PRINTED: 02/17/2021 FORM APPROVED OMR NO 0938-0391

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
|--------------------------|-------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------|---------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------------------------|---------------------------|
| | | 495424 | B. WING | | 02/27/2020 | |
| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | 5 | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD | | (X5) OMPLETION DATE |
| E 000 | Initial Comments | | E 00 | 0 | | |
| F 000 | survey was conducte 2/27/2020. The facili compliance with 42 C Requirement for Long | ty was in substantial FR Part 483.73, g-Term Care Facilities. No stigated during the survey. | F 00 | 0 | | |
| | inspection was condu 02/27/2020. Correcti compliance with 42 C Term Care requireme Regulations for the Li | FR Part 483 Federal Long nts and Virginia Rules and | | | | |
| | 109 at the time of the consisted of 42 curre closed record reviews | odations Needs/Preferences | F 55 | 8 | 3/1 | 16/20 |
| | services in the facility accommodation of re preferences except we endanger the health other residents. This REQUIREMENT by: | sident needs and when to do so would or safety of the resident or is not met as evidenced | | | | |
| ı | record review, it was staff failed to ensure residents, (Resident a call bell were accomm | n, staff interview, and clinical determined that the facility one of 49 sampled \$275) needs for the use of a nodated. The facility staff | | The statements made in the following plan of correction are not an admission and do not constitute an agreement with the alleged deficiencies nor the reporter conversations and other information cit | th ed ted | DATE |

03/12/2020

Electronically Signed

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 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING | (X3) DATE SURVEY COMPLETED |
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| 495424 B. WNG | 02/27/2020 |
| NAME OF PROVIDER OR SUPPLIER STREET ADDRESS | |
| 14935 HOLLY KNO | ANE |
| LAKE MANASSAS HEALTH & REHABILITATION CENTER GAINESVILLE, V | 0155 |
| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH | R'S PLAN OF CORRECTION (X5) RECTIVE ACTION SHOULD BE COMPLETION RENCED TO THE APPROPRIATE DEFICIENCY) CX5) COMPLETION DATE |
| F 558 Continued From page 1 F 558 | |
| 1 333 | allowed definionsing. The |
| | alleged deficiencies. The the following plan of |
| | nain in compliance with all |
| | e regulations. The facility |
| | take the actions set forth |
| | rrection. The following |
| | n constitutes the facility |
| | npliance. All alleged |
| | d have been or will be |
| had not been a resident of the facility long enough corrected by | date or dates indicated. |
| for an MDS (minimum data set) assessment to | |
| | rence to 12 VAC |
| assessment dated 2/23/20, he was documented 5-371-220 | ļ |
| as being oriented only to person. He was | |
| and the state of t | ?75 call bell was ensured |
| | th since 2/26/2020. |
| - | low-up on the patient are that his call bell is |
| | ach when in his room. |
| | Managers/Designee will |
| | patients rooms to |
| | call bells are always |
| | n when in bed/chair. Any |
| | their bed/chair without call |
| | have it immediately |
| on left side of bed, out of the resident's reach, as accessible to | em and assigned staff |
| described above. Resident #275 stated, "I need identified fo | nediation. |
| | nee to provide an |
| in-service to | staff on the following |
| A review of Resident #275's care plan dated topics: | |
| | nagement and response |
| resident's call light is within reach and encourage 4. Directo | _ |
| | esignee to complete 10% |
| 273 | pied rooms weekly x4 |
| , , | thly x3 months to Ill bells are within the |
| ' | s. Any deficient finding will |
| | rectified and forwarded to |
| | littee for further review |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1 ' | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WNG _ | | 02/2 | 02/27/2020 | |
| | ROVIDER OR SUPPLIER | IABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | |
| F 558 | Resident #275, LPN # him a few days that h asked where his call bell gown so that it is acceased who is responsive resident's call bell is with a sked who is responsive resident's call bell is with a sked who is responsive resident's call bell is with a sked who is responsive resident's call bell is with a sked that it should a resident's reach. When Resident #275, CNA care of him when she stated she puts the call bell to call state since he was admitted to call bell to call state since he was admitted to call state on 2/27/2020 at 11:00 staff member) #1, the director of nursing, As consultant, and ASM nursing, were informed policy regarding call be requested. At this time requested. At this time requested. | #4 stated: "I have cared for e has been here." When bell should be located, LPN should be clipped to his essible if he needs it. When bible for making sure a within reach, LPN #4 stated, eam." a.m., CNA (certified nursing enviewed, regarding where could be located. CNA #4 lways be located within the en asked if she takes care of #4 stated she usually takes works the night shift. She call bell close to Resident e can use it to call staff. members the resident using ff on multiple occasions d. D a.m., ASM (administrative administrator, ASM #2, the SM #3, the regional nurse #4, the assistant director of ed of these concerns. A bell placement was e, ASM #2 stated the facility | F 5: | and recommendation. 5. Date of compliance: 03/16/2020 | | | |
| | Free from Abuse and CFR(s): 483.12(a)(1) | was provided prior to exit. | F 6 | 00 | | 3/16/20 | |
| | | | 1 | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| | | 495424 | B. WING | B. WING | | 02/ | 02/27/2020 | |
| NAME OF PROVIDER OR SUPPLIER LAKE MANASSAS HEALTH & REHABILITATION CENTER | | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE SAINESVILLE, VA 20155 | | | | |
| (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 E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | OULD BE COMPLETION | | |
| F 600 | neglect, misappropria and exploitation as de includes but is not lim corporal punishment, any physical or chemitreat the resident's me §483.12(a) The facility §483.12(a) The facility §483.12(a) The facility sale abuse, corporative involuntary seclusion; This REQUIREMENT by: Based on clinical recifacility document revie Reported Incident (FF the facility staff failed residents, Resident # abuse and coercion be facility staff failed to effect from inappropriate Resident #21 on 11/20. The findings include: Resident #7 was adm 2/28/18; diagnoses in dementia with behavior psychosis, anxiety dis disorder, depression, MDS (Minimum Data ARD (Assessment Recoded the resident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident as ability to make daily little in the sident and little in the sid | right to be free from abuse, tion of resident property, efined in this subpart. This ited to freedom from involuntary seclusion and ical restraint not required to edical symptoms. by must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced ord review, staff interview, ew, and review of a Facility RI), it was determined that to ensure that one of 49 7, was free from sexual y another resident. The nsure that Resident #7 was e touching and coercion by 6/19. iitted to the facility on clude but are not limited to ors, high blood pressure, order, schizoaffective and diabetes. The annual Set) assessment with an eference Date) of 11/4/19 being severely impaired in | F | 600 | F600 cross reference to 12 VAC 5-371-110 & 12 VAC 5-371-140 1. Resident #7 inappropriate touchin Resident #21 was FRI □ed on 11/26/20 and has not experienced such an incid since then. Resident #21 was also more to another Unit and did not exhibit such posture towards others until discharge on 02/19/2020. 2. Administrator/Discharge Planning/Designee will interview all patients with frequency of interaction were sident #21 to ascertain that there has not been any incident of sexual impropriety against them from her until her discharged on 02/19/2020. Any impropriety credence of an FRI will be immediately reported as per MFA policiand procedure and the state regulation abuse. 3. The Administrator/Discharge Planning/Designee will in-service all ston the following: | ont ent ved n a d vith s | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 1'' | PLE CONSTRUCTION G | (X3) DATE SURVEY COMPLETED | | |
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| | | 495424 | B. WING | | 02/27/2020 | |
| | ROVIDER OR SUPPLIER | ABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | | | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 600 | 7/14/19; diagnoses in diabetes, depression, pulmonary disease, p and high blood pressi (Minimum Data Set) of Reference Date) of 1' as being mildly impair life decisions. The rerequiring total care fo transfers and toileting hygiene and dressing A review of a FRI date "Resident (#21) unzip #7) and was attempting his pants. Residents separated." A review of the witness investigation revealed (Resident #7) so I app and CNA #2 and she me and told me to was glass at me then proced #7) pants and pulled she could follow. She walking to his room. Up multiple times but his arm." CNA #2 statement do dining room not at the same vicinity (Resident #7). (Resident #7) inapproced | clude but are not limited to hernia, chronic obstructive eripheral vascular disease, ure. The quarterly MDS with an ARD (Assessment 1/22/19 coded the resident red in ability to make daily sident was coded as r bathing; extensive care for a limited assistance for and supervision for eating. Led 11/26/19 documented, upped the pants of (Resident reg to put her hands inside were immediately | F 60 | a) Types of abuse b) Preventing abuse c) Reporting requirements of an abu 4. Administrator/Discharge Planning attend residents council meetings monthly x3 months to check whether there have been any unreported abuse related incidents from the patients. Any incident emanating from the meeting w be reviewed and reported accordingly, assessed to be an FRI ed incident. Ti unreported FRI related incident(s) will be forwarded to the QAPI Committee f further review and recommendation as applicable. 5. Date of compliance: 03/16/2020 | will y y yill if he also | |

| STATEMENT OF DEFICIEN AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WING | B. WING | | 02/ | 27/2020 |
| NAME OF PROVIDER OR SUPPLIER LAKE MANASSAS HEALTH & REHABILITATION CENTER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | | |
| | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | | | (X5) COMPLETION DATE |
| was give RN #2 (F documen #2 - Othe interview Asked pa remembe stated "N She then same tab table, I w my husb heavily c A review "(Resider of Nursin (Adminis Nursing) states he The final documen was an ir residents occurred. A review the follow A nurse's "Pt (patie inapprope Staff inter away fror distress. | Registered N Inted, "Unit mer Staff Mem ed (Residen atient if there ers that happ lo, I don't thin stated "Somble" and stated as playing wand - he's a sonfused." of the investing and Unit N trative Staff I and RN [registed and a state and registed an | urse) statement anager (RN #2) and (OSM ber) discharge planner, t #21) regarding situation. was an incident that she bened during lunch. Patient hak so but I can't remember." heone was arguing at the ed, "Man at the end of the with his belly and arm - it was son of a bitch." Patient ligation report documented, ewed by DON/UM (Director flanager - ASM #2 Member, (the Director of listered nurse] #2) and | F | 600 | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WING | | 02/27/2020 | | |
| | ROVIDER OR SUPPLIER | IABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | • | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETION DATE | |
| F 600 | deemed appropriate in Staff will continue to repatient." The comprehensive of dated 3/1/18, documed (Resident #7) has additionable such as hx (history) postient's) privacy (was unannounced), and work (related to) Demendocumented were as offering pleasant diversional from the preferences." This in "Monitor location. No behavior and attempts interventions." This in 4/2/19. "Monitor/documented symptoms dated 11/3/19. "Wandialert staff of patient les intervention was dated alert staff of patient existed intervention was dated intervention was dated." | this time and interventions in addition to the above. Inonitor the safety of the sare plan For Resident #7, ented one for "Behaviors - werse behavioral symptoms rotruding on other pt's alking into pt rooms randering with exit-seeking tia." The interventions follows: "Distract resident by risions, structured activities, elevision shows based on his tervention was dated 4/2/19, tify the nurse of wandering ed diversional intervention was dated ment/report any adverse." This intervention was er Alert: Wander guard to aving the building." This id 4/2/19. "Wander guard to kit seeking behavior." This | F 60 | | | | |
| | the following: A nurse's note dated "Pt was noted to be in another pt in dining romisidentification of pt" 1300 (1:00 pm). Staff pt's; assessed both pto (psychiatric) consult of | 11/27/19 that documented, appropriately touching | | | | | |

| | OF DEFICIENCIES CORRECTION | | | | (X3) DATE SURVEY COMPLETED | | | |
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| | | 495424 | B. WNG | 8. WING | | 02/ | 02/27/2020 | |
| | ROVIDER OR SUPPLIER | IABILITATION CENTER | | 14 | TREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE AINESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | | | |
| F 600 | Current care plan on at this time and is deed to the above intervent. An order dated 11/26/[psychiatric] consult. record failed to reveal a psych consult. The comprehensive of dated 9/16/19, docum (Resident #21) exhibit symptoms as evidence herself on floor, remowrapping them around (oxygen) NC (nasal of misidentification of oth husband, and inapproof The interventions docure asonable, discuss the Explain/reinforce why and/or unacceptable to intervential for the reside offering tasks which dwatching television or intervention was dated (document)/report and (symptoms)." This intervention was provide opportunity for attention. Stop and tast This intervention was | behavior has been reviewed emed appropriate in addition tions." 19 for geriatric psych Further review of the clinical documentation evidencing are plan for Resident #21, tented, "Behaviors: its adverse behavioral ted by frequently positioning ving sheets off of bed and id her body, taking O2 annula) off, rejection of care, ter pt's (patients) as her expriately touching other pt's." tumented were as follows: "If the resident's behavior. behavior is inappropriate to the resident." This id 9/16/19. "Minimize ent's disruptive behaviors by ivert attention such as a listening to music." This id 9/16/19. "Monitor/doc diadverse behavioral sx's tervention was dated any indication of the approvement in behavior." idated 9/16/19. "Staff to repositive interaction, alk with her as passing by." idated 11/27/19. | F | 006 | | | | |
| | On 2/26/20 at 1:26 PM conducted with RN #2 | | | | | | | |

| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLI A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| AMME OF PROVIDER OR SUPPLIER LAKE MANASSAS HEALTH & REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE | | | 495424 | 8. WNG | | 02/27/2020 | |
| F 600 Continued From page 8 Minimum Data Set), regarding the incident. RN #2 stated, "My CNA had come to me and said that she saw (Resident #21) back to her room, and then came and notified me." RN #2 stated, "I don't remember much after that. I know we put (Resident #21) on a different unit. She is pleasantly confused most of the time. (Resident #21) said that was her husband. The touching was inappropriate touching, from what the CNA told me, I didn't witness it myself. She said it was inappropriate and that (Resident #21) had PREFIX TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLET TAG PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFERENCED TO THE APPROPRIATE DATION TO THE APPROPRIATE PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATION TO THE APPROPRIATE COMPLET TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 600 F 600 | | | ABILITATION CENTER | 1 | 14935 HOLLY KNOLL LANE | , , , , , , , , , , , , , , , , , , , , | |
| Minimum Data Set), regarding the incident. RN #2 stated, "My CNA had come to me and said that she saw (Resident #21) mess with (Resident #7) private area in the dining room. The CNA said she helped (Resident #21) back to her room, and then came and notified me." RN #2 stated, "I don't remember much after that. I know we put (Resident #21) on a different unit. She is pleasantly confused most of the time. (Resident #21) said that was her husband. The touching was inappropriate touching, from what the CNA told me, I didn't witness it myself. She said it was inappropriate and that (Resident #21) had | PREFIX | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP | BE COMPLETION | |
| When asked if a resident, touches another resident in a private area is that considered any type of abuse, RN #2 stated, "It is if it is unwarranted." When asked if Resident #7 can consent to sexual contact, RN #2 stated, "It think he could consent." When asked about being able to consent to sexual activity with a low cognitive status reflected by a BIMS (Brief Interview for Mental Status) of 5 (five), RN #2 stated, "I don't not know if someone with a BIMS of 5 can consent. I just learned what the BIMS is. He has dementia." When asked if someone with dementia can consent to sexual contact, RN #2 stated, "I think it is a case by case basis." When asked if there is a process that has to be followed to determine if someone who wants to have sexual contact can consent, RN #2 stated, "If there is anything it would be in policy. I don't know if there is one." On 2/26/20 at 1:42 PM, an interview was conducted with OSM #2, discharge planner. OSM #2 stated that she was present for the interview with Resident #21. She stated that she asked | F 600 | Minimum Data Set), r #2 stated, "My CNA h that she saw (Reside #7) private area in the said she helped (Res and then came and n don't remember much (Resident #21) on a c pleasantly confused r #21) said that was he was inappropriate tou told me, I didn't witne inappropriate and that touched his private at When asked if a resid resident in a private at type of abuse, RN #2 unwarranted." When consent to sexual conhe could consent." W to consent to sexual conhe could consent. When consent I just learned dementia. When ask dementia can consent stated, "I think it is a asked if there is a pro to determine if some sexual contact can con there is anything it wo know if there is one." On 2/26/20 at 1:42 Pl conducted with OSM #2 stated that she wa | regarding the incident. RN and come to me and said int #21) mess with (Resident a dining room. The CNA ident #21) back to her room, otified me." RN #2 stated, "I in after that. I know we put different unit. She is most of the time. (Resident ar husband. The touching arching, from what the CNA ass it myself. She said it was at (Resident #21) had ass it myself. She said it was at (Resident #21) had assed if Resident #7 can attact, RN #2 stated, "I think when asked about being able activity with a low cognitive BIMS (Brief Interview for aive), RN #2 stated, "I don't with a BIMS of 5 can and what the BIMS is. He has asked if someone with at to sexual contact, RN #2 case by case basis." When access that has to be followed one who wants to have ansent, RN #2 stated, "If and the policy. I don't M, an interview was #2, discharge planner. OSM as present for the interview | F 600 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495424 | B. WING | | | 02/27/2020 | |
| | NAME OF PROVIDER OR SUPPLIER LAKE MANASSAS HEALTH & REHABILITATION CENTER | | | 14935 HOLLY | RESS, CITY, STATE, ZIP CODE Y KNOLL LANE LE, VA 20155 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | N SHOULD BE E APPROPRIATE | |
| F 600 | lunch and Resident # remember. OSM #2 sesident #21 if anythman, and Resident #2 remember, and then sesident #7 being hemessing with his belly that she wrote her offit to the DON (ASM #4 the DON's office when to notify them and she police. She stated that the investigation any the investigation any statements are documented in the facility of as-needed status and unavailable for interviews. | ing unusual happened at 21 said she could not stated she then asked ing unusual happened with a 21 stated she couldn't started talking about r husband and she was r. OSM #2 stated that after icial statement and handed 2). She stated she was in n both families were called the non-emergent at she was not involved in further than that. CNA #3, who were present dent, whose written mented above, were no r were working on an it were in school and ew. | F | 00 | | | |
| | mistreatment, abuse, property, or any crime (facility). Procedure: have the legal right to mental and physical a involuntary seclusion or enabled through th free from chemical an in an emergency and/by a physicianIn deand Misappropriation definitions will apply: | * 90 * 1 | | | | | |

| | ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER: | | | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE COMPLETION | |
| F 600 | Sexual coercion. (3) | Sexual assault or allowing a abused by another. (4) | F 600 | | | |
| F 655 SS=D | On 2/27/20 at 10:27 A Staff Member, the Ada aware of the findings. provided. Baseline Care Plan | NM, ASM #1 (Administrative ministrator) was made No further information was | F 655 | | 3/16/20 | |
| | Planning §483.21(a) Baseline (§483.21(a)(1) The fac- implement a baseline that includes the instr- effective and person- that meet professiona The baseline care pla (i) Be developed within admission. | cility must develop and care plan for each resident uctions needed to provide centered care of the resident all standards of quality care. In musting 48 hours of a resident's arm healthcare information | | | 3 | |
| | including, but not limit (A) Initial goals based (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recomm §483.21(a)(2) The factomprehensive care plan if the comprehension of the comprehension o | ed to- on admission orders. endation, if applicable. cility may develop a plan in place of the baseline | | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WNG | B. WING | | 02/: | 27/2020 |
| NAME OF PROVIDER OR SUPPLIER LAKE MANASSAS HEALTH & REHABILITATION CENTER | | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE SAINESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | | | | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 655 | (ii) Meets the requirent (b) of this section (exc this section). §483.21(a)(3) The farresident and their reprof the baseline care plimited to: (i) The initial goals of (ii) A summary of the dietary instructions. (iii) Any services and administered by the facility (iv) Any updated inform of the comprehensive This REQUIREMENT by: Based on observation record review, it was a staff failed to implement for one of 49 residents. Resident #275. The faimplement Resident #call bell within reach. conducted on 2/25/20 #275's call bell was lobar and hanging down resident's reach. The findings include: | nents set forth in paragraph cepting paragraph (b)(2)(i) of cility must provide the resentative with a summary fan that includes but is not the resident. The resident resident resident and personnel acting your mation based on the details care plan, as necessary. It is not met as evidenced that the facility and the baseline care plan as in the survey sample, actility staff failed to 1275's care plan to place the During observations 20 and 2/26/2020, Resident oped around the left grab in near the floor, out of the demitted to the facility on demitted to the facility on | F | 655 | F 655 cross reference to 12VAC 5-371-250 1. Resident #275 call bell was ensure to be within reach since 2/26/2020. Management follow-up on the patient continue to assure that his call bell is always within reach when in his room a per his care plan. 2. ADON/Unit Managers/Designee w audit all current patients rooms to ensure that their call bells are always within their reach when in bed/chair as their respective care plans. Any patien found in their bed/chair without call bell reach will have it immediately accessib | ill per t in | |
| | 2/23/2020 with diagnoses including, but not limited to pneumonia and difficulty swallowing. He had not been a resident of the facility long enough for an MDS (minimum data set) to be completed. On the admission nursing assessment dated 2/23/20, he was documented as being oriented | | | | to them and assigned staff identified for remediation. 3. Staff Development Coordinator will in-service the staff on the following: a) Implementing patient care plan for | 15 | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | (X2) MULTII A. BUILDINI | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WING | | 02 | 2/27/2020 |
| | ROVIDER OR SUPPLIER | ABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY) | ULD BE | (X5) COMPLETION DATE |
| F 655 | only to person. He way of his extremities well. A review of Resident at 2/23/2020 revealed, in resident's call light is at the resident to use it for the resident to use it for the resident to use it for the resident's reach and 2/26/2020 at 8:36 and 2/26/2020 at | #275's care plan dated in part: "Be sure the within reach and encourage or assistance as needed." s and times, Resident beerved looped around the ging down near the floor, out is 2/25/20 20 at 2:21 p.m. is a.m. m., Resident #275 was call bell was hanging down it of the resident's reach, as ident #275 stated: "I need an't reach it." a.m., LPN (licensed as interviewed. When asked pable of using a call bell each, LPN #4 stated it if she is familiar with if s | F 68 | service provision, including that obell 4. DON/UMs will audit 10% of a patients weekly x4 weeks and more months to assure that their call be management is in conformity with respective care plans. The outcor audit will be used to conduct conteducation on call bell management then forwarded to the QAPI communitarither review and guidance. 5. Date of compliance: 03/16/20 | Il current inthly x3 ell their ne of the inuing nt and nittee for | |
| | staff members are res | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WNG | | | 02/ | 27/2020 |
| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | 14 | TREET ADDRESS, CITY, STATE, ZIP CODE 1935 HOLLY KNOLL LANE AINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 655 | assistant) #4 was interesidents call bells shistated that it should a resident's reach. Whe Resident #275, CNA care of him when she stated she puts the call that the call bell to call state since he was admitted aware of what a resident CNA #4 stated the number of the care plant the entire care plant the entire care plant for the call that the care plant that the care plant that the care plant that the care plant for the care plant that the director of nursing, As consultant, and ASM nursing, were informed A review of the facility revealed, in part: "A licoordination with the develops and implem plan for each patient in person-centered care health-related care armaintain the highest pand psychosocial well | a.m., CNA (certified nursing erviewed, regarding where ould be located. CNA #4 always be located within the en asked if she takes care of #4 stated she usually takes works the night shift. She all bell close to Resident e can use it to call staff. It members the resident using eff on multiple occasions d. When asked if she is lent's care plan documents, arses assign CNAs relevant. She stated she cannot see or any resident. O a.m., ASM (administrative administrator, ASM #2, the SM #3, the regional nurse #4, the assistant director of ed of these concerns. If policy "Care Planning" censed nurse, in interdisciplinary team, ents an individualized care in order to provide effective, | F | 355 | | | |
| F 656 SS=D | | comprehensive Care Plan | F | 556 | | | 3/16/20 |
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| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | E SURVEY IPLETED |
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| | | 495424 | B. WING_ | | 02 | 2/27/2020 |
| 01 | ROVIDER OR SUPPLIER NASSAS HEALTH & REH | IABILITATION CENTER | <i>_</i> | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFII TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 656 | §483.21(b)(1) The faci implement a compreh care plan for each resersident rights set for §483.10(c)(3), that incobjectives and timeframedical, nursing, and needs that are identificant assessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, includit reatment under §483. (iii) Any specialized screhabilitative services provide as a result of recommendations. If findings of the PASAF rationale in the resident's represental (A) The resident's prefuture discharge. Fact whether the resident's prefuture discharge plans it plan, as appropriate, | cility must develop and densive person-centered sident, consistent with the shart §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial ded in the comprehensive aprehensive care plan must personal development of the following as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse \$10(c)(6)\$. Parvices or specialized the nursing facility will passage as a facility disagrees with the RR, it must indicate its ent's medical record. In the resident and the tive(s)-als for admission and deference and potential for illities must document as desire to return to the seed and any referrals to and/or other appropriate | F | 556 | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
| | | 495424 | B. WING | | | 02/ | 27/2020 |
| NAME OF PROVIDER OR SUPPL LAKE MANASSAS HEALTH | | ABBILITATION CENTER | | 14 | TREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE BAINESVILLE, VA 20155 | | |
| PREFIX (EACH DE | FICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| by: Based on obsidocument review determined that implement the of 49 residents 72. The staff facomprehensive ordered by the The findings in Resident # 72 diagnoses that multiple sclerot Resident # 72's set), a quarterl (assessment for of 0 - 15, 15- bid daily decisions Procedures and was coded as a The comprehe with a revision part, "Focus. Of has oxygen the exchange. Re "Interventions" O2 [oxygen] via Revision on: 10 | ervation erv | is not met as evidenced on, staff interview, facility d clinical record review it was acility staff failed to ehensive care plan for one survey sample, Residents # implement Resident #72's plan to administer oxygen as cian. dmitted to the facility with led but were not limited to: and high blood pressure. recent MDS (minimum data essment with an ARD ce date) of 01/18/2020, as scoring a 15 on the staff al status (BIMS) of a score cognitively intact for making ection O "Special Treatment, irams", coded Resident # 72 ng oxygen. care plan for Resident # 72 f 10/15/2019 documented in Therapy: [Resident # 72] /t [related to] ineffective gas on: 10/15/2019." Under umented, "Oxygen Setting: I cannula as ordered. | F | 656 | 1. Resident #72 oxygen flow rate wa adjusted to 2L/minute as per physician order and has continue to be maintaine at the ordered rate. 2. DON/UMs will audit the oxygen concentrator of all current patients with oxygen supplementation to ascertain the ordered rate is accurately administered in accordance with their comprehensive care plan. Any noted inaccurate rate administration will be rectified and assigned nurse identified on the spot documented in-service. 3. SDC/UMs will re-educate the nurse on the following topics: a) Setting the oxygen flow rate on a concentrator. b) Implementing patient comprehensicate plan 4. DON/UMs to perform 10% audit or current residents on oxygen weekly x1 month and monthly x3 months to ascertain that they are receiving accurate ordered oxygen therapy. Any noted inaccurate administration will be rectificand continuing education provided to affected identified assigned patient. The issue will also be forwarded to the QAF Committee for further review and recommendation 5. Date of compliance: 03/16/2020 | sed for es ive ed, e | |

| AND PLAN OF CORRECTION IDENTIFICATION NUMBER | | 1 ` ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD | | | (X5) COMPLETION DATE |
| F 656 | connected to an oxygrunning. Observation oxygen concentrator in passed through the mindicating an oxygen minute. On 02/26/20 at 10:13 Resident # 72 revealed awake receiving oxygrunning. Observation oxygen connected to an oxygrunning. Observation oxygen concentrator in passed through the mindicating an oxygen minute. The POS [physician's 221 dated February 2 "Oxygen 2L [two liters cannula] continuous standard continuous s | en concentrator that was of the flow meter on the revealed the three-liter line iddle of the flow meter ball flow rate of three liters per a.m., an observation of ed the resident lying in bed en by nasal cannula en concentrator that was of the flow meter on the revealed the three-liter line iddle of the flow meter ball flow rate of three liters per order sheet] for Resident # 020 documented in part, i] VIA [by] NC [nasal shift. Order Date: te: 12/04/2019." treatment administration 72 dated February 2020 the physician order for the of the eTAR revealed that and oxygen at two liters per | F | 356 | | | |
| W | observation of Reside oxygen concentrator a conducted with LPN [3. When asked how to the oxygen concentral liter line should pass to | proximately 1:25 p.m., an earl # 72's flow meter on their and interview was licensed practical nurse] # to read the flow meter on tor, LPN # 3 stated that the through the middle of the eter. After observing the | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| 1070000 | ROVIDER OR SUPPLIER | ABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CO 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | ODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTIC PREFIX (EACH CORRECTIVE ACTION SHOULI TAG CROSS-REFERENCED TO THE APPROF DEFICIENCY) | | | | (X5) COMPLETION DATE |
| F 656 | flow meter on Resider concentrator, LPN # 3 three liters per minute the physician prescrib Resident # 72. LPN # order and then stated two liters per minute. the purpose of a resid plan, LPN # 3 stated to for the patient. After a comprehensive care pLPN # 3 was asked if implemented for the atwo liters per minute. On 2/25/2020 at approved the director of numbers their policie Lippincott as their state. The facility's policy "R Planning" documented nurse, in coordination team, develops and in care plan for each pate effective, person-cent necessary health-rela attain or maintain the mental and psychosometer and pate of the director of patient."." According to Fundame Williams and Wilkins 2 documented, "A writter communication tool as members that helps e care The nursing car information about the | at # 72's oxygen by stated that it was set at c. LPN #3 was asked what bed oxygen flow rate was for 3 reviewed the physician's that it should have been at When asked to describe ent's comprehensive care that it was a treatment plan reviewing Resident # 72's rolan for oxygen therapy, the care plan was being dministration of oxygen at LPN # 3 stated no. Deximately 11:30 a.m., ASM using stated that the facility s, procedures, and andard of practice. Resident Assessment & Care dd in part, "Policy: A licensed with the interdisciplinary inplements an individualized ient in order to provide ered care, and the ted care and services to highest practical physical, cial well-being of the rentals of Nursing Lippincott 2007 pages 65-77 on care plan serves as a mong health care team | F6 | :56 | | | |

| ı | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A BUILDING | | SURVEY PLETED |
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| | ROVIDER OR SUPPLIER | ABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 656 F 692 SS=D | and is used to direct or revise and update the there are changes in with new orders" (1) Lippincott Williams & Company Philadelphi On 02/26/2020 at 4:4 staff member] # 1, addirector of nursing, ar consultants were madfindings. No further information References: [1] A nervous system brain and spinal cord. sheath, the material tilyour nerve cells. This blocks messages betwork, leading to the sinformation was obtain https://medlineplus.go. Nutrition/Hydration St CFR(s): 483.25(g) (1)-§483.25(g) Assisted in (Includes naso-gastric both percutaneous endoscenteral fluids). Based enteral fluids). Based | stablished for the patient careexpect to review, a care plan regularly, when condition, treatments, and production, treatments, and product a pages 65-77. 5 p.m. ASM [administrative ministrator, ASM # 2, and ASM # 3, regional nursing de aware of the above aware of the above aware of the above are to the above aware slows down or ween your brain and your symptoms of MS. This ned from the website: by/multiplesclerosis.html. actus Maintenance and gastrostomy tubes, adoscopic gastrostomy and to no a resident's assment, the facility must | F 6 | | | 3/16/20 |
| | | ins acceptable parameters uch as usual body weight or | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | I ' ' | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | | |
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| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | 14 | REET ADDRESS, CITY, STATE, ZIP CODE 935 HOLLY KNOLL LANE AINESVILLE, VA 20155 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 692 | desirable body weight balance, unless their demonstrates that the preferences indicate §483.25(g)(2) Is offer maintain proper hydrogen with the series a nutritional provider orders at the This REQUIREMENT by: Based on observation record review, it was staff failed to provide maintain hydration strain the survey sample staff failed to offer flux Resident #275's react 2/25/2020 and 2/26/27. The findings include: Resident #275 was a 2/23/2020; diagnose to pneumonia and dinot been a resident can MDS (minimum dompleted. On the act assessment dated 2/2 as being oriented ond documented as moving the admission assess documentation of his eating/drinking. | ant range and electrolyte resident's clinical condition is is not possible or resident otherwise; ared sufficient fluid intake to ation and health; ared a therapeutic diet when problem and the health care rapeutic diet. To is not met as evidenced an, staff interview, and clinical determined that the facility care and services to ratus for one of 49 residents, Resident #275. The facility ids to or place fluids within the during observations on 2020. Admitted to the facility on a include, but are not limited fficulty swallowing. He had of the facility long enough for ata set) assessment to be demission nursing 23/20, he was documented by to person. He was ng all of his extremities well. | F | 692 | F692 cross reference to 12 VAC 5-371-220 & 12 VAC 5-371-340 1. Resident #275 nectar thick liquid continue to be offered to him since 02/26/2020. The patient has also been assessed to have the capacity to call a to self-hydrate □ the nectar thick liquid has, therefore, been made easily accessible to him. 2. DON/Dietitian/UMs will audit all current patients with ordered altered flu (thickened liquids) to ascertain that the are always within the reach of the patie and/or offered by staff for at least every hours as tolerated by the affected patie 3. SDC/Dietitian will in-service the nursing staff on the following: a) Managing altered fluids (thickened liquids) for patient hydration 4. DON/Dietitian will complete 10% of current patient on altered fluids weekly month and monthly x3 months to ascertain that they are being hydrated adequately as tolerated. Any inadequately affects the control of patient noted will be rectificated. | uids y ent / 2 ent. | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1'' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | , | 5. XI |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD | | | (X5) COMPLETION DATE |
| F 692 | mouth appeared dry. within the resident's rethick water and juice bed, but was position reach. On 2/26/2020 at 10:3 Resident #275 was of fluids were observed was observed for the time, two nurses and assistants) went into these staff members placed any fluids with nectar thick water and his bed, but was positive reach. On 2/27/2020 at 8:36 observed sitting up in observed the resident fluids from a cup on head of the control of the cont | No fluids were observed each. A cooler with nectar was observed beside his ed out of the resident's 7 a.m. and 2:02 p.m., bserved sitting up in bed. No within reach. Resident #275 next two hours. During that two CNAs (certified nursing the resident's room; none of offered the resident fluids or ain his reach. A cooler with diplice was observed beside tioned out of the resident's a.m., Resident # 275 was bed. The surveyor trusing his right arm to drink his over bed table. #275's care plan dated to information related to his ccupational therapy) L/2020 revealed, in part: E (upper extremity) ROM JE (right upper extremity) unctional limitations)." A rm goals within this in the goals related to | F | 692 | accordingly, including that of an addition remedial session with assigned staff to the affected patient. The result will also forwarded to the QAPI committee for review/recommendation. 5. Date of compliance: 03/16/2020 | | |
| | | stered dietician, was sked for an approximation of | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | TIPLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | |
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| 377.73 | ROVIDER OR SUPPLIER | ABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | 1 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROFICE DEFICIENCY) | | SHOULD BE | | (X5) COMPLETION DATE |
| F 692 | maintain good hydrati "Of course, every resi say usually between day." When asked if a that amount of fluid ju intake, OSM #8 stated supplemented during trays do not contain e On 2/27/2020 at 9:40 practical nurse) #4 wa if a resident receives a needs at meal times, need to have fluids all stated the nursing sta She stated the CNAs assistants) pass out id times. She stated that goes in a room; they s resident has fluids acc asked specifically abo stated the resident ha a few days. For this re important for the staff and to make sure he i On 2/27/2020 at 9:56 conducted with CNA f hydration. When asked drink fluids at other tin to maintain hydration the residents need to time." CNA #4 stated during the day." She s residents whenever the | dent needs to take in to on status, OSM #8 stated, dent is different, but I would 1600 milliliters and 2 liters a president usually takes in st from mealtime fluid dithe fluids, should be the day because the meal nough fluids. a.m., LPN (licensed as interviewed. When asked all the fluids, he or she LPN #4 stated, "No. They through the day." She ff offers fluids "all the time." (certified nursing be water at designated as each time a staff member should be making sure the cessible to them. When nout Resident #275, LPN #4 is not been at the facility but eason, it is even more to monitor him frequently has fluids within reach. a.m., an interview was f4, regarding resident dif a resident needs to nee other than meal times status, CNA #4 stated, "Yes, be offered fluids all the "We pass fluids like water stated she takes fluids to ney ask for it, and if they are ffers fluids whenever she | F | 692 | | | |

| | LAN OF CORRECTION IDENTIFICATION NUMBER | | 200 | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | IABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| F 692 | On 2/27/2020 at 10:10 member) #9, the specinterviewed. When as therapy for Resident # working on upper extresident's ability to swresident is at risk for a liquids. When asked in have nectar-thick fluids consume these fluids OSM #9 stated, "He is reach if they are nectared if they | 6 a.m., OSM (other staff ech therapist, was ked about her focus for #275, she stated she is remity strength, and on the vallow. OSM #9 stated the aspiration if he drinks thin if the resident was safe to its within reach, and to without staff supervision, as safe to have fluids within ar thick." 10 a.m., ASM (administrative administrator, ASM #2, the SM #3, the regional nurse #4, the assistant director of its of these concerns. 1 policy "Hydration" revealed, be appropriately hydrated by uids and encouraging aroughout the day The staff its to consume all fluids on | F 692 | | | |
| | No further information Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care an The facility must ensu- needs respiratory care | d tracheal suctioning. are that a resident who e, including tracheostomy | F 69 | 5 | 3/16/20 | |
| | care and tracheal suc | tioning, is provided such professional standards of | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | 495424 | B. WNG | | | 02/ | 27/2020 |
| NAME OF PROVIDER OR SUPPLIER LAKE MANASSAS HEALTH & REH | HABILITATION CENTER | | 14 | TREET ADDRESS, CITY, STATE, ZIP CODE 4936 HOLLY KNOLL LANE AINESVILLE, VA 20155 | , | |
| PREFIX (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| care plan, the resident and 483.65 of this sulfation interview, facility document of the facility of the facility and failed to provide respins with professional stand comprehensive person of 49 residents in the #322, #321, #118, #20 nebulizer masks for Resident #118 and Re | nensive person-centered hts' goals and preferences, bpart. is not met as evidenced In, resident interview, staff ument review and clinical determined facility staff iratory services consistent hadards of practice, and the on-centered care plan, for six survey sample, Residents 21, #47 and #72. The Residents #322, #321, esident #47 were observed he residents' nebulizer bed tables; and the for Resident #321 and 221, rered on the resident night able. Resident #72 was keygen at 3 LPM (liter per e 2 LPM ordered by the sadmitted to the facility on oses that included but were obstructive pulmonary illation (3) and legal #322's most recent MDS was not due at the time of ty's nursing admission 14/2020 coded Resident ed times four, "Oriented to | F | 695 | F695 1. Residents #322, #321, #118, #22 and #47 s nebulizer masks and tubes were returned to the Center s designated holding bags on 2/25/2020 and have estince been maintained. The incentive spirometer for Residents #321 and #25 were placed in Center designated hold bag when not in use. Resident #72 oxygen flow rate was adjusted to 2L/minute as per physician order ar has continue to be maintained at the ordered rate. Medication error protoco be initiated. No side effect experienced the patient. An in-service on the calibration of oxygen rate on concentrations are provided to the assigned nurse(s) the patient on 2/25/2020 and 2/26/202 Residents #221 and #118 discharged 3/6/2020 and 3/4/2020 respectively. 2. DON/ADON/UMs to audit all current patients on ordered nebulizer and incentive spirometer therapies to assurthat the nebulizer masks and incentive spirometers are placed in Center selesignated holding bags when not in undersignated holdi | ated ever 21 ling ad will by ator to 0. on ent re en that | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPI A. BUILDING | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | ROVIDER OR SUPPLIER NASSAS HEALTH & REF | ABILITATION CENTER | ļ | STREET ADDRESS, CITY, STATE, ZIP CODE 14936 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | D BE COMPLETION |
| F 695 | time. A nebulizer unit top of the resident's n the bed. An uncovere attached to the nebuli on top of the nebulize | was not in the room at the was observed located on ightstand to the left side of ed mask was observed zer machine and was lying r machine. | F 69 | not bagged will be immediately retu designated holding bag. Any inaccu oxygen calibrated flow rate noted w rectified immediately. The outcome above audit will also be used to con a targeted in-service with nurses as to affected patients. | rate ill be of the aplete |
| | of the bed revealed the mask was lying on top as documented in the asked about the nebul #322 stated that she is needed for shortness (chronic obstructive president #322 stated nebulizer a couple of she got short of breat asked how the facility nebulizer and mask, is she was not sure becand had a hard time state. | ent #322. During the all observation of the post the nightstand to the left the uncovered nebulizer to of the nebulizer machine to observations above. When allizer and mask, Resident received the nebulizer as of breath due to COPD ulmonary disease). It that she had used the times since admission when the after therapy. When staff maintains the Resident #322 stated that ause she was legally blind seeing things. | | SDC/Designee will provide in-sto the nursing staff on the following a) Maintaining sanitary condition of nebulizer mask and incentive spiror b) Calibrating ordered oxygen rate the oxygen concentrator. DON/UMs will audit 10% of all patients with ordered oxygen, nebuliand incentive spirometer therapies oxygens are that unused masks/incentive spirometer are place designated hobags and oxygen rate are calibrated the concentrator as ordered. Any arrotted will be rectified accordingly as appropriate and then forwarded to the QAPI Committee for further review are recommendation. | topics: of neter e on current izer, weekly ding I on nomaly she |
| v | "Feb (February) 26, 2 documented in part, " Solution 0.5-2.5 MG ((milliliter), 3 ml inhale as needed for wheezi obstructive pulmonary Order Date: 02/14/20. The comprehensive of documented in part, " | r Summary Report" dated 020" for Resident #322 Ipratropium-Albuterol (4) milligram)/3 (three) ML orally every 4 (four) hours ng related to chronic v disease, unspecified, 20, Start Date: 02/14/2020." are plan for Resident #322 Nursing Care Needs: [Name s nursing care needs r/t | | 5. Date of compliance: 03/16/2020 | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1''' | | CONSTRUCTION | (X3) DATE COMP | SURVEY LETED |
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| | ROVIDER OR SUPPLIER | ABILITATION CENTER | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE BAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 695 | to rectal ulcer (5), pne (7), hyperlipidemia (8) 02/14/2020, Revision "Interventions" it documedications as orders effectiveness/side effe 02/14/2020." The "Medication Adm Resident #322, dated documented Resident "Ipratropium-Albutero 5:21 a.m. On 2/26/20 at 1:25 p.i conducted with LPN (When asked about the residents with as need orders, LPN #1 stated are kept in the rooms stated that the masks nebulizers are change Mondays, Wednesday asked about the proceed nebulizers after admir when not in use, LPN administered to the renebulizer is rinsed out LPN #1 stated that aft placed in a bag for stolong the nebulizer is a placed in the bag, LPI nebulizer is air dried for minutes and then placed storage until needed. nebulizer mask is storit is for infection control. | intestinal) bleed secondary sumonia (6), hypertension (6), hypertension (7), COPD Created on on 02/25/2020." Under smented in part, "Administer ed and monitor for ect. Created on inistration Record" for "2/1/2020-2/29/2020" to #322 receiving (7) Solution" on 2/18/2020 at m., an interview was discensed practical nurse) #1. The process staff follows for ded nebulizer medication (8) I that nebulizer medication (9) I that nebulizer machines of the residents. LPN #1 and tubing for the ed three times a week on the ed three times a week on the ed three times and the ed three times and #1 stated the medication is sident and afterwards the ed and allowed to air dry. For the nebulizer is dried it is prage. When asked how allowed to dry before being (8) #1 stated that the or at least ten to fifteen ed back in the bag for | F | 695 | | | |

| | TEMENT OF DEFICIENCIES OPLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | | |
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| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 4936 HOLLY KNOLL LANE SAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 695 | is considered a respirated, "Yes." When mask observed in Readvised of the above 2:05 p.m. and 4:30 p a.m., LPN #1 stated mask this morning duaround 9:00 a.m. LP was uncovered and traccording to the practice discarded it. On 2/26/20 at approximate request was made by (administrative staff in nursing for the facility. The facility policy "Reactive in part, "Medicated Name out nebulizer in and place in a plastic Nebulizers and bags Monday, Wednesday. On 2/25/2020 at appreximate approximate policies and the policies of the facility policy and place in a plastic Nebulizers and bags monday, Wednesday. On 2/25/2020 at appreximate approximate approxi | ratory treatment, LPN #1 asked about the nebulizer sident #322's room and observations on 2/25/20 at m. and on 2/26/20 at 8:30 that she had discarded the tring her room rounds N #1 stated that the mask that it was not stored tice of the facility so she had imately 11:00 a.m., a written list to ASM member) #2, the director of policy on nebulizer therapy. respiratory/Oxygen Date 11/01/19" documented ebulizer Treatment5. reservoir with tap water, dry, bag when not in use. must be changed every must be changed every must be changed every must a stated that the facility res, procedures, and | F | 695 | | | |
| | clean nebulizer after equipment in the pati is changed according | ons. 2. Disassemble and | | | 0. | | |

| | OF DEFICIENCIES F CORRECTION | [V . V | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | |
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| F 695 | 5 Continued From page 27 | | F 695 | | |
| | tubing and mouthpied cleaning, sterilization | | | | |
| | (administrative staff n administrator, ASM # | 2, the director of nursing and nurse consultant were | | | |
| | No further information was provided prior to exit. | | | | |
| | Reference: | | | | : |
| | turns liquid medicine machine and breathe mouthpiece. This info the website: https: | izer is a small machine that into a mist. You sit with the in through a connected ormation was obtained from ov/ency/patientinstructions/0 | | | |
| | breath that can lead tinformation was obtain | e pulmonary disease that makes it difficult to o shortness of breath. This ned from the website: ov/medlineplus/copd.html. | | | |
| | rhythm of the heartbe obtained from the wel | a problem with the speed or at. This information was bsite: ov/medlineplus/atrialfibrillati | | | |
| | Albuterol and ipratrop medications called bro | tropium oral inhalation. ium are in a class of onchodilators. Albuterol and ion works by relaxing and | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE A. BUILDING | CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| | ROVIDER OR SUPPLIER | HABILITATION CENTER | 14 | TREET ADDRESS, CITY, STATE, ZIP CODE 1935 HOLLY KNOLL LANE AINESVILLE, VA 20155 | , 522,233 |
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| F 695 | Continued From pag | je 28 | F 695 | | |
| | breathing easier. The from the website: | ages to the lungs to make his information was obtained gov/druginfo/meds/a601063.h | | | |
| | an uncommon condi- and women, and is a constipation and pro- movement. In this co- rectum (typically in ti- leads to passing bloo- rectum. This informative website: https://www.asge.org | ary rectal ulcer syndrome is tion that can affect both men associated with long-standing clonged straining during bowel bondition, an area in the he form of a single ulcer) and mucus from the ation was obtained from the g/home/for-patients/patient-inf ling-minor-rectal-bleeding | | | |
| | 6. Pneumonia is an lungs. Many germs, and fungi, can cause get pneumonia by in This information was https://medlineplus.g | infection in one or both of the such as bacteria, viruses, e pneumonia. You can also haling a liquid or chemical. | | | |
| | 8. Hyperlipidemia is blood cholesterol is loor hypercholesterole obtained from the weathers://medlineplus.g 2. Resident #321 was | gov/ency/article/000403.htm. as admitted to the facility on noses that included but were | | | e e |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE S COMPLI | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIADELICIENCY) | | (X5) COMPLETION DATE |
| F 695 | #321's most recent M was not due at the tin facility's nursing admi 2/13/2020 coded Resoriented times three, and situation." On 2/25/20 at 2:35 p.: conducted with Residinterview, observation revealed a nebulizer nightstand to the left window and an uncovered mask with the nebulizer machine. We nebulizer machine nebulizer machine nebulizer and mask, for received the nebulizer his admission to the fithe incentive spirome Resident #321 stated the hospital and still uwhen asked if he required the nebulizer and ince #321 stated that the secure of his neck of wear and limited mobifacility staff maintains nebulizer and mask, for does not really pay at takes care of them. We seen the staff put the spirometer in a bag we Resident #321 stated. | prertension (5). Resident DS (minimum data set), ne of the survey. The ssion assessment dated ident #321 as being "Oriented to person, place, m., an interview was ent #321. During the n of Resident #321's room unit located on top of the side of the bed near the rered incentive spirometer. vas observed attached to e and was lying on top of the When asked about the Resident #321 stated that he r on a regular basis since acility. When asked about ther on the nightstand that he received it while in uses it at least once a day. uired assistance when using entive spirometer, Resident staff assists him with both collar that he is required to illity. When asked how the the incentive spirometer, Resident #321 stated that he tention to it, that the staff When asked if he has ever nebulizer or the incentive | F | 695 | | | |
| | • | for the nebulizer, nebulizer | | | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUC | | (X3) DATE SURVEY COMPLETED | | | |
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| . 1.1 | ROVIDER OR SUPPLIER | IABILITATION CENTER | | STREET ADDRESS, CITY, STATE, 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | ZIP CODE | 022772020 |
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| F 695 | mask and incentive s The physicians "Orde "Feb (February) 26, 2 documented in part," Nebulization Solution (three) ML (milliliter), orally via (by way of) shortness of breath, (Start Date: 02/14/202 summary report for R evidence documental incentive spirometer. The comprehensive of documented in part, of Resident #321) has (related to) HTN (hyp prostatic hypertrophy hypoxemia (9) Cre Revision on 02/24/20 it documented in part medications/treatmer 02/13/2020." The "Medication Adm Resident #321, dated documented Resident Sulfate Nebulization 3 5:00 p.m. each day fr The "Rehab [rehabilit the transferring hospi a.m. included in Resi medical record docur and Plan/Medical AssTransient hypoxia (| pirometer. Pr Summary Report" dated (2020" for Resident #321 Albuterol Sulfate (6) (2.5 MG (milligram)/3 0.083% 3 (three) m! inhale nebulizer two times a day for Order Date: 02/13/2020, 0." The physician order esident #321 failed to cion for the use of the sare plan for Resident #321 Nursing Care Needs: [Name is nursing care needs r/t ertension), BPH (benign (7), dysphagia (8), eated on 02/13/2020, 20." Under "Interventions", "Administer it as ordered. Created on inistration Record" for 1"2/1/2020-2/29/2020" at 321 receiving "Albuterol Solution" at 9:00 a.m. and om 2/14/20 through 2/26/20. Pation] Progress Note" from tal dated 2/12/2020 at 11:43 dent #321's electronic mented in part, "Impression sessment: Rehab Plan: 10)/abnormal chest x-ray-recommendations from | F6 | 595 | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | ONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | ROVIDER OR SUPPLIER | IABILITATION CENTER | • | 1493 | EET ADDRESS, CITY, STATE, ZIP CODE 35 HOLLY KNOLL LANE INESVILLE, VA 20155 | | İ |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 695 | record, a "Progress N | #321's electronic medical lote-Physician" from the lated 2/12/2020 at 3:01 p.m. nically signed by the mmendations were | F | 695 | | | |
| | documented above. documented in part, " Abnormal CXR (chesinfiltrates, 2. Cough. Agree with empiric Lecomplete a seven day day) and PRN (as need | The progress note Impression and Plan, 1. t x-ray), L. (left) sided Recommendations: 1. | | | | | |
| | When asked about the residents with as need orders, LPN #1 stated are kept in the rooms stated that the masks nebulizers are change Mondays, Wednesday asked about the procenebulizers after administration. | licensed practical nurse) #1. e process staff follows for ded nebulizer medication that nebulizer machines of the residents. LPN #1 | | | | | |
| | administered to the renebulizer is rinsed ou LPN #1 stated that affiliated in a bag for stolong the nebulizer is a placed in the bag, LP nebulizer is air dried filminutes and then places storage until needed. | esident and afterwards the t and allowed to air dry. ter the nebulizer is dried it is prage. When asked how allowed to dry before being | | | | | |

| | ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | X3) DATE SURVEY COMPLETED | | |
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| | ROVIDER OR SUPPLIER | HABILITATION CENTER | • | STREET ADDRESS, CITY, STATE, ZIP CO 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE |
| F 695 | is considered a respiring stated, "Yes." When incentive spirometers #1 stated that they shall the process staff follow an incentive spirometer hospital that they use physician is called to needed for the reside #1 observed Resider the uncovered mask top of the nightstand near the window and spirometer. LPN #1 that there was no bag incentive spirometer that the incentive spirometer that the incentive spirometer was at the bedside for should be a physiciar. On 2/26/20 at approximation request was made by (administrative staff in nursing for the facility and incentive spirometer. Effective to evidence guidance. The facility policy "Recequipment, Effective to evidence guidance." The facility policy "Recequipment, Effective in part, "Medicated N Rinse out nebulizer reand place in a plastic Nebulizers and bags." | When asked if a nebulizer ratory treatment, LPN #1 asked if residents who use is should have an order, LPN hould. When asked about was for residents who have, were brought in from the continue using it. LPN #1 stated that the determine if an order is not to continue using it. LPN it #321's nebulizer unit with on top of the unit located on to the left side of the bed the uncovered incentive checked the area and stated for the mask or the lobe stored. LPN #1 stated cometer was available for a Resident #321 and there in order for its use. Immately 11:00 a.m., a print written list to ASM member) #2, the director of policy on nebulizer therapy entry. Immately 12:00 p.m., ASM #2 Respiratory/Oxygen Date 11/01/19" which failed to in incentive spirometry. | Fé | 695 | | |

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| HT0100 | ROVIDER OR SUPPLIER | HABILITATION CENTER | | 149 | REET ADDRESS, CITY, STATE, ZIP CODE 035 HOLLY KNOLL LANE NINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF. TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 695 | #2, the director of nurstaff uses their policies. Lippincott as their star According to The Lipp Practice 10th Edition, Guidelines 10-11 doc phase 1. Record medescription of secretic clean nebulizer after equipment in the patic is changed according patient has own breat tubing and mouthpied cleaning, sterilization, | oximately 11:30 a.m., ASM sing stated that the facility is, procedures, and indard of practice. Dincott Manual of Nursing 2014, page 236, Procedure umented in part, "Follow-up dication used and ons. 2. Disassemble and each use. Keep this ent's room. The equipment to facility policy. Each thing circuit (nebulizer, | F | 695 | | | |
| | (sixth Edition) 2013, "warm water and dry it spirometer itself in water and internal filter's effective inhalation of extraneous mouthpiece in a plast exercises, and label it applicable, with the painadvertent use by an incentive spirometer was exercised to Lippinco Seventh edition, page supervision of incentinecessary after the paproper technique. However water water the part of the par | owth and impairs the reness in preventing us material. Place the ic storage bag between and the spirometer, if atient's name to avoid other patient. Keep the within the patient's reach." Itt Nursing Procedures, a 383 documented, "Direct we spirometry use isn't atient is able to demonstrate | | | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495424 | B. WING _ | | | 2/27/2020 |
| | ROVIDER OR SUPPLIER | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COD 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIE | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI) TAG | PROVIDER'S PLAN OF CO ({EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| F 695 | patient complies wi 384 documented inDocument the flotime of the procedunumber of breaths patient's condition tolerance for the proper procedure and On 2/27/20 at approper (administrative staff administrator, ASM ASM #3, the region #4, the assistant dia aware of the finding On 2/27/20 at approper stated that upon adsummary is reviews sent from the hosping used then the graduate away from it is sent home. AS Note-Physician for dated 2/12/2020 for documented recoms spirometer use as of that it would be included records. | part "Documentation w or volume levels, date and re, type of spirometer, and taken. Also record the pefore and after the procedure, ocedure, and the results of the post procedure auscultation." eximately 11:00 a.m., ASM f member) #1, the #2, the director of nursing, all nurse consultant and ASM rector of nursing were made | F6 | 95. | | |
| | Nebulizer- a net turns liquid medicin machine and breat | oulizer is a small machine that le into a mist. You sit with the he in through a connected nformation was obtained from | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1, , | ULTIPLE CONSTRUCTION (X3) DATE COMI | | SURVEY LETED | |
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| | | 495424 | B. WNG | | | 02/ | 27/2020 |
| | ROVIDER OR SUPPLIER | ABILITATION CENTER | 75 | 149 | REET ADDRESS, CITY, STATE, ZIP CODE 935 HOLLY KNOLL LANE AINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 695 | Continued From page the website: https://medlineplus.go 00006.htm. 2. Incentive spiromet you keep your lungs information was obtain https://medlineplus.go 00451.htm. 3. Cervical disc disor Your backbone, or spidiscs called vertebrae spinal cord and allow number of problems of the spine or damage is surrounding tissue. The Injuries, Tumors, Conspondylitis and scolios come with age, such a herniated disks, Spina when bone changes proord or nerves. They or Treatments differ by dinclude back braces a information was obtain | er is a device used to help healthy after surgery or when s, such as pneumonia. This hed from the website: hy/ency/patientinstructions/0 der he, is made up of 26 bone he, is structure of the vertebrae and hey include Infections, ditions, such as ankylosing he, is spinal stenosis and he diseases often cause pain heat pressure on the spinal can also limit movement, isease, but sometimes they nd surgery. This | | 695 | | | |
| | lungs. This information website: https://medlin. 5. Hypertension is hig information was obtain | nfection in one or both of the n was obtained from the neplus.gov/pneumonia.html. This ned from the website: bv/medlineplus/highbloodpr | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDENTIFICATION NUMBER | | TIPLE CONSTRUCTION NG | | (X3) DATE SURVEY COMPLETED |
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| | | 495424 | B. WING_ | | | 02/27/2020 |
| | PROVIDER OR SUPPLIER | HABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIF 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | ZIP CODE | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH CORRECTIVE CROSS-REFERENCED | | |
| F 695 | 6. Albuterol is in a combronchodilators. It with air passages to the easier. This information website: https://medlineplus.gtml 7. Benign prostation prostation prostate. This information website: https://www.nlm.nih.statebph.html. 8. Dysphagia is a syinformation was obtaintys://www.nlm.nih.sorders.html. 9. Hypoxemia is low the blood. This information was obtained from the website: https://ghr.nlm.nih.gc.ction. 10. Hypoxia is a defined the tissues of the boodbained from the website: https://www.merriamoxia. 3. Resident #118 with 1/30/2020, with diagnot limited to hyperted disease (3) and ather Resident #118's mosset), an admission a (assessment reference in the sident #118's mosset), an admission a (assessment reference in the sident #118's mosset), an admission a (assessment reference in the sident #118's mosset), an admission a (assessment reference in the sident #118's mosset), an admission a (assessment reference in the sident #118's mosset), an admission a (assessment reference in the sident #118's mosset), an admission a (assessment reference in the sident #118's mosset). | class of medications called orks by relaxing and opening the lungs to make breathing attion was obtained from the gov/druginfo/meds/a607004.h hyperplasia is an enlarged nation was obtained from the gov/medlineplus/enlargedpro wallowing disorder. This ained from the website: gov/medlineplus/swallowingdi or concentrations of oxygen in mation was obtained from the website. The concentrations of oxygen in mation was obtained from the cov/condition/surfactant-dysfun diciency of oxygen reaching dy. This information was | F | 595 | | |

| | STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | 100 | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WING | | | 02/: | 27/2020 |
| | ROVIDER OR SUPPLIER | ABILITATION CENTER | • | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | / I | | | ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY) | | | (X5) COMPLETION DATE |
| F 695 | of 0 - 15, 0- being set daily decisions. On 2/25/20 at 2:25 p. and 2/26/20 at 8:50 at Resident #118's room was observed located the right side of the binask was attached to was propped on top obag was observed hanebulizer machine on "2/5/20." The physicians "Orde "Feb (February) 26, 2 documented in part, "Solution 0.5-2.5 MG (milliliter), 3 ml inhale nebulizer three times asthma (6) Order Dat 02/12/2020." The comprehensive of documented in part, " | al status (BIMS) of a score verely impaired for making m., on 2/25/20 at 4:45 p.m. m., observations of a revealed a nebulizer unit don top of the nightstand to ed. An uncovered nebulizer to the nebulizer machine and of the machine. A plastic anging underneath the attention the nightstand dated er Summary Report" dated 2020" for Resident #118 [Ipratropium-Albuterol (5) (milligram)/3 (three) ML | F | 695 | | | |
| | hyponatremia (6), rigl Created on 01/30/2 02/11/2020." Under " documented in part, " | | | | | | |
| | Resident #118, dated documented Residen "Ipratropium-Albutero | inistration Record" for "2/1/2020-2/29/2020" It #118 receiving Il Solution" four times a day In 2/11/2020 and three times | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | IDEATURIOATION NUMBER | | 2) MULTIPLE CONSTRUCTION BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| | | 495424 | B. WNG | | | 02/ | 27/2020 | | |
| | ROVIDER OR SUPPLIER | ABILITATION CENTER | , | 1493 | ET ADDRESS, CITY, STATE, ZIP CODE 5 HOLLY KNOLL LANE NESVILLE, VA 20155 | 1 02/ | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY) | BE | (X5) COMPLETION DATE | | |
| F 695 | a day from 2/12/20 the On 2/26/20 at 1:25 p. conducted with LPN (When asked about the residents with as need orders, LPN #1 stated are kept in the rooms stated that the masks nebulizers are changed Mondays, Wednesda asked about the proceeding when not in use, LPN administered to the renebulizer is rinsed out LPN #1 stated that affoliated in a bag for stellong the nebulizer is air dried in minutes and then placed in the bag, LP nebulizer mask is sto it is for infection contron the residents face is considered a respirit stated, "Yes." LPN # unit with the uncovered located on top of the of the bed. LPN #1 versus and stated that On 2/26/20 at approximation of the process was made by (administrative staffing the second in the state). | m., an interview was (licensed practical nurse) #1. e process staff follows for ded nebulizer medication d that nebulizer machines of the residents. LPN #1 and tubing for the ed three times a week on ys and Fridays. When ess staff follows storing nistration of treatments and #1 stated the medication is esident and afterwards the t and allowed to air dry. ter the nebulizer is dried it is orage. When asked how allowed to dry before being N #1 stated that the for at least ten to fifteen ced back in the bag for When asked why the red in a bag, LPN #1 stated fol purposes because it goes When asked if a nebulizer ratory treatment, LPN #1 et observed the nebulizer ed mask on top of the unit nightstand to the right side iewed the nebulizer and the it was not in a bag. imately 11:00 a.m., a written list to ASM nember) #2, the director of policy on nebulizer therapy. | F | 595 | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION () | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WNG_ | | | 02/ | 27/2020 |
| | ROVIDER OR SUPPLIER | ABILITATION CENTER | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | EFIX (EACH CORRECTIVE ACTION SHOULD BE | | | (X5) COMPLETION DATE |
| F 695 | in part, "Medicated Ne Rinse out nebulizer re and place in a plastic Nebulizers and bags of Monday, Wednesday, On 2/25/2020 at approximate the director of numbers of | Date 11/01/19" documented ebulizer Treatment5. eservoir with tap water, dry, bag when not in use. must be changed every and Friday and dated." Doximately 11:30 a.m., ASM sing stated that the facility s, procedures, and indard of practice. Interpretation of the director of nursing and nurse consultant were | F | 395 | | | |
| | information was obtain https://www.nlm.nih.go essure.html. | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X1) PROVIDER/SUPPLIER/CLIA IN IDENTIFICATION NUMBER: | (X2) MULT | IPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCE | ON SHOULD BE HE APPROPRIATE | (X5) COMPLETION DATE | |
| F 695 | and can't filter blood, | as they should. This | F 6 | 95 | | | |
| | | ined from the website: ov/chronickidneydisease.htm | | | | | |
| | builds up inside your substance made up of and other substances time, plaque hardens That limits the flow of body. This information website: | disease in which plaque arteries. Plaque is a sticky of fat, cholesterol, calcium, s found in the blood. Over and narrows your arteries. Toxygen-rich blood to your on was obtained from the ov/atherosclerosis.html. | | | | | |
| | Albuterol and ipratrop medications called br ipratropium combinat opening the air passa breathing easier. Thi from the website: | tropium oral inhalation- pium are in a class of conchodilators. Albuterol and ion works by relaxing and ages to the lungs to make s information was obtained by/druginfo/meds/a601063.h | | | | | |
| | information was obtain | ow sodium (salt) level. This ned from the website: ov/ency/article/000394.htm. | | | | | |
| : | 7. Asthma is a disease that causes the airways of the lungs to swell and narrow. It leads to wheezing, shortness of breath, chest tightness, and coughing. This information was obtained from the website: https://medlineplus.gov/ency/article/000141.htm. | | | | | | |
| | with diagnoses that in | as admitted to the facility acluded but were not limited apnea [1] and high blood | | | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WNG | | | 02/: | 27/2020 |
| | ROVIDER OR SUPPLIER | IABILITATION CENTER | | 149 | REET ADDRESS, CITY, STATE. ZIP CODE 135 HOLLY KNOLL LANE MNESVILLE, VA 20155 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | × | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 695 | set), assessment was survey. The facility's Assessment" for Resipart, "2. Orientation: a (day, month, year), d. On 02/25/20 at 11:57 and 02/26/20 at 10:03 Resident # 221's roor spirometer on the overone on the overone on the overone on the overone on 02/27/20 at 11:25 conducted with Resid they used the incentive stated that they used The POS [physician's 221 dated February 2 "Incentive Spirometer needed] when awake The comprehensive of dated 02/20/2020 doc Altered Respiratory Staffered respiratory staffered Tespiratory Staffered Monitor for effects. Created on: On 02/26/2020 at 1:2 Resident # 221's incentive bedside table unconducted with LPN [3. When asked if an considered respirator | 221's MDS (minimum data anot due at the time of the nursing "Admission dent # 221 documented in a Person, b. Place, c. Time Situation." a.m., 02/25/20 at 2:00 p.m. a.m., an observations of m revealed an incentive exthe-bed table uncovered. a.m., an interview was lent #221. When asked if we spirometer Resident 221 it a couple of times a day. corder sheet] for Resident # 1020 documented in part, and in PRN (every hour as a corder Date: 02/22/2020." care plan for Resident # 221 cumented in part, "Focus. Itatus: [Resident # 221] has atus, difficulty breathing r/t lea. Created on: "Interventions" it ster medications/puffers as effectiveness and side | F | 595 | | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | LE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | | |
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| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | | | | |
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| F 695 | spirometer when not should be placed in a observing the spirom table uncovered, LPI placed in a bag. On 2/25/2020 at app #2, the director of nustaff uses their polici Lippincott as their staff member] #1, and director of nursing, a consultants were martindings. No further information. References: [1] Sleep apnea is a causes your breathing pauses can minutes. They may consultants were martindings. This information website: https://medi. Resident #47 was diagnoses that include pneumonia, respirated obstructive pulmonations. Reference date) of 12 as scoring a 15 of mental status (BIMS being cognitively intal In Section O "Special assertions of the spirote | in use, LPN # 3 stated, "It a bag and dated." After neter sitting on the bedside N # 3 stated that it should be roximately 11:30 a.m., ASM ursing stated that the facility es, procedures, and | F 69 | 5 | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | ABILITATION CENTER | | 14 | TREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE SAINESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL. SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | 1 | (X5) COMPLETION DATE | |
| F 695 | and 02/26/20 at 10:08 Resident # 47's nebul on the bedside table of The POS [physician's 47 dated February 20 "Nebulizer tubing sett [Monday-Wednesday 7:00 a.m.] shift every Order Date: 09/03/20 The comprehensive of dated 09/13/2019 doc Oxygen Therapy: [Re therapy r/t [related to] pulmonary disease]. of breath] when lying Created on: 09/13/20 documented, "Give m physician. Created on On 02/26/2020 at app observation of Reside sitting on their bedsid interview was conduct practical nurse] # 3. N mask was considered LPN # 3 stated yes. N nebulizer mask should LPN # 3 stated, "It sho | p.m., 02/25/20 at 3:45 p.m., a.m., observations of izer mask revealed it was uncovered. order sheet] for Resident # 20 documented in part, up change M-W-F-Friday] 11-7 [11:00 p.m night shift for Protocol. 19. Start Date: 09/03/2019." are plan for Resident # 47 sumented in part, "Focus. sident # 47] has oxygen COPD [chronic obstructive Patient has sob [shortness flat and with exertion. 19." Under "Interventions" it edications as ordered by 1: 09/13/2019." proximately 1:25 p.m., an and 47's nebulizer mask to table uncovered and ted with LPN [licensed When asked if a nebulizer respiratory equipment, | F | 695 | | | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDI | TIPLE CONSTRUCTION NG | (X3) DATE SURVEY COMPLETED | | | |
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| | ROVIDER OR SUPPLIER | EHABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFII TAG | | OULD BE COMPLETION | | |
| F 695 | staff uses their polic Lippincott as their s On 02/26/2020 at 4 staff member] # 1, a director of nursing, consultants were m findings. No further information of the second seco | cies, procedures, and standard of practice. :45 p.m. ASM [administrative administrator, ASM # 2, and ASM # 3, regional nursing ade aware of the above on was provided prior to exit. kes it difficult to breath that as of breath. This information the website: .gov/medlineplus/copd.html. as admitted to the facility with aded but were not limited to: all and high blood pressure. st recent MDS (minimum data bessment with an ARD nice date) of 01/18/2020, 2 as scoring a 15 on the staff intal status (BIMS) of a score cognitively intact for making Section O "Special Treatment, orgrams", coded Resident # 72 | F | 695 | | | |
| | a.m., Resident # 72 receiving oxygen by an oxygen concentr Observation of the concentrator reveal | was observed lying in bed y nasal cannula connected to rator that was running. flow meter on the oxygen ed the three-liter line passed of the flow meter ball | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A, BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | HABILITATION CENTER | • | STREET ADDRESS, CITY, STA 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | | ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPROFILE OF THE APPROPR | | | (X5) COMPLETION DATE |
| F 695 | minute. The POS [physician's 221 dated February 2"Oxygen 2L [two liter cannula] continuous 12/04/2019. Start Da The eTAR [electronic record] for Resident a documented the sam review of the eTAR received oxygen at two 02/25/20 and 02/26/2 The comprehensive with a revision date opart, "Focus. Oxygen has oxygen therapy rexchange. Revision "Interventions" it docu 02 [oxygen] via nasa Revision on: 10/15/20 On 02/26/2020 at apposervation of Residoxygen concentrator conducted with LPN 3. When asked how concentrator is read, line should pass throinside the flow meter meter on Resident # LPN # 3 stated that it minute. When asked prescribed oxygen flow #72, LPN # 3 looked | sorder sheet] for Resident # 2020 documented in part, s] VIA [by] NC [nasal shift. Order Date: ate: 12/04/2019." It treatment administration # 72 dated February 2020 e order as above. Further evealed that Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo liters per minute on 20. Care plan for Resident # 72 vo | F | 695 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION IG | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WING _ | | | 02/27/2020 | |
| | ROVIDER OR SUPPLIER | ABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PREFIX (EACH CORRECTIVE ACTION SHOULD | | (X5) COMPLETION DATE | |
| F 695 | Continued From page | 46 | F6 | 95 | | | |
| | | ediately readjusted the esident # 72's oxygen | | | | | |
| | | | | | | | |
| V | Cannula, Simple Mas Oximizer. 3. Set appr | Oxygen Therapy via Nasal k, Venturi Mask and opriate flow rate and place | | | | | |
| | oxygen delivery device on the patient." The [Name of Manufacturer's] instructions for Resident # 72's oxygen concentrator documented in part, "Chapter 2: Operating Instructions. 5. Adjust the flow to the prescribed setting by turning the knob on the top of the flow meter until the ball is centered on the line making the specific flow rate." | | | | | | |
| | staff member] # 1, add | d ASM # 3, regional nursing | | ¥ | | | |
| | No further information | was provided prior to exit. | | | | | |
| | brain and spinal cord. sheath, the material the your nerve cells. This | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER NASSAS HEALTH & REH | ATEMENT OF DEFICIENCIES | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 ID PROVIDER'S PLAN OF CORRE | | | | (X5) |
| PREFIX TAG | (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFI TAG | × | (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | COMPLETION DATE |
| F 695 F 698 SS=D | Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensurequire dialysis receive with professional standomprehensive personal the residents' goals a This REQUIREMENT by: Based on observation document review and was determined facility complete dialysis (1) of 49 residents in the #113. The facility staff communication book completed to ensure the dialysis center. The finding include: Resident #113 was as 5/3/2019 with a reading dialysis. Resident #1 (minimum data set), a with an ARD (assessing 2/3/2020, coded Resident) of a score of cimpaired for making dialysis. | are that residents who re such services, consistent dards of practice, the n-centered care plan, and nd preferences. is not met as evidenced n, staff interview, facility clinical record review, it ry staff failed to provide a communication plan for one survey sample, Resident if failed to ensure the dialysis fro Resident #113 was ongoing communication with dmitted to the facility on nission on 1/28/20, with ed but were not limited to almonary disease (2), atrial pendence on renal (kidney) | | 695 698 | F698 1. Resident #113 dialysis communication book was fully completed on 2/28/2020 dialysis appointment date and has ever since been completed on her dialysis d. ADON/UMs will audit all current patients on dialysis to ascertain that the communication book is fully completed with every visit to a dialysis Center. Anyidentified inadequacy will be rectified, a result used to provide targeted remediation to affected staff. 3. SDC to provide in-service to all charge nurses on the following topics: a) Maintaining the dialysis communication book b) Managing dialysis patient 4. DON/UMs to perform a 100% audit the communication books for all current dialysis patients weekly x1 month and monthly x3 months to assure that they being fully completed consistently withou missing appointment days. Any identified deficient practice noted will be rectified | or ray. eir y and it of t are out ed | 3/16/20 |
| | receiving dialysis. | | | | accordingly and as appropriate and the | | |

| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: | | A. BUILDING | | | (X3) DATE SURVEY COMPLETED | | |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | ID PREFIX TAG | (EACH CORRECTIVE ACTION | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| F 698 | The physicians "Orde "Feb (February) 27, 2 documented in part, "for dialysis at [Name, of Dialysis Center]. M Fridays. Every day sl Wed, (Wednesday) F 02/17/2020; Start Dat The comprehensive of documented, "Hemoor #113] requires hemoor failure. [Name, location Dialysis Center]. Wedwednesdays and Frid 06/01/2019, Revision On 2/27/20 at approxication of the comprehensive of the comprehe | r Summary Report" dated 020" for Resident #113 Hemodialysis: Patient goes location and phone number fondays, Wednesdays and nift every Mon, (Monday) ri (Friday). Order Date: e: 02/19/2020." are plan for Resident #113 lialysis- [Name of Resident lialysis r/t (related to) renal on and phone number of ekly Schedule: Mondays, lays. Created on: on: 02/17/2020." Imately 9:00 a.m., LPN rse) #1 provided a white rourse's station labeled with eand room number and dialysis communication th Resident #113 each time | F 6 | forwarded to the QAPI commit further review/recommendatio 5. Date of compliance: 03/16 | n. | | |
| | number of Resident # included Resident #1 paper documenting rebut not limited to nam payer information, concurrent physician ordetitled "Dialysis Committee pages titled "Dialy revealed "Section A: I completed by Health is | er summary, and 11 pages unication Form." Review of sis Communication Form" Pre-Dialysis (to be & (and) Rehab Center); b be completed by Dialysis | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | X (EACH CORRECTIVE CROSS REFERENCED | IN OF CORRECTION E ACTION SHOULD BI D TO THE APPROPRIA CIENCY) | | (X5) COMPLETION DATE |
| F 698 | A documented the for communicated to the - "Meal provided - Medication req Name of med(s) (mean - Has resident has before going to dialys - Medication to be yes/no, Name of med - Signature:" Further review of the and Section C completed to the section C completed to be blank were observed to be blank were observed to be on 2/27/20 at 9:15 a. conducted with LPN with the medical with the residents treatments LPN #1 states to the section of the facility of the facility of the center to communication with the center to communication with the depointment for Residents and the section of the dialysis for residents treatments LPN #1 stated that if in the resident's conducted with the center to communication with the center calls them as they do not call the diappointment for Resident with binder label | & Rehab Center)." Section llowing information to be dialysis center pre-dialysis: to take to dialysis: yes/no uired before dialysis: yes/no, dications): ad a change in condition sis: yes/no, Describe: se given during dialysis: d(s): pages revealed Section A seted by the facility on one of D, ten pages failed to tion of communication to the he facility. Ten pages were in Sections A. Nine pages blank in Sections C. m., an interview was (licensed practical nurse) #1. sess for communication with who require offsite sated that the dialysis book is at to dialysis at each lity to communicate lialysis center and for the te information back to them. there is a significant change littion a phone call is made to center and the dialysis well. LPN #1 stated that the is utilized. LPN #1 reviewed led "[Name and Room #113] Dialysis Transfer Book" | F | 598 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 33.65 | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE | |
| F 698 | to the diatysis center stated that it appeare and other times it was stated that Sections A communication form facility staff and show each dialysis treatme On 2/27/20 at approx request was made by (administrative staff in nursing for the facility The facility policy "He 11/01/19" documente Communication Form sending patient for diaton for diadministrator, ASM # ASM #3, the regional #4, the assistant direct aware of the findings. No further information Reference: 1. Hemodialysis Dialysis treats end-stremoves waste from kidneys can no longe (and other types of diaformation was obtain information was obtain the state of the kidneys when the information was obtain the state of the kidneys when the information was obtain the state of the kidneys when the state of the kidneys when the information was obtain the state of the kidneys when the state of the state of the kidneys when the state of the state of the kidneys when the state of the st | "failed to evidence munication from the facility on 10 of 11 pages. LPN #1 d to be completed at times is not being done. LPN #1 A and Sections C of the are the responsibility of the lid have been completed for int Resident #113 received. Imately 11:00 a.m., a written list to ASM member) #2, the director of policy on dialysis. Immodialysis, Effective Date d in part, "7. The Dialysis will be initiated prior to alysis" Immately 11:00 a.m., ASM member) #1, the 2, the director of nursing, nurse consultant and ASM ctor of nursing were made | F 6 | 98 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 698 | lead to shortness of botained from the well https://www.nlm.nih.g 3. Atrial fibrillation A problem with the spheartbeat. This inform the website: https://www.nlm.nih.g on.html. Behavioral Health SecFR(s): 483.40 \$483.40 Behavioral heach resident must reprovide the necessary services to attain or in practicable physical, in well-being, in accordansessment and planencompasses a residmental well-being, whilmited to, the preventiand substance use difficulties that the facility document that the facility staff faper a physician's orderincident for one of 49 sample, Resident #21 | e pulmonary disease t difficult to breath that can breath. This information was bosite: ov/medlineplus/copd.html. leed or rhythm of the mation was obtained from ov/medlineplus/atrialfibrillati rvices ealth services. eceive and the facility must y behavioral health care and maintain the highest mental, and psychosocial ance with the comprehensive of care. Behavioral health ent's whole emotional and aich includes, but is not ion and treatment of mental | | 740 | F740 1. Resident #21 was discharged on 02/19/2019. Resident #21 initial and la psychiatry evaluation was on 2/14/2020 Center spsychiatrist. No changes to h care resulted from the evaluation. |) by | 3/16/20 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | E SURVEY PLETED |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| F 740 | a psychiatric consult facility staff failed to dordered. The findings include: Resident #21 was ad 7/14/19 with the diagrication diabetes, depression, pulmonary disease, pand high blood pression (Minimum Data Set) of 1 as being mildly impair life decisions. The rerequiring total care for transfers and toileting hygiene and dressing Resident #7 was adm 2/28/18 with the diagrication dementia with behaving psychosis, anxiety disdisorder, depression, MDS (Minimum Data) | g of another resident, /19. The physician ordered for Resident #21, and the btain the consult as mitted to the facility on noses of but not limited to hernia, chronic obstructive eripheral vascular disease, ure. The quarterly MDS with an ARD (Assessment 1/22/19 coded the resident red in ability to make daily sident was coded as r bathing; extensive care for i, limited assistance for ; and supervision for eating. mitted to the facility on noses of but not limited to ors, high blood pressure, corder, schizoaffective and diabetes. The annual | F 740 | 2. DON/UMs to review all curripatients with incidents requiring consult to ascertain that they we completed as ordered by the ph Anyone noted incomplete will be as a stat order for the psychiatric 3. SDC/Designee will use the result in Step 2 above to conduct in-service with the nurses on the a) Managing psychiatry consult. DON/UMs to audit 10% of a with psychiatry consult weekly and monthly x3 months to ascert they were completed as ordered found not to have been complete initiated as a stat order for the prindings will also be forwarded QAPI Committee for additional recommendation where applicated. 5. Date of compliance: 3/16/26 | psych ere hysician. e initiated ist to see. review ct an e following: ults. all patients c1 month rtain that d. Anyone ted will be esychiatrist. to the review and ble. | |
| | the resident as being to make daily life dec coded as limited assis toileting, dressing, an for ambulation and ea A review of a FRI date "Resident (#21) unzip | severely impaired in ability sions. The resident was stance for bathing, hygiene, d transfers; and supervision uting. ed 11/26/19 documented, ped the pants of (Residenting to put her hands inside | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 740 | investigation revealed CNA #1 (Certified Nur documented, "(Reside (Resident #7) so I app and CNA #2) and she me and told me to wa glass at me then proceed #7) pants and pulled a she could follow. She walking to his room. The walking to his room of up multiple times but his arm." CNA #2 statement does dining room not at the same vicinity(Resident #7) inappro (on top of clothing). I was given." RN #2 (Registered Nothing). I was given." RN #2 (Registered Nothing). I was given." RN #2 (Registered Nothing) interviewed (Resident Asked patient if there remembers that happ stated "No, I don't thir She then stated "Som same table" and state table, I was playing we my husband - he's a sheavily confused." | as statements and FRI If the following: rsing Assistant) statement ent #21) was touching broached her with (CNA #3 If (Resident #21) cursed at If way / tried throwing her eeded to unzip (Resident eat him to go to his room so e stood up and started (Resident #7) tried to stand (Resident #21) kept pulling cumented, "I was in the e site of incident but in the dent #21) abusive language (Resident #21) touching priately in his private areas am unsure whether consent | F | 740 | | | |

| PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIP A. BUILDING | LE CONSTRUCTION | | E SURVEY IPLETED | |
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| LAKE MANASSAS HEALTH & REHABILITATION CENTER (A) DISTRICT ADDRESS. CITY, STATE, JP CODE (A) DISTRICT ADDRESS. CITY, STATE, JP CODE (B) DISTRICT ADDRESS. CITY, STATE, JP CODE (B) DISTRICT ADDRESS AND ADDRESS | | | 495424 | B. WING | | 02 | 2/27/2020 |
| PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 740 Continued From page 54 "(Resident #7) interviewed by DON/UM (Director of Nursing and Unit Manager - ASM #2 (Administrative Staff Member, (the Director of Nursing) and Unit Manager - ASM #2 (Administrative Staff Member, (the Director of Nursing) and Interviewed by Don/UM (Director of Nursing) and Interviewed by Don/UM (Director of Nursing) and RN #2) and states he doesn't remember" The final report of the incident, dated 11/26/19, documented, "it has been determined that there was an inappropriate interaction between the two residents but that no sexual abuse/assault occurred." A review of the clinical record for Resident #21 revealed a nurse's note dated 11/27/19 that documented, "Pt was noted to be inappropriately touching another pt in dining room dt (due to) misidentification of pt's husband on 11/26/19 at 1300 (1:00 pm). Staff immediately separated pt's; assessed both pts, notified MD/RP, Psych (psychiatric) consult ordered, completed FRI on the incident, and moved her to another unit. Current care plan on behavior has been reviewed at this time and is deemed appropriate in addition to the above interventions." A physician's order dated 11/26/19, documented geriatric psych [psychiatric] consult. Further review of the clinical record failed to reveal documentation evidencing a psych consult was completed. The "Geriatric Psychiatry initial Evaluation" dated 2/14/2020, documented, "Asked to evaluate Review Mood + (plus) Medications." Further review of the contuct failed to reveal any | | | IABILITATION CENTER | | 14935 HOLLY KNOLL LANE | | |
| "(Resident #7) interviewed by DON/UM (Director of Nursing and Unit Manager - ASM #2 (Administrative Staff Member, (the Director of Nursing) and RN #2) and states he doesn't remember" The final report of the incident, dated 11/26/19, documented, "it has been determined that there was an inappropriate interaction between the two residents but that no sexual abuse/assault occurred." A review of the clinical record for Resident #21 revealed a nurse's note dated 11/27/19 that documented, "Pt was noted to be inappropriately touching another pt in dining room dt (due to) misidentification of pt's husband on 11/26/19 at 1300 (1:00 pm). Staff immediately separated pt's; assessed both pts, notified MD/RP, Psych (psychiatric) consult ordered, completed FRI on the incident, and moved her to another unit. Current care plan on behavior has been reviewed at this time and is deemed appropriate in addition to the above interventions." A physician's order dated 11/26/19, documented geriatric psych [psychiatric] consult. Further review of the clinical record failed to reveal documentation evidencing a psych consult was completed. The "Geriatric Psychiatry initial Evaluation" dated 2/14/2020, documented, "Asked to evaluate Review Mood + (plus) Medications." Further review of the consult failed to reveal any | PREFIX | (EACH DEFICIENC) | Y MUST BE PRECEDED BY FULL | PREFIX | (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE | SHOULD BE | (X5) COMPLETION DATE |
| Review Mood + (plus) Medications." Further review of the consult failed to reveal any | F 740 | "(Resident #7) intervice of Nursing and Unit M (Administrative Staff M Nursing) and RN #2) remember" The final report of the documented, "it has was an inappropriate residents but that no soccurred." A review of the clinical revealed a nurse's not documented, "Pt was touching another pt in misidentification of pt' 1300 (1:00 pm). Staff pt's; assessed both pt (psychiatric) consult of the incident, and move Current care plan on lat this time and is deed to the above intervent. A physician's order dageriatric psych [psych review of the clinical redocumentation evider completed. The "Geriatric Psychiatric | ewed by DON/UM (Director lanager - ASM #2 Member, (the Director of and states he doesn't incident, dated 11/26/19, see been determined that there interaction between the two sexual abuse/assault If record for Resident #21 the dated 11/27/19 that noted to be inappropriately dining room d/t (due to) is husband on 11/26/19 at fimmediately separated its, notified MD/RP, Psychordered, completed FRI on each her to another unit. Dehavior has been reviewed emed appropriate in addition itions." Atted 11/26/19, documented itatric] consult. Further ecord failed to reveal incing a psych consult was attry initial Evaluation" dated | F 74 | | | |
| On 2/27/20 at 8:47 AM, an interview was | | Review Mood + (plus) review of the consult of documentation regard | Medications." Further failed to reveal any ling the 11/26/19 incident. | | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| F 740 | conducted with ASM Member) the Director that the February psy was done; that none as ordered. She stat wasn't done. She stat psychiatric physician see's everyone that is ASM #2 stated that s list but does not have evidence that. She s resident was out of the visit and it should have ASM #2 stated that a got missed. On 2/27/20 at 10:21 there wasn't a policy as ordered. The polic Consultation' docummay order a consultation health care provide Report of Consultation. | #2 (Administrative Staff of Nursing. ASM #2 stated which eval is the first one that was done after the incident ed she was not sure why it ated she reached out to the and that he stated that he is on the list provided to him, he put the resident on the the list any longer to tated that it could be the fe facility at the time of the we been followed up on, t this point she would say it AM, ASM #2 stated that on providing psych services by provided, "Report of ented, "Policy: The physician for. Procedure: 1. Review the of Physician Progress | F | 740 | | | |
| F 812 SS=E | Staff Member, the Adaware of the findings provided. Food Procurement,S | ty requirements. | F | 812 | | | 3/16/20 |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1, , | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | D BE COMPLETION | |
| F 812 | approved or consider state or local authoriti (i) This may include for from local producers, and local laws or regulii) This provision doe facilities from using progradens, subject to consider a safe growing and food (iii) This provision doe from consuming foods from consuming foods from consuming foods standards for food set andards for food set andards for food set andards for food set This REQUIREMENT by: Based on observation document review, it was facility staff failed to smanner on one of four The facility staff failed to smanner on one of four The facility staff failed putting thumbs on the of the plate and the facility and the facility staff failed: On 2/25/20 at 11:50 A was made on the 400 (Other Staff Member) the unit dining room stood from the steam to was noted to be wear serving spoon handle of the steam table, an observed handling plaside of the rim, which | ed satisfactory by federal, es. pod items obtained directly subject to applicable State alations. It is not prohibit or prevent roduce grown in facility perpliance with applicable dehandling practices. It is not procured by the facility. It is not procured by the facility prepare, distribute and note with professional roice safety. It is not met as evidenced in, staff interview, and facility has determined that the erve food in a sanitary or nursing units, the 400 unit. It to handle plates without the food contact, surface area accility staff failed to cover line service. In the dining observation—unit dining room. OSM #3 a dining associate, was in mall kitchen area, plating able for the residents. She ing gloves but was handling s, meal tickets, the surface d other items. She was attes with her thumb on top | F 81 | F812 cross reference to 12 VAC 5-371-140; 12 VAC 5-371-180; & 12 5-371-340 1. The dining services employee observed touching the rim of the plat with a gloved thumb was given 1:1 coaching on 2/26/20. Also, the dinin services staff observed with partially uncovered facial hairs was given 1-1 remediation on 2/26/2020. 2. All meal services will be observe ensure that staff are handling dishes gloved hands but without touching of surfaces prior to handling individual dishware that would contain food. Di Services Manager (DSM) will purchabeard guards that are large enough cover mustache, beard and sides of that may contain facial hairs. These be made available to all facility staff entering kitchen area. All dining serv | e g ed to with ther ning tse to face will upon | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | HABILITATION CENTER | 33 | STREET ADDRESS, CITY, STATE, ZIP 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | CODE | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN | CTION SHOULD BE THE APPROPRIA | | (X5) COMPLETION DATE |
| F 812 | items. OSM #3 was a rolls with her hand an plates, wearing the satongs. On 2/26/20 at 8:55 Al conducted with OSM thumb should not be surface area, and that up with tongs and not "I usually grab them was tongs." A review of the facility Use" documented, "Tof gloves to avoid direduring meal service to garnishes, baked pot not include any criteristouching the food corrol on 2/26/20 at 12:05 for tray line temperatures 400 dining room area Manager, was assisting preparing bowls of changes on the same and beard. How beard only covered the beard and not the back the sideburns. In add which was not covered the sideburns are sideburns. In add which was not covered the sideburns are sideburns. In add which was not covered the sideburns are sideburns are sideburns. In add which was not covered the sideburns are sideburns are sideburns are sideburns. | hile touching multiple other also observed picking up and placing them on the ame gloves, and not using the mane gloves, and not using the should the plate's food at she should pick the rolls ther hand. OSM #3 stated, with my gloves but I should the policy, "Glove and Utensil fongs may be used instead the policy, "Glove and Utensil fongs may be used instead to portion meats, bread, atoes, etc." The policy did as for handling plates without that the policy did as for handling plates without that the surface area. PM, during observation of the form the served with a hairnet on his wever, the hairnet on his me front visible portion of the ck portion under the chin or dition, he had a mustache, | F 8 | staff were in-serviced regarded precautions while serving 3. SDC/Dietitian/Design the following in-service to a. Standard precautions services: such as handling covering of facial hairs 4. Dietitian/Dining Servi Manager/Designee will auservices weekly x1 month months to ascertain that sprecautions are followed of services. Any deficient probe rectified accordingly are forwarded to the QAPI confurther review and recomm 5. Date of compliance: 6 | on 2/26/20. nee will comple all dining states during meal g dishware and disces udit meal and monthly standard during meal actice noted wind then ammittee for mendation. | ete ff: nd x3 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WING | | 02/27/2020 | |
| | ROVIDER OR SUPPLIER | ABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | |
| F 812 F 814 SS=C | preparing the bowls of A review of the facility and Dress Code" doc food preparation and wear hair restraints sunets, or beard guards designed and worn to from contacting exposutensils, linens, and utarticles. Hats may be net." On 2/27/20 at 10:27 A Staff Member, the Adaware of the findings. provided. Dispose Garbage and CFR(s): 483.60(i)(4)- Dispose properly. This REQUIREMENT by: Based on observation determined that the fathe dumpster in a sampests. During the kitcle | f chicken noodle soup. policy, "Personal Hygiene umented, "All persons in the food storage areas shall uch as hair coverings, hair where necessary, that are effectively keep their hair sed food, clean equipment, inwrapped single-use worn over top of a hair MM, ASM #1 (Administrative ministrator) was made No further information was I Refuse Properly e of garbage and refuse is not met as evidenced in and staff interview, it was icility staff failed to maintain itary manner to prevent | F 81 | 2 | 3/16/20 | |
| | trash bags lying on the confines of the dumps. The findings include: On 2/25/2020 at 11:30 member) #4, the dieta | | | placed in the dumpster on 2/25/2020. There has been no siting of trash on ground by the dumpster ever since. Als there has been no siting of pest within facility and its premises. 2. The House Keeping Manager/Maintenance Director will aud all the premises of the Center to ascert that the ground is free of trash and | lit | |
| | 50 10,01 011 011 01 | 20. Tadoir of the facility | | and the ground is free or trasti and | | |

| | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A, BUILDING | | | ATE SURVEY OMPLETED |
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| | ROVIDER OR SUPPLIER NASSAS HEALTH & REH | ABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | · | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 814 | dumpster. There were trash on the ground a dumpster. On the back there were multiple or multiple trash bags ly the confines of the dusour smell. OSM #4 we the dumpster should I "Of course not. All the the dumpster is especially the dumpster is especially the dumpster onto the compactor company of garbage to their vehicle compactor company of "typically every day." I had come to the facility stated it had not. Whe trash visible behind the since the day before, I'm going to have one When asked who is reafter the trash compactor asked his responsibility everyone's responsibility everyon | e several pieces of paper round and in front of the ekside of the dumpster, verturned boxes of trash and ing on the ground outside impster. The trash had a vas asked if the trash behind be there. OSM #4 stated, is ematerials should be in hind it." He stated when the versonnel transfers the ide. OSM #4 stated the trash comes to the facility when asked if the company by that day (2/25/2020), he is asked if that meant the ide dumpster had been there OSM #4 stated, "I guess so, of my folks jump on this." is esponsible for following up coro company has come to stated, "Maintenance." a.m., OSM #7, the was interviewed. When the stated this includes in the stated this includes in the stated this includes in aware that when the inpany comes, "lots of times atted the walk around occur cting company has come for a facility does not have a | F 8 | garbage. Any siting of trash/garbage be immediately cleaned, and result reported to the daily stand-up mee interdepartmental intervention. 3. House Keeping Manager/Maintenance Director/De will complete in-service with all the staff on the following topics: a. Reporting garbage/trash siting the Center and its premises b. Maintenance of dumpster area sanitary condition 4. House Keeping/Maintenance to audit the dumpster area weekly month and monthly x3 months to a that there are no trash and/or garb the ground. Any continuing deficient practice will be rectified immediate then forwarded to the QAPI Comm further review and recommendation. 5. Date of compliance: 03/16/202 | signee Center within a in a Director x1 ssure age on at ly and ittee for | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLI A. BUILDING | E CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | IABILITATION CENTER | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
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| F 880 SS=E | On 2/27/2020 at 11:00 staff member) #1, the director of nursing, AS consultant, and ASM nursing, were informed. A review of a docume for the facility from the company revealed, in dumpsters for cleanling. No further information infection Prevention & CFR(s): 483.80(a)(1)(s) §483.80 infection Control facility must estatinfection prevention and designed to provide a comfortable environmed development and transitional diseases and infection program. The facility must estating and control program (a minimum, the follows §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visited providing services und arrangement based under the direction of the communicable distaff, volunteers, visited providing services under a staff of the control program of the communicable distaff, volunteers, visited providing services under a staff of the control program of the communicable distaff, volunteers, visited providing services under the control program of the communicable distaff, volunteers, visited providing services under the control program of th | a.m., ASM (administrative administrator, ASM #2, the SM #3, the regional nurse #4, the assistant director of ed of these concerns. Int that provides instructions emaintenance software part: "Check area around ness and security." In was provided prior to exit. It Control (2)(4)(e)(f) Introl blish and maintain an and control program asafe, sanitary and leent and to help prevent the esmission of communicable ins. In prevention and control blish an infection prevention IPCP) that must include, at ring elements: In for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following | F 880 | | 3/16/20 | |
| | | | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER NASSAS HEALTH & REH | ABILITATION CENTER | | 14 | TREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE AINESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE | |
| F 880 | procedures for the probut are not limited to: (i) A system of surveil possible communication infections before they persons in the facility: (ii) When and to whor communicable diseast reported; (iii) Standard and trant to be followed to prev (iv) When and how is cresident; including but (A) The type and durate depending upon the initial involved, and (B) A requirement that least restrictive possibility circumstances. (v) The circumstances must prohibit employed disease or infected secontact with residents contact will transmit the (vi) The hand hygiene by staff involved in directive actions take §483.80(e) Linens. Personnel must hand | standards, policies, and ogram, which must include, blance designed to identify ble diseases or can spread to other in possible incidents of se or infections should be assession-based precautions ent spread of infections; blation should be used for a trot limited to: attorn of the isolation, infectious agent or organism at the isolation should be the ble for the resident under the ses with a communicable time lesions from direct to or their food, if direct in disease; and procedures to be followed elect resident contact. In for recording incidents incility's IPCP and the en by the facility. It is store, process, and to prevent the spread of | F | 880 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | - 1 | LE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| F 880 | Continued From page | e 62 oct an annual review of its | F 88 | 0 | | |
| | IPCP and update the This REQUIREMENT by: Based on observation interview, facility door record review, it was staff failed to implement procedures to prevent residents in the survet #321, #118, #221 and to implement infection storage of nebulizer residents #322, #32: Resident #47 and fail control procedures for #321 and 221's incentuse. The findings include: 1. Resident #322 was 2/14/2020, with diagrant limited to chronic disease (2), atrial fibroblindness. Resident: (minimum data set), with the survey. The facility assessment dated 2/ #322 as being oriented person, place, time a con 2/25/20 at 2:05 p. p.m., observations of revealed a nebulizer located on top of the | ir program, as necessary. is not met as evidenced n, resident interview, staff ument review and clinical determined, that the facility ent infection control t infection for five of 49 ey sample, Residents #322, d #47. The facility staff failed in control procedures for the masks when not in use for fi, Resident #118 and ed to implement infection ir the storage of Resident titive spirometers when not in s admitted to the facility on moses that included but were obstructive pulmonary illation (3) and legal #322's most recent MDS was not due at the time of ty's nursing admission 14/2020 coded Resident ed times four, "Oriented to | | 1. Residents #322, #321, #118, #22 and #47□s nebulizer masks and tube were returned to the Center□s design storage bags on 2/25/2020 and have since been maintained. The incentive spirometer for Residents #321 and #2 were placed in Center designated storage when not in use. Residents #221 #118 discharged on 3/6/2020 and 3/4/2020 respectively. 2. DON/ADON/UMs to audit all curripatients on ordered nebulizer and incentive spirometer therapies to assist that all necessary standard precaution are maintained. Any unused nebulizer mask and incentive spirometer not bagged will be cleanse as ordered an immediately returned to designated storage bag. The outcome of the abova audit will also be used to complete a targeted in-service with nurses assign to affected patients. 3. SDC/Designee will provide in-ser to the nursing staff on the following to c) Maintaining sanitary condition of nebulizer mask and incentive spiromed d) Maintaining standard precaution management of nebulizer/incentive spirometer therapies. 4. DON/UMs will audit 10% of all cupatients with ordered nebulizer and incentive spirometer therapies weekly | s lated ever | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER'SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | EHABILITATION CENTER | | 14 | TREET ADDRESS, CITY, STATE, ZIP CODE 1935 HOLLY KNOLL LANE AINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | x | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 880 | conducted with Res observation of the n nightstand to the lef uncovered mask lyir machine as observed the nebulizer and m that she received the shortness of breath obstructive pulmona stated that she had of times since admis breath after therapy staff maintains the m #322 stated that she was legally blind and things. The physicians "Ord "Feb (February) 26, documented in part, Solution 0.5-2.5 MG (milliliter), 3 ml inhal as needed for whee obstructive pulmona Order Date: 02/14/2 The comprehensive documented in part, of Resident #322] had (related to) GI (gastrato rectal ulcer (5), pr (7), hyperlipidemia (02/14/2020, Revisio | machine. a.m., an interview was ident #322. An additional ebulizer unit on top of the tof the bed revealed the ng on top of the nebulizer ed above. When asked about ask, Resident #322 stated e nebulizer as needed for due to COPD (chronic ary disease). Resident #322 used the nebulizer a couple ssion when she got short of . When asked how the facility rebulizer and mask, Resident e was not sure because she di had a hard time seeing der Summary Report" dated 2020" for Resident #322 "Ipratropium-Albuterol (4) (milligram)/3 (three) ML (e orally every 4 (four) hours zing related to chronic ary disease, unspecified, 020, Start Date: 02/14/2020." care plan for Resident #322 "Nursing Care Needs: [Name as nursing care needs r/t rointestinal) bleed secondary neumonia (6), hypertension 8), COPD Created on non 02/25/2020." Under cumented in part, "Administer ared and monitor for | F | 880 | that standard precautions are maintain in their administration. Any deficient practice noted will be rectified according and then forwarded to the QAPI Committee for further review and recommendation. 5. Date of compliance: 03/16/2020 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION IG | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | ABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE DEFICIENCY) | JLD BE COMPLETION |
| F 880 | Resident #322, dated documented Residen "Ipratropium-Albutero 5:21 a.m. On 2/26/20 at 1:25 p.: conducted with LPN (When asked about the the storage of the net medications, LPN #1 administered to the renebulizer is rinsed out LPN #1 stated that affiglaced in a bag for stoten the nebulizer is air driminutes and then placed in a bag for stoten endication contron the residents face, is considered a respiritated, "Yes." When a mask observed in Residents face, is considered a respiritated, "Yes." When a mask observed in Residents that she had morning during her roa.m. LPN #1 agreed uncovered and that it the practice of the face. On 2/26/20 at approximation and the stated that she had uncovered and that it the practice of the face. | inistration Record" for "2/1/2020-2/29/2020" t #322 receiving I Solution" on 2/18/2020 at m., an interview was licensed practical nurse) #1. e process staff follows for pulizer after administration of stated that the medication is esident and afterwards the t and allowed to air dry. ter the nebulizer is dried it is brage. LPN #1 stated that ed for at least ten to fifteen bed back in the bag for When asked why the red in a bag, LPN #1 stated bol purposes because it goes When asked if a nebulizer atory treatment, LPN #1 asked about the nebulizer asident #322's room during as on 2/25/20 at 2:05 p.m. 2/26/20 at 8:30 a.m., LPN d discarded the mask this om rounds around 9:00 that the mask was was not stored according to ility so she had discarded it. mately 11:00 a.m., a | F 8 | 80 | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | ABILITATION CENTER | • | 149 | REET ADDRESS, CITY, STATE, ZIP CODE 135 HOLLY KNOLL LANE MNESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | BE . | (X5) COMPLETION DATE | |
| F 880 | in part, "Medicated Norman Part," Medicated Norman Part Part Part Part Part Part Part Part | paper and storage of equipment to facility policy. Each thing circuit (nebulizer, nebulizer). The equipment and storage of equipment, and storage of | F | 880 | | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | A. BUILDING | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | |
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| F 880 | 2. Chronic obstructiv (COPD) is a disease breath that can lead information was obtathttps://www.nlm.nih.go.https://www.nlm.nih.go.html. 4. Albuterol and Ipra a class of medication Albuterol and ipratrol relaxing and opening lungs to make breath was obtained from the https://medlineplus.gtml 5. Rectal ulcer- In the | ebsite: https: ov/ency/patientinstructions/0 /e pulmonary disease that makes it difficult to to shortness of breath. This lined from the website: gov/medlineplus/copd.html. a problem with the speed or eat. This information was ebsite: gov/medlineplus/atrialfibrillati atropium oral inhalation are in as called bronchodilators. pium combination works by the air passages to the ning easier. This information | F 88 | | |
| | leads to passing bloc rectum. This information website: https://www.asge.org ormation/understand 6. Pneumonia is an lungs. This information website: https://medl 7. Hypertension is h | od and mucus from the ation was obtained from the althon was obtained from the althon was obtained from the infection in one or both of the on was obtained from the ineplus.gov/pneumonia.html. | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | ROVIDER OR SUPPLIER | IABILITATION CENTER | | 14 | TREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE AINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 880 | essure.html. 8. Hyperlipidemia- Cl called a lipid) that you properly. The medical cholesterol is lipid dishypercholesterolemia obtained from the well https://medlineplus.gd. 2. Resident #321 wa: 2/13/2020, with diagn not limited to cervical pneumonia (4) and hy Resident #321's most data set), was not due The facility's nursing a dated 2/13/2020 code oriented times three, and situation." On 2/25/20 at 2:35 p. conducted with Resid Resident #321's room was observed located the left side of the bed uncovered incentive smask was observed a machine and lying on machine. When aske mask, Resident #321 nebulizer on a regular to the facility. When a spirometer on the night stated that he receive still uses it at least on | holesterol is a fat (also ar body needs to work I term for high blood order, hyperlipidemia, or . This information was bosite: by/ency/article/000403.htm. Is admitted to the facility on oses that included but were disc disorder (3), ypertension (5). It recent MDS (minimum et at the time of the survey, admission assessment and Resident #321 as being "Oriented to person, place, m., an interview was ent #321. Observation of a revealed a nebulizer unit I on top of the nightstand to dinear the window and an epirometer. An uncovered attached to the nebulizer | F | 880 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTI A. BUILDIN | PLE CONSTRUCTION | (X3) DATE COMP | SURVEY |
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| | ROVIDER OR SUPPLIER | ABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | OULD BE | (X5) COMPLETION DATE |
| F 880 | the staff assists him verification in the staff assists him verification in the staff assists him verification in the staff put the nebulizer in a bag when not be stated that he did not. An additional observation and additional observation in a bag when not be stated that he did not. An additional observation is a bag when not be stated that he did not. An additional observation is a bag when not be stated that he did not. An additional observation is a bag when not be stated that he did not. The physicians "Orde "Feb (February) 26, 2 documented in part, "Nebulization Solution (three) ML (milliliter)), orally via (by way of) is shortness of breath, Ostart Date: 02/14/202 summary report for Revidence documentation in part, "of Resident #321] has (related to) HTN (hypprostatic hypertrophy) hypoxemia (9) Cre Revision on 02/24/20 it documented in part, "of the staff as a bag and | Resident #321 stated that with both because of his required to wear and limited of how the facility staff re spirometer, nebulizer and stated that he does not it, that the staff takes care of if he has ever seem the ror the incentive spirometering used, Resident #321 remember. Intion made on 2/25/20 at at at 8:45 a.m. revealed the ar Summary Report" dated at 8:45 a.m. revealed the ar Summary Report" dated at 8:45 a.m. revealed the ar Summary Report" dated at 8:45 a.m. revealed the ar Summary Report" dated at 8:45 a.m. revealed the ar Summary Report" dated at 8:45 a.m. revealed the ar Summary Report" dated at 8:45 a.m. revealed the ar Summary Report" dated at 8:45 a.m. revealed the are plate to find the summary Report at 8:45 a.m. revealed the are plate of the are plan for Resident #321 failed to find for the use of the are plan for Resident #321 Nursing Care Needs: [Name are plan for Resident #321 Nursing Care needs r/t ertension), BPH (benign to 7), dysphagia (8), sated on 02/13/2020, 20." Under "Interventions", | F8 | 80 | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WING | | | 02/27/2020 | |
| | ROVIDER OR SUPPLIER | IABILITATION CENTER | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 880 | Resident #321, dated documented Resident Sulfate Nebulization S 5:00 p.m. each day for The "Rehab [rehability the transferring hospita.m. included in Resident and Plan/Medical AssTransient hypoxia (appreciate input and [Name of Physician]." Included in Resident arecord, a "Progress N transferring hospital dwas observed to be ephysician whose recorrequested in the rehad documented above. documented in part, "Abnormal CXR (chest infiltrates, 2. Cough. Agree with empiric Lecomplete a seven day day) and PRN (as need a seven day) and PRN (as | inistration Record" for "2/1/2020-2/29/2020" It #321 receiving "Albuterol Solution" at 9:00 a.m. and om 2/14/20 through 2/26/20. Interest of the second of | F | 880 | | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA (X2) MUI IDENTIFICATION NUMBER: A. BUILD | | PLE CONSTRUCTION G | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B, WING _ | | | 02/27/2020 | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE EAPPROPRIATE | (X5) COMPLETION DATE | |
| F 880 | nebulizer after admin #1 stated that the methe resident and after rinsed out and allower that after the nebulizer bag for storage. LPN is air dried for at least then placed back in the needed. When asked stored in a bag, LPN control purposes becase. When asked if respiratory treatment When asked about the spirometer, LPN #1 stimprove deep breathincentive spirometer treatment, LPN #1 strobserved the nebulizer mask on top of the unightstand to the left window and the uncountry and the uncountry spirometer to be stored incentive spirometer to be s | ws for the storage of the istration of medications, LPN dication is administered to wards the nebulizer is do to air dry. LPN #1 stated ar is dried it is placed in a #1 stated that the nebulizer to ten to fifteen minutes and the bag for storage until do why the nebulizer mask is #1 stated it is for infection ause it goes on the residents a nebulizer is considered a purpose of an incentive tated that it is used to the purpose of an incentive tated that it is used to the is considered a respiratory ated, "Yes." The purpose of an incentive tated that it is used to the incentive tated incentive spirometer. It is used to the bed near the vered incentive spirometer. It is used that there ask or the incentive ed. LPN #1 stated that the was available for use at the #321. | F 88 | | | | |
| | nursing for the facility and incentive spirome On 2/26/20 at approx provided the policy "F Equipment, Effective | policy on nebulizer therapy etry. imately 12:00 p.m., ASM #2 | | 9 | | | |

| | TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED | | | | |
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| LAKE MA | ROVIDER OR SUPPLIER | | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 880 | in part, "Medicated No Rinse out nebulizer re and place in a plastic Nebulizers and bags of Monday, Wednesday, | spiratory/Oxygen Date 11/01/19" documented ebulizer Treatment5. eservoir with tap water, dry, bag when not in use. must be changed every, and Friday and dated." oximately 11:30 a.m., ASM sing stated that the facility is, procedures and indard of practice. oincott Manual of Nursing 2014, page 236, Procedure umented in part, "Follow-up dication used and ions. 2. Disassemble and each use. Keep this ent's room. The equipment to facility policy. Each hing circuit (nebulizer, e). Through proper and storage of equipment, wented from entering the vater and dry it. Avoid eter itself in water because erial growth and impairs the | F | 880 | DEFICIENCY) | | |
| | exercises, and label it applicable, with the pa | and the spirometer, if | | | | | |

| DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | A. BUILDING | | 12. 2 | SURVEY |
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| (EACH DEFICIENC | Y MUST BE PRECEDED BY FULL | ID PREFIX TAG | ((EACH CORRECTIVE ACTION S | HOULD BE | (X5) COMPLETION DATE |
| On 2/27/20 at approx (administrative staff in administrator, ASM # ASM #3, the regional #4, the assistant direct aware of the findings. No further information Reference: 1. Nebulizer is a smamedicine into a mist obtained from the we https://medlineplus.gd 00006.htm. 2. Incentive spirometic keep your lungs health have a lung illness, sinformation was obtain https://medlineplus.gd 00451.htm. 3. Cervical disc disor cause pain when bon the spinal cord or ner movement. Treatment sometimes they incluit This information was https://medlineplus.gd .html | imately 11:00 a.m., ASM nember) #1, the 2, the director of nursing, nurse consultant and ASM ctor of nursing were made as was provided prior to exit. Ill machine that turns liquid This information was besite: https: by/ency/patientinstructions/0 are a device used to help you thy after surgery or when you uch as pneumonia. This ned from the website: by/ency/patientinstructions/0 der -Spinal diseases often e changes put pressure on yes. They can also limit to differ by disease, but de back braces and surgery. by/spineinjuriesanddisorders | F8 | 380 | | |
| lungs. This information | n was obtained from the | 1 | N 2 | | |
| | ROVIDER OR SUPPLIER NASSAS HEALTH & REF SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page incentive spirometer v On 2/27/20 at approx (administrator, ASM # ASM #3, the regional #4, the assistant direc aware of the findings. No further information Reference: 1. Nebulizer is a sma medicine into a mist. obtained from the we https://medlineplus.gd 00006.htm. 2. Incentive spiromet keep your lungs health have a lung illness, su information was obtain https://medlineplus.gd 00451.htm. 3. Cervical disc disor cause pain when bon the spinal cord or ner movement. Treatment sometimes they include this information was https://medlineplus.gd .html 4. Pneumonia is an infungs. This information | A95424 ROVIDER OR SUPPLIER NASSAS HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 72 incentive spirometer within the patient's reach." On 2/27/20 at approximately 11:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit. Reference: 1. Nebulizer is a small machine that turns liquid medicine into a mist. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00006.htm. 2. Incentive spirometer a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00451.htm. 3. Cervical disc disorder -Spinal diseases often cause pain when bone changes put pressure on the spinal cord or nerves. They can also limit movement. Treatments differ by disease, but sometimes they include back braces and surgery. This information was obtained from the website: https://medlineplus.gov/spineinjuriesanddisorders | A BUILDIN 495424 B. WING ROVIDER OR SUPPLIER NASSAS HEALTH & REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 72 incentive spirometer within the patient's reach." On 2/27/20 at approximately 11:00 a.m., ASM (administrative staff member) #1, the administrative staff member) #1, the administrative staff member) #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit. Reference: 1. Nebulizer is a small machine that turns liquid medicine into a mist. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00006.htm. 2. 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On 2/27/20 at approximately 11:00 a.m., ASM (administrative staff member) #1, the administrative staff member) #1, the administration, ASM #2, the regional nurse consultant and ASM #4, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit. Reference: 1. Nebulizer is a small machine that turns liquid medicine into a mist. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00006.htm. 2. Incentive spirometer a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00451.htm. 3. Cervical disc disorder -Spinal diseases often cause pain when bone changes put pressure on the spinal cord or nerves. They can also limit movement. Treatments differ by disease, but sometimes they include back braces and surgery. This information was obtained from the website: https://medlineplus.gov/spineinjuriesanddisorders.html 4. Pneumonia is an infection in one or both of the lungs. This information was obtained from the lungs. This information was obtained from the | A BUILDING B. WING B. WING D.2 A BUILDING B. WING B. WING D.2 SITREET ADDRESS, CITY, STATE, ZIP CODE 14934 HOLLY KINGLI LANE SUMMARY STATEMENT OF DEFICIENCIES GARDEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 72 incentive spirometer within the patient's reach." Continued From page 72 incentive spirometer within the patient's reach." Con 2/27/20 at approximately 11:00 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the regional nurse consultant and ASM #4, the assistant director of nursing were made aware of the findings. No further information was provided prior to exit. Reference: 1. Nebulizer is a small machine that turns liquid medicine into a mist. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00006.htm. 2. Incentive spirometer a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/0 00451.htm. 3. Cervical disc disorder -Spinal diseases often cause pain when bone changes put pressure on the spinal cord or nerves. They can also limit movement. Treatments differ by disease, but sometimes they include back braces and surgery. This information was obtained from the website: https://medlineplus.gov/spineinjuriesanddisorders.html |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | ' ' | PLE CONSTRUCTION G | | (X3) DATE COMP | SURVEY LETED |
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| F 880 | Continued From page | 73 | F 88 | 80 | | | |
| | information was obtain | gh blood pressure. This ned from the website: ov/medlineplus/highbloodpr | | | | • | |
| | bronchodilators. It wo the air passages to th easier. This informati website: | ass of medications called rks by relaxing and opening e lungs to make breathing on was obtained from the by/druginfo/meds/a607004.h | | | | | |
| | prostate. This inform website: | yperplasia is an enlarged ation was obtained from the ov/medlineplus/enlargedpro | | | | | |
| | information was obtai | allowing disorder. This ned from the website: ov/medlineplus/swallowingdi | | | | | |
| | the blood. This informathe website: | concentrations of oxygen in nation was obtained from //condition/surfactant-dysfun | | | | | |
| | tissues of the body. Tobtained from the well | | | | | | |
| | | s admitted to the facility on oses that included but were | | | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 | PLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | | |
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| F 880 | not limited to hypertendisease (3) and ather Resident #118's most set), an admission as (assessment reference Resident #118, as set assessment for ments of 0 - 15, 0- being set daily decisions. On 2/25/20 at 2:25 p.1 made of Resident #11 nebulizer unit located the right side of the bewas observed attache propped on top of the was observed hangin machine on the nights. Additional observation on 2/25/20 at 4:45 p.r revealed the findings. The physicians "Orde "Feb (February) 26, 2 documented in part, "Solution 0.5-2.5 MG (milliliter), 3 ml inhale nebulizer three times asthma (6) Order Dat 02/12/2020." The comprehensive of documented in part, "of Resident #118] has (related to) hypertens | nsion (2), chronic kidney osclerotic heart disease (4). recent MDS (minimum data sessment with an ARD se date) of 2/5/2020, coded oring a 0 (zero) on the staff al status (BIMS) of a score verely impaired for making m., an observation was 18's room revealed a on top of the nightstand to sed. An uncovered mask sed to the nebulizer machine, machine. A plastic bag g underneath the nebulizer stand dated "2/5/20." ns of Resident #118's room n. and 2/26/20 at 8:50 a.m. above. r Summary Report" dated 020" for Resident #118 Ipratropium-Albuterol (5) milligram)/3 (three) ML orally via (by way of) a day related to other e: 02/11/2020, Start Date: sare plan for Resident #118 Nursing Care Needs: [Name is nursing care needs r/t ion, chronic kidney disease, at eye blindness, asthma (7), | F8 | 80 | | | |

| | DF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT A. BUILDII | | ONSTRUCTION | (X3) DATE COMP | SURVEY PLETED |
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| | ROVIDER OR SUPPLIER | ABILITATION CENTER | , | 1493 | EET ADDRESS, CITY, STATE, ZIP CODE 35 HOLLY KNOLL LANE INESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFII TAG | · | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY) | 3E | (X5) COMPLETION DATE |
| F 880 | The "Medication Adm Resident #118, dated documented Resident "Ipratropium-Albutero from 2/1/2020 through a day from 2/12/20 th On 2/26/20 at 1:25 p. conducted with LPN (When asked about the residents with ordered LPN #1 stated that not in the rooms of the rethe masks and tubing changed three times: Wednesdays and Frict the process staff follonebulizer after admini #1 stated that the methe resident and after rinsed out and allowe that after the nebulizer bag for storage. LPN is air dried for at least then placed back in the needed. When asked if a control purposes becaface. When asked if a respiratory treatment, #1 observed the nebulizers and to the right | Interventions", it Administer medications and Created on 01/30/2020." inistration Record" for "2/1/2020-2/29/2020" t #118 receiving I Solution" four times a day n 2/11/2020 and three times rough 2/26/20. m., an interview was dicensed practical nurse) #1. te process staff follows for d nebulizer medications, ebulizer machines are kept sidents. LPN #1 stated that for the nebulizers are a week on Mondays, days. When asked about ws for the storage of the istration of medications, LPN dication is administered to wards the nebulizer is d to air dry. LPN #1 stated er is dried it is placed in a #1 stated that the nebulizer at ten to fifteen minutes and the bag for storage until d why the nebulizer mask is #1 stated it is for infection ause it goes on the residents a nebulizer is considered a LPN #1 stated, "Yes." LPN dizer unit with the uncovered dit located on top of the a side of the bed. LPN #1 and the mask and stated | F | 380 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X3) DATE SURVEY COMPLETED | |
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| (X4) ID PREFIX TAG | (EACH DEFICIENC) | NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY) | BE | (X5) COMPLETION DATE |
| F 880 | Continued From page | | F 880 | | | |
| | | | | | | |
| | in part, "Medicated Ne Rinse out nebulizer re and place in a plastic Nebulizers and bags of Monday, Wednesday, On 2/25/2020 at appro | Date 11/01/19" documented ebulizer Treatment5. eservoir with tap water, dry, bag when not in use. must be changed every and Friday and dated." Desimately 11:30 a.m., ASM sing stated that the facility | | | | |
| | Practice 10th Edition, Guidelines 10-11 doct phase 1. Record med description of secretic clean nebulizer after equipment in the patie is changed according patient has own breat tubing and mouthpiec cleaning, sterilization, organisms can be prelungs." | incott Manual of Nursing 2014, page 236, Procedure umented in part, "Follow-up dication used and ons. 2. Disassemble and each use. Keep this ent's room. The equipment to facility policy. Each hing circuit (nebulizer, | | | | |
| | (administrative staff madministrator, ASM #2 | nember) #1, the 2, the director of nursing and nurse consultant were | | * | | |

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| 2000 | ROVIDER OR SUPPLIER | EHABILITATION CENTER | | 1493 | EET ADDRESS, CITY, STATE, ZIP CODE 35 HOLLY KNOLL LANE NESVILLE, VA 20155 | , | |
| (X4) ID PREFIX TAG | (EACH DEFICIEN | STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | | (X5) COMPLETION DATE |
| F 880 | No further information Reference: 1. Nebulizer is a sm medicine into a mist breathe in through a information was obtaintps://medlineplus.goooo6.htm. 2. Hypertension is hinformation was obtaintps://www.nlm.nih.essure.html. 3. Chronic kidney dand cannot filter blooinformation was obtaintps://medlineplus.gooodings.//medlineplus.gooodings.//medlineplus.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.gooodings.go | anall machine that turns liquid . You sit with the machine and of connected mouthpiece. This ained from the website: https: gov/ency/patientinstructions/0 high blood pressure. This ained from the website: gov/medlineplus/highbloodpr isease: Kidneys are damaged od, as they should. This ained from the website: gov/chronickidneydisease.htm is a disease in which plaque of fat, cholesterol, calcium, os found in the blood. Over is and narrows your arteries. If oxygen-rich blood to your ion was obtained from the gov/atherosclerosis.html. atropium oral inhalation are in ons called bronchodilators. Opium combination works by og the air passages to the hing easier. This information | F | 380 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL' A. BUILDI | IPLE CONSTRUCTION NG | | | E SURVEY PLETED |
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| | | 495424 | B. WING | · · · · · · · · · · · · · · · · · · · | | 02 | /27/2020 |
| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | STREET ADDRESS, 14935 HOLLY KNO GAINESVILLE, V | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | (EACH | OVIDER'S PLAN OF CORRECTI I CORRECTIVE ACTION SHOUL REFERENCED TO THE APPRO DEFICIENCY) | .D BE | (X5) COMPLETION DATE |
| F 880 | information was obta https://medlineplus.g 7. Asthma is a disea of the lungs to swell a wheezing, shortness and coughing. This i from the website: https://medlineplus.g 4. The facility staff fa control procedures for 221's incentive spiror. Resident # 221 was a diagnoses that include obstructive sleep apropressure. Resident # set), was not due at the facility's nursing "Adr. Resident # 221 docur. Orientation: a. Persomonth, year), d. Situation on 02/25/20 at 11:57 and on 02/25/20 at 11:57 and on 02/25/20 at 11:25 conducted with Resident # 221's root spirometer on the over the original of the pused the incentificated that they used | by sodium (salt) level. This ined from the website: by/ency/article/000394.htm. se that causes the airways and narrow. It leads to of breath, chest tightness, information was obtained by/ency/article/000141.htm. billed to implement infection or the storage of Resident # meter. admitted to the facility with led but were not limited to: lea [1] and high blood to 221's MDS (minimum data the time of the survey. The mission Assessment" for mented in part, "2. In, b. Place, c. Time (day, | F | 380 | | | |
| | 221 dated February 2 | 2020 documented in part, r Q 1 H PRN [every hour as | | | | | |

| OLIVILIY | O TOR MEDICARE & | MEDICAID SEKAIOES | | | | OWID IT | 7. 0000-0001 |
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| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | 495424 | B. WING | | | 02/ | 27/2020 |
| | ROVIDER OR SUPPLIER | IABILITATION CENTER | | STREET ADDRESS, CITY, STATE, ZIP COD 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | E | (X5) COMPLETION DATE |
| F 880 | The comprehensive of dated 02/20/2020 dod Altered Respiratory Staltered respiratory Staltered respiratory Staltered respiratory Staltered respiratory Staltered respiratory Staltered Tespiratory Staltered Tespiratory and Staltered Tespiratory Staltered Staltered Tespiratory Staltered Te | care plan for Resident # 221 cumented in part, "Focus. tatus: [Resident # 221] has atus, difficulty breathing r/t tea. Created on: Interventions" it ster medications/puffers as effectiveness and side 02/20/2020." 5 p.m., an observation of entive spirometer sitting on ecovered and interview was licensed practical nurse] # incentive spirometer was by equipment, LPN # 3 stated w an incentive spirometer on not in use, LPN # 3 claced in a bag and dated." corrometer sitting on the red, LPN # 3 stated that it bag. When asked why it the the incentive spirometer in if to prevent infection. In to prevent infection. In the procedures and indend of practice. The procedures and indend of practice. The procedures in of extraneous material. The procedure in a plastic storage bag | F | 880 | | | |

| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | 1 ' ' | | PLE CONSTRUCTION | | ATE SURVEY |
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| | | 495424 | B. WING | | | | 2/27/2020 |
| | ROVIDER OR SUPPLIER | HABILITATION CENTER | | 14935 | ET ADDRESS, CITY, STATE, ZIP CODE HOLLY KNOLL LANE IESVILLE, VA 20155 | • | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCE | TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) | LD BE | (X5) COMPLETION DATE |
| F 880 | spirometer, if applicate to avoid inadvertent the incentive spiromereach." Lippincott's Edition) 2013. On 02/26/2020 at 4: staff member] # 1, and director of nursing, a consultants were marked findings. No further information. References: [1] Sleep apnea is a causes your breathing pauses caminutes. They may chour. This information website: https://medispneumonia, respirate obstructive pulmona. Resident # 47 was diagnoses that include pneumonia, respirate obstructive pulmona. Resident # 47's mos set), a quarterly asse (assessment referenced Resident # 47 assessment for men of 0 - 15, 15- being codally decisions. In S Procedures and Prowas coded as received. | able, with the patient's name use by another patient. Keep eter within the patient's Nursing Procedures (6th 45 p.m. ASM [administrative diministrator, ASM # 2, and ASM # 3, regional nursing ide aware of the above on was provided prior to exit. Common disorder that ag to stop or get very shallow in last from a few seconds to occur 30 times or more an on was obtained from the ineplus.gov/sleepapnea.html. Is admitted to the facility with ded but were not limited to: ory failure and chronic ry disease [1]. It recent MDS (minimum data essment with an ARD ce date) of 12/19/2019, as scoring a 15 on the staff tal status (BIMS) of a score cognitively intact for making ection O "Special Treatment, grams", coded Resident # 47 | F | 880 | | | |

| STATEMENT OF DEFICIEN AND PLAN OF CORRECTI | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WNG_ | | | 02/ | 27/2020 |
| NAME OF PROVIDER OF | | ABILITATION CENTER | | 1 | STREET ADDRESS, CITY, STATE, ZIP CODE 14935 HOLLY KNOLL LANE GAINESVILLE, VA 20155 | | |
| | ACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY) | _ | (X5) COMPLETION DATE |
| Residen on the box 17 dated 18 dated 19 | edside table of the service of the s | lizer mask revealed it was | F | 880 | | | |

| | OF DEFICIENCIES CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | - COCC | | CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
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| | | 495424 | B. WING | | | 02/27/2020 | |
| | ROVIDER OR SUPPLIER NASSAS HEALTH & REH | ABILITATION CENTER | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 4935 HOLLY KNOLL LANE SAINESVILLE, VA 20155 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) | PREFIX (EACH CORRECTIVE ACTION SHOUL | | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY) | | (X5) COMPLETION DATE |
| F 880 | On 02/26/2020 at 4:45 p.m. ASM [administrative staff member] # 1, administrator, ASM # 2, | | F | 880 | | | |
| | director of nursing, ar consultants were mad findings. | nd ASM # 3, regional nursing de aware of the above | | | | | |
| | References: [1] Disease that make can lead to shortness was obtained from the | n was provided prior to exit. es it difficult to breath that s of breath. This information e website: pov/medlineplus/copd.html. | | | | | |
| | | | | | | | |