observed lying in bed with bilateral one half bed rails raised in the upright position. Review of Resident #90's clinical record failed to reveal a physician's order for bed rails. Resident #90's comprehensive care plan initiated on 2/10/21 failed to document information regarding bed rails. On 3/3/21 at 9:26 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of a care plan is to individualize residents' care. RN #2 stated the use of bed rails should be included in residents' care plans so staff is aware. On 3/3/21 at 2:15 p.m., ASM (administrative staff	F 657	bed rails for Resident #90, Resident #65 and Resident #194. 2. All residents are at risk if facility staff fail to review and revise their comprehensive care plan to reflect a change in resident care needs. Resident's care plans will be reviewed with change of condition and their next scheduled assessment and revised accordingly to reflect care needs. 3. Director of Nursing will educate licensed nursing staff and interdisciplinary team members on the requirement to review and revise comprehensive care plans to reflect changes in resident care needs. 4. DON or designee will review comprehensive care plans for 5 different residents daily (M-F) for five (5) days, weekly for three (3) weeks and monthly for two (2) months, to ensure they are reviewed and revised to reflect resident care needs. Findings will be reviewed with the QAPI Committee.	

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

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F 657	Continued From page 14 member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility bed rail policy documented, "Based upon the individualized comprehensive assessment if it is determined that bed rail(s) will be indicated to assist resident in maintaining or improving functional ability and do not constitute a restriction as defined as a restraint, bed rail(s) may be utilized and care planned with the consent of the resident/resident representative to meet the individualized need." No further information was presented prior to exit. 2. The facility staff failed to review and revise Resident #65's comprehensive care plan for the use of bed rails. Resident #65 was admitted to the facility on 12/14/18. Resident #65's diagnoses included but were not limited to dementia, diabetes and major depressive disorder. Resident #65's quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 2/1/21, coded the resident's cognition as severely impaired. On 3/2/21 at 11:38 a.m. and 3/3/21 at 8:34 a.m., Resident #65 was observed lying in bed with bilateral quarter bed rails raised in the upright position. Review of Resident #65's clinical record failed to reveal a physician's order for bed rails. Resident #65's comprehensive care plan initiated on 12/14/18 failed to document information	F 657		

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

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F 657	Continued From page 15 regarding bed rails. On 3/3/21 at 9:26 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of a care plan is to individualize residents' care. RN #2 stated the use of bed rails should be included in residents' care plans so staff is aware. On 3/3/21 at 2:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to review and revise Resident #194's comprehensive care plan for the use of bed rails. Resident #194 was admitted to the facility on 2/22/21. Resident #194's diagnoses included but were not limited to chronic kidney disease, major depressive disorder and Alzheimer's disease. Resident #194's admission minimum data set assessment was in progress. An admission nursing assessment dated 2/22/21 documented Resident #194 was oriented to self and able to follow directions. On 3/2/21 at 11:35 a.m., Resident #194 was observed lying in bed with bilateral half bed rails in the upright position. Review of Resident #194's clinical record failed to reveal a physician's order for bed rails. Resident #194's comprehensive care plan initiated on 2/22/21 failed to document	F 657		

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F 657	Continued From page 16 information regarding bed rails. On 3/3/21 at 9:26 a.m., an interview was conducted with RN (registered nurse) #2. RN #2 stated the purpose of a care plan is to individualize residents' care. RN #2 stated the use of bed rails should be included in residents' care plans so staff is aware. On 3/3/21 at 2:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 657		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, it was determined that facility staff failed to provide respiratory care, consistent with professional standards of practice, for three of 46 residents in the survey sample, Residents # 61, # 64 and #53. The facility staff failed to store Resident #61 and # 53's incentive spirometers and Resident #64's C-PAP [continuous positive	F 695	1. Respiratory device storage for Resident #61, Resident #53 and Resident #64 was corrected. 2. All residents with respiratory devices have the potential to be affected if facility staff fail to store devices in a sanitary manner. Rounds will be conducted for residents with respiratory devices to ensure they are stored in a sanitary	4/14/21

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

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F 695	Continued From page 17 airway pressure] mask in a sanitary manner. The findings include: 1. The facility staff failed to store Resident # 61's incentive spirometer [1] in a sanitary manner. Multiple observations revealed Resident #61's incentive spirometer on the bedside table uncovered when not in use. Resident # 61 was admitted to the facility with diagnoses that included but were not limited to: chronic obstructive pulmonary disease [2]. Resident # 61's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 01/26/2021, coded Resident # 61 as scoring a 12 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 12- being moderately impaired of cognition for making daily decisions. On 03/02/21 at approximately 2:45 p.m., an observation of Resident #61 room revealed an incentive spirometer on the bedside table uncovered. On 03/02/21 at approximately 5:09 p.m., observation of Resident #61's room revealed the incentive spirometer remained on the over-the-bed table uncovered. On 03/03/21 at approximately 8:25 a.m., an observation of Resident #61 room revealed an incentive spirometer on the over-the-bed table uncovered. The physician's order for Resident # 61 dated "1/8/2021" documented, "Incentive Spirometer x 10 HR [ten times per hour] while awake.	F 695	manner. Variances will be addressed. 3. Administrator or designee will educate facility staff regarding appropriate methods to store respiratory devices in a sanitary manner. 4. Administrator or designee will conduct environmental rounds for residents with respiratory devices daily (M-F) for five (5) days, weekly for three (3) weeks and monthly for two (2) months, to verify storage in a sanitary manner. Findings will be reviewed with the QAPI Committee.	

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F 695	Continued From page 18 Frequency: every shift. Schedule Type: Everyday." The comprehensive care plan for Resident # 61 dated of 02/17/2021 failed to address or evidence the use of an incentive spirometer. On 03/02/2021 at approximately 2:45 p.m., an interview with Resident # 61. When asked about the incentive spirometer Resident # 61 stated, "I use it several times a week." On 03/03/2021 at approximately 3:30 p.m., an interview regarding the storage of an incentive spirometer was conducted with LPN [licensed practical nurse] # 5. When asked if an incentive spirometer was considered a piece of respiratory equipment, LPN # 5 stated yes. When asked about the procedure staff follows for storing an incentive spirometer that is not in use, LPN # 5 stated that it should be placed in a Ziploc bag to prevent the spread of bacteria. At this time, an observation of Resident #61's room was conducted with LPN #5. LPN # 5 entered Resident # 61's room with their permission at approximately 3:35 p.m. An observation of the incentive spirometer revealed it was on top the bedside table setting inside a Ziploc bag. Further observation revealed the Ziploc bag was open and the mouth piece on the incentive spirometer was exposed to the environment. LPN # 5 was asked if the incentive spirometer was stored in a sanitary manner. LPN # 5 stated no the mouth piece should have been placed inside the bag and the bag closed. In "Fundamentals of Nursing" 7th edition, 2009: Patricia A. Potter and Anne Griffin Perry: Mosby, Inc; Page 648. "Box 34-2 Sites for and Causes of	F 695		

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

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F 695	Continued From page 19 Health Care-Associated Infections under Respiratory Tract -- Contaminated respiratory therapy equipment." On 03/03/2021 at 5:25 p.m., ASM # 1 [administrative staff member], administrator, was made aware of the findings. No further information was provided prior to exit. References: [1] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm. [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. The facility staff failed to store Resident # 64's C-PAP [continuous positive airway pressure] mask [1] in a sanitary manner. Multiple observations revealed Resident #64's C-PAP mask on the bedside table uncovered when not in use. Resident # 64 was readmitted to the facility with diagnoses that included but were not limited to: obstructive sleep apnea [2]. Resident # 64's most recent comprehensive MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/01/2021, coded Resident # 64 as scoring an eight on the	F 695		

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 20 staff assessment for mental status (BIMS) of a score of 0 - 15, eight- being moderately impaired of cognition for making daily decisions. On 03/02/21 at approximately12:03 p.m., and at approximately 12:35 p.m., observations of Resident # 64's room revealed a C-PAP mask laying on top of the bedside table uncovered. On 03/02/21 at approximately 2:58 p.m., an observation of Resident # 64's room revealed the C-PAP mask remained on top of the bedside table uncovered. The physician's order dated 02/21/2021 for Resident # 64 documented, "CPAP @ [at] 10pm [10:00 p.m.]. Frequency: at bedtime. Schedule Type: Everyday." The comprehensive care plan for Resident # 64 with a revision date of 03/21/2020 documented, "Focus: [Name of Resident # 64] has impaired respiratory System. Hx [history]: obstructive sleep apnea, uses present CPAP at bedtime but will sometimes refuse to wear despite education on importance. Date Initiated: 02/19/2020. Revision on: 03/21/2020." Under "Interventions/Tasks" it documented in part, "Cpap as ordered. Date Initiated: 02/19/2020. Revision on: 03/21/2020." On 03/03/2021 at approximately 3:19 p.m., an interview regarding the storage of a C-PAP mask was conducted with LPN [licensed practical nurse] # 5. When asked if a C-PAP mask was considered a piece of respiratory equipment, LPN # 5 stated yes. When asked to describe the procedure staff follows for storing a C-PAP mask when not in use, LPN # 5 stated that it should be	F 695		

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 _____	03/05/2021

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MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

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F 695	Continued From page 21 placed in a Ziploc bag to prevent the spread of bacteria. At this time an observation was conducted with LPN #5 of Resident #64's room. LPN #5 entered Resident # 64's room at approximately 3:27 p.m., and observed the C-PAP mask laying on top of the bedside table uncovered. LPN # 5 stated that the CPAP mask was not stored in a sanitary manner. The facility's policy "CPAP and BiPAP [Bi-level Positive Airway Pressure]" documented in part, "2. Equipment Care. a. Everyday the mask is to be wiped with a sanitizing cloth and then wiped with a wet washcloth. It is then to be dried with a paper towel and placed in a bag for storage when not in use." On 03/03/2021 at 5:25 p.m., ASM # 1 [administrative staff member], administrator, was made aware of the findings. No further information was provided prior to exit. References: [1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm. [2] Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an	F 695		

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 _____	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 22 hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html. 3. The facility staff failed to store respiratory equipment in a sanitary manner, the incentive spirometer for Resident #53. Observation revealed Resident #53's incentive spirometer on the bedside table uncovered when not in use. Resident #53 was admitted to the facility on 2/22/20 with diagnoses that included but were not limited to: bipolar (mental disorder characterized by periods of mania and depression) (1), diabetes mellitus (inability of insulin to function normally in the body) (2) and angina (severe pain in the chest accompanied by a choking feeling) (3). The most recent MDS (minimum data set) assessment, an annual, with an ARD (assessment reference date) of 1/24/21, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact. A review of the MDS Section G-functional status coded the resident as limited assistance for bed mobility, hygiene, bathing, dressing; supervision for eating / locomotion and independence in walking. A review of MDS Section H- bowel and bladder coded the resident as always continent for bowel and occasionally incontinent for bladder. Resident #53's bedside table was observed with an uncovered incentive spirometer during observations on 3/2/21 at 11:15 AM, 3/2/21 at 1:00 PM and 3/3/21at 8:00 AM. A review of Resident #53's physician orders failed to evidence any order for the use of an incentive spirometer.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

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F 695	Continued From page 23 A review of the physical therapy notes dated 1/22/21 at 3:22 PM, documented in part, "Diaphragmatic breathing exercises to improve lung capacity followed by use of incentive spirometer. Oxygen saturation was 97% at room air post incentive spirometer use. Instructed resident in using the incentive spirometer to improve lung capacity with good carry over noted." A review of Resident #53's comprehensive care plan failed to address or evidence any documentation for the use of an incentive spirometer. An interview was conducted on 3/3/21 at 2:00 PM with Resident #53. When asked if he used his incentive spirometer, Resident #53 stated, "Oh yes! It makes such a difference. I use it four times a day. Therapy helped me get it. When I use it, my oxygen levels get to 97% or 98%, when I do not it is 91%. I can't believe how much better I breathe when I use it." An interview was conducted on 3/3/21 at 2:30 PM with LPN (licensed practical nurse) #3. When asked how incentive spirometers should be stored, LPN #3 stated, "The incentive spirometer should be covered when not in use." An interview was conducted on 3/3/21 at 4:10 PM with LPN #2, the unit manager. When asked how the incentive spirometer should be stored when not in use, LPN #2 stated, "It should be covered when not in use." LPN #2 stated, "The resident can cover it with the bag and nursing checks it to make sure it is covered. It is nursing's responsibility."	F 695		

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 _____	03/05/2021

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 695	Continued From page 24 When asked if there was a policy for incentive spirometer, LPN #2, the unit manager stated, "No, there is not a policy." On 3/4/21 at 8:59 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director or nursing and ASM #3 the nurse consultant were informed of the above concerns. No further information was provided prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 71. 2. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 160. 3. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 34.	F 695		
F 700 SS=D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.	F 700		4/14/21

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 _____	03/05/2021

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F 700	Continued From page 25 §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to implement bed rail requirements for three of 46 residents in the survey sample, Residents #90, #65 and #194. 1. The facility staff failed to assess Resident #90 as requiring the use of bed rails and failed to obtain consent for the use of bed rails. On 3/2/21, the resident was observed lying in bed with bed rails in the upright position. 2. The facility staff failed to assess Resident #65 as requiring the use of bed rails. On 3/2/21 and 3/3/21 Resident #65 was observed lying in bed with bed rails in the upright position. 3. The facility staff failed to assess Resident #194 for the use of bed rails and failed to obtain consent for the use of bed rails. On 3/2/21 Resident #194 was observed lying in bed with bed rails in the upright position. The findings include: 1. The facility staff failed to assess Resident #90 as requiring the use of bed rails and failed to obtain consent for the use of bed rails.	F 700	1. Resident #90, Resident #65 and Resident #194 were assessed for the use of bed rails. Facility staff reviewed and obtained consents for bed rail use for Resident #65, Resident #90 and Resident #194. 2. All residents have the potential to be affected if facility staff fail to assess residents for the use of bed rails and if facility staff fail to obtain consent for use. A review of the medical record for residents who require bed rails will be conducted to verify an assessment has been completed and a consent was obtained for use. Variances will be addressed. 3. Director of Nursing or designee will provide education to licensed nursing staff on the requirement to assess residents for the use of bed rails and the requirement to obtain consent for the use of bed rails. 4. DON or designee will audit newly admitted resident□s medical records daily (M-F) for five(5) days, weekly for three (3) weeks and monthly for two (2) months, for completed bed rail assessments and bed rail consents when appropriate. Findings will be reviewed with the QAPI Committee.	

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F 700	Continued From page 26 Resident #90 was admitted to the facility on 2/10/21. Resident #90's diagnoses included but were not limited to muscle weakness, dementia and difficulty swallowing. Resident #90's admission MDS (minimum data set) assessment, with an ARD (assessment reference date) of 2/15/21 coded the resident's cognition as severely impaired. On 3/2/21 at 4:33 p.m., Resident #90 was observed lying in bed with bilateral one half bed rails raised in the upright position. Review of Resident #90's clinical record failed to reveal a physician's order for bed rails. An informed consent form for bed rails signed by the resident's representative on 2/10/21 documented a check mark beside, "I DO NOT consent to the use of bed rail(s) as recommended and understand the risk and benefits." Resident #90's comprehensive care plan initiated on 2/10/21 failed to document information regarding bed rails. A bed rail evaluation dated 2/12/21 documented, "NO bed rail(s) required." On 3/3/21 at 9:26 a.m., an interview was conducted with RN (registered nurse) #2, the nurse who completed the 2/12/21 bed rail evaluation, regarding the facility process for the use of bed rails. RN #2 stated, "We do an assessment to see what they need it for, we get a consent from the family and let the family know the risks and benefits of the side rails, then we let the doctor know and if they meet the criteria, get an order, put it in the care plan and let staff know what it is used for." RN #2 was informed Resident #90's bed rail assessment documented	F 700		

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

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F 700	Continued From page 27	F 700		

bed rails were not required and an informed consent form documented the resident's representative did not consent to the use of bed rails and was made aware of the above observation of Resident #90 lying in bed with bed rails in the upright position. RN #2 stated she was not aware the CNAs (certified nursing assistants) were raising Resident #90's bed rails.

On 3/3/21 at 2:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern.

The facility bed rail policy documented, "It is the policy of this facility that after appropriate alternatives have been attempted and the alternatives that were attempted were not adequate to meet the resident's needs, the resident will be assessed for the use of bed rails. This assessment will include, but is not limited to, a review of risks including entrapment. An informed consent will be obtained from the resident or if applicable, the resident representative if bed rail use is indicated."

No further information regarding this concern was presented prior to exit.

2. The facility staff failed to assess Resident #65 as requiring the use of bed rails. On 3/2/21 and 3/3/21 Resident #65 was observed lying in bed with bed rails in the upright position.

Resident #65 was admitted to the facility on 12/14/18. Resident #65's diagnoses included but were not limited to dementia, diabetes and major depressive disorder. Resident #65's quarterly MDS (minimum data set) assessment with an

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 _____	03/05/2021

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MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

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F 700	Continued From page 28 ARD (assessment reference date) of 2/1/21, coded the resident's cognition as severely impaired. On 3/2/21 at 11:38 a.m. and 3/3/21 at 8:34 a.m., Resident #65 was observed lying in bed with bilateral quarter bed rails raised in the upright position. Review of Resident #65's clinical record failed to reveal a physician's order for bed rails. Resident #65's comprehensive care plan initiated on 12/14/18 failed to document information regarding bed rails. The most recent bed rail evaluation for Resident #65 was dated 12/7/20 and documented, "NO bed rail(s) required." On 3/3/21 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse who completed the 12/7/20 bed rail evaluation, regarding the facility process for the use of bed rails. LPN #2 stated, "When a resident is admitted, part of our process is to evaluate the use of bed rails. They should come in not using bed rails." LPN #2 stated, "then if it is necessary for the of use of a bed rail, review the risks and benefits, obtain consent, depending on what they check off, assess the resident for the need, if yes, explain why. The consent form needs to be signed by the resident or responsible party. There should be a risk vs benefits conversation with the resident or responsible party. If yes, there should be a generic order put in place and the care plan should briefly be updated for bedrails as indicated." LPN #2 was informed Resident #65's bed rail assessment	F 700		

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F 700	Continued From page 29 documented bed rails were not required, and was made aware of the above observation of Resident #65 lying in bed with bed rails in the upright position. LPN #2 could not provide any additional information. On 3/3/21 at 2:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit. 3. The facility staff failed to assess Resident #194 for the use of bed rails and failed to obtain consent for the use of bed rails. On 3/2/21 Resident #194 was observed lying in bed with bed rails in the upright position. Resident #194 was admitted to the facility on 2/22/21. Resident #194's diagnoses included but were not limited to chronic kidney disease, major depressive disorder and Alzheimer's disease. Resident #194's admission minimum data set assessment was in progress. An admission nursing assessment dated 2/22/21 documented Resident #194 was oriented to self and able to follow directions. On 3/2/21 at 11:35 a.m., Resident #194 was observed lying in bed with bilateral half bed rails in the upright position. Review of Resident #194's clinical record failed to reveal a physician's order for bed rails, a bed rail evaluation and an informed consent form for the use of bed rails. Resident #194's comprehensive care plan	F 700		

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

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MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

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F 700	Continued From page 30 initiated on 2/22/21 failed to address or document information regarding the use of bed rails. On 3/3/21 at 10:04 a.m., an interview was conducted with LPN (licensed practical nurse) #2, the nurse who completed the 12/7/20 bed rail evaluation, regarding the facility process for the use of bed rails. LPN #2 stated, "When a resident is admitted, part of our process is to evaluate the use of bed rails. They should come in not using bed rails." LPN #2 stated, "then if it is necessary for the of use of a bed rail, review the risks and benefits, obtain consent, depending on what they check off, assess the resident for the need, if yes, explain why. The consent form needs to be signed by the resident or responsible party. There should be a risk vs benefits conversation with the resident or responsible party. If yes, there should be a generic order put in place and the care plan should briefly be updated for bedrails as indicated." LPN #2 further stated that Resident #194 was transferred to this facility from a sister facility so she could see if a bed rail evaluation and informed consent form were completed at the sister facility. When asked if those documents should be completed upon admission to this facility, LPN #2 stated, "They should be." On 3/3/21 at 2:15 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 700		
F 770 SS=F	Laboratory Services CFR(s): 483.50(a)(1)(i)	F 770		4/14/21

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 _____	03/05/2021

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F 770	Continued From page 31 §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to dispose of laboratory vaccutainers upon expiration date in three of three medication storage rooms, (Evergreen, Magnolia and Dogwood medication storage rooms). Expired laboratory vaccutainer tubes were observed available for use in Evergreen, Magnolia and Dogwood medication storage rooms. The Evergreen medication storage room contained 17 expired laboratory (lab) vaccutainer tubes, Magnolia medication storage room contained 18 expired lab vaccutainer tubes and Dogwood medication storage room contained seven expired lab vaccutainer tubes. The findings include: During the medication storage and labeling facility task on 3/3/21 at 8:14 AM with LPN (licensed practical nurse) #2, the unit manager a review of the Evergreen and Magnolia medication storage rooms was conducted. During the observation and review with LPN #2, the following expired laboratory supplies were observed: -In the Evergreen medication storage room: eight	F 770	1. Expired vacutainers observed in 3 medication storage rooms were disposed of. 2. All residents have the potential to be affected if facility staff fail to dispose of expired vacutainers. Rounds will be conducted in three medication storage rooms auditing for expired vacutainers. Variances will be addressed. 3. Director of Nursing or designee will educate licensed nursing staff regarding the storage and disposal requirements for laboratory vacutainers. 4. DON or designee will conduct environmental rounds in three medication storage rooms daily (M-F) for five (5) days, weekly for three (3) weeks and monthly for two (2) months, to ensure expired vacutainers are not available for use. Findings will be reviewed with the QAPI Committee.	

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

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F 770	Continued From page 32 purple top (hematology, platelet count) (1) vaccutainer tubes (5), expired 8-12-20 volume: 4 milliliter, five blue top (prothrombin and partial thromboplastin time) (2) vaccutainer tubes, expired 1-10-21 volume: 3.5 milliliter, one red top (chemistry) (3) vaccuatiner tube, expired 9-10-20 volume: 8 milliliter, and three green top (chemistry, ammonia, carboxyhemoglobin) (4) vaccuatiner tubes, expired 12-9-20 volume: 5 milliliter. All expired vaccutainer tubes were found in a red 4-quadrant basket. - In the Magnolia medication storage room: six purple top (hematology, platelet count), vaccutainer tubes, expired 8-12-20 volume: 4 milliliter, five blue top (prothrombin and partial thromboplastin time), vaccuatiner tubes, expired 1-10-21 volume: 3.5 milliliter, four red top (chemistry) vaccuatiner tubes, expired 9-10-20 volume: 8 milliliter, and three green top (chemistry, ammonia, carboxyhemoglobin) vaccuatiner tubes, expired 12-9-20 volume: 5 milliliter. All expired vaccutainer tubes were found in a red 4-quadrant basket. An interview was conducted on 03/03/21 at 8:14 AM with LPN #2, the unit manager. When asked about the above laboratory vaccutainer tubes, LPN #2 stated, "Yes, it is expired". When asked about the process for disposing of expired laboratory supplies, LPN #2 stated, "I do not know. The director of nursing would know. We use a laboratory vendor though." An interview was conducted on 3/03/21 at 8:38 AM with ASM (administrator staff member) #2, the director of nursing. When asked about the process staff follows for disposing of expired laboratory vaccutainer tubes, ASM #2 stated, "We	F 770		

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

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F 770	Continued From page 33	F 770		

use a vendor for our lab. We do check the lab [laboratory] vaccutainers date, we check them and the lab person checks them. The lab tech said that Dogwood is central location for laboratory supplies. During COVID, we tried to decentralize the lab process to prevent spread of COVID, got smaller lab baskets, and put them on Evergreen and Magnolia. The lab person said they were too small. The nurses were checking them but I thought they were disposed of. Dogwood is central storage and all vaccutainer tubes should be good in there because we did not decentralize there. It is the same process of supply and restocking."

An observation was conducted in the Dogwood medication storage room and seven green top vaccutainer tubes (chemistry, ammonia, carboxyhemoglobin), expired 12-9-20 volume: 5 milliliter were found. All expired vaccutainer tubes were found in a red 4-quadrant basket.

On 3/4/21 at 8:59 AM, ASM (administrative staff member) #1, the administrator, ASM #2, the director or nursing and ASM #3 the nurse consultant were informed of the above concerns.

According to the facility's "Medication Storage" policy dated 7/23/19, which documents in part, "Medications and biologicals are stored safely, securely and properly following manufacturer's recommendations. Potentially harmful substances (e.g. test reagents) are identified and stored away from medications. Outdated, contaminated or deteriorated medications are immediately removed from stock, disposed of according to procedures."

According to applicable requirements for

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	495038	A. BUILDING _____ B. WING _____	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

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F 770	Continued From page 34 laboratories specified in Part 493 of this chapter: § 493.1252 Standard: Test systems, equipment, instruments, reagents, materials, and supplies.(4) (d) Reagents, solutions, culture media, control materials, calibration materials, and other supplies must not be used when they have exceeded their expiration date, have deteriorated, or are of substandard quality. No further information was provided prior to exit. References: (1) Mosby's Manual of Diagnostic and Laboratory Tests, 6th edition, Elsevier, page 15. (2) Mosby's Manual of Diagnostic and Laboratory Tests, 6th edition, Elsevier, page 15. (3) Mosby's Manual of Diagnostic and Laboratory Tests, 6th edition, Elsevier, page 15. (4) Mosby's Manual of Diagnostic and Laboratory Tests, 6th edition, Elsevier, page 15. (5) Vacutainer. (n.d.) McGraw-Hill Concise Dictionary of Modern Medicine. (2002). Retrieved March 9 2021 from https://medical-dictionary.thefreedictionary.com/Vacutainer	F 770		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.	F 812		4/14/21

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 _____	03/05/2021

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F 812	Continued From page 35 (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review it was determined facility staff failed to store food in the kitchen and in one of three nourishment rooms in accordance with professional standards for food service safety. The findings include: 1. The facility failed to properly store opened, available for use dry goods in the kitchen and failed to dispose of dry goods that were past their expiration date. On 3/2/21 at approximately 11:20 a.m., an observation of the facility's kitchen was conducted with OSM (other staff member) #7, the dietary manager. Observation of the kitchen's dry storage area revealed a gallon sized zipper closure plastic bag containing two 1.41-pound bags of dry chicken gravy. One package was observed unopened and the other was observed opened. OSM #7 confirmed that the package of dry chicken gravy was opened inside of the plastic bag and was not dated. OSM #7 stated that staff were to date any item that was opened with the date it was opened and a use by date. Further observation in the dry storage area	F 812	1. Improper storage of opened, available for use, dry goods was resolved and dry goods that were past their expiration date were disposed of. 2. All residents have the potential to be affected if facility staff fail to store food and dispose of expired food in the kitchen and nourishment rooms in accordance with professional standards for food service safety. Dietary Director will check dry good storage in the kitchen and nourishment rooms to verify opened food storage and disposal of expired food. Variances will be addressed. 3. Administrator or designee will educate dietary staff on the proper storage of dry goods in the kitchen. Facility staff will be educated to dispose of dry goods upon expiration date in the nourishment rooms. 4. Dietary Director or designee will conduct rounds in the kitchen and nourishment rooms daily (M-F) for five (5) days, weekly for three (3) weeks and monthly for two (2) months, to ensure proper storage of opened, available for use, dry goods and disposal of dry goods upon expiration. Findings will be reviewed	

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 _____	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 812	Continued From page 36 revealed an opened two-pound bag of dry curly medium pasta noodles. OSM #7 confirmed that the bag was opened and approximately one-quarter full and was not dated with an opened or use by date. The dry storage area also contained two unopened boxes of instant grits, which contained 12 one-ounce packages of grits in each box. Observation of both boxes revealed they were labeled with, "Best if used by Oct 08 20 (10/08/2020)." An additional box of instant grits that contained four packs was observed opened with the date, "Best if used by Oct 08 20." OSM #7 confirmed that the date on the box was the date that they would have discarded them. An opened 25-pound bag of panko breadcrumbs was observed on the wire shelf in the dry storage area. The bag was observed opened at the top and partially rolled down on itself exposing a gap in the bag and revealing the inside contents. OSM #7 confirmed that the bread crumbs were normally kept in a clean sealed bin like the sugar and flour and were not to be stored in the bag as observed. On 3/2/21 at approximately 11:45 a.m., an interview was conducted with OSM #7. OSM #7 stated that opened dry good stored in the dry storage area were dated with the opened date and the use by date. OSM #7 stated that when opened goods were found without an opened or use by date they were discarded. OSM #7 stated that dry goods like breadcrumbs were stored in a sealed bin to prevent contamination like the flour and sugar. On 3/3/21 at approximately 9:45 a.m., a request was made to OSM #7 for the facility policy for storage of dry goods in the facility.	F 812	with the QAPI Committee.	

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 _____	03/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANASSAS HEALTH AND REHAB CENTER	8575 RIXLEW LANE MANASSAS, VA 20109

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F 812	Continued From page 37 The facility policy "Food and Supply Storage" documented in part, "...Dry Goods ...3. Opened packages must be securely closed and product identified. 4. Boxes and cans should be dated with the date of delivery and stored according to the first-in-first out procedure ..." On 3/3/21 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #3, the regional clinical director were made aware of the findings. No further information was provided prior to exit. 2. The facility staff failed to dispose of available for use sugar-free cookies that were past their best use by date in one of three nourishment rooms in the facility. On 3/3/21 at approximately 9:35 a.m., an observation was made of the nourishment room on the Dogwood unit at the facility. Observations revealed one soft baked sugar free lemon cookie packaged in a plastic wrapper. The wrapper was observed dated "BB (best by) 03/01/2021." Additional observations revealed four soft baked sugar free chocolate chip cookies dated, "BB 02/12/2021" and five soft baked sugar free chocolate chip cookies dated "BB 02/17/2021." On 3/3/21 at 9:42 a.m., an interview was conducted with OSM #7, the dietary manager. OSM #7 stated that the dietary staff maintained the stock of the snacks and drinks that were available for use to them in the nourishment rooms in the facility. OSM #7 stated that they ordered boxes of the cookies every week and that the dietary staff stocked the nourishment rooms	F 812		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 812	Continued From page 38 twice a day, checking the expiration dates on the products and rotating the stock. OSM #7 stated that when food items were found expired or past the best by date, they discarded them. OSM #7 confirmed the dates on the cookies in the Dogwood nourishment room and stated that they thought the BB on the package meant "best by" and they should be discarded. OSM #7 stated that they would confirm the best by date on the box of cookies they had in the dry storage in the kitchen to ensure that they were in date. On 3/3/21 at approximately 5:30 p.m., ASM (administrative staff member) #1, the administrator and ASM #3, the regional clinical director were made aware of the findings. No further information was provided prior to exit.	F 812		