PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT		(X3) DATE SURVEY COMPLETED			
			A. BUILUI	NG			
		495217	B. WING	B. WING		C	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE	4/08/2021	
MANORO	ARE HEALTH SERVIC	ES-FAIR OAKS	1	12475 LEE JACKSON MEMORIAL HIG			
				FAIRFAX, VA 22033			
(X4) ID PREFIX	SUMMARY (FACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL	QI	PROVIDER'S PLAN OF C		(X5)	
TAG	REGULATORY	R LSC IDENTIFYING INFORMATION)	TAG	((EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETION	
E 000	Initial Comments		EC	000			
F 000	survey was conduct 04/08/2021. The fact compliance with 42 Requirement for Lot	ng-Term Care Facilities.					
1 000	HALLIYE COMMENT	5	F0	00			
	conducted 04/06/20 complaint (VA00050 deficiencies), was in	Life Safety Code					
	time of survey. The same as a current resident records.	45 bed facility was 130 at the survey sample consisted of ecord reviews and three					
SS=D	§483.10(a) Resident The resident has a riself-determination, a access to persons aroutside the facility, in this section. §483.10(a)(1) A facil with respect and digresident in a manner promotes maintenant	Rights. ght to a dignified existence, and communication with and and services inside and actuding those specified in ity must treat each resident and in an environment that are or enhancement of his or ognizing each resident's lity must protect and	F 55	1. Corrective Action Certified Nursing Assistant a educated on resident rights emphasis on assisting with r dignified manner. Resident no ill effects from this deficie 2. Other Potential Residents All residents have the potent affected by this deficient prac RECEIVED MAY 07 2021	with an meals in a #101 suffered ent practice.		
		UPPLIER REPRESENTATIVE'S SIGNATURE		VRH/OLC		X6) DATE	

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 program participation.

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS	B. WING	<u> </u>	С
			04/08/2021
		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	U4/U8/2021
(X4) ID SUMMARY STATEMENT OF DEFICIEN PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFO	BY FULL PREF		
§483.10(a)(2) The facility must provide access to quality care regardless of dia severity of condition, or payment source must establish and maintain identical propractices regarding transfer, discharge, provision of services under the State phresidents regardless of payment source §483.10(b) Exercise of Rights. The resident has the right to exercise hirights as a resident of the facility and as or resident of the United States. §483.10(b)(1) The facility must ensure the resident can exercise his or her rights we interference, coercion, discrimination, of from the facility. §483.10(b)(2) The resident has the right free of interference, coercion, discriminating reprisal from the facility in exercising his rights and to be supported by the facility exercise of his or her rights as required a subpart. This REQUIREMENT is not met as evid by: Based on observation, staff interview, for document review and clinical record review as determined that facility staff failed to lunch in a manner to promote resident one of 33 current residents in the survey Resident # 101. CNA (certified nursing a # 3 was observed standing next to Resided, while feeding Resident # 101 their meal. The findings include:	equal gnosis, e. A facility olicies and and the an for all e. e. e. a citizen to be eation, and e or her e in the under this elenced eacility elew, it o serve lignity for example, eassistant) elent 101's	3. New Measures or Systemic Change The Director of Nursing and/or register nurse (RN) unit managers and/or RN supervisors will re-educate the Certific Nursing Assistant's on resident rights an emphasis on assisting with meals dignified manner. 4. Monitoring The Director of Nursing and/or register nurse (RN) unit managers and/or RN supervisors will make rounds during a time times to ensure resident's requir assistance with meals are fed in a digmanner. These rounds will be compleand documented as done daily for on week then three times weekly for an additional week, followed by two times weekly for an additional week, followed one time per week for an additional to months. These results of these round be reported monthly to the Administrational the QAPI Committee. 5. Completion Date May 18, 2021 RECEIVED MAY 07 2021 VDH/OLC	ered ied s with in a ered meal ing gnified eted ie es ed by wo ds will

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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A. BUILD		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED C 04/08/2021	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 550	Resident # 101 was a diagnoses that included dementia [1], and material mat	admitted to the facility with led but were not limited to: illnutrition. Set recent MDS (minimum at change assessment with a reference date) of esident # 101 as unable to orief interview for mental sessment for Mental ent # 101 as being for making daily decisions. To ded as requiring extensive eff member for eating. 2 p.m., an observation was entified nursing assistant] # 3 101 with their lunch. After dent # 101's bed and ent to an upright position, tainers and uncovered the D1's lunch try. CNA # 3 then dent's bed and fed Resident 0 p.m., an interview was # 3. When asked if they lent # 101, CNA # 3 stated out their position while D1, CNA # 3 stated, "I was ed if was dignified to feed ing, CNA # 3 stated no. ibe the correct position ent, CNA # 3 stated,	F	550				

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Event ID: OKNR11

Facility ID: VA0153

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDING	(X3) DATE SURVEY COMPLETED				
	495217 B. WIN		B. WING		C 04/08/2021		
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	3-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			
	member] # 1, administ director of nursing. We of practice the nursing. ASM # 2 stated that it policies and procedur. The facility's policy "Neart, "7. If patient requiver do not serve the tray assistance. Perform he with eating. Sit next to them to eat, rather the conditional of the process. It administrator and nursing, were made at the conditional of	strator and ASM # 2, the then asked what standards g staff follow ASM # 1 and they follow the facility's res. Meal Service" documented in uires assistance with eating, until able to stay and provide the patient while assisting an standing over them." Droximately 4:55 p.m., ASM of ASM # 2, director of the above findings. In was provided prior to exit. In was provided prior to exit. In the total occurs with certain the emory, thinking, language, for. This information was the bite: Droylarticle/000739.htm. Indications Needs/Preferences In the to reside and receive the with reasonable sident needs and then to do so would or safety of the resident or its not met as evidenced and, staff interview, resident	F 55	1. Corrective Action Resident #44 and # 49 suffered ill no from this deficient practice. 2. Other Potential Residents All residents have the potential to be affected by this deficient practice.			

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Event ID: OKNR11

Facility ID: VA0153

If continuation sheet Page 4 of 127



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			1			С	
		495217	B. WING_		04/	08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW			
MANONVANE HEALTH SERVICES AIR SARS			FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORI ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 558	determined that the f accommodations of r current residents in the 44 and # 49. The fathe call bells [a device pushed to alert staff for Resident #44 and maintained within real maintained within real for Resident # 44 was diagnoses that include arthritis and dementiarecent MDS (minimulassessment with an adate) of 02/04/2021, scoring a 9 [nine] on status (BIMS) of a somoderately impaired decisions. Resident # extensive assistance activities of daily livin "Functional Limitation Resident # 44 as "Not extremities [shoulder "Impairment on both extremities [hip, kneed on 04/07/21 at 8:24 Resident # 44. At this conducted with Resident # 44 stated can reach it.	resident needs for two of 33 the survey sample, Residents acility staff failed to ensure the with a button that can be when assistance is needed] I Resident #49's were ach for use. Is admitted to the facility with the but were not limited to: a [1]. Resident # 44's most m data set), a quarterly ARD (assessment reference coded Resident # 44 as the brief interview for mental tore of 0 - 15, 9 - being of cognition for making daily # 44 was coded as requiring of one staff member for ag. Section G0400 in in Range of Motion" coded of impairment" of their upper c, elbow, wrist, and hand] and sides" of their lower	F	3. New Measures or Systemi The Director of Nursing and/o nurse (RN) unit managers and supervisors will re-educate staimportance of ensuring the camaintained within the reach or resident. 4. Monitoring The Director of Nursing and/o nurse (RN) unit managers and supervisors will make rounds shifts to ensure the call bell is within the reach of each reside rounds will be completed for edocumented and will occur as for one week then three times additional week, followed by tweekly for an additional week one time per week for an addimonths. These results of these he reported monthly to the Ad and the QAPI Committee. 5. Completion Date May 18, 2021	r registered d/or RN aff on the aff or RN on all three maintained ent. These each shift, follows: daily weekly for an wo times followed by tional two se rounds will		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495217	B. WING _		C 04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	E C	(X5) COMPLETION DATE
F 558	Resident # 44's room Resident # 44. Furth revealed the blanket the call bell on the flot 44. On 04/07/21 at 9:20 observations of Resiresident lying in bed to the right of Reside The comprehensive dated 12/06/2020 do risk for falls due to ur Date Initiated: 12/06/it documented in para assistance. Date Initiated: 12/06/it documented with LPN 2, regarding the posi residents. LPN # 2 si within reach at all time. O4/07/21 at 1:13 p.m. conducted with CNA 6, regarding the posi residents. CNA # 6 si When asked how oftis checked, CNA # 6 time you go in [the reinformed of the obse on 04/07/21, at 8:26]	g assistant] # 6 entered n to provide a blanket to er observation at 8:27 a.m., covering Resident # 44 and por to the right of Resident # a.m., and 10:50 a.m., dent # 44 revealed the and the call bell on the floor ent # 44. care plan for Resident # 44 cumented in part, "Focus: At ensteady gait and confusion. (2020." Under "Interventions" t, "Reinforce need to call for iated: 12/06/2020." p.m., an interview was [licensed practical nurse] # tioning of call bells for lated, "The call bell is to be lies."	F 5	58		
		l if they had checked the # 44's call bell, CNA # 6 k for the call bell."				

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Event ID: OKNR11

Facility ID: VA0153

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I	PLE CONSTRUCTION 3	1, ,	(X3) DATE SURVEY COMPLETED C 04/08/2021	
	495217					
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 558	On 04/06/2021 at all entrance conference conducted with ASM member] # 1, admir director of nursing. To practice the nursing of practice the nursing ASM # 2 stated that policies and proced. The facility's policy part, "6. Always posuse and within react secure the light." On 04/07/2021 at all # 1, administrator and nursing, were made. No further information. References: [1] A loss of brain furth diseases. It affects in judgment, and behad obtained from the whittps://medlineplus. 2. The facility staff farth 49's call bell within Observations reveal the call bell draped out of the residents. Resident #49 was a 2/10/2021 with diagnot limited to: cellulity especially that below redness, pain and sextremities, sarcope extremities, sarcope	proximately 11:30 a.m., the e for the survey was a [administrative staff inistrator and ASM # 2, the When asked what standards ing staff follow ASM # 1 and a they follow the facility's ures. "Call Light" documented in ition call light conveniently for the A clip may be used to a proximately 4:55 p.m., ASM and ASM # 2, director of aware of the above findings. The proximately 4:55 p.m., as a provided prior to exit. Inction that occurs with certain memory, thinking, language, vior. This information was ebsite: The proximately 4:55 p.m. and a provided prior to exit. The proximately 4:55 p.m. as a provided prior to exit. The proximately 4:55 p.m. as a provided prior to exit. The proximately 4:55 p.m. as a provided prior to exit. The proximately 4:55 p.m. as a provided prior to exit. The proximately 4:55 p.m. as a provided prior to exit.	F 55	58		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	495217		B. WING _	B. WING		C 04/08/2021	
	MANORCARE HEALTH SERVICES-FAIR OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHV FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE		
F 558	esophagus, usually sphincter muscle be symptoms include be commonly known as The most recent MD assessment, an admassessment reference the resident as scori interview for mental resident is cognitivel decisions. The resident extensive assistance members for all of hiexcept eating. Reside difficulty in his range extremities. Observation was mad/6/2021 at 12:49 pulwas observed drape of Resident #49's resident #49's resident #49's resident #49's resident #49's resident #49 stated, "It's probsometimes." When a help, Resident #49's The comprehensive documented in part, to unsteady gait and	ents of the stomach into the caused by malfunction of the tween the two organs; urning pain in the esophagus, heartburn) (3). S (minimum data set) hission assessment, with an ce date of 2/16/2021, codeding a "15" on the BIMS (brief status) score, indicating the yintact to make daily ent was coded as requiring ent was coded as requiring ent #49 was coded as having of motion in both of his lower de of Resident #49 in bed on m. The resident's call bell dover the bedside table, out each. The resident #49 in bed on m. The resident's call bell dover the bedside table, out each. The resident #49 in bed on m. The resident's call bell dover the bedside table, out each. The resident #49 in bed on m. The resident's call bell, Resident each. An interview was dent #49 at this time. When attion of his call bell, Resident ably on the floor as it's there each how he would ask for tated, "He'd call out." Care plan dated 2/10/2021, "Focus: At risk for falls due	F	558			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C 04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COD 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033	Ε	1410612021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 558	An interview was cornursing assistant) #2 regarding positioning #2 stated it should be CNA #2 was asked if resident's night stand resident in bed that regetting in and out of ton, it would not be in On 4/7/2021, at 11:13 conducted with LPN regarding positioning #1 stated it should be LPN #1 was asked if resident's night stand resident in bed that regetting in and out of to it would not." ASM (administrative administrator, and AS nursing, were made at 4/7/2021 at 4:54 p.m. No further information References: (1) Barron's Dictionar Non-Medical Reader, Chapman, page 111. (2) This information of following website: https://medlineplus.go.	iducted with CNA (certified of on 4/7/2021 at 11:09 a.m., of resident call bells. CNA is within the resident's reach. It is a call bell draped over a large over	F 5	58			

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Event ID: OKNR11



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STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
			A BOILDII	1 G _			С
		495217	B. WING_	B. WING			08/2021
NAME OF P	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE	04/	06/2021
					2475 LEE JACKSON MEMORIAL HIGHWAY		
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS	- 1		FAIRFAX, VA 22033		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG			ID PREFIX TAG	Κ	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		(X5) COMPLETION DATE
F 558	Continued From page	9	F 5	558			·
	Chapman, page 243,		İ				
F 656 SS=D	Develop/Implement C CFR(s): 483.21(b)(1)	Comprehensive Care Plan	Fé		Corrective Action A care plan has been developed and implemented for transmission based preduction.	cautions	
	§483.21(b) Comprehe	ensive Care Plans cility must develop and			for resident #336.	Jaations	
		ensive person-centered			A care plan has been developed and		
		sident, consistent with the			implemented for oxygen administration	for	
		th at §483.10(c)(2) and		resident #128.			
	§483.10(c)(3), that inc				Resident #44 was given an incentive spin	ometer	
		ames to meet a resident's			and a care plan has been developed and implemented for continuous positive airs		
		mental and psychosocial			pressure (C-PAP) and the incentive spiro		
		ed in the comprehensive			pressure (C-r Ar) and the incentive spire	meter.	
	describe the following	nprehensive care plan must			2. Other Potential Residents		
		re to be furnished to attain			All residents have the potential to be affe	ected by	
		ent's highest practicable			this deficient practice.		
		psychosocial well-being as			•		
		24, §483.25 or §483.40; and			3. New Measures or Systemic Change		
	(ii) Any services that v	would otherwise be required			The Director of Nursing, RN unit manag		
		25 or §483.40 but are not			and/or RN supervisors will audit 100% of	of the	
		esident's exercise of rights			care plans for residents with orders for		
	under §483.10, includ	ling the right to refuse			transmission based precautions, supplem		
	treatment under §483				oxygen use and continuous airway press	ure to	
	(iii) Any specialized se				ensure all are care planned. The Director of Nursing, RN unit manag		
ļ	provide as a result of	the nursing facility will			and/or RN supervisors will re-educate sta		i
	•	rasakk a facility disagrees withthe			transmission based precautions, supplem		į
		RR, it must indicate its			oxygen use and continuous airway press		
	rationale in the reside				The need for a fully developed and imple	emented	
	(iv)In consultation with				care plan will be included in this educati		
	resident's representat						
	(A) The resident's goa						
	desired outcomes.						
		ference and potential for					
	future discharge. Faci			į			
		desire to return to the					
	community was asses	ssed and any referralsto					

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Event ID: QKNR11

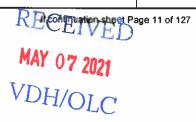


PRINTED: 04/19/2021 **FORM APPROVED** OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS COMPAND CONTINUES OF PROVIDER OR SUPPLIER		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
MANDEOF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS POPPLY SUMMARY STATEMENT OF DEFICIENCIES TANK N. V. 22033 TANK N. V. 22033				A. BUILDING				
MANORCARE HEALTH SERVICES-FAIR OAKS CALID SUMMANY STATEMENT OF DESCRIPTIONS SUMMANY STATEMENT OF SUMMANY STATEMENT O			405247 P MINO			-		
MANORCARE HEALTH SERVICES-FAIR OAKS T2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033 DESCRIPTION OF THE PRECEDED BY FULL RECOULTION OF ALSO EDEFLICENCY MUST BE PRECEDED BY FULL RECOULTION OF ALSO EDEFLICENCY MUST BE PRECEDED BY FULL RECOULTION OF ALSO EDEFLICENCY MUST BE PRECEDED BY FULL RECOULTION OF ALSO EDEFLICENCY MUST BE PRECEDED BY FULL RECOULTION OF ALSO EDEFLICENCY MUST BE PRECEDED BY FULL RECOULTION OF ALSO EDEFLICENCY MUST BE PRECEDED BY FULL RECOULTION OF ALSO EDEFLICENCY MUST BE PRECEDED BY FULL RECOULT OF A MUST AND THE PROPORATE DEFLICENCY OF A MUST AND THE PROPORATE DEFL	NAME OF D	POVIDED OF CHERNIES	430217	D. WIIIG _		04	1/08/2021	
CAJ ID PROMORENE HALTH SERVICES-FAIR OAKS FAIRFAX, VA 22033	MANUE OF FE	TANKE OF FROM DET ON OUT FIELD		ŀ				
PROPERTY TATEMENT OF OFFIciALCES PROPERTY TAG REACH DEFRICENCY WIST BE REFECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REACH DEFRICENCY WIST BE REFECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG REACH DEFRICENCY F 656 Continued From page 10 Local contact agencies and/or other appropriate entitles, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop and implement the comprehensive care plan for three of 33 current residents in the survey sample, (Residents #336, #128, and #44). The facility staff failed to develop and implement a comprehensive care plan to include physician ordered transmission based precautions for Resident #4128's comprehensive care plan to include physician ordered C-PAP [continuous positive ainway pressure], with mask, and incentive spirometer. The findings include: 1. Resident #336 was admitted to the facility on 3/30/21 with diagnoses including, but not limited to a stroke and right side paralysis. Resident #336 had not been admitted to the facility long enough for an MDS (minimum data set) assessment to be completed. On the admission nursing assessment to be completed. On the admission nursing assessment to be completed. On the admission nursing assessment of the complete of the pacifity on 3/30/21 with diagnoses including, but not limited to a stroke and right side paralysis. Resident #336 was documented as *alert and oriented X 3 [person, place, and time].* On 4/06/21 at 1:56 p.m., Resident #336 was	MANORCARE HEALTH SERVICES-FAIR OAKS		S-FAIR OAKS			•		
F 656 Continued From page 10 local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in pragragathy (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop and implement the comprehensive care plan for three of 33 current residents in the survey sample, (Resident #336, #138, dialed to implement a comprehensive care plan to include physician ordered transmission based precautions for Resident #44's use of the physician ordered C-PAF [continuous positive airway pressure], with mask, and incentive spirometer. The findings include: 1. Resident #336 was admitted to the facility on 3/30/21 with diagnoses including, but not limited to a stroke and right side paralysis. Resident #336 had not been admitted to the facility long enough for an MDS (minimum data set) assessment to be completed. On the admission nursing assessment of a completed on the admission nursing assessment of a completed on the admission nursing assessment of a completed on the admission nursing assessment afted 3/30/21, Resident #336 was documented as "alert and oriented X 3 [person, place, and time]." On 4/06/21 at 1:56 p.m., Resident #336 was					FAIRFAX, VA 22033			
local contact agencies and/or other appropriate entitles, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to develop and implement the comprehensive care plan for three of 33 current residents in the survey sample, (Residents #336, #128, and #44). The facility staff failed to develop and implement a comprehensive care plan to include physician ordered transmission based precautions for Resident #336, failed to implement Resident #128's comprehensive care plan to administer oxygen as prescribed by the physician, and failed to develop a comprehensive care plan for Resident #336 was admitted to the facility on 3/30/21 with diagnoses including, but not limited to a stroke and right side paralysis. Resident #338 had not been admitted to the facility tong enough for an MDS (minimum data set) assessment to be completed. On the admission nursing assessment dated 3/30/21, Resident #336 was documented as "alert and oriented X 3 [person, place, and time]." On 4/06/21 at 1:56 p.m., Resident #336 was	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP	ULD 8E	COMPLETION	
nursing assessment dated 3/30/21, Resident #336 was documented as "alert and oriented X 3 [person, place, and time]." On 4/06/21 at 1:56 p.m., Resident #336 was		Continued From page local contact agencie entities, for this purpo (C) Discharge plans in plan, as appropriate, requirements set forti section. This REQUIREMENT by: Based on observation document review, and was determined that develop and implement plan for three of 33 cts sample, (Residents # facility staff failed to comprehensive care ordered transmission Resident #336, failed #128's comprehensive oxygen as prescribed to develop a comprehensive oxygen as prescribed to develop a comprehensive to develop a comprehensive to develop a comprehensive oxygen as prescribed to develop a comprehensive to develop a comprehensive to develop a comprehensive oxygen as prescribed to develop a comprehensive oxygen as prescribed to develop a comprehensive to develop a comprehensive to develop a comprehensive sident # 44's use of C-PAP [continuous pmask, and incentive statement # 336 was 3/30/21 with diagnost to a stroke and right statement # 336 had not been as enough for an MDS (in the property of the p	e 10 s and/or other appropriate ose. In the comprehensive care in accordance with the in in paragraph (c) of this is not met as evidenced on, staff interview, facility d clinical record review, it the facility staff failed to ent the comprehensive care current residents in the survey 1336, #128, and #44). The develop and implement a plan to include physician based precautions for to implement Resident re care plan to administer by the physician, and failed mensive care plan for of the physician ordered ositive airway pressure], with spirometer. s admitted to the facility on es including, but not limited side paralysis. Resident dmitted to the facility long minimum data set)		Continued From page 10 4. Monitoring Three times weekly over the next of Director of Nursing and/or register (RN) unit managers and/or RN surreport the findings of their visual of transmission based precautions, su oxygen use and continuous airway been added to the care plans for all with orders. The compliance of the observations will be reported to the Administrator and to the QAPI Co 5. Completion Date	0 days the ed nurse ervisors will necks that oplemental pressure has residents see visual		
LODEODIOS CITIOS IN SUBSSISSION IN NO FRANK (In		nursing assessment of #336 was documented [person, place, and tied on 4/06/21 at 1:56 p.	dated 3/30/21, Resident and oriented X 3 me]."					

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Event ID: OKNR11



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495217			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING_		C 04/08/2021		
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 656	the outside of his dooresident as on airborr observed. OSM (other physical therapist, was floor in front of the se observed repeatedly arms and shoulders. #11's clothing was in #336, and the floor, mearing a mask, face However, he was not A review of Resident revealed the following 3/30/21: "Airborne and COVID-19 (3) Protocol A review of Resident revealed the following 3/30/21: "Airborne and COVID-19 (3) Protocol A review of Resident 3/30/21 revealed no in infection control or iso observation. On 4/7/21 at 3:53 p.m. nurse) #4 was interview admitting nurse is resonewly-admitted resident the MDS nurse is the development of th LPN #4 stated the careach resident, with the individual resident's in physician ordered isoli included on a residen #4 stated they should On 4/8/21 at 8:25 a.m.	ar, signs designating the me and droplet isolation were ar staff member) #11, a is observed kneeling on the ated resident. OSM #11 was touching the resident's legs, Observation revealed OSM direct contact with Resident multiple times. OSM #11 was shield, and gloves. wearing an isolation gown. #336's clinical record g physician's order, dated d Droplet Precaution for col." #336's care plan dated information related to plation for COVID-19 a., LPN (licensed practical ewed. She stated that the ponsible for creating a ent's baseline care plan, and a responsible for overseeing the comprehensive care plan. The plan is developed for the purpose of meeting each eeds. When asked if lation precautions should be t's baseline care plan, LPN a., RNs (registered nurses)	F 6	56		
	#8 and #9, MDS coor RN #8 stated the MD	dinators, were interviewed. S coordinators develop the information contained in the				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIEM DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	MDS, physicians' ord She stated various material team complete portion their specialties. She wait the traditional 21 comprehensive care Resident #336's care comprehensive care When asked if isolating included on a resider "Yes." No further information REFERENCES (1) "Droplet Precautions are particles that cannot far. They are transmisted that cannot far. They are transmisted the website https://www.cdc.gov/E102-508.pdf. (2) "Airborne precaution particles may remain move depending on the where there is inaded airborne particle may and be inhaled by a recontrol and prevention infections are not simulariflow with the use of the website may and the inhaled by a recontrol and prevention infections are not simulariflow with the use of the weight of the website may and be inhaled by a recontrol and prevention infections are not simulariflow with the use of the weight of the w	lers, and resident history. Itembers of the care plan Ins of the MDS according to Itembers of the MDS according to Itempers of the M	F6	56			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _		_	l	C /08/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE	<u> </u>	
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		12475 LEE JACKSON MEM FAIRFAX, VA 22033	ORIAL HIGHWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRI EFICIENCY)		(X5) COMPLETION DATE
F 656	F 656 Continued From page 13 techniques, wearing personalized protection		F6	56			
		d performing basic infection like hand washing. This					
	· · · ·	echniques for minimizing the					
		seases and the role of the					
		n in maximizing airborne ize the spread of disease."					
		taken from the website					
	https://www.ncbi.nlm.	nih.gov/books/NBK531468/					
		Oprecautions%20necessitate					
	%20the%20prevention n%20the%20airflow.	n,move%20depending%20o					
		re a large family of viruses					
		nt species of animals, tle, and bats. The new strain					
	-	ied as the cause of the					
		y illness in people first					
		China, has been named					
	· · · · · · · · · · · · · · · · · · ·	rly, it was referred to as					
	2019-nCoV.) The disc	-					
		en named COVID-19." This ned from the website:					
		.gov/health/in-the-news-coro					
	navirus-and-alternativ	•					
		s admitted to the facility on					
		oses that included cancer of					
		pressure, fractured ribs and					
		t recent MDS (minimum					
		, an admission assessment, eference date (ARD) of					
		resident as scoring a "14"					
		erview for mental status),					
		resident was capable of					
	making daily cognitive	e decisions. The resident					
	•	ng extensive assistance of					
		mbers for most of her					
	•	g. Section O - Special					
	reatments, Procedu	res and Programs coded the					I

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING		C 04/08/2021		
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENT	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION		
F 656	resident as receiving the facility. The comprehensive documented in part, altered respiratory s disease process [Lu fracture]." The "Interpart, "Provide oxyge The physician order documented, "O2 (o minute via N/C (nas that has two prongs every shift for SOB (Observation was mad/6/2021 at 1:00 p.n. her oxygen on via than oxygen concentrator at 2 liters per minute Observation was mad/7/2021 at 12:15 p. had a window visit was getting ready to Resident #128 was the nasal cannula concentrator flow med LPM (liters per minute An interview was copractical nurse) #3 regarding the purposplan. LPN #3 stated	care plan dated 3/20/2021, "Focus: The resident has tatus with SOB r/t (related to) ing CA {cancer}recent rib rventions" documented in en as ordered." dated 3/20/2021, exygen) @ (at) 2 liters per al cannula - a plastic tubing that insert into the nose) (shortness of breath)." ade of Resident #128 on in. She was resting in bed with the nasal cannula connected to ator that was running. The in flow meter was observed set the (LPM). ade of Resident #128 on in. Resi	F 656				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		NSTRUCTION		E SURVEY IPLETED
		495217	B. WING			04	C I/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			BE	(X5) COMPLETION DATE	
F 656	implemented, LPN #3 followed. A review of the facility Care Planning," revenues develop and imperson-centered care includes measurable to meet a patient's management of the positive administrator and AS were made aware of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order positive airway press incentive spirometer of the physician order pressure pre	y policy, "Interdisciplinary aled, in part, "The facility plement a comprehensive e plan for each patient that objectives and timeframes edical, nursing, mental and hat are identified in the ssment." staff member) #1, the M #2, the director of nursing, the above concern on was provided prior to exit. led to develop a plan for Resident # 44's use red C-PAP [continuous ure], with mask [1], and [5]. dmitted to the facility with ed but were not limited to: lea [2] and respiratory failure recent comprehensive MDS an admission assessment ment reference date) of esident # 44 as scoring a 9 erview for mental status	F	556			
	impaired of cognition Section "O Special Tr	O - 15, 9 - being moderately for making daily decisions. reatments, Procedures and sident # 44 as having a dent."					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495217	B. WING_			C 04/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE:	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW. FAIRFAX, VA 22033	AY	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	DED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE	
F 656	Continued From page	e 16	F6	56		
	observation of Reside C-PAP mask on top of uncovered. Further of room failed to eviden On 04/06/2021 at approbation of Reside C-PAP mask on top of uncovered. Further of room failed to eviden On 04/07/2021 at approbation of Reside C-PAP mask laying of dresser uncovered. From the Resident #44's room incentive spirometer. The physician's order					
	during the day while so 02/17/2021." - "4/2021" document keep at bedside even elevated CO2 [carbor day and evening shift Everyday." The comprehensive of dated of 12/06/2020 to documentation for the to evidence document incentive spirometer.	ed, "Incentive Spirometer y day and evening shift for n dioxide. Frequency: every . Schedule Type: care plan for Resident # 44 failed to evidence e use of a C-PAP and failed tation for the use of an				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495217	B. WING _		C 04/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES 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 APPROPRI DEFICIENCY)	
F 656	documented the above eTAR further docume the C-PAP on 04/06/2 evening shifts and on day and evening shifts and on day and evening shift documented Residen spirometer on 04/06/2 shifts and on 04/07/26 shifts. On 04/07/21 at 12:58 conducted with LPN [2, regarding the purpocomprehensive care pyou what to do for the asked to review Reside care plan to determine 44's use of a C-PAP at LPN # 2 and LPN # 3 care and stated that it documentation of Resuse of an incentive sponducted with LPN # When asked about up comprehensive care promoted with LPN # When asked about up comprehensive care promoted with the physician of spirometer missing from plan, LPN # 3 stated to the one of the physician of the phys	ne physician's orders. The need Resident # 44's use of 1021, on the day and 04/07/2021 2021, on the s. The eMAR further t # 44's use of an incentive 1021 on the day and evening 1021 on the day and e	F 6	56	

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Event ID: OKNR11

Facility ID: VA0153

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		(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
- 32		495217	B. WING		C 04/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 656	of practice the nursing ASM # 2 stated that the policies and procedure. On 04/07/2021 at app # 1, administrator and nursing, were made at the No further information. References: [1] Positive airway pread a machine to pump at airway of the lungs. The CPAP (continuous poprevents episodes of	g staff follow ASM # 1 and hey follow the facility's res. proximately 4:55 p.m., ASM ASM # 2, director of tware of the above findings. It was provided prior to exit. Passure (PAP) treatment uses in under pressure into the his helps keep the windpipe he forced air delivered by sitive airway pressure) airway collapse that block he with obstructive sleep thing problems. This	F 65	6	
	[2] Sleep apnea is a causes your breathing Breathing pauses can minutes. They may on hour. This information website: https://medlin/website: https://medlin/li> [3] When not enough lungs into your blood. obtained from the web https://www.nlm.nih.go.ilure.html. [4] Deficiency of oxygothe body. This informativebsite:	to stop or get very shallow. I last from a few seconds to cour 30 times or more an was obtained from the eplus.gov/sleepapnea.html. oxygen passes from your This information was			

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AND DI AN OF CODDECTION IDENTIFICATION NUMBER.		I ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		495217	B. WING _		C 04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS	•	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 656	healthy after surgery illness, such as pneu spirometer teaches y breaths. This informativebsite: https://medlineplus.g	help you keep your lungs or when you have a lung imonia. Using the incentive you how to take slow deep ation was obtained from the ov/ency/patientinstructions/0	F6			
	be- (i) Developed within the comprehensive a (ii) Prepared by an in includes but is not lin (A) The attending ph (B) Aregistered nurse resident. (C) Anurse aide with resident. (D) A member of foo (E) To the extent practice the resident and the An explanation must medical record if the and their resident repnot practicable for the resident's care plan. (F) Other appropriate disciplines as determor as requested by th (iii)Reviewed and revision in the comprehension of t	ensive Care Plans prehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that nited to ysician. e with responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined e development of the e staff or professionals in ined by the resident's needs	F6	1. Corrective Action The care plan for resident #75's splint been reviewed and revised and a theral evaluation was completed April 16, 20. The care plan for resident #51's prosth has been reviewed and revised and he an appointment on April 20, 2021 to he prostheses re-evaluated. No new order received. The care plan for resident #94's use of compression wraps has been reviewed 2. Other Potential Residents All residents have the potential to be a this deficient practice. 3. New Measures or Systemic Change The Director of Nursing, RN unit manand/or RN supervisors will audit 100% care plans for residents with orders for prostheses and compression wraps to e are care planned properly in accordance current physician orders. The Director of Nursing, RN unit manand/or RN supervisors will re-educate the importance of physician ordered sp prostheses and compression wraps bein planned and updated as needed.	eses use went for ave his s were revised. ffected by agers of the splints, nsure all e with agers staff on lints,	

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	FIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			1130.00			С
		495217	B. WING _		04	/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	3-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		LD BE	(X5) COMPLETION DATE		
F 657	comprehensive and coassessments. This REQUIREMENT by: Based on observation record review, facility interview, it was detereview and revise the for three of 33 currents sample, (Resident #7 facility staff failed to recomprehensive care include the use of a president #51 to incluent extremity prostheses address the residents.	is not met as evidenced n, resident interview, clinical document review and staff rmined facility staff failed to comprehensive care plant residents in the survey 5, #51, and #94). The eview and revise the plans for Resident #75 to hysician ordered splint; for de the use of bilateral lower and for Resident #94 to lower extremity edema and ordered compression wraps	F	4. Monitoring Three times weekly over the nex then two times weekly over the form days followed by one time weekly additional 30 days the Director of and/or registered nurse (RN) unit and/or RN supervisors will report findings of their visual checks the prostheses use and application of compression wraps has been can per physician orders. The completinese visual checks will be report Administrator and the QAPI Communication Date May 18, 2021	Illowing 30 for an Nursing managers the splint and fee planned ance of ed to the	
	comprehensive care include the use of a wiphysician. Resident #75 was ad diagnoses that includ diabetes (1), dementi Resident #75's most set), a quarterly asses (assessment reference Resident #75 as scor assessment for mental of 0 - 15, 6- being set daily decisions. Section	e date) of 2/27/2021, coded ing a 6 on the staff al status (BIMS) of a score rerely impaired for making on G coded Resident #75 assistance from two or				

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Facility ID: VA0153

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	PLE CONSTRUCTION 3		(X3) DATE SURVEY COMPLETED		
		495217	B. WING			C 04/08/2021		
	ROVIDER OR SUPPLIER	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		
F 657	transfers. Section Grequiring extensive for dressing, eating, hygiene. Section Ghaving functional linone side of the upper On 4/6/2021 at approbservation was maroom in bed. Reside groomed. Resident on top of the sheet. Resident #75's right Resident #75's room attempted at this time could not be conducted at the	assistance from one person, toilet use and personal coded Resident #75 as nitation in range of motion to er and lower extremity. roximately 12:28 p.m., an ade of Resident #75 in their ent #75 appeared well #75's hands were observed No splint was observed on twist or observed in sight in m. An interview was ne, with Resident #75 but cted due to their cognitive from of Resident #75 on m., 4/7/2021 at 9:45 a.m., and m. failed to reveal a splint on twist.	F 65					
	On 4/7/2021 at appr	roximately 1:20 p.m., an						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		DITIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED						
		495217	B. WING _		0.	C 4/08/2021		
	NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETION DATE		
F 657	nursing assistant) #4 had never observed on their right wrist and used on their unit. Claresident required a scare plan in the company they were encourage plan to give quality cathey would not know On 4/7/2021 at approinterview was conducted practical nurse) #2. LCNAs applied splints that splints were orderals on the residents that it was document resident refused to whe physician and the notified. LPN #2 revimedical record and sfor a wrist splint to the LPN #2 stated that the addressed on the camanager updated the On 4/7/2021 at approinterview was conducted manager. LPN #3 stated that the care plan provided stoverall plan of the pathat splints were adal be on the care plan. If #75's comprehensive the right wrist splint were plan and should the care plan and should the splints were plan and should the care pla	cted with CNA (certified . CNA #4 stated that they Resident #75 wear a splint d that splints were not really NA #4 stated that when a plint they would see it on the outer. CNA #4 stated that d to read the residents care are and if they did not read it what each resident needed. eximately 1:25 p.m., an oted with LPN (licensed PN #2 stated that nurses or as ordered. LPN #2 stated ered by the physician and ocare plan. LPN #2 stated ed in the progress notes if a ear a splint as ordered and e responsible party was ewed Resident #75's tated that there was an order e right wrist at all times.	F 6	57				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	(X3) DATE SURVEY COMPLETED	
		495217	B. WING _		C 04/08/2021
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 657	plan. LPN #3 reviewed and stated that the ri addressed on it either as well. On 4/8/2021 at approinterview was conducted therapists had provided the provided via email of the provided via email addressed on the provided via email of the provided via email addressed on the provided via email of the provided via email addressed on the provided via email of the provided via email addressed on the provided via email of the provided via e	ed the CNA kardex care plan ght wrist splint was not and should be added there eximately 10:00 a.m., an exted with OSM #9, st. OSM #9 stated that they to Resident #75 in 2019. They did not remember a splint on the right wrist eximately 11:30 a.m., ASM member) #1, the director of nursing their policies and	F6		
	policy, "Interdisciplina documented in part," a communication too interdisciplinary healt each individual patier the types and method should receive Inte individualized element which will help patient laterventions are the patient care and allow				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B. WING		MIN. 4	1	C /08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY 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 657	and measurable" I documented, " The must describe the fo are to be furnished to highest practicable p psychosocial well-be. On 4/7/2021 at appropriate administrator and nursing were made at No further information. References: 1. Diabetes mellitus the body cannot regulate blood. This information the website: https://www.nlm.nih.go.out.et/li> 2. Dementia- a loss with certain diseases language, judgment, information was obtain https://medlineplus.guide	The policy further comprehensive care plan flowing: the services that or maintain the patient's hysical, mental, and ing" Disciplification of the findings. In was provided prior to exit. In a chronic disease in which plate the amount of sugar in mation was obtained from the provided prior to exit. In the findings of the findings of the findings of the findings of the findings. In was provided prior to exit. In a chronic disease in which plate the amount of sugar in mation was obtained from the provided from the finding of the f	F	957				

PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B, WING _			ı	C 08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMORIAL HIG FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 657	Continued From page	e 25	Fe	657			
	2. The facility staff fai	led to review and revise the plan to include the use of					
3	diagnoses that includend stage renal diseabilateral below the kn #51's most recent MC quarterly assessment reference date) of 2/9 as scoring a 15 on the	mitted to the facility with ed but were not limited to use (2), diabetes (3) and ee amputation (4). Resident DS (minimum data set), a with an ARD (assessment U2021, coded Resident #51 e staff assessment for		şi.			
	being cognitively intact Section G coded Res supervision from one mobility, dressing and assistance of one per and personal hygiene #51 as having functio motion to both lower of	d eating and limited son for transfers, toilet use s. Section G coded Resident nal limitation in range of extremities. Section G as not walking during the nd failed to evidence					
	interview was conduct their room. Resident a manual wheelchair prosthetic legs were of Resident #51's room. conducted with Resides asked about the prost that he used to wear to received therapy. Resides was taught how to pure their room.	observed in the corner of					

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Event ID: OKNR11

Facility ID: VA0153

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495217	B. WING_			C 04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVIC	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 657	walking. Resident # prosthetic did not fit discharged from the to wear the leg. Respoken to the previous manager regarding get the prosthetic reset up. Resident #5 worker left and that other prosthetic leg them both and just Resident #51 stated attend therapy but the without the prosthetic without the prosthetic without the prosthetic with the comprehensive documented in part (activities of daily like chronic disease problem that therapy had not since he was dischanged by the comprehensive documented in part (activities of daily like chronic disease problem the knee ample 01/28/2019, Create [Name of staff mem 08/31/2020" Under documented in part equipment such as board for transfers. The comprehensive documentation for the resident #51. The "PT (physical the dated "10/22/2018-documented in part documented in part d	beside the window and with 51 stated that the right properly and he was grapy because he was unable sident #51 stated that he had bus social worker and the unit setting up an appointment to effitted but nothing had been 1 stated that the social he had just stop using the because he could not use used the wheelchair. If that he really wanted to hey (staff) would not let him tics on. Resident #51 stated to looked at the prosthetics arged from them and that the arrange the repairs to the clinic. If care plan for Resident #51, "At risk for decline in ADLs ring) & (and) mobility related to cess and BKAs (bilateral butation). Date Initiated: d on: 01/31/2018, Created by: ber] Revision on:	F	57			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL* A. BUILDI		(X3) DATE SURVEY COMPLETED		
		495217	B. WING	B. WING		C 04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS	10	1247	EET ADDRESS, CITY, STATE, ZIP CODE 5 LEE JACKSON MEMORIAL HIGHWAY RFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 657	PT for prosthetic train gait training. On eval several times to get the extremity) prosthesis Pt able to get the LLE prosthesis on. On Evor of prosthetic clinic prosthesis, but cont (with R LE (right lower Have left multiple me prosthetic clinic]. Pt he without teh [sic] while ambualting [sic]. Pt he without teh [sic] while ambualting [Name of pr R (right) prosthesis. If (hospital) due to med to receive skilled Fonly. He is MI (modification mobility & transfers a mobility. His R (right) prosthetic sleeve (who prosthetic clinic) need being appropriate for nursing aware. No skat this time" On 4/7/2021 at approximate interview was conducting assistant) #4 had never observed I prosthetic legs and the did not fit them proped CNA #4 stated that the	and requirign [sic] skilled high [sic] with transfers and (evaluation), Pt attempted he RLE (right lower on, but unable to get it on. E (left lower extremity) al. (evaluation) day [Name ad adjsuted [sic] teh [sic] continues) to have difficulty rextremity) prosthetic liner. It is sages with [Name of has been donning prosthesis a liner and standing and as met all of his goals. It is sues" It creening dated "01/18/19" umented in part, "Pt or P.T. (physical therapy). PT for prosthetic training ed independent) with bed s well as w/c (wheelchair) LE (lower extremity) ite) does not fit. [Name of dit o address it prior to patient skilled PT services warranted eximately 1:20 p.m., an otted with CNA (certified and contains they was a stated that they	F	357			

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
			A. BUILDIN	NG _				
		495217	8. WING _				C /08/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				1	2475 LEE JACKSON MEMORIAL HIGHWAY			
MANORC	ARE HEALTH SERVICES	FAIR OAKS		FAIRFAX, VA 22033				
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	((EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE	
F 657	Continued From page	28	F6	357				
	were encouraged to read the residents care plan to give quality care and if they did not read it they would not know what each resident needed.							
			-					
			i					
	On 4/7/2021 at appro-	ximately 1:32 p.m., an						
:		ted with LPN (licensed			ŧ«			
		terim unit manager. LPN		i]	
		se could update the care						
	plan. LPN #3 stated ti	nat the care plan provided						
	staff with information	on the overall plan of the	9				ŀ	
	patient's care. LPN #3	3 stated that adaptive						
	equipment should be	on the care plan. LPN #3						
		ck there were issues with						
	the [Name of prosthet	ic clinic] when trying to get						
	Resident #51, an app	ointment to have his						
		LPN #3 stated that the last						
		with anyone at the clinic,	1				1	
	the person who had p	•						
		er worked at the clinic. LPN						
	•	other staff member) #8,						
		spoken with the prosthetic						
		osthesis problems in the						
		nat they did not know the					1	
		esident #51 to have his						
		and they were not sure who						
		etting it up. LPN #3 stated						
		id to set up an appointment						
		e [Name of prosthetic clinic]					1	
	and would follow up w	in Resident#51.						
	On 4/7/2021 at annual	vimotoly 4:55 n m ACM 44						
		ximately 4:55 p.m., ASM #1, ASM #2, the director of						
	nursing were made av							
	muraniy were made at	wate of the infulligs.		-				
	No further information	was provided prior to exit.						
	References:							
	1. Prosthesis - is a pro	osthesis is a device						

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Event ID: OKNR11

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If continuation sheet Page 29 of 127



AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B. WING_			l	08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 657	designed to replace to make a part of the or missing eyes, are commonly replaced information was obte https://medlineplus 2. End-stage kidney chronic kidney disease can no longer support information was obte https://medlineplus 3. Diabetes mellitus the body cannot regithe blood. This information was obten the blood. This information was obten the website: https://www.nlm.nih.goo1214.htm. 4. Amputation: Leg removal of a leg, for These body parts and Amputations are do occur by accident of the resident #94's commaddress the care of use of physician or distributed to: gout (uric acid metabolism to accumulate in the pain and swelling of	a missing part of the body or e body work better. Diseased ins, hands, legs, or joints are by prosthetic devices. This ained from the website: gov/ency/article/002286.htm I disease - the last stage of ise. This is when your kidneys out your body's needs. This ained from the website: gov/ency/article/000500.htm. Is a chronic disease in which ulate the amount of sugar in mation was obtained from gov/medlineplus/ency/article/ or foot amputation is the of or toes from the body. The called extremities. The either by surgery orthey or trauma to the body. The ailed to review and revise prehensive care plan to the resident's edema and the ered compression wraps to	F	557			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495217	B. WING _		C 04/08/2021			
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRICIENCY)	BE	(X5) COMPLETION DATE		
F 657	into the esophagus, in malfunction of the sp two organs; symptome esophagus, common organs essessment, an admassessment reference the resident as scorir interview for mental sizes identification. The resident extensive assistance members for most of the office office organs organs or the extensive assistance members for most of t	the contents of the stomach usually caused by chincter muscle between the institute institute burning pain in the ally known as heartburn) (2). S (minimum data set) ission assessment, with an activitie of the status) score, indicating the end as coded as requiring of one or more staff her activities of daily living. Resident #94, dated do, "Compression wraps to the light) while awake for ery day shift for edema." The hensive care plan for 3/9/2021, did not evidence are resident's edema or the use graps to the residents in inistration Record (TAR)" ression wraps to both the while awake for peripheral fit for edema." The TAR inistration of the content of the content in the resident #94 on the revealed the resident.	F 6	57				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		495217	B. WING _			04/0) 08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	RECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE		(X5) COMPLETION DATE
F 657	swollen. An interview Resident #94 at this to swollen ankles, the rechange her medication she doesn't remember revealed grippy socks the bottom to prevent #94's feet. A second observation 11:21 a.m. of the residual covers were off her feet conducted at this time therapist (occupational process of getting her to have grippy socks the nurses had put on or wraps on her legs spointed to her feet with stated that they were since she came to the to be swollen. An observation was mad 4/7/2021 at 2:32 p.m. her wheelchair with he with only grippy socks. An interview was concupractical nurse) # 3 or When asked who can care plan, LPN #3 state can update a care plan when asked if new treater planned, LPN #3 managers go back an yes, it should be care	was conducted with ime. When asked about her esident stated that the doctor ins around the other day but it what it was. Observation is (socks with substance on slippage), on Resident was made on 4/7/2021 at dent in her bed but the est. During an interview is, Resident #94 stated the fall therapist) was in the rup. The resident was noted on her feet. When asked if any other type of stocking since Sunday, Resident #94 in the grippy socks on and the only socks she's worn in facility. Her legs appeared was a facility. Her legs appeared in ade of Resident #94 on Resident #94 was sitting in er legs elevated on her bed, is observed on her feet. Succeeding the property of the property in a scan any disciplines are the that any nursing staff in as can any disciplines. The planned when asked in	F 6	57			
	yes, it should be care			DDG			

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Event ID: OKNR11

Facility ID: VA0153

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495217	B. WING_		C 04/08/2021		
-	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	04,00/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION		
F 657	resident is provided.	e 32 is how the care to that ducted with RN (registered	F6	57			
	nurse) #6, the interim at approximately 2:45 compression wraps for reviewed with RN #6. and the edema should	unit manager, on 4/7/2021 p.m. The above order for					
	were made aware of t 4/7/2021 at 4:54 p.m.	M #2, the director of nursing,					
	(1) Barron's Dictionary Non-Medical Reader, Chapman, page 252. (2) Barron's Dictionary Non-Medical Reader, Chapman, page 243. Services Provided Me CFR(s): 483.21(b)(3)(s) \$483.21(b)(3) Compressional Services provided as outlined by the commustification of the services provided as This REQUIREMENT by: Based on observation document review, and	y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and et Professional Standards i) ehensive Care Plans I or arranged by the facility, hprehensive care plan,	F 6:	1. Corrective Action Resident #13, #74, and # 38 suffer effects from this deficient practice. After learning this deficient practice Nurse #7 and Nurse #2 were immere-educated. 2. Other Potential Residents All residents have the potential to taffected by this deficient practice.	e Agency ediately		

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

Event ID: OKNR11



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A, BUILDING		, ,	SURVEY PLETED
					С
	495217	B. WING _		04	/08/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORCARE HEALTH SERVICES-	-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY		AY	
			FAIRFAX, VA 22033		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ECTION HOULD BE PROPRIATE	(X5) COMPLETION DATE	
the medication adminis (Resident #13), and fo residents in the survey and #38). RN (register nurse used a facility nu password to sign of me administered to Reside medication pass obser nurse's computer name medications that she a #74 and #38. The findings include: 1. An outside agency r computer username ar medications given to R Resident #13 was adm 7/10/19, and most rece with diagnoses includir and Parkinson's diseas MDS (minimum data s with an ARD (assessm 1/4/21, Resident #13 w intact for making daily out of 15 on the BIMS status). On 4/7/21 at 9:15 a.m. administration observa practical nurse) #2 and were observed standin just outside Resident # computer was located cart. LPN #2 typed on	andards of practice for a for one of six residents in stration observation, or two other current or sample, (Residents #74 and agency curse's computer name and edications that she ents #13, during the rotation, and used a facility e and password to sign of administered to Resident #13 on 4/7/21. Initted to the facility on ently readmitted on 6/4/20, and Multiple Sclerosis (1) see (2). On the most recent ent reference date) of was coded as cognitively decision, having scored 13 (brief interview for mental ent. LPN (licensed of RN (registered nurse) #7 and at the medication cart	F	3. New Measures or Systemic The Director of Nursing and/or nurse (RN) unit managers and supervisors will re-educate nur the importance of never sharin and passwords. Staff were recisign the acknowledgment of the Confidentiality and Responsibil Agreement to ensure their und this standard. 4. Monitoring The Director of Nursing and/or nurse (RN) unit managers and supervisors will verify that the I who is passing medications is LPN or RN signing for the adm This will be done by comparing Medication Administration Recknown assigned team of reside specific shift/date. This verificate occur three times each week of selected shifts over the course month then two times each we additional month and once we another month. These results audits will be reported monthly Administrator and the QAPI Co. 5. Completion Date May 18, 2021	registered /or RN resing staff on g usernames quired to re- e Individual lity erstanding of registered /or RN LPN or RN actually the inistration. g the ord to the ents for that ation will en randomly of one ek for an ekly for of these to the	

PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B. WING			1	C /08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL BLSC IDENTIFYING INFORMATION)	ID PREFI TAG			(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
F 658	stepped up to the cascreen, and began to medications for admarked - Tylenol (3) 656 - Amlodipine (4) - Aspirin 81 mg - Baclofen (5) 5 - Colace (6) 100 - Lexapro (7) 20 - Miralax (8) 1 g - Senna (9) 8.6 - Multivitamin ta - Vitamin C 100 - Iron (10mg) 32 - Fluticasone (1) spray - Vitamin D 100, RN #7 was observed these medications to the initials of LPN #2 On 4/7/21 at 12:30 p When asked to look the 9:00 medication electronic document computer. Across the abanner stated: "We #7 was observed rev #13's medications as morning. When asked blocks beside the me Resident #13, RN #7 asked if LPN #2 had	ort, checked the computer or prepare the following inistration to Resident #13: 0 mg (milligrams) tablets 5 mg tablet tablet mg tablet m	F	658				

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

Event ID: OKNR11

Facility ID: VA0153

If continuation sheet Page 35 of 127



		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495217	B. WING _			C 04/08/2021		
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP	CODE	1 04	10012021	
MANORC	ARE HEALTH SERVICE	S-FAIR OAKS	!	12475 LEE JACKSON MEMORIAL H FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE	
F 658	did." When asked will blocks on the MAR be meant, RN #7 stated medications. But I di happened, she state and that morning was the facility. She states she was briefly orien needed to "be on a rimmediately because #7 stated she did no or password of her or her credentials, and administering medications under a and password, RN # On 4/7/21 at 1:53 p.r. She stated she does any new staff, but the nurses who are new ever worked at the fathink so. LPN #2 states seeing her. I have or I just got my license Resident #13's MAR medications adminis 4/7/21, and was asked mark in each box memy sign off for [name software]." When asl 9:00 a.m. medication stated, "No. [RN #7] because she does no asked if this is acceptated it is not. She stemember who, but stemember who who was a stemember who, but stemember who was a stem	that LPN #2's initials in the deside the medications and the looks like she gave the direct when asked what dishe was an agency nurse, is her very first day working in the difference of the was told that she med (medication) cart is "state is in the building." RN is have a computer username who, so LPN #2 signed in with instructed her to start actions under her name. Thould be administering my other nurse's username of stated, "No. I know better." The property was interviewed. The property worked if RN #7 had actility, she stated she did not ted, "This is my first time ally worked here four months. In June." LPN #2 was shown for the 9:00 a.m. tered to the resident on the difference of the administered the last to Resident #13, LPN #2 was using my password of have a sign on." When stable nursing practice, she	F6	558				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		IDEATH IOATION NOMBER.	A. BUILD	NG _		COMP	CETED	
		405045				'	С	
		495217	B. WING			04/	08/2021	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		1	2475 LEE JACKSON MEMORIAL HIGHWAY			
				F	FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)				(X5) COMPLETION DATE	
F 658	Continued From page	e 36	F	658				
	password because "s	state is in the building." LPN						
		g to share her computer						
		stated, "If anything goes						
	wrong, it's on me. It's	not correct. I'm not the one						
	who gave the medica	ition." She stated she						
		interim unit manager, had						
		computer credentials so RN						
	#7 could give medica	tions.						
	On 4/7/21 at 2:05 p.n	n., LPN #3 was interviewed.						
	-	y the interim unit manager,				İ		
		g" for the unit manager on						
	the floor where Resid	lent #13 resides. She stated						
	her role with new nur	ses is to be a resource to					ļ	
l	answer questions, to	give assistance, and to						
		e stated the facility expects						
		ne in with experience with						
		l record software, and to be						
		floor right away. When						
		y nurse receives computer						
		he stated she thought the						
	request is made throu	sked what she would say to						
		her that the new nurse had						
		ister medications but did not						
		gn on credentials, LPN #3						
		the nurse to go back and						
		sources). She stated she						
	•	w nurse to use another						
	nurse's computer cre	dentials. She stated it is not						
		se another nurse's computer						
	credentials because t	_						
	document, and is adr	nissible in court.				1		
	On 4/7/21 at 2:46 p.n	n., OSM (other staff						
		offing coordinator, was						
		ed her role with new agency						
	nurses is all about so							
		rientation and onboarding is						

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			C 04/08/2021	
	ROVIDER OR SUPPLIER	ES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033			1 04/00/2021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	'	ACTION SHOULD B TO THE APPROPRI		
F 658	an HR function. Sh before 8:00 a.m. th she accompanied F (administrative stafnursing, just after 8 "There was some of would even need to #2 instructed RN # helping to pass out to help the CNAs (of She stated that one floor, the unit mana a change in assign RN #7 was needed the second floor. We for setting up RN # username and pass [human resources]. On 4/7/21 at 3:11 presources director, new agency nurses orientation, which in and procedures, confide and abuse. He state tour of the building, ready to begin work computer credentia technology department through the usual a process with RN #7 a tour of the building rush." He stated she building because she clinical classes ther computer access, C	e stated she met with RN #7 at morning. OSM #10 stated RN #7 to meet with ASM if member) #2, the director of i:00 a.m. OSM #7 stated, question as to whether she o work today." She stated ASM if to work on the second floor food trays, to make beds, and certified nursing assistants). ice RN #7 got to the second iger on the first floor had made ments, and the result was that it to administer medications on if the maked who is responsible if with her own computer is word, OSM #10 stated, "HR	F	558			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED			
		495217	B. WING			C 04/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	1	HOULD BE	(X5) COMPLETION DATE
F 658	stated that, as of tha received computer a He stated he had realevel at that point. He #7 had been administ computer access. Obreakdown in command there was also a at the corporate level. On 4/7/21 at 4:03 p.r. When asked if a nural medication administr name, ASM #2 state false information." Si sure things are coord agency nurses. She sure new agency nurses with they get to the floor to stated HR is response computer sign on crewing the unit managers with the properties of the unit managers with the properties of the unit managers with the properties of the stated LPN #2 to the stated LPN #2 to the stated LPN #2 to the stated LPN #2 to the stated LPN #2 to the concerns. Both facility's professional facility's professional stated LPN #2 to the stated LPN #	t moment, he still had not cocess credentials for RN #7. ached out to the corporate estated he did not know RN stering medications without SM #5 stated there was a unication at the facility level, a communication breakdown I. m., ASM #2 was interviewed. See should ever chart ration under another nurse's d, "No. It is a violation. It is ne stated she tries to make dinated between HR and new stated her role is to make rese have the proper everything they need before to work with residents. She stated for new nurses, as aware what had 7, ASM #2 stated, "It is told her to wait until she got as." She stated that one of as under the impression RN puter access, and told her and administer medications. #7] got on the cart without LPN #2 is a relatively new not really know the process.	F	658		

	F CORRECTION	IDENTIFICATION NUMBER:				COMPLETED	
		495217	B. WING_			l	C /08/2021
	PROVIDER OR SUPPLIER	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(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 658	its standard for prace computer logins was On 4/8/21 at 10:28 policy, "Individual Compositive to the policy revealed, in percentials to anyor including employee to access [electroniunder my credentials. No further information of the following quota Perry's Fundamenta (2005, p. 477): "Downtten or printed the proof for authorized within a client medianursing practice. Not accurate, comprehere trieve critical data track client outcome standards of nursing client record provided level of quality of capotter and Perry (20 following information care team, nurses minformation about client record provided level of quality of capotter and Perry (20 following information care team, nurses minformation about cliently, effective management of the provided level of quality of capotter and perry (20 following information about cliently, effective management of the provided level of quality of capotter and perry (20 following information about cliently, effective management of the provided level of quality of capotter and perry (20 following information about cliently, effective management of the provided level of quality of capotter and perry (20 following information about cliently, effective management of the provided level of quality of capotter and perry (20 following information about cliently, effective management of the provided level of quality of capotter and perry (20 following information about cliently, effective management of the provided level of quality of capotter and perry (20 following information about cliently, effective management of the provided level of quality of capotter and perry (20 following information about cliently, effective management of the provided level of quality of capotter and perry (20 following information about cliently, effective management of the provided level of quality of capotter and perry (20 following information about cliently).	ctice. A policy regarding staff is requested. a.m., ASM #1 provided a confidentiality and the surveyor. A review of the coart: "Never reveal computer theNever allow others, is or other workforce members to medical record software] is." on was provided prior to exit. tion is found in Potter and the computer of the exit. tion is found in Potter and the persons. Documentation compersons. Documentation call record is a vital aspect of compersons. Documentation must be existed, and flexible enough to the existed, and reflect current the gractice. Information in the compersons includes the competition of the competition in the competition. The competition in the compet	F	558			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		-	COMPLETED	
		495217	B. WING			1	C 08/2021
	ROVIDER OR SUPPLIER	ES-FAIR OAKS		STREET ADDRESS, CITY, S' 12475 LEE JACKSON MER FAIRFAX, VA 22033	•		0.3021
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRE CROSS-REFEREI	S PLAN OF CORRECTION ECTIVE ACTION SHOULD B NCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	and burning sensati coordination and bavision problems, an control. People with and have trouble the information is taken https://nccih.nih.gov. (2) "Parkinson's dismovement disorder in the brain don't prochemical called dop genetic, but most cafamilies." This information website https://medlineplus.g. (3) "Acetaminophen moderate pain from menstrual periods, acetaminophen mapain of osteoarthritis breakdown of the lir Acetaminophen is in analgesics (pain rel reducers). It works I senses pain and by information is taken https://medlineplus.g. tml. (4) "Amlodipine (No combination with ottolood pressure in acolder. It is also used angina (chest pain)	ions, numbness, chronic pain, alance problems, fatigue, d difficulty with bladder MS also may feel depressed inking clearly." This from the website whealth/multiple-sclerosis. ease (PD) is a type of the happens when nerve cells oduce enough of a brain from the seem to run in mation is taken from the mov/parkinsonsdisease.html. It is used to relieve mild to headaches, muscle aches, colds and sore throats, hes, and reactions to head to reduce fever. It is a class of medications called fievers) and antipyretics (fever by changing the way the body cooling the body." This	F	658			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	- 25	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
,		DETTI OTTO TO TO BETT	A. BUILDI	NG _				
		495217	B. WING				C	
NAME OF D	ROVIDER OR SUPPLIER	430217	B. 1111113		TOTAL CORPORATION OF THE PROPERTY OF THE PROPE	04/	08/2021	
IAVIAIC OL L	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY			
MANORC	ARE HEALTH SERVICE:	S-FAIR OAKS						
	<u> </u>				AIRFAX, VA 22033			
(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 658	lowers blood pressur vessels so the heart hard. It controls ches supply of blood to the taken from the websithtps://medlineplus.gotml. (5) "Baclofen is used types of spasticity (mightness) from multipiniuries, or other spins in a class of medication relaxants. Baclofen a and decreases the numuscle spasms caus spinal cord conditions improves muscle most taken from the websithtps://medlineplus.gotml. (6) "Docusate sodium Stool softeners are us relieve constipation be straining during bowers."	pine is in a class of alcium channel blockers. It is by relaxing the blood does not have to pump as it pain by increasing the element." This information is the by/druginfo/meds/a692044.h to treat pain and certain uscle stiffness and ble sclerosis, spinal cordial cord diseases. Baclofen is ons called skeletal muscle cts on the spinal cordinerves umber and severity of ed by multiple sclerosis or is. It also relieves pain and element." This information is the by/druginfo/meds/a682530.h	F	658				
	them easier to pass." from the website	by softening stools to make This information is taken by/druginfo/meds/a601113.ht						
	(7) "Escitalopram is u adults and children a age or older. Escitalo	rsed to treat depressionin nd teenagers 12 years of pram is also used to treat disorder (GAD: excessive						

PRINTED: 04/19/2021 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B. WING		C 04/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 658	, ,		F 65	3	
	for 6 months or longe in a class of antidepre serotonin reuptake in increasing the amour substance in the brain balance." This inform website https://medlineplus.go tml.	at disrupts daily life and lasts or) in adults. Escitalopram is essants called selective hibitors (SSRIs). It works by not of serotonin, a natural in that helps maintainmental ation is taken from the ov/druginfo/meds/a603005.h			
•	occasional constipation is in a class of medical laxatives. It works by with the stool. This in bowel movements an easier to pass." This	col 3350 is used to treat on. Polyethylene glycol3350 ations called osmotic causing water to be retained creases the number of d softens the stool so it is information is taken from the			
	website https://medlineplus.gov tml.	v/druginfo/meds/a603032.h			
	constipation. It also is before surgery and co Senna is in a class of stimulant laxatives. It of the intestines to ca This information is tal	works by increasing activity use a bowel movement."			
	ferrous sulfate) is used (a lower than normal when the amount of in not enough. Iron is a dietary supplement. If	narate, ferrous gluconate, ed to treat or prevent anemia number of red blood cells) ron taken in from the diet is mineral that is available as a t works by helping the body cells." This information is			

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

Event ID: OKNR11

Facility ID: VA0153

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTI A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		495217	B. WING _				08/2021
	ROVIDER OR SUPPLIER	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD I			(X5) COMPLETION DATE
F 658	taken from the websithttps://medlineplus.gdtml#:~:text=Iron%20(fe Oferrous%20gluconated dietary%20suppleme (11) "Nonprescription (Flonase Allergy) is urhinitis such as sneed itchy nose and itchy, fever or other allergie pollen, mold, dust, or fluticasone is also use nonallergic rhinitis sustuffy nose which are Prescription fluticasone used to treat nasal pothe nose). Fluticasone used to treat symptom runny, itchy nose) car Fluticasone is in a clasorticosteroids. It wor certain natural substates symptoms." This inforwebsite	by/druginfo/meds/a682778.h errous%20fumarate%2C%2 available%20as%20a%20 nt. fluticasone nasal spray sed to relieve symptoms of cing and a runny, stuffy, or watery eyes caused by hay s (caused by an allergy to	F 6	58			
	computer username a medications given to Resident #74 was ad 12/1/17, and most required with diagnoses included of a stroke. On the medata set), a quarterly	nurse used a facility nurse's and password to sign off on Resident #74 on 4/7/21. mitted to the facility on cently readmitted on 2/5/19, ing heart failure and history ost recent MDS (minimum assessment with an ARD see date) of 2/27/21, Resident		8			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
	_	495217	B. WING			04/	/08/2021
NAME OF P	ROVIDER OR SUPPLIER		•		TREET ADDRESS, CITY, STATE, ZIP CODE	·	
MANORO	ARE HEALTH CERVICE	S EAID OAKO		1	2475 LEE JACKSON MEMORIAL HIGHWAY		
MANURCA	ARE HEALTH SERVICES	5-FAIR OAKS		F	FAIRFAX, VA 22033		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	I ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLÉTION DATE
F 658	Continued From page	2 44	F	658			
	#74 was coded as ha	ving no cognitive					
	impairment for making	•					
		#74's MARs (medication					
		s) for 4/7/21 at 9:00 a.m.					
	revealed that she rec	eived the following					
	medications:						
	- Aspirin 81 mg (
	- Vitamin B comp	tion 200 units (1) nose spray					
	- Calcium Citrate						
	- Folic Acid (2) 1	•					
	- Multivitamin tab	•					
	- Norvasc (3) 10						
	- Fish oil tablet						
	- Senna (4) 8.6 m	ng tablet					
	- Torsemide (5) 4						
	- Vitamin D3 20 r	mcg (microgram) tablet					
		m., RN #7 was interviewed.					
		at Resident #74's MAR from				:	
		dministration, she pulled the					
		up on the medication cart					
	•	top of the computer screen, come [name of RN #7]." RN					
		ewing the MAR for Resident					
		ministered at 9:00 a.m. that					
		d whose initials were in the					
	blocks beside the me						
		stated, "[LPN #2]'s." When					
	asked if LPN #2 had a						
		ent #74, RN #7 stated, "No. I					
		at LPN #2's initials in the					
	blocks on the MAR be						
		"It looks like she gave the					
	medications. But I did						
		I she was an agency nurse,					
		her very first day working in when she arrived for work,					

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _			1	C /08/2021
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 0-4	100/2021
****				1247	75 LEE JACKSON MEMORIAL HIGHWAY		
MANORC	ARE HEALTH SERVICE	ES-FAIR OAKS	FAIRFAX, VA 22033		RFAX, VA 22033		
(X4) ID		STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID	.	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETION
PREFIX TAG		R LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	_	DATE
F 658	Continued From pag	ge 4 5	F6	558			
	she was briefly oriei	nted, but was told that she					
	needed to "be on a	med (medication) cart					
	immediately becaus	se "state is in the building." RN		İ			
		ot have a computer username					
		own, so LPN #2 signed in with					
		I instructed her to start					
		cations under her name.					
		should be administering					
		any other nurse's username					
	and password, KN #	‡7 stated, "No. I know better."					
	On 4/7/21 at 1:53 p.	.m., LPN #2, was interviewed.	j				
		s not have a formal role for					
	any new staff, but th	nat she tries to help agency					
	nurses who are new	v. When asked if RN #7 had					
	ever worked at the f	facility, she stated she did not					
		ated, "This is my first time					
		nly worked here four months.		- 1			
		in June." LPN #2 was shown					
	Resident #74's MAF						
		stered to the resident on					
		ed what the initials and check					
		eant. LPN #2 stated, "That is					
		e of electronic medical record					
	-	sked if she administered the		-			
		ns to Resident #74, LPN #2					
		was using my password not have a sign on." When					
		ptable nursing practice, she					
		stated she could not					
		someone in management					
		okay for her to give RN #7 her					
		"state is in the building." LPN					
		ong to share her computer					
		stated, "If anything goes					
		's not correct. I'm not the one					
		cation." She stated she					
	_	interim unit manager, had					
	_	r computer credentials so RN					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			C 4/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	#7 could give medical On 4/7/21 at 2:05 p.r. She stated she is on and was "just covering the floor where Reside her role with new nursus answer questions, to provide guidance. She agency nurses to conthe electronic medical ready to work on the asked how an agency sign on credentials, so request is made through the area of the electronic medical ready to work on the asked how an agency sign on credentials, so request is made through the following	ations. m., LPN #3 was interviewed. by the interim unit manager, ng" for the unit manager on clent #74 resides. She stated reses is to be a resource to give assistance, and to ne stated the facility expects me in with experience with all record software, and to be floor right away. When y nurse receives computer she stated she thought the ugh the technology sked what she would say to d her that the new nurse had sister medications but did not gn on credentials, LPN #3 the nurse to go back and sources). She stated she w nurse to use another dentials. She stated it is not se another nurse's computer the MAR is a legal missible in court.	F6	558			
	"There was some qu	00 a.m. OSM #7 stated, estion as to whether she work today." She statedASM					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		A. BUILDII		(X3) DATE SURVEY COMPLETED			
		495217	B. WING)	C /08/2021
NAME OF P	ROVIDER OR SUPPLIER		' - 	STR	EET ADDRESS, CITY, STATE, ZIP CODE	0-41	00,2021
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS			75 LEE JACKSON MEMORIAL HIGHWAY RFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ARY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL RY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE		
F 658	#2 instructed RN #7 thelping to pass out for to help the CNAs (ceres She stated that once floor, the unit manage a change in assignme RN #7 was needed to the second floor. Who for setting up RN #7 username and passwe [human resources]." On 4/7/21 at 3:11 p.m resources director, wo new agency nurses gorientation, which income and procedures, confidentiand abuse. He stated tour of the building, a ready to begin work. computer credentials technology department through the usual age process with RN #7. If a tour of the building rush." He stated she building because she clinical classes there computer access, OS me. I enter the requestions.	o work on the second floor od trays, to make beds, and diffied nursing assistants). RN #7 got to the second or on the first floor had made ents, and the result was that o administer medications on on asked who is responsible with her own computer ford, OSM #10 stated, "HR a., OSM #5, the human as interviewed. He stated enerally receive a 1.5 hour ludes a review of policies ty, security, emergency diality of resident information, and the agency nurse is the stated he requests from the corporate ont. OSM #5 stated he went ency nurse orientation he stated he did not give her because "we were in a was already familiar with the had done nursing school. When asked about RN #7's off #5 stated, "It starts with est." He stated the access is	F	558			
	stated that, as of that received computer ac He stated he had rea level at that point. He #7 had been administ computer access. OS	thin 30 minutes or so. He moment, he still had not cess credentials for RN #7. The ched out to the corporate stated he did not know RN tering medications without M #5 stated there was a nication at the facility level,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		495217	B. WING			ł	C 08/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE ZIP CODE	04/	00/2021
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		12475 LEE JACKSON MEM FAIRFAX, VA 22033	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	((EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD B CED TO THE APPROPRI EFICIENCY)		(X5) COMPLETION DATE
F 658	and there was also a at the corporate level On 4/7/21 at 4:03 p.m When asked if a nurs medication administra name, ASM #2 stated false information." She sure things are coord agency nurses. She sure new agency nurses in the get to the floor to stated HR is responsice computer sign on crewing the with the get to the floor to stated HR is responsice to the get to the floor to stated HR is responsice to the get to the floor to stated HR is responsice to the get to the floor to stated HR is responsice to the get to the floor to stated HR is responsice to the get to the floor to stated HR is responsice to the get to the floor to stated HR is responsice to the get to the floor to stated HR is responsice to the get to the floor to stated HR is responsively a mistake. If her [computer] access the unit managers was #7 already had compushe could go ahead at ASM #2 stated, "[RN access." She stated LPN #2 lo On 4/7/21 at 4:54 p.m administrator, and AS these concerns. Both facility's professional	a., ASM #2 was interviewed. e should ever chart ation under another nurse's if, "No. It is a violation. It is e stated she tries to make inated between HR and new stated her role is to make ses have the proper everything they need before owork with residents. She fible for obtaining the dentials for new nurses. as aware what had if ASM #2 stated, "It is told her to wait until she got is." She stated that one of is under the impression RN uter access, and told her and administer medications. if and in the cart without if and in t	F	358	EFICIENCY)		
	On 4/8/21 at 10:28 a. policy, "Individual Cor Responsibility" to the	m., ASM #1 provided a					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG			PLETED
		495217	B. WING _			1	C '08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP 12475 LEE JACKSON MEMORIAL F FAIRFAX, VA 22033		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD B THE APPROPRI		(X5) COMPLETION DATE
F 658	credentials to anyone including employees to access [electronic under my credentials]. No further information REFERENCES (1) "Nasal calcitonin treatment for establis calcitonin is safe, prebone mass in the lunis taken from https://pubmed.ncbi.! (2) "Folic acid is used deficiency. It is a B-c the body to manufact deficiency of this vital anemia (low red blood information is taken in https://medlineplus.grtml. (3) "Amlodipine (Noncombination with othe blood pressure in addolder. It is also used angina (chest pain) a (narrowing of the bloot to the heart). Amloding medications called collowers blood pressur vessels so the heart hard. It controls ches supply of blood to the taken from the websi	eNever allow others, or other workforce members medical record software] In was provided prior to exit. It is a newly approved shed osteoporosis. Nasal eventative, and may increase abar spine." This information infim.nih.gov/9001161/. If to treat or prevent folic acid complex vitamin needed by sure red blood cells. A min causes certain types of d cell count)." This rom the website by/druginfo/meds/a682591.h It is used alone or in the redications to treat high alts and children 6 years and to treat certain types of and coronary artery disease by relaxing the blood does not have to pump as t pain by increasing the eneat." This information is	F	658			

PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		E SURVEY PLETED
		495217	B. WING			1	C /08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		12	REET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033		
(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 658	(4) "Senna is used or constipation. It also is before surgery and constipation. It also is before surgery and constipation. It also is before surgery and constitution is in a class of stimulant laxatives. It of the intestines to can this information is tall https://medlineplus.go ml. (5) "Torsemide is usewith other medication pressure. Torsemide retention; excess fluid caused by various metheart, kidney, or liver class of medications of the works by causing the unneeded water and urine." This information https://medlineplus.go tml. 3. An outside agency computer username a medications given to Resident #38 was ad 6/3/11 with diagnoses epilepsy (2). On the redata set), a quarterly (assessment reference #38 was coded as be	a a short-term basis to treat sused to empty the bowels entain medical procedures. If medications called works by increasing activity use a bowel movement." It was a bowel movement. It was a bowel movement of the foot of t	F	658			

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

Event ID: OKNR11

Facility ID: VA0153

RECEIE Configuration sheet Page 51 of 127

MAY 07 2021

VDH/OLC

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	СОМЕ	SURVEY PLETED
		495217	B. WING			l	C /08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS	· · · · · · ·	1	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 658	administration recon- revealed that she re- medications: - Lasix (3) 20 m - Multivitamin ta - Potassium 20 - Vitamin B12 ta - Vitamin D3 tat - Metoprolol (4) - Tramadol (5) 2 On 4/7/21 at 12:30 p When asked to look the 9:00 medication electronic document computer. Across tha banner stated: "We #7 was observed rev #38's medications acmorning. When asked blocks beside the me Resident #38, RN #3 asked if LPN #2 had medications to Resid did." When asked will blocks on the MAR to meant, RN #7 stated medications. But I di happened, she state and that morning wa the facility. She state she was briefly orien needed to "be on a r immediately because #7 stated she did no or password of her o her credentials, and	t #38's MARs (medication ds) for 4/7/21 at 9:00 a.m. ceived the following g (milligrams) tablet blet mEq (milliequivalent) tablet ablet 50 mg tablet 50 mg tablet 5.m., RN #7 was interviewed. at Resident #38's MAR from administration, she pulled the up on the medication cart e top of the computer screen, elcome [name of RN #7]." RN viewing the MAR for Resident dministered at 9:00 a.m. that ed whose initials were in the edications she gave to 7 stated, "[LPN #2]'s." When	F	658			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495217	B. WING		1	C '08/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY	1 04/	00/2021
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	When asked if she sh medications under an and password, RN #7 On 4/7/21 at 1:53 p.m She stated she does any new staff, but tha nurses who are new. ever worked at the fact think so. LPN #2 state seeing her. I have on! I just got my license in Resident #38's MAR if medications administed 4/7/21, and was asked mark in each box meaning stated, "No. [RN #7] when asked if this is accept stated it is not. She st remember who, but so had told her it was oke password because "st #2 stated it was wrong credentials. LPN #2 s wrong, it's on me. It's who gave the medications and password because "st wrong, it's on me. It's who gave the medications and password because "st wrong, it's on me. It's who gave the medications and password because "st wrong, it's on me. It's who gave the medications and password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medications are password because "st wrong, it's on me. It's who gave the medicati	ould be administering by other nurse's username of stated, "No. I know better." In., LPN #2, was interviewed. Inot have a formal role for to she tries to help agency When asked if RN #7 had cility, she stated she did not ed, "This is my first time by worked here four months. In June." LPN #2 was shown for the 9:00 a.m. In June." LPN #2 was shown for the 9:00 a.m. In June." LPN #2 stated on It what the initials and check ant. LPN #2 stated, "That is of electronic medical record and if she administered the so to Resident #38, LPN #2 was using my password to have a sign on." When able nursing practice, she ated she could not comeone in management any for her to give RN #7 her tate is in the building." LPN ag to share her computer tated, "If anything goes not correct. I'm not the one	F6			
	#7 could give medicate On 4/7/21 at 2:05 p.m. She stated she is only and was "just covering the floor where Reside	computer credentials so RN tions. I., LPN #3 was interviewed. I., the interim unit manager, go for the unit manager on the unit manager on the the theorem is the stated that is the ses is to be a resource to				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		E SURVEY
		495217	B. WING _		0.	C 4/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLE CROSS-REFERENCED TO THE APPROPRIES OF THE APP	LD BE	(X5) COMPLETION DATE
F 658	answer questions, to provide guidance. Si agency nurses to co the electronic medic ready to work on the asked how an agency sign on credentials, request is made through the second of the electronic medic ready to work on the asked how an agency sign on credentials, request is made through the electronic made and the	o give assistance, and to the stated the facility expects are in with experience with all record software, and to be afloor right away. When any nurse receives computer she stated she thought the hugh the technology sked what she would say to do her that the new nurse had nister medications but did not lign on credentials, LPN #3 at the nurse to go back and resources). She stated she we nurse to use another edentials. She stated it is not lise another nurse's computer the MAR is a legal missible in court.	F 6			
	to help the CNAs (co She stated that once floor, the unit manag a change in assignm	ertified nursing assistants). RN #7 got to the second er on the first floor had made ents, and the result was that o administer medications on				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C 04/08/2021	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMORIAL HIG FAIRFAX, VA 22033		04/08/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIA		ΠÓΝ
F 658	the second floor. Whe for setting up RN #7 username and passw [human resources]." On 4/7/21 at 3:11 p.m resources director, wo new agency nurses gorientation, which incomposedures, confident and abuse. He stated tour of the building, a ready to begin work computer credentials technology departmenthrough the usual age process with RN #7. If a tour of the building rush." He stated she building because she clinical classes there computer access, OS me. I enter the requesusually completed with stated that, as of that received computer access. OS me that the stated he had real level at that point. He #7 had been administrative computer access. OS breakdown in commutant there was also a at the corporate level. On 4/7/21 at 4:03 p.m. When asked if a nurs medication administrative medication administrative computer access.	en asked who is responsible with her own computer yord, OSM #10 stated, "HR a., OSM #5, the human as interviewed. He stated generally receive a 1.5 hour ludes a review of policies ty, security, emergency tiality of resident information, and the agency nurse is the stated he requests from the corporate ent. OSM #5 stated he went ency nurse orientation he stated he did not give her because "we were in a was already familiar with the had done nursing school. When asked about RN #7's SM #5 stated, "It starts with st." He stated the access is thin 30 minutes or so. He moment, he still had not access credentials for RN #7. It ched out to the corporate stated he did not know RN tering medications without the stated there was a unication at the facility level, communication breakdown.	F	658			

PRINTED: 04/19/2021 **FORM APPROVED** OMB NO. 0938-0391

-	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495217	B. WING	· · · · · · · · · · · · · · · · · · ·		C 04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMORIAL HIG FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BI HE APPROPRIA		
F 658	sure things are coord agency nurses. She is sure new agency nur orientation, and have they get to the floor to stated HR is respons computer sign on cre. When asked if she was happened with RN #7 honestly a mistake. I her [computer] access the unit managers was #7 already had comp she could go ahead a ASM #2 stated, "[RN access." She stated LPN #2 loon 4/7/21 at 4:54 p.m administrator, and AST these concerns. Both facility's professional #2 both verified that the its standard for practic computer logins was On 4/8/21 at 10:28 a. policy, "Individual Con Responsibility" to the policy revealed, in pacredentials to anyone including employees to access [electronic under my credentials	the stated she tries to make inated between HR and new stated her role is to make sees have the proper everything they need before to work with residents. She lible for obtaining the dentials for new nurses. It is as aware what had to a saware what had to a relatively new and to a relatively new not really know the process. It is a relatively ne	F	558			

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

Event ID: OKNR11

Facility ID: VA0153



MANORCARE HEALTH SERVICES-FAIR OAKS 12475 LEE JAC FAIRFAX, VA	ESS, CITY, STATE, ZIP CODE EKSON MEMORIAL HIGHWAY 22033 PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETIO
MANORCARE HEALTH SERVICES-FAIR OAKS (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 658 Continued From page 56 F 658	CKSON MEMORIAL HIGHWAY 22033 PROVIDER'S PLAN OF CORRECTION ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI	E COMPLETIO
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 658 Continued From page 56 F 658	ACH CORRECTIVE ACTION SHOULD B SS-REFERENCED TO THE APPROPRI	E COMPLETIO
REFERENCES (1) "Dementia is a gradual and permanent loss of brain function. This occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior." This information is taken from the website https://medlineplus.gov/ency/article/000746.htm. (2) "The epilepsies are a spectrum of brain disorders ranging from severe, life-threatening and disabling, to ones that are much more benign. In epilepsy, the normal pattern of neuronal activity becomes disturbed, causing strange sensations, emotions, and behavior or sometimes convulsions, muscle spasms, and loss of consciousness." This information is taken from the website https://www.ninds.nih.gov/Disorders/Atl-Disorders //Epilepsy-Information-Page. (3) "Furosemide (Lasix) is used alone or in combination with other medications to treat high blood pressure. Furosemide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, and liver disease. Furosemide is in a class of medications called diuretics ('water pills'). It works by causing the kidneys to get rid of unneeded water and salt from the body into the urine." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682858.h tml. (4) "Metoprolol is used alone or in combination with other medications to treat high blood pressure. It also is used to prevent angina (chest pain) and to improve survival after a heart attack. Metoprolol also is used in combination with other		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE COMP	SURVEY
		495217	B. WING		l	C 08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	medications to treat had class of medication works by relaxing blo heart rate to improve blood pressure." This the website https://medlineplus.gotml. (5) "Tramadol is used moderately severe pataken from the website."	teart failure. Metoprolol is in so called beta blockers. It od vessels and slowing blood flow and decrease information is taken from ov/druginfo/meds/a682864.h	F 65			
SS=D	S483.21(b)(3) Comport The services provided as outlined by the commustiii) Be provided by quaccordance with each care. This REQUIREMENT by: Based on observation document review and was determined the forespiratory services we persons in accordance care for one of 33 cur sample, Resident #128 was reconcentrator by CNA #10, who then switches	ehensive Care Plans d or arranged by the facility, mprehensive care plan, alified persons in a resident's written plan of is not met as evidenced an, staff interview, facility a clinical record review, it acility staff failed to ensure were provided by qualified with the written plan of rent residents in the survey	F 65	1. Corrective Action Resident #128 suffered no ill effects this deficient practice and Certified N Assistant #10 was re-educated on performing tasks which fall within his of practice only upon learning of this deficient practice. 2. Other Potential Residents All residents who have orders for oxy have the potential to be affected by t deficient practice.	scope /gen	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		ECONSTRUCTION	(X3) DATE COMP	SURVEY
						(c
		495217	B. WING_			04/	08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		1	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033		
/V () ID	CLIMMADV CT	ATEMENT OF DEFICIENCIES	11		·		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 659	Continued From page	- 58	F	359	Continued From page 58		
	(liters per minute) and LPM. CNA #10 is not	h had a flow rate of 3 LPM d not the physician ordered 2 qualified to remove ce residents on an oxygen			3. New Measures or Systemic Chan The Director of Nursing and/or regist nurse (RN) unit managers and/or RN supervisors will re-educate nursing s the importance of only performing jol which are within their scope of practi	ered I taff on b tasks	
	3/20/2021 with diagnorm the lung, high blood propersion. The most data set) assessment with an assessment of coded the resident as (brief interview for me the resident was capacognitive decisions. Frequiring extensive as staff members for moliving. Section O - Sport Procedures and Progreceiving oxygen while The physician order of documented, "O2 (oximinute via N/C (nasal)	tesident #128 was coded as esistance of one or more st of her activities of daily ecial Treatments, rams coded the resident as e a resident in the facility. Lated 3/20/2021, ygen) @ (at) 2 liters per cannula - a plastic tubing that insert into the nose)			4. Monitoring The Director of Nursing and/or regist nurse (RN) unit managers and/or RN supervisors will verify that the MD or liters of oxygen flowing is correct for residents using supplemental oxyger follows: daily for one week then three times verification for an additional week, followed by the times weekly for an additional week, followed by one time per week for an additional two months. These results these rounds will be reported monthly Administrator and the QAPI Committed. 5. Completion Date May 18, 2021	ered dered all as veekly vo s of y to the	
	4/6/2021 at 1:00 p.m. her oxygen on via the an oxygen concentrato oxygen concentrator ((liters per minute).	le of Resident #128 on She was resting in bed with nasal cannula connected to or that was running. The flow meter was set at 2 LPM				7	
	Observation was mad	le of Resident #128 on					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 ' '	IPLE CONSTRUCTION NG		E SURVEY PLETED
		495217	B. WING _			C /08/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROVIDENCY)	D BE	(X5) COMPLETION DATE
F 659	4/7/2021 at 12:15 p.n observed with her ox cannula connected to that was running. Fur oxygen concentrator oxygen was set at 3 l. An interview was connurse) #5 on 4/7/202 the physician ordered resident #128. RN #5 and stated the reside #5 was asked to go to observe the residents asked if it was set at stated that it wasn't a 2 LPM. When asked oxygen concentrator had looked at it earlied #5, then stated, (namperson, took and chat this morning. When a Resident #128's conditions.	n. Resident #128 was ygen on via the nasal of an oxygen concentrator ther observation of the flow meter revealed that the LPM (liters per minute). ducted with RN (registered 1 at 12:25 p.m., regarding I flow rate of oxygen for reviewed the clinical record int was to be on 2 LPM. RN in Resident 128's room to is oxygen flow rate. When the correct rate, RN #5 ind that the rate should be at if she had checked the that day, RN #5 stated she if she had checked the that day, RN #5 stated she if and it was at 2 LPM. RN is of CNA #10), the supply inged out the concentrator isked if she had checked itentrator after that, RN #5 in #5 proceeded to adjust	F 6	59		
	nursing assistant) #16 supply for the day, or When asked if he had concentrator into Res 4/7/2021, CNA #10 stated they were having on the concentrators. resident's rate of oxygwhen he brought it into CNA #10 stated he juif he adjusted the rate	ducted with CNA (certified D, the person working in a 4/7/2021 at 1:36 p.m. It taken a new oxygen sident #128's room on tated he had. CNA #10 ng the yearly maintenance When asked who set the gen on the concentrator to the Resident #128's room, ast turned it on. When asked to of oxygen by the knob, and not CNA #10 stated he				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING	_		C 04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS	J.,	1	STREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHO			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 659	told the nurse he cha When asked if he not was on the machine, When asked if it was remove residents frot and place them on a no, it was not. When adjust the rate of oxy not. An interview was commanager, on 4/7/202 a CNA is able to rem back on an oxygen of "They shouldn't." At to of the above observa stated he (CNA #10) The comprehensive of documented in part, altered respiratory sta disease process [Lur fracture]." The "Interv part, "Provide oxyger The facility policy, "O documented in part," Physician's orderPr For oxygen concentra unit on and set flow r "Oxygen should be tr dangerous side effect oxygen toxicity. As w concentration of oxyg monitored. The nurse physician's orders to receiving the prescrit	nged out the concentrator. red the rate of oxygen that CNA #10 stated he had not. in his scope of practice to m an oxygen concentrator new one, CNA #10 stated asked if he was allowed to gen, CNA #10 stated he was ducted with RN #6, the unit 1 at 2:42 p.m. When asked if ove and place a resident oncentrator, RN #6 stated, his time RN #6 was informed tion and interviews, RN #6 shouldn't have done that. care plan dated 3/20/2021, 'Focus: The resident has atus with SOB r/t (related to) ag CA {cancer}recent rib rentions" documented in a so ordered."	F	659			

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AND DIAN OF CORRECTION IDENTIFICATION NUMBER		1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495217	8. WING) 08/2021	
	ROVIDER OR SUPPLIER	S-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033				
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	pertain to oxygen addition in the nurse when you do administration system oxygen, sets the flow administration device. ASM (administrative administrator and AS were made aware of 4/7/2021 at 4:54 p.m. No further information (1) Fundamentals of 6th edition, page 112 (2) Mosby's Textbook Assistances, fourth equality of Care CFR(s): 483.25 § 483.25 Quality of c Quality of care is a fundamental of a resistance with professional control of a resistance with professional control of the control of a resistance with professional control of the control of a resistance with professional control of the control of a resistance with professional control of the control	Administration."(1) Administration Set-up" was on not administer oxygen. Tell inish setting up the oxygen on. The nurse turns on the rate, and applies the rate, and applies the rate, and applies the rate, and applies the rate, and applies the rate, and applies the rate, and applies the rate, and applies the rate, and applies the rate, above concern on rate above concern on rate applies. Aursing, Perry and Potter, 2, for Long-Term Care dition, 2003, page 499. The rate and care provided to red on the comprehensive dent, the facility must ensure a treatment and care in ressional standards of the resive person-centered.	F 659	1. Corrective Action Resident #94 was discharge home of 15, 2021. The staff nurses who signs the application of the wraps but did napply them have been re-educated of importance of following physician or and disciplined for failure to do so. Resident #120 suffered no ill effects to this deficient practice and #6 nurse educated on the importance of rema with the resident until medication is fadministered.	ed for lot in the lers related e re- ining		
	by: Based on staff inter- clinical record review	is not met as evidenced riew, resident interview, and facility document ined the facility staff failed to		The care plan for resident #75's splir has been reviewed and revised and therapy evaluation was completed A 2021.	a		

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

Event ID: OKNR11

Facility ID: VA0153

If continuation sheet Page 62 of 127



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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		"	A BOILD	NG_		,	3
		495217	B. WING			1	08/2021
NAME OF P	ROVIDER OR SUPPLIER		·	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		1	2475 LEE JACKSON MEMORIAL HIGHWAY		
				F	AIRFAX, VA 22033		
(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 684	Continued From page provide treatment and	e62 d care in accordance with	F		Continued From page 62 2. Other Potential Residents		
profession standards of practice and the comprehensive care plan for three of 33 current residents in the survey sample, (Resident #94, #120 and Resident #75). 1. Resident #94 was observed without compression wraps to both feet/legs (knee height) while awake for peripheral edema as ordered by the physician.		All residents have the potential to b affected by this deficient practice.					
		observed without o both feet/legs (knee or peripheral edema as			 New Measures or Systemic Chan The Director of Nursing and/or regist nurse (RN) unit managers and/or RN supervisors will re-educate the nursi on the importance of remaining with resident until they are certain they ha 	ered I ng staff each	
	2. The facility nurse did not remain with Resident #120 for the duration of a nebulizer (1) treatment to ensure all of the nebulizer medication was administered as ordered by the physician. Resident #120 was observed unattended while receiving a nebulizer treatment and was observed pulling the nebulizer mask off his face multiple times during the treatment.				successfully been administered all medications. The Director of Nursing, RN unit man and/or RN supervisors will re-educat on the importance of following physic orders for physician ordered splints a compression wraps. 4. Monitoring	e staff cian	
	Resident #75's right v physician.	3. The facility staff failed to apply a splint to Resident #75's right wrist as ordered by the physician.			The Director of Nursing and/or regist nurse (RN) unit managers and/or RN supervisors will verify through visual observation that the MD ordered compression wraps and splints are in		
	The findings include: 1. Resident #94 was admitted to the facility on 3/8/2021 with diagnoses that included but were not limited to: gout (disease in which a defect in uric acid metabolism causes the acid and its salts to accumulate in the blood and joints, causing pain and swelling of the joints) (1), high blood pressure and GERD (gastroesophageal reflux disease - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn) (2).				for all residents with orders and that nurse administering nebulizer treatmoremains at bedside throughout the dof the treatment as follows: daily for one week then three times were for an additional week, followed by the times weekly for an additional week, followed by one time per week for an additional two months. These result these observations will be reported in the Administrator and the QAPI Committee.		

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

Event ID: OKNR11

Facility ID: VA0153

If continuation sheet Page 63 of 127



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495217	B. WING_		C 04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	BE	(X5) COMPLETION DATE
F 684	The most recent MDS assessment, an admiassessment reference the resident as scorir interview for mental serident was capable decisions. The resident extensive assistance members for most of Observation was made 4/6/2021, at 3:12 p.m. sitting in a wheelchait Observation revealed swollen. An interview Resident #94 at this it swollen ankles, the rechange her medications she doesn't remember revealed grippy socks the bottom to prevent #94's feet. A second observation 11:21 a.m. of the resident was endoucted at this time therapist (occupation process of getting he to have grippy socks the nurses had put or or wraps on her legs pointed to her feet wistated that they were since she came to the swollen. An observation was resident.	S (minimum data set) ission assessment, with an e date of 3/13/2021, coded ag a "13" on the BIMS (brief status) score, indicating the of making daily cognitive ent was coded as requiring of one or more staff her activities of daily living. The de of Resident #94 on an entire the bedside.	F 6	5. Completion Date May 18, 2021		

PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		MULTIPLE CONSTRUCTION JILDING			(X3) DATE SURVEY COMPLETED	
							С	
		495217	B. WING			04	/08/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
MANORCA	ARE HEALTH SERVICES	S-FAIR OAKS		1247	75 LEE JACKSON MEMORIAL HIGHWAY			
iii.Aitotto.	AND HEAD III OUR VIOL	S-I AIN CANS		FAI	RFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	κ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	Continued From page	e 64	Fé	884				
	her wheelchair with h	er legs elevated on her bed,						
		s observed on her feet.						
	A physician order for							
		d, "Compression wraps to						
		neight) while awake for ery day shift for edema."						
	periprierar ederna eve	ery day sillit for edema.						
	The "Treatment Admi	inistration Record (TAR)"	1					
	documented, "Compr	, ,	9					
	feet/legs (knee heigh	t) while awake for peripheral						
	• •	ft for edema." The TAR	3					
	documented the adm							
	compression wraps o	on 4/4/2021 through						
	4/7/2021.							
	Review of the compre	ehensive care plan for						
		3/9/2021, did not evidence						
11		resident's edema or the use						
	of the compression w							
	bilateral feet and legs	5.						
	An intension was can	ducted with RN (registered						
		caring for the resident on						
		ately 2:35 p.m. RN #5 had						
		on the TAR the application						
	•	raps on Resident #94.						
		ompression wraps she used,						
	RN #5 stated she wo	uld go get ace wraps out of						
		l apply them. When asked if						
		raps each day, RN #5 stated						
		ave thrown them away. RN						
	#5 stated that therapy	y nad just gotten her						
	(Resident #94) up.							
2	An interview was con	ducted with RN #6, the						
	interim unit manager,	· · · · · · · · · · · · · · · · · · ·						
	approximately 2:45 p							
		der for Resident #94, was						

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

Event ID: OKNR11

Facility ID. VA0153

MAY 07 2021 VDH/OLC

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B. WING			1	C /08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		12475 L	ADDRESS, CITY, STATE, ZIP CODE EE JACKSON MEMORIAL HIGHWAY AX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 684	should let therapy known would come and wrap and legs up to the known staff do if the resident #6 stated the nurse ecompression wrap from the staff throw the ace writer from the staff throw the ace writer from the staff throw the ace writer from the staff throw the ace writer from the staff throw the ace writer from the staff throw the ace writer from the staff throw the ace writer from the staff throw the ace writer from the staff throw the ace writer from the staff throw throw the staff throw throw the staff throw throw the staff throw throw the staff throw throw throw throw throw throw throw throw throw throw throw throw throw throw throw throw throw throw th	RN #6 stated the nurse ow of the order. Therapy of them [Resident #94's feet ees]. RN #6 was asked what it was up in a wheelchair . RN ither gets ace wraps or get a om therapy. When asked if raps or compression wraps ach day, RN #6 stated the stockings that are put on it bed and taken off when the rouldn't throw them away was made aware of the and documentation related to pression wraps. In the stated the stockings that are put on it bed and taken off when the rouldn't throw them away was made aware of the and documentation related to pression wraps. In the stated the stockings that are put on it bed and taken off when the rouldn't throw them away was made aware of the and documentation related to pression wraps. In the state of the difference of collity follows the facility and of practice. Nursing 6th edition, 2005; Anne Griffin Perry; Mosby, ohysician is responsible for atment. Nurses are yesician's orders unless they are in error or would harm staff member) #1, the staff member) #1, the staff member) #1, the director of aware of this concern on	F	884				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		CTION	(X3) DATE SURVEY COMPLETED					
		495217	B. WING			C	8/2021	
	ROVIDER OR SUPPLIER	ES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 684	(1) Barron's Dictional Non-Medical Reader Chapman, page 252 (2) Barron's Dictional Non-Medical Reader Chapman, page 243 2. The nurse did not for the duration of a ensure all of the neb administered as order Resident #120 was a series of the	ary of Medical Terms for the r, 5th edition, Rothenberg and the r, 5th edition, Rothenberg and the r, 5th edition, Rothenberg and the r, 5th edition, Rothenberg and the r, 5th edition, Rothenberg and the remain with Resident #120 nebulizer (1) treatment to builizer medication was the physician.	F	684				
	3/17/21 with diagnost cancer. On the most set), an admission at (assessment referent #120 was coded as impairment for making scored 15 out of 15 for mental status). On 4/6/21 at 1:53 p. observed lying in his bed elevated. Residuelivered through na oxygen concentrator #120 had a nebulizer mouth. Steam was of mask, indicating meadministered through staff members were Resident #120 remo	m., Resident #120 was bed, with the head of the ent #120 had oxygen being usal cannula connected to an or that was running. Resident or mask over his nose and coming from the holes in the						

AND PLAN OF CORRECTION IDENTIFICATION NUMBER		600 600	(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B, WING			1	C 08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS						
(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 684	approximately ten to p.m., the steam was if from the holes in the medication was being nebulizer mask. At the resting partially over I nose, and partially hap.m., LPN (licensed pthe room. He remove it off, and returned the the resident's bedsided A review of Resident revealed the following 4/6/21: "Ipratropium-Amg/3ml (milligrams per inhale three times and breath)." A second phe 4/6/21, documented, minute] via nasal can A review of Resident administration record in the box for this medindicating he had admordered. A review of Resident plan, dated 3/22/21, cophysician ordered nel On 4/6/21 at 2:21 p.m. When asked if he had treatment earlier in the stated he had. When certain Resident #120	fifteen seconds. At 2:03 no longer observed coming mask, indicating no more g administered through the is time, the mask was Resident #120's mouth and anging off his face. At 2:12 practical nurse) #6 entered d the nebulizer mask, rinsed e mask to a storage bag on e table. #120's clinical record g physician's order, dated Albuterol Solution (2) 0.5-2.5 er three milliliters) 1 vial lay for SOB (shortness of hysicians order, dated "Oxygen 2L (liters) [per	F	684				
		I ask everyone to keep an know when he is finished."						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION		PLETED
		495217	B. WING			C '08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS	1	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETION DATE
F 684	When asked which s "keep an eye" on the usually he asks the (assistants). When as received all of the ne stated he thought so that order for him." Wimportant for Residenebulizer treatment, lungs. He needs the breathe easier." On 4/7/21 at 2:38 p.r nurse) #5 was intervinurse's role in admintreatment, she stated setting up the nebulizer medication, and for r for the duration of the why this is important make sure the reside them taking the mast necessary." On 4/7/21 at 4:54 p.r administrator, and Ast these concerns. Both facility's professional #2 both verified that the its standard for pract medication administrator. On 4/8/21 at 10:28 a policy, "Medication a Guidelines." The poli related to a nurse reithe duration of a neb	pecific staff he asked to resident, LPN #6 stated that CNAs (certified nursing sked if Resident #120 had bulizer treatment, LPN #6. LPN #6 stated, "We just got when asked why it was not #120 to receive the LPN #6 stated, "He has bad nebs (nebulizer) to help him the stated. "He has bad nebs (nebulizer) to help him the nurse is responsible for the treatment. When asked a sistering a nebulizer of the nurse is responsible for the treatment. When asked a stering with the correct the emaining with the resident to treatment. When asked a stering and the treatment when asked a stering as the stated, "You want to ent gets it all. You don't want to come the standard. ASM #1 and ASM the facility uses its policies as sice. A policy regarding ation was requested. In the stated to clarify the standard. ASM #1 and ASM the facility uses its policies as sice. A policy regarding ation was requested. In the stated that the stated the not treatment Administration cy contained no information maining with a resident for	F 684			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			A. BUILDI	NG_					
		495217	B. WING		=	ı	C /08/2021		
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE				
MANORC	ARE HEALTH SERVICE	e Eaid Oave		1	2475 LEE JACKSON MEMORIAL HIGHWAY				
MANORO	ARE HEALTH SERVICE	S-FAIR CANS		F	FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 684	Process, and Practic Mosby-Year Book, Ir any sort should not be patients should be of medication. This avoidabuse, or misuse of the safety of the patients after the safety of the patients are the safety of the patients. We further information of the safety of the patients are the safety of the patients. We safety of the patients are the safety of the patients. We safety of the patients are the safety of the patients. We safety of th	s of Nursing: Concepts, e", 4th ed. St Louis: nc., 1997: " Medications of pe left unattended, and all poserved taking the pids the disposal, hoarding, the medication, and assures ent" In was provided prior to exit. In turn a liquid into a fine ion is taken from the website ov/publications/dictionaries/culizer. In of albuterol and ipratropium neezing, difficulty breathing, coughing in people with ulmonary disease (COPD; a lat affect the lungs and onic bronchitis (swelling of the lead to the lungs) and le to the air sacs in the ipratropium combination is see symptoms have not been enhaled medication. Polymare in a class of ronchodilators. Albuteroland tion works by relaxing and lages to the lungs to make iis information is taken from	F	684					
	tml.	ov/druginfo/meds/a601063.h							
	3. The facility staff fa	iled to apply a splint to							

PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	CORRECTION	IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	COMPLETED			
		495217	B. WING		C 04/08/2021			
	ROVIDER OR SUPPLIER ARE HEALTH SERVIC	ES-FAIR OAKS	1	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION			
F 684	Resident #75's righ physician. Resident #75 was a diagnoses that includiabetes (1), demer Resident #75's mos set), a quarterly ass (assessment refere Resident #75 as so assessment for merof 0 - 15, 6- being sidaily decisions. Set as requiring extensimore staff members transfers. Section Grequiring extensive for dressing, eating hygiene. Section Ghaving functional lirrone side of the upposervation was marroom in bed. Reside observed on top of observed on Reside observed in sight in interview was atterr could not be conducted to the conducted to	Idmitted to the facility with aded but were not limited to ntia (2), and epilepsy (3). It recent MDS (minimum data dessment with an ARD nce date) of 2/27/2021, coded oring a 6 on the staff ntal status (BIMS) of a score everely impaired for making otion G coded Resident #75 as assistance from two or is for bed mobility and is coded Resident #75 as assistance from one person at total tuse and personal coded Resident #75 as an intation in range of motion to the rand lower extremity. In the impaired for making the impaired for motion to the rand lower extremity. In the impaired for motion to the rand lower extremity in their ent #75's hands were the sheet. No splint was ent #75's right wrist or Resident #75's room. An appeted with Resident #75 but coted due to their cognitive in the impaired for	F 684					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B. WING_			1	C /08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(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 8 OSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ON SHOULD BE COMPLE HE APPROPRIATE DAT		
F 684	documented in part, "living) self care and n physical limitations (le cognitive impairment. Revision on: 09/16/20 it documented in part equipment (Gerichair 09/16/2020" Review of the nursing Resident #75 failed to Resident #75 wearing splint on the right wrist. The eTAR (electronic record) and eMAR (e administration record "4/1/2021-4/30/2021" documentation of Resident greater the self-based failed to evidence documents of the self-based fa	Active, Order Date: Care plan for Resident #75 CADL (activities of daily nobility deficits related to eff hemiplegia) (4) and Date Initiated: 08/10/2020, 020" Under "Interventions", "Uses adaptive Date Initiated: I progress notes for evidence documentation of gor refusing to wear the st splint. It treatment administration electronic medication I for Resident #75 dated failed to evidence sident #75 wearing or splint on the right wrist. I therapy) Discharge ent #75, dated "11/25/2019" cumentation of the right wrist eximately 1:20 p.m., an eled with CNA (certified CNA #4 stated that they Resident #75 wear a splint d that splints were not really	F	84				
	interview was conduct nursing assistant) #4. had never observed I on their right wrist and used on their unit. CN	cted with CNA (certified CNA #4 stated that they Resident #75 wear a splint d that splints were not really JA #4 stated that when a Dint they would see it on the		ä				

PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED				
		495217	B. WING			l	C /08/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	04/	06/2021
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		12475 LEE JACKSON MEMORIAL HI FAIRFAX, VA 22033	GHWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	,	ION SHOULD 8: HE APPROPRIA		(X5) COMPLETION DATE
F 684	On 4/7/2021 at approinterview was conducted nurse) #2. LCNAs applied splints that splints were ordered also on the residents that it was documenteresident refused to with the physician and the notified. LPN #2 reviewed ical record and strong for a wrist splint to the conserved Resident #3 observed Resident #3 using a during therapy. On 4/8/2021 at approinterview was conducted that the position of the procedure strategy and the procedures as their strategy was made to member) #1, the admitted policy for splints.	eximately 1:25 p.m., an exted with LPN (licensed PN #2 stated that nurses or as ordered. LPN #2 stated exted by the physician and care plan. LPN #2 stated and in the progress notes if a sear a splint as ordered and exercised responsible party was exted that there was an order aright wrist at all times. Eximately 1:30 p.m., LPN #2 r5 in their room. LPN #2 r5 in their room. LPN #2 r5's right hand and stated in the right wrist. Eximately 10:00 a.m., an exted with OSM #9, t. OSM #9 stated that they to Resident #75 in 2019. They did not remember splint on the right wrist eximately 11:30 a.m., ASM member) #1, the M #2, the director of nursing their policies and	F	684			
	#1 provided via email	, "Braces/Splints" dated					

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Event ID: OKNR11

Facility ID: VA0153

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
	= 2: = = + 11 V 11	BEITH TONTION HOMBER.	A. BUILDI	NG_				
		495217	B. WING			l	C	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	04/	08/2021	
	TO THE ETT.]		2475 LEE JACKSON MEMORIAL HIGHWAY			
MANORC	ARE HEALTH SERVICE	S-FAIR OAKS			AIRFAX, VA 22033			
074) 15	CUMMADVC	ATEMENT OF DEFICIENCIES			1			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT 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 684	Continued From pag	e 73	F	684				
	"Updated: 12/2009, 0	09/2018." The facility policy,						
		umented in part, "Purpose:						
		al range of motion, decrease						
		and provide support and						
		ned limbs through use of						
	braces and/or splints							
		e provided in POC (plan of te including completion of						
	procedure and tolera							
	procedure and tolera	nce of procedure						
	The facility documen	t "Resident Rights"	ŀ		VI.			
	,	"Resident Rights, The					:	
		wing rights 34. To reside						
	and receive services	•						
		odation of individual needs						
	=	ept when the health or						
	be endangered"	al or other residents would						
	oo ondangerea							
	On 4/7/2021 at appro	oximately 4:55 p.m., ASM #1,					=	
	the administrator and	I ASM #2, the director of						
	nursing were made a	ware of the findings.						
	No further information	n was provided prior to exit.						
	References:							
	1. Diabetes mellitus	- a chronic disease in which						
		late the amount of sugar in						
		nation was obtained from						
	the website:							
	https://www.nlm.nih.g 001214.htm,	ov/medlineplus/ency/article/						
		s of brain function that						
		seases. It affects memory,						
		idgment, and behavior. This						
		ined from the website:						
	nttps://medlineplus.g	ov/ency/article/000739.htm.						

PRINTED: 04/19/2021 **FORM APPROVED** OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			100		c	;
		495217	B. WING _		04/0	8/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	Continued From page		F6	84		
F 695 SS=D	to have recurring seize when clusters of nerve brain send out the with have strange sensation strangely. They may for lose consciousnes obtained from the we https://medlineplus.go Respiratory/Tracheos CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care are The facility must ensure needs respiratory care care and tracheal succare, consistent with practice, the compreheare plan, the resident and 483.65 of this sull This REQUIREMENT by: Based on observation document review and was determined the farespiratory care and sprofessional standard comprehensive person three of 33 current resample, Residents #1 1. The facility staff fait the physician order at professional standard comprehensional standard	by/epilepsy.html. stomy Care and Suctioning ry care, including and tracheal suctioning, are that a resident who e, including tracheostomy stioning, is provided such professional standards of pensive person-centered tts' goals and preferences, opart. Tis not met as evidenced an, staff interview, facility clinical record review, it acility staff failed to provide services consistent with ls of practice, and the an-centered care plan for sidents in the survey 128, #44 and #73.	F6	1. Corrective Action Resident #128 suffered no ill effects this deficient practice and Certified Assistant #10 was re-educated on performing tasks which fall within his of practice only upon learning of this deficient practice. Resident #44 suffered no ill effects deficient practice and was provided new incentive spirometer and the appropriate staff were re-educated storage of the C-Pap in a sanitary in Resident #73 suffered no ill effects deficient practice and LPN #1 was reducated on oxygen administration care. 2. Other Potential Residents All residents who receive suppleme oxygen have the potential to be affect this deficient practice.	Nursing s scope s from this with a n on the nanner. from this e- and	

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Event ID: OKNR11

Facility ID: VA0153

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	MULTIPLE CONSTRUCTION JILDING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C	
NAME OF D	ROVIDER OR SUPPLIER	100011	3.7	STREET ADDRESS, CITY, STATE, ZIP CO		4/08/2021	
TWIME OF T	NOTIBELL ON OUT FEEL		ľ				
MANORC	ARE HEALTH SERVICE:	S-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIG	HVVAT		
				FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 695		e 75 ailed to store Resident #44's ositive airway pressure)	F 6	95 Continued From page 75 3. New Measures or Syste	mic Change		
		anner and failed to provide		The Director of Nursing and			
		centive spirometer for use as		nurse (RN) unit managers a			
	ordered by the physic			supervisors will re-educate			
	ordered by the physic	J		the importance of suppleme			
	3. The facility staff fa	iled to provide respiratory		administration, the importar			
		manner for Resident #73.		maintaining it in a sanitary i		:	
		cannula oxygen tubing was		administrator of it as it relat	es to scope of		
	observed on the floor	r on 4/6/21 at 12:40 PM		practice.			
	-	observation rounds. LPN					
		rse) #1 was observed wiping		 Monitoring The Director of Nursing and 			
i		th an alcohol wipe and					
	placing it back on Re	sident #73.		nurse (RN) unit managers a supervisors will verify that t			
	The findings include:			liters of oxygen flowing is o			
	The findings include:			residents using supplement	tal oxygen, the		
		is admitted to the facility on		sanitary storage and care o			
		oses that included cancer of		related supplies as follows:			
		pressure, fractured ribs and		daily for one week then three for an additional week, follow			
		t recent MDS (minimum t, an admission assessment,		times weekly for an addition			
		reference date of 3/25/2021,		followed by one time per we			
		s scoring a "14" on the BIMS		additional two months. The			
		ental status) score, indicating		their findings will be reporte			
	the resident was cap			Administrator and the QAPI		1	
		Resident #128 was coded as					
	requiring extensive a	ssistance of one or more		5. Completion Date			
		st of her activities of daily		May 18, 2021		ļ	
	living. Section O - Sp	•					
	_	grams coded the resident as					
	receiving oxygen whi	le a resident in the facility.					
;	minute via N/C (nasa	oygen) @ (at) 2 liters per order to the connula - a plastic tubing that insert into the nose)					
		·		1			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		495217	B. WING_				C /08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COD 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		SHOULD B		(X5) COMPLETION DATE	
F 695	The comprehensive documented in part, altered respiratory st disease process [Lut fracture]." The "Interpart, "Provide oxyge Observation was ma 4/6/2021 at 1:00 p.m her oxygen concentrator (liters per minute). Observation was ma 4/7/2021 at 12:15 p.m window visit with her getting ready to go to Resident #128 was ovia the nasal cannula concentrator that wa observation of the oxygen concentrator that wa observation of the oxygen concentrator that wa observation of the oxygen concentrator that was observation of the oxygen concentrator that was asked to go to Fobserve the resident was asked to go to Fobserve the resident was asked if it was set at stated that it wasn't a 2 LPM. When asked oxygen concentrator had looked at it earlief then stated, (name 15 then stated, (name 15 then stated, (name 16 the stated)	care plan dated 3/20/2021, "Focus: The resident has fatus with SOB r/t (related to) ing CA {cancer}recent rib ventions" documented in in as ordered." de of Resident #128 on it. She was resting in bed with ite nasal cannula connected to ator that was running. The iflow meter was set at 2 LPM de of Resident #128 on im. Resident had just had a is son and stated she was or radiation in a little bit. observed with her oxygen on a connected to an oxygen	F	395				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	1, ,	(X3) DATE SURVEY COMPLETED		
		495217	B. WING			C 04/08/2021		
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIF 12475 LEE JACKSON MEMORIAL I FAIRFAX, VA 22033	CODE			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 695	Continued From pag	e 77	F	695				
F 695	this morning. When a Resident #128's constated she had not. If the oxygen to the connursing assistant) #1 supply for the day, or When asked if he had concentrator into Res 4/7/2021, CNA #10 stated they were have on the concentrators resident's rate of oxywhen he brought it in CNA #10 stated he juif he adjusted the rate CNA #10 stated he hold the nurse he chat When asked if he now was on the machine, When asked if it was put residents on oxygwas not. When asked the rate of oxygen, CAn interview was commanager, on 4/7/202 a CNA is able to rem back on an oxygen of "They shouldn't." RN above observation and the control of the contro	asked if she had checked centrator after that, RN #5 RN #5 proceeded to adjust rect level. Inducted with CNA (certified 0, the person working in 1 4/7/2021 at 1:36 p.m. Indicated the had consider the stated he had. CNA #10 ing the yearly maintenance when asked who set the gen on the concentrator ato the Resident #128's room, ast turned it on. When asked in order to end of oxygen by the knob, and not. CNA #10 stated he had not. CNA #10 stated he had not. In his scope of practice to gen, CNA #10 stated he was not. Inducted with RN #6, the unit of the was allowed to adjust the concentrator, in the was allowed to adjust the concentrator, in the was allowed to adjust the concentrator, RN #6, the unit ove and place a resident oncentrator, RN #6 stated, #6 was informed of the indinterviews, RN #6 stated	F	595				
- A40	documented in part, Physician's orderPr For oxygen concentre	In't nave done that. Exygen Administration" "Procedure: 1. Verify reparation of Equipment: 3. ator, plug in power cord, turn meter to correct flow rate."						

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Event ID: OKNR11

Facility ID: VA0153



	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD			(:
		495217	B. WING			1	08/2021
NAME OF P	ROVIDER OR SUPPLIER			l	STREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY		
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS			FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC 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 695	"Oxygen should be tr	e 78 reated as a drug. It has ts, such as atelectasis or	F	695			:
	oxygen toxicity. As w concentration of oxyg	ith any drug, the dosage or gen should be continuously a should routinely check the				į	
,	physician's orders to receiving the prescrit	verify that the client is bed oxygen concentration.					
	The six rights of med pertain to oxygen add	lication administration also ministration."(1)					
	documented, "You de the nurse when you a administration syster	n Administration Set-up" was o not administer oxygen. Tell finish setting up the oxygen n. The nurse turns on the varte, and applies the e."(2)					
	administrator and AS	staff member) #1, the SM #2, the director of nursing, the above concern on					
	No further informatio	n was provided prior to exit.					
	6th edition, page 112 (2) Mosby's Textbook	Nursing, Perry and Potter, 22, c for Long-Term Care ition, 2003, page499.					
	C-PAP [continuous r						
	Resident # 44 was a	dmitted to the facility with					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING			COMPLETED			
		495217	B. WING _			C 04/08/2021
	ROVIDER OR SUPPLIER	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COD 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033	E	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695		· ·	F	895		
	_	uded but were not limited to: pnea [2] and respiratory failure				
	(minimum data set with an ARD (asse 11/06/2020, coded [nine] on the brief i (BIMS) of a score of impaired of cognition Under section "O S Procedures and Pr	ost recent comprehensive MDS), an admission assessment ssment reference date) of Resident # 44 as scoring a 9 interview for mental status of 0 - 15, 9 - being moderately on for making daily decisions. Special Treatments, regrams" coded Resident # 44 or "While a Resident."				
	observation of Res C-PAP mask on to uncovered. Further	approximately 12:53 p.m., an ident # 44's room revealed a p of Resident # 44's dresser robservation of Resident #44's dence an incentive spirometer.				
	observation of Res C-PAP mask on to uncovered. Further	approximately 2:48 p.m., an sident # 44's room revealed a p of Resident # 44's dresser robservation of Resident #44's dence an incentive spirometer.				
a	observation by and 44's room revealed Resident # 44's dra	approximately 8:24 a.m., an other surveyor of Resident # d a C-PAP mask on top of esser uncovered. Further sident #44's room, failed to tive spirometer.				
		r dated 04/2021 for Resident # CPAP on at night and off in the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ON NUMBER		ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495217	B. WING_			l	C /08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	G-FAIR OAKS		1247	EET ADDRESS, CITY, STATE, ZIP CODE 75 LEE JACKSON MEMORIAL HIGHWAY RFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	AM [a.m.] and during Start Date: 02/17/202 order for Resident #4 documented, "Incenti bedside every day and CO2 [carbon dioxide. evening shift. Schedular CO2 [carbon dioxide. evening shift. Schedular CO2 [carbon dioxide. evening shift. Schedular CO2 [carbon dioxide. evening shift. Schedular CO2 [carbon dioxide. evening shift. Schedular CO2 [carbon dioxide. evening shift. Schedular CO2 [carbon dioxide. evening shift. Schedular CO2 [carbon dioxide. evening shift. Schedular CO2 [carbon dioxide. evening shifts and evening sh	the day while sleeping. 1." A second physician's 14 dated "4/2021" we Spirometer keep at d evening shift for elevated Frequency: every day and alle Type: Everyday." Pare plan for Resident # 44 ailed to evidence e use of a C-PAP or the use neter. It reatment administration 15 44 dated April 2021 re physician's order for the her documented Resident # 2 on 04/06/2021 on the day d on 04/07/2021 2021 on shifts. Further review of the dication administration 15 44 documented the above	F6	395			
	spirometer, and docur of an incentive spirom day and evening shift day and evening shift. On 04/07/21 at 12:58 Resident # 44's room conducted with LPN [2. When asked to des storage of a C-PAP m 2 stated that it should asked why the C-PAP	p.m. an observation of					

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	T OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DEPORT (X2) MULTIPLE CONSTRUCTION A. BUILDING		1 ' '	COMPLETED				
		495217	B. WING_			04/08/2021		
	ROVIDER OR SUPPLIER ARE HEALTH SERVIC	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COU 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE		
F 695	observing the C-PA uncovered, LPN # 3 stored in a sanitary locate Resident # 4 # 2 searched all the compartments of R standing closet]. LF could not locate the asked why someon spirometer, LPN # 3 lungs." On 04/06/2021 at a entrance conference conducted with ASI member] # 1, admindirector of nursing. of practice the nurs ASM # 2 stated that policies and proced. The facility's policy evidence document mask when not in the Con 04/07/2021 at a # 1, administrator at nursing, were made. No further information References: [1] Positive airway a machine to pump airway of the lungs.	g Resident # 44's room and AP mask on top of the dresser 2 stated that the mask was not manner. When asked to 4's incentive spirometer, LPN a dresser drawers and all the esident # 44's armoire [free PN # 2 then stated that they a incentive spirometer. When he would use an incentive 2 stated, "To expand your Approximately 11:30 a.m., the he for the survey was M [administrative staff inistrator and ASM # 2, the When asked what standards ing staff follow ASM # 1 and they follow the facility's lures. "BiPAP /CPAP" Failed to tation for storage of the C- PAP	F6	395				
		positive airway pressure)		n-	. A			

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MAY 07 2021

VDH/OLC

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCT		COMP	SURVEY
		495217	B. WING			1	C '08/2021
NAME OF P	ROVIDER OR SUPPLIER				ESS, CITY, STATE, ZIP CODE CKSON MEMORIAL HIGHWAY	1 0	-
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		FAIRFAX, VA			
(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 CORRECTION ACH CORRECTIVE ACTION SHOULD B DSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 695	Communication Page		F 6	95			
	the breathing in peop apnea and other brea information was obtai https://medlineplus.go	airway collapse that block ble with obstructive sleep athing problems. This ined from the website: bv/ency/article/001916.htm.					
	Breathing pauses car minutes. They may o hour. This information	g to stop or get very shallow. In last from a few seconds to ccur 30 times or more an In was obtained from the seplus.gov/sleepapnea.html.					
	lungs into your blood obtained from the we	oxygen passes from your . This information was bsite: ov/medlineplus/respiratoryfa					
	the body. This inform website:	en reaching the tissues of ation was obtained from the webster.com/dictionary/hyp					
	healthy after surgery illness, such as pneu spirometer teaches y breaths. This informa website: https://medlineplus.go/00451.htm. 3. Resident #73's nas was observed on the during initial resident (licensed practical nu	help you keep your lungs or when you have a lung monia. Using the incentive ou how to take slow deep tion was obtained from the ov/ency/patientinstructions/0 sal cannula oxygen tubing floor on 4/6/21 at 12:40 PM observation rounds. LPN rse) #1 was observed wiping h an alcohol wipe and sident #73.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	IULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
		495217	B. WING _			1	C /08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS	•	STREET ADDRESS, CITY, STATE, ZIF 12475 LEE JACKSON MEMORIAL FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD B THE APPROPRI		(X5) COMPLETION DATE	
F 695	8/26/17 with diagnost limited to: Congestive heart fail circulatory congestion water by the kidneys disease (narrowing congestion water by the kidneys disease (narrowing contract consideration of the heart fail (rapid/random contract chambers of the heart chambers of the heart fail (rapid/random contract chambers of the heart fail (rapid/random contract chambers of the heart fail (rapid/random contract chambers of the heart fail (rapid/random contract chambers of the heart fail (rapid/random contract	dmitted to the facility on ses that include but are not dure (characterized by an and retention of salt and a) (1), peripheral vascular of blood vessels in the aque) (2) and atrial fibrillation actions of the upper art) (3). recent MDS (minimum data quarterly assessment, with an act date of 2/25/21, coded the 2 out of 15 on the BIMS ental status score), indicating derately cognitively intact. ded as requiring extensive obility, transfers, dressing, in room, bathing and apervision in eating. PM, during the initial resident Resident #73's oxygen nasaled on the floor beside her the oxygen concentrator.	F	DEFICIEN 395	ICY)			
	to the room and put i LPN #1 was then ob- cannula and tubing u wiped the nasal cann placed it back on Re wiping oxygen tubing	or. LPN #1 stated, "I'll come t back on her after I clean it." served picking the nasal up off the floor and then hula with an alcohol wipe and sident #73. When asked if g and replacing it on the rect process, LPN #1 stated, hat."						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE	SURVEY
			/ JOILD				c
		495217	B. WING			04/	08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		2475 LEE JACKSON MEMORIAL HIGHWAY		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PI		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(XS) COMPLETION DATE	
F 695	A review of the physicocumented in part, 'minute via nasal cand' A review of the nurse 4/6/21 at 3:04 PM, do continues on oxygen per minute. Saturation o complaints of short Prevision date of 3/8/2 "Focus: At risk for reschronic hypoxia. Interescent in part of the physical stress of the physical s	cian's orders dated 7/9/20, l'Oxygen at 2 liters per nula." 's progress note dated cumented in part, "Resident by nasal cannula at 2 liters n steady and above 92%,	F	695			
	An interview was con AM with RN (register manager. When aske managed, RN #2 state more often if needed. cannula and oxygen process followed for cannula off with alcol resident, RN #2 state tubing and put new to the follows when a ron the floor. RN #1 state you would wipe dowr the floor with alcohol resident, RN #1 state	·					

PRINTED: 04/19/2021 FORM APPROVED OMB NO, 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495217	B. WING		C 04/08/2021	
	ROVIDER OR SUPPLIER	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 695	administration record documented in part, "once weekly." The TA #73's nasal cannula a changed once weekly ASM (administrative administrator, and AS were informed of the PM. A review of the facility Administration" policy specify nasal cannulation.	#73's TAR (treatment) for March and April 2021, Change the oxygen tubing AR documented Resident and oxygen tubing as v in March and April 2021. Staff member) #1, the SM #2 the director of nursing finding on 4/7/21 at 5:00 V's "Respiratory: Oxygen dated 1/19, does not	F 69	95		
F 696 SS=D	Non-Medical Reader, Chapman, page 239. (2) Barron's Dictionar Non-Medical Reader, Chapman, page 131. (3) Barron Dictionary edition, Rothenberg a Prostheses CFR(s): 483.25(j) §483.25(j) Prostheses The facility must ensu prosthesis is provided consistent with profes the comprehensive pe	y of Medical Terms for the 5th edition, Rothenberg and y of Medical Terms for the 5th edition, Rothenberg and of Medical Terms, 7th and Kaplan, page 490.	F 69	1. Corrective Action Resident #51 went to his prostheses specialty appointment on April 20, 20 Follow up is required in four to six w following the resident establishing a consistent routine of applying and w his shrinkers and prostheses.	021. eeks	

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

Event ID: OKNR11

Facility ID: VA0153

If continuation sheet Page 86 of 127



	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		SURVEY
			1 55.25	_		-200.00	С
		495217	B. WING			l	/08/2021
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORO	ARE HEALTH SERVICES	S-FAIR OAKS		1	2475 LEE JACKSON MEMORIAL HIGHWAY		
				F	FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			(X5) COMPLETION DATE	
F 696	be able to use the promotion of the course o	costhetic device. T is not met as evidenced In, resident interview, clinical of document review and staff rmined facility staff failed to a services for one of 33 are survey sample, Resident as unable to wear their right an improper fit which was an an addressed. In mitted to the facility with ed but were not limited to ase (2), diabetes (3) and are amputation (4). Resident and S (minimum data set), and are with an ARD (assessment by 2021, coded Resident #51 are staff assessment for of a score of 0 - 15, 15-ct for making daily decisions. A ident #51 requiring staff member for bed are along and limited aron for transfers, toilet use are section G coded Resident limitation in range of motion ties. Section G coded not walked during the and failed to evidence and use of limb prosthesis. Eximately 11:45 a.m., an atted with Resident #51 in his	F		Continued From page 86 2. Other Potential Residents All residents who have a prosthes have the potential to be affected I deficient practice. 3. New Measures or Systemic Cl The Director of Nursing, RN unit managers and/or RN supervisors re-educate staff on the importance encouraging resident to wear and offering assistance in donning prostheses to resident who have 4. Monitoring The Director of Nursing and/or registered nurse (RN) unit manage and/or RN supervisors will verify through visual observations that residents with prosthesis are weat them. These visual observations occur daily for one week then three times weekly for an additional wee followed by two times weekly for a additional week, followed by one per week for an additional two mon These results of these observation be reported monthly to the Administrator and the QAPI Comm 5. Completion Date May 18, 2021	hange will e of them. ers ring will ee ek, an time onths. ns will	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							С
		495217	B. WING			04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		1	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD B TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			- N. 171	(X5) COMPLETION DATE
F 696	prosthetics, Resident wear them a while ag Resident #51 stated to put them on and had the motorized wheeld beside the window an #51 stated that the rig properly and he was a because he was unat #51 stated that he has social worker and the setting up an appoint refitted but nothing ha #51 stated that the social worker and the setting up an appoint refitted but nothing ha #51 stated that the social worker and the setting up an appoint refitted but nothing ha #51 stated that the social worker and the setting up an appoint refitted but nothing ha #51 stated that the social worker and the setting up an appoint refitted but nothing ha #51 stated that the social was to be could not used the wheelchair. really wanted to atten would not let him with Resident #51 stated that the prosthetics since their services and that arrange the repairs to clinic. The comprehensive of documented in part, "A (activities of daily livin chronic disease proceed below the knee amputed 1/28/2019, Created of Name of staff member 08/31/2020" Under "documented in part, "A equipment such as us board for transfers. Date of the process of the part, "A equipment such as us board for transfers. Date of the part of the pa	When asked about the #51 stated that he used to o when he received therapy, hat he was taught how to worked with therapy using hair located in his room and with walking. Resident the prosthetic did not fit them discharged from therapy ble to wear the leg. Resident dispoken to the previous unit manager regarding ment to get the prosthetic did been set up. Resident cial worker left and that he ele other prosthetic leg use them both and just Resident #51 stated that he did therapy but they (staff) out the prosthetics on. That therapy had not looked the he was discharged from the nurses were left to the prosthetic with the was discharged from the nurses were left to the prosthetic with the lare plan for Resident #51 At risk for decline in ADLs go & (and) mobility related to set and BKAs (bilateral tation). Date Initiated: on: 01/31/2018, Created by: er Revision on:	F	696			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CON	STRUCTION		TE SURVEY
		495217	B. WING				С
NAME OF D	DOMBED OF OURSE LES	450217	D. WING			04	4/08/2021
	ROVIDER OR SUPPLIER				T ADDRESS, CITY, STATE, ZIP CODE LEE JACKSON MEMORIAL HIGHWAY		
MANORO	ARE HEALTH SERVICES	S-FAIR OAKS		FAIRF	AX, VA 22033		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
	failed to evidence doc communication with the "PT (physical the dated "10/22/2018-11 documented in part," his prosthesis for Bil (extremities) on 9/24/1 PT for prosthetic train gait training. On evaluation several times to get the extremity) prosthesis. Pt able to get the LLE prosthesis on. On Evaluation of prosthetic clinic] has prosthesis, but cont (owith R LE (right lower Have left multiple mes prosthetic clinic]. Pt has without teh [sic] while ambualting [sic]. Pt has Awaiting [Name of prosthetic clinic] has orders for Resident #51 docu (patient) has orders for Pt to receive skilled Ponly. He is MI (modified mobility. His R (right) prosthetic sleeve (whith prosthetic sleeve (whith prosthetic sleeve (whith prosthetic sleeve) in this time"	cumentation of he prosthetic clinic. Prapy) Discharge Summary" /27/2018" for Resident #51 Pt (patient) now received (bilateral) LE's (lower 8 and requirign [sic] skilled ign [sic] with transfers and (evaluation), Pt attempted he RLE (right lower on, but unable to get it on. if (left lower extremity) al. (evaluation) day [Name and adjusted [sic] teh [sic] continues) to have difficulty extremity) prosthetic liner. In sages with [Name of as been donning prosthesis liner and standing and as met all of his goals. In transferred to hosp cal issues" Precening" dated "01/18/19" In part, "Pt or P.T. (physical therapy). The for prosthetic training and independent) with bed in well as w/c (wheelchair) LE (lower extremity) tee does not fit. [Name of to address it prior to patient skilled PT services warranted lied PT services warranted	F	696			
	On 4/7/2021 at approx	amately 1:20 p.m., an					1 [

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	
AND FEAR OF	CORRECTION	IDENTIFICATION NUMBER:	A, BUILDI	NG.	<u> </u>	COMP	PLETED
]				1	C
		495217	B. WING	_		04/	08/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		··· <u>-</u>
MANORO	ARE HEALTH SERVICE	S-FAIR MAKS		1	2475 LEE JACKSON MEMORIAL HIGHWAY		
MANONO	ARE HEALING SERVICE	5-PAIR OARS		ı	FAIRFAX, VA 22033		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ΙD		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
F 696	Continued From pag	e 89	F	696			
		cted with CNA (certified					
		. CNA #4 stated that they					
		Resident #51 use their					1
		nat as far as they knew they					
		ly so they were not used.			:		
	, ,	•					
	On 4/7/2021 at appro	oximately 1:32 p.m., an					
	interview was conduc	cted with LPN (licensed					
		nterim unit manager. LPN					
		back there were issues with					
	_ ·	tic clinic] when trying to get					
		pointment to have their	}				
	•	LPN #3 stated that the last					
		n with anyone at the clinic,					
		previously worked with ger worked at the clinic. LPN					
	-	other staff member) #8,					
		d spoken with the prosthetic					
		rosthesis problems in the					
		that they did not know the					
	I	Resident #51 to have their					
		and they were not sure who					
		setting it up. LPN #3 stated					
		ad to set up an appointment					
	for Resident #51 at the	ne [Name of prosthetic clinic]					
	and would follow up	with Resident#51.					
	On 4/7/2021 at appre	oximately 3:00 p.m., a					
		vas conducted with OSM #8,					
	-	SM #8 stated that they had					
		Resident #51 when he came					
		#8 stated that Resident #51					
		ateral below the knee					
		[Name of prosthetic clinic]					
	•	aking the prosthetics for					
		that they worked with					
	Resident #51 on star	nding and walking with the					
	prosthetics. OSM #8	stated that one of the					
	prosthetics would not	t lock all the way in and they					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG			SURVEY
		495217	B. WING				C /08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE:	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 696	had called the clinic for to have the prosthetic that the prosthetic clip prosthetic but someh had reached out to the that Resident #51 was that point and they have reached out to the number of they did not get a refet they did not get a refet they did follow up with prosthetic adjustment when they discharged he was independent transferring and gettin OSM #8 stated that Fusing the prosthetics wasn't fitting correctly so they did not feel till On 4/6/2021 at approximately as their side of the did not feel till on 4/7/2021 at approximately as their side of the did not feel till on 4/7/2021 at approximately as their side of the did not feel till on 4/7/2021 at approximately as their side of the did not feel till on 4/7/2021 at approximately as their side of the did not feel till on 4/7/2021 at approximately as their side of the did not feel till on 4/7/2021 at approximately as their side of the did not feel till on 4/7/2021 at approximately ap	or an outpatient appointment or adjusted. OSM #8 stated nic had adjusted the ow it did not work and they seem again. OSM #8 stated is admitted to the hospital at ad discontinued therapy and string staff to follow up on ments. OSM #8 stated that was readmitted to the facility erral to see them again but in nursing to set up the its. OSM #8 stated that id Resident #51 from therapy at wheelchair level for mg around in the wheelchair. Resident #51 had stopped and said that one side or and was getting in their way see putting it on. Eximately 11:30 a.m., ASM member) #1, the M #2, the director of nursing their policies and tandard of practice.	F	696			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI	(X3) DATE SURVEY COMPLETED			
		4 9 5217	B. WING	B. WING		С	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		04.	/08/2021
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFII TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 696	verify straps are in go abnormalities or complianctioning to therapis. The facility document documented in part, "resident has the follow and receive services reasonable accommon and preferences, excessfety of the individuable endangered" On 4/7/2021 at approximate administrator and nursing were made as No further information. References: 1. Prosthesis- a prost to replace a missing part of the body work eyes, arms, hands, learned by prosthetic was obtained from the https://medlineplus.go 2. End-stage kidney dochronic kidney disease can no longer support information was obtain https://medlineplus.go 3. Diabetes mellitus-the body cannot regulated.	plaints about prosthesis fit or st and/or physician" "Resident Rights" Resident Rights, The wing rights 34. To reside in the facility with dation of individual needs ept when the health or all or other residents would eximately 4:55 p.m., ASM #1, ASM #2, the director of ware of the findings. It was provided prior to exit. It hesis is a device designed eart of the body or to make a better. Diseased or missing gs, or joints are commonly to devices. This information is executed website: It was the last stage of eart of the last stage of eart of the last stage of eart of this is when your kidneys to your body's needs. This	F	396			

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495217	B. WING _		C 04/08/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/08/2021
MANORO	ARE HEALTH SERVICES	EAID OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY	
MANONO		-FAIR OARS		FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 696	Continued From page	92	F 6	96	
	https://www.nlm.nih.gov/medlineplus/ency/article/ 001214.htm.				
F 698 SS=D	removal of a leg, foot These body parts are Amputations are done occur by accident or to Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure quire dialysis receive with professional standomprehensive personal standomprehensive personal facility staff failed to edialysis, receive service professional standard thirty-three residents in Resident #436. The facing communication the dialysis facility for Monday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Wednesday/Funday/Funday/Wednesday/Funda	re that residents who e such services, consistent dards of practice, the n-centered care plan, and nd preferences. is not met as evidenced ew, facility document review riew, it was determined the nsure residents' that require ces, consistent with s of practice for one of an the survey sample, acility staff failed to evidence on and collaboration with Resident #436, during her Friday dialysis treatments.	F 6:	1. Corrective Action - Dialysis Resident #436 suffered no ill effects this deficient practice. 2. Other Potential Residents All dialysis residents have the poter be affected by this deficient practice 3. New Measures or Systemic Cha The Director of Nursing and/or regis nurse (RN) unit managers and/or R supervisors will re-educate licensed staff on the importance of using the established communication tools (b and dialysis communication forms).	ntial to nge ntered N nursing

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	TIPLE CONSTRUCTION		E SURVEY
		1	A. BUILDI	VG		C
		495217	B. WING		رم ا	4/08/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		10012021
MANORC	ARE HEALTH SERVICE	S-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHW	AY	
				FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 698	chambers of the hear The most recent MDS assessment, an adm ARD (assessment recoded the resident as the BIMS (brief intervindicating the resident mpaired. In Section 6 resident was coded a assistance for bed motoilet use, personal his supervision for eating procedures) - the resident receiving dialysis which are view of the physic documented in part, "[mechanical purification substitute for normal Monday, Wednesday A review of nursing procedures of nursing p	S (minimum data set) ission assessment, with an ference date) of 3/31/21, is scoring a 11 out of 15 on view for mental status) score, at was cognitively moderately G (functional status)- the as requiring extensive obility, transfer, dressing, ygiene and bathing; g. In Section O (special ident was coded "Yes" as le a resident. Cian's orders dated 3/26/21, 'Patient is on hemodialysis on of the blood as a kidney function] every and Friday". Togress notes revealed the ion: 1, "Resident left for dialysis." "Resident left for dialysis." Resident left for dialysis. ntact with no bleeding, bruit Resident came backfrom "Resident left for dialysis." 436's dialysis revealed there were no from the facility to the dates of 3/29/21, 3/31/21,	F	4. Monitoring The Director of Nursing and/or nurse (RN) unit managers and supervisors will review the dia communication binder for each who receives dialysis to ensur with communication is occurring three times per week for one with the times per week for one with the weeks. After this month or reviews, the dialysis communication will be reviewed monthly for an 60 days. The results of these reported monthly to the Adrand the QAPI Committee. 5. Completion Date May 18, 2021	d/or RN lysis h resident re compliance ng as follows: week then two week, n additional f increased cation binder n additional reviews will	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		TE SURVEY
		495217	B. WING _			C 4/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COI 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033	DE	4/06/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
F 698	communication form #436 receives dialys Monday/Wednesday, since 3/29/21 for a to four communication of A review of Resident plan dated 3/29/21, of Focus: dated 11/13/1 related to acute rena dialysis three times a and Friday. Send me On 4/8/21 at 8:05 Aff conducted with RN (rasked the purpose of forms, RN #1 stated, information to the dialymedications and any center provides informational #1 stated, "I don't know the dialysis company on 4/8/21 at 8:30 Aff member) #1, the admost the concern regard dialysis center for Re #1; the dialysis compinformation. On 4/8/21 at 11:00 Aff communication binded provided. The information provided. The information provided. The information provided. The information provided. The information provided. The information provided. The information provided. The information provided. The information provided. The information provided. The information provided provided provided. The information provided provi	dated 4/7/21. Resident s /Friday dialysis treatments tal of five dialysis visits, with forms missing. #436's comprehensive care locumented in part, "The 9 "Renal insufficiencies I failure. The Interventions: week, Monday, Wednesday al with the resident". M and interview was egistered nurse) #1. When the dialysis communication "They are to provide current lysis center about vital signs, changes. The dialysis mation back to us regarding for that day." When asked forms would be found, RN ow where they are. I'll call and they will send them." J. ASM (administrative staff hinistrator was made aware ling communication with the sident #436 and that per RN any would be sending M, the dialysis of the four the four the sident #436's treatment on the four the seident #436's treatment on the to evidence of the four the sheets from the facility	F 6	98		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495217	B. WING _		C 04/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	OULD BE COMPLETION
F 698	On 4/8/21 at 11:30 A administrator, and A were informed of the The facility's contract documented in part, appropriate medical, other information accresidents at the time This information, shato, where appropriate medical records, including a provided to the including medication condition and any ot	M, ASM #1, the SM #2 the director of nursing finding. It with the dialysis facility, "Facility shall ensure that all social, administrative, and company all designated of transfer to the center. Ill include, but is not limited e, the following: appropriate	F 6	98	
F 812 SS=E	reasonably determine No further information References: 1. Barron Dictionary edition, Rothenberg 2. This information we following website: w. 3. Barron Dictionary edition, Rothenberg Food Procurement, SCFR(s): 483.60(i)(1) §483.60(i) Food safe The facility must -	of Medical Terms, 7th and Kaplan, page 498. vs. CDC.gov. of Medical Terms, 7th and Kaplan, page 54. store/Prepare/Serve-Sanitary (2)	F8	12 1. Corrective Action All food items identified during to as not being properly stored we discarded.	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION NG		E SURVEY
		495217	B. WING_			C I/08/2021
NAME OF F	ROVIDER OR SUPPLIER	<u> </u>		STREET ADDRESS, CITY, STATE, ZIP CODE	04	1/08/2021
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
(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 CORREC ((EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 812	state or local authoriti (i) This may include for from local producers, and local laws or regulation of the from local producers, and local laws or regulation of the from consuming progradens, subject to consume the from consuming food from consuming food from consuming food from consuming food standards for food setting REQUIREMENT by: Based on observation document review, it with staff failed to store an manner in the kitchen. The findings include: Observation was made frozen biscuit was operated air. Further observation date of the freezer. A box of the freezer.	des. cood items obtained directly subject to applicable State allations. Is not prohibit or prevent roduce grown in facility ampliance with applicable di-handling practices. It is not procured by the facility. It is not procured by the facility. It is not met as evidenced and the professional role safety. It is not met as evidenced and serve food in a sanitary. It is entitle the facility discrete food in a sanitary. It is not met as evidenced a serve food in a sanitary. It is not met as evidenced a serve food in a sanitary. It is not met as evidenced a serve food in a sanitary. It is not met as evidenced a serve food in a sanitary. It is not met as evidenced a serve food in a sanitary. It is not met as evidenced a serve food in a sanitary. It is not met as evidenced a serve food in a sanitary. It is not met as evidenced a serve food in a sanitary and the plastic bag inside a serve food in a sanitary. It is not met as evidenced a serve food in a sanitary and the plastic bag inside a serve food in a sanitary. It is not met as evidenced a serve food in a sanitary and facility as determined the fac	F8	2. Other Potential Residents All residents have the potential to affected by this deficient practice 3. New Measures or Systemic Council All dietary staff employees were educated on proper and sanitary storage and service by the Food Director. 4. Monitoring The Food Services Director and/Registered Dietician will perform inspection of the kitchen to ensuritems are properly stored in a sar manner weekly for one month the for an additional two months. The these inspections will be reported to the Administrator and the QAP Committee. 5. Completion Date May 18, 2021	hange re- food Services or an e food hitary en monthly e results of	

	F CORRECTION	IDENTIFICATION NUMBER:	I * '	RIPLE CONSTRUCTION NG		(X3) DATE	SURVEY
		495217	B. WING			1	08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD B SED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 812	when the box was box should be open OSM #7 stated, no opening. When ask opened, OSM #7 stated they have receiving the grated they haven't few weeks now. Observation was most the kitchen. It was brown material was oven doors. When cleaned, OSM #7 sago. He further stated broken and they are the only oven in using the only oven in using the cleaned. Review of the policity documented in part following date mark label open frozen for exceeded the expirity use-by-date is uncleased. Review of the policity Marking" documented in part following delivery, pidentify the item and temperature information date of preparation is to be used or condate marking."	opened. When asked if the with the plastic opened to air, it should be closed after and when the donuts were tated he couldn't tell when as ted when opened. OSM #7 and a resident in house that alluten free food; OSM #7 had a gluten free diet for a made of an oven on the far wall as in use. It was opened and a noted on the racks and the asked when it was last tated about a week and a half and that the other oven is a awaiting another oven so it's a awaiting another oven so it's a. When asked if it was in OSM #7 stated, yes it needed over ", "10. Label opened foods and that has ation date or when	F	312			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A BOILDIN		С
		495217	B. WING _		04/08/2021
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY	
			İ	FAIRFAX, VA 22033	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION ATE DATE
F 812	812 Continued From page 98		F8	12	
	administrator, and AS				
	nursing, were made a 4/7/2021 at 4:54 p.m.	ware of this concern on			
	No further information	was provided prior to exit.			
F 814	Dispose Garbage and	Refuse Properly	F8	14 1. Corrective Action	
SS=F	CFR(s): 483.60(i)(4)			The area surrounding the dumpster	<i>N</i> as
	\$483 60(i)/4\ Dianas	of gorbone and seture		swept clean by the housekeeping did and staff during survey. On Tuesday	
	properly.	e of garbage and refuse		20, 2021 the provider of waste	/, April
		is not met as evidenced		management for the facility placed a	lock on
	by:		the dumpster to ensure no wildlife c		uld get
		n, staff interview and facility		in.	
		as determined the facility			
		the dumpster area in a		2. Other Potential Residents	5:-:4
	sanitary manner to pre	·		No residents were affected by this de practice.	ricient
		ear gloves were noted on			
	paper trash was obser	dumpsters and bits of		New Measures or Systemic Chan The Housekeeping Supervisor or de	ge
	throughout the area a	round the dumpeters		in his absence will inspect the area	signee
	and agreed the area ar	odita the dumpsters		surrounding the dumpsters to ensure	nroper
	The findings include:			disposal of all trash twice daily over t	he next
				90 days. In addition, the Administrat	or will
	Observation was made	e of the dumpster area on		do random visual checks of this area	
	4///2021 at 8:49 a.m.	accompanied by other staff		weekly over the next 60 days.	
i	were three metal dumi	e dietary manager. There psters. One for cardboard		4 Monitorina	
	and two for trash. App		İ	 Monitoring The results of the inspections surrou 	odina
		the ground around the		the dumpster area will be reported m	onthly
	dumpsters. When ask	ed which department uses		to the Administrator and the QAPI	
	the clear gloves, OSM	#7 stated that they are		Committee.	
	used throughout the fa	cility. There were bits of			
	paper trash throughou	tine area around the		5. Completion Date	
	as it had dirt and mud	did not appear to be fresh on it. When asked whose		May 18, 2021	
		ep the area clean, OSM#7			
	stated it's both the kitc	hen and housekeeping			
İ		F ···· •			

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
		495217	B. WING			C 04/08/0004	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			04/08/2021	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)				(XS) COMPLETION DATE	
F 814	staff. OSM #7 informed had a raccoon proble dumpster had metal of had plastic closing do get in the one with plate. The policy, "Houseker Policies" documented Sidewalks, Dumpster Inspect areas daily. Sinterior and exterior an occurSweep sidewal areas with a hard brist Sweep debris into trace. ASM (administrative sadministrator, and AS	ed this surveyor that they m. He stated that the one closing doors and the other ors. He stated the raccoons astic closing doors. eping Manual Standards & in part, "Entrances, and Driveway Cleaning: weep daily. Clean all rea when spills alks, dumpster and delivery the 30-inch push broom. Sh container."	F	814			
F 842 \$S=E	at 8:00 a.m. of an ematheir corporate office to dated 2/9/2021, that do 8 yard trash container. We are having raccoordiner. No further information Resident Records - Id CFR(s): 483.20(f)(5), 48483.20(f)(5) Resident (i) A facility may not represident-identifiable to resident-identifiable to resident-identifiable to resident-identifiable to resident-identifiable to	483.70(i)(1)-(5) t-identifiable information. lease information that is the public. ease information that is	F8	142			

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Event ID: OKNR11

Facility ID: VA0153

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
					С	
	495217	B. WING			04	1/08/2021
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICE	S-FAIR OAKS		1	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033		
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
except to the extent of to do so. §483.70(i) Medical reseas §483.70(i)(1) In accordance professional standard must maintain medical that are- (i) Complete; (ii) Accurately docum (iii) Readily accessible (iv) Systematically or systematically or systematically or records, except where (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, participations, as permit with 45 CFR 164.506 (iv) For public health an eglect, or domestic activities, judicial and law enforcement purpurposes, research predical examiners, for a serious threat to he by and in compliance §483.70(i)(3) The fact record information agunauthorized use.	disclose the information the facility itself is permitted ecords. rdance with accepted dis and practices, the facility all records on each resident ented; e; and ganized distinct in the resident's records, in or storage method of the interesident permitted by applicable law; eyment, or health care ted by and in compliance	F (50)		1. Corrective Action Resident #13, #74, and #38 suffered effects from this deficient practice. After learning of this incident Registe Nurse (RN) #7 and Licensed Practice Nurse (LPN) #2 were re-educated or importance of maintaining an accurat medical record. 2. Other Potential Residents All residents have the potential to be affected by this deficient practice. 3. New Measures or Systemic Chan The Director of Nursing and/or regist nurse (RN) unit managers and/or RN supervisors will re-educate all license nursing staff on the importance maintain accurate medical record. 4. Monitoring The Director of Nursing and/or regist nurse (RN) unit managers and/or RN supervisors will make random visual observations during medication administration times to ensure that th nurse administering the medication is the nurse signed into the system. The random visual observations will occur follows: three times per week for two then two times weekly for an addition weeks, followed by once weekly for a additional 60 days. The results of these rounds will be remonthly to the Administrator and the Committee. 5. Completion Date May 18, 2021	ge ered ed taining ered es in fact ese ras weeks al two in ported	

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Event ID: OKNR11

Facility ID: VA0153

If continuation sheet Page 101 of 127

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	8. WING				С
1111E 0E D		430217	D. 11110_			04/	08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033			
(X4) ID PREFIX TAG			HOULD BE		(X5) COMPLETION DATE		
F 842	(ii) Five years from the there is no requireme (iii) For a minor, 3 years legal age under State §483.70(i)(5) The me (i) Sufficient informaticii) A record of the residii) The comprehensing provided; (iv) The results of any and resident review edeterminations conductory (v) Physician's, nurse professional's progresional's rvices reports as residents as residents and accurate residents in the medicobservation, Resident maintain an accurate residents in the medicobservation, Resident was determined that in the medicobservation, Resident was determined that in the medicobservation, Resident was determined that in the medicobservation, Resident was determined that in the medicobservation, Resident was determined that in the medicobservation, Resident was determined that in the medicobservation was determ	required by State law; or e date of discharge when in State law; or ars after a resident reaches law. dical record must containt on to identify the resident; sident's assessments; we plan of care and services or preadmission screening evaluations and locted by the State; 's, and other licensed is notes; and logy and other diagnostic equired under §483.50. It is not met as evidenced one, staff interview, facility diclinical record review, it the facility staff failed to clinical record for one of six cation administration that #13; and for two other is survey sample, Residents on administration record) for different and the survey sample, Residents on administration is staff as administering sidents on 4/7/21 at 9:00	F	342			
	1. Resident #13's MA	R (medication					

	F CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		COMF	PLETED
		495217	B. WING _			1	C '08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVIC	ES-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CORE	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD E RENCED TO THE APPROPR DEFICIENCY)	BE .	(X5) COMPLETION DATE
F 842	administration recomedications was in: Resident #13 was a 7/10/19, and most rwith diagnoses included Parkinson's dis MDS (minimum datwith an ARD (asses 1/4/21, she was conformaking daily dec 15 on the BIMS (briton the BIMS) (bri	admitted to the facility on recently readmitted on 6/4/20, uding Multiple Sclerosis (1) rease (2). On the most recent a set), a quarterly assessment reference date) of ded as being cognitively intact cision, having scored 13 out of reference for mental status). I.m., during the medication revation) LPN (licensed and RN (registered nurse) #7 rading at the medication cart int #13's room. A laptopied on top of the medication on the computer keyboard for dithen walked away. RN #7 rart, checked the computer to prepare the following ministration to Resident #13: 50 mg (milligrams) tablets of mg tablet of mg tablet gram powder of mg tablet gram	F	42			

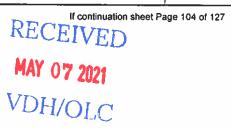
PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		OATE SURVEY OMPLETED
		495217	B. WING _			C 04/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		04/06/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	these medications to A review of Resident administration record revealed a block for above. Each block of the initials of LPN #2 On 4/7/21 at 12:30 p When asked to look the 9:00 medication electronic document computer. Across the abanner stated: "We 4/7/21 at 12:30 p.m., When asked to look the 9:00 medication a electronic document computer. Across the abanner stated: "We #7 was observed rev #13's medications admorning. When aske blocks beside the me Resident #13, RN #7 asked if LPN #2 had medications to Resid did." When asked wholocks on the MAR besident #18 p. 12 p. 12 p. 13 p. 14 p. 15 p. 1	#13's MARs (medication is) for 4/7/21 at 9:00 a.m. each medication listed ontained a check mark and .m., RN #7 was interviewed. at Resident #13's MAR from administration, she pulled the up on the medication cart etop of the computer screen, elcome [name of RN #7]." On RN #7 was interviewed. at Resident #13's MAR from administration, she pulled the up on the medication cart etop of the computer screen, elcome [name of RN #7]." RN iewing the MAR for Resident liministered at 9:00 a.m. that d whose initials were in the edications she gave to stated, "[LPN #2]'s." When administered those ent #13, RN #7 stated, "No. I lat LPN #2's initials in the eside the medications, "It looks like she gave the	F8			V(2) 19
	happened, she stated and that morning was the facility. She state she was briefly orient needed to "be on a m immediately because #7 stated she did not	d she was an agency nurse, ther very first day working in d when she arrived for work, ted, but was told that she				

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Event ID: OKNR11

Facility ID: VA0153



AND PLAN OF CORRECTION (X1)	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	MULTIPLE CONSTRUCTION UILDING			(X3) DATE SURVEY COMPLETED		
		495217	B. WING _			C 04/08/2021		
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP COO 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			TE	(X5) COMPLETION DATE	i
F 842	her credentials, and administering medic When asked if Resid accurate, RN #7 stated on 4/7/21 at 1:53 p. She stated she does any new staff, but the nurses who are new ever worked at the fathink so. She stated here. I have only wo got my license in Jur Resident #13's MAR medications on 4/7/2 initials and check ma #2 stated, "That is melectronic medical relif she administered to Resident #13, LPN #2 using my password sign on." When asked if a nurs medication administre name, she stated: "Nunderstanding that Leduring the morning mon to 4/7/21 at 4:54 p.r. administrator, and Ast these concerns. Both facility's professional #2 both verified that the seconcerns in the seconce	instructed her to start rations under her name. Ident #13's MAR was ted it was not. m., LPN #2, was interviewed. Is not have a formal role for rat she tries to help agency of When asked if RN #7 had acility, she stated she did not it: "This is my first time seeing when the four months. I just the." LPN #2 was shown it for the 9:00 a.m. 21, and was asked what the rark in each box meant. LPN my sign off for [name of the ecord software]." When asked the 9:00 a.m. medications to the 9:00 a.m. medications to the 9:00 a.m. medications to the 9:00 a.m. medications to the 9:00 a.m. medications to the 9:00 a.m. medication to the 9:00 a.m. medica	F 84	42				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		2773-023	(X3) DATE SURVEY COMPLETED				
		495217	B. WING			1	C /08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP C 12475 LEE JACKSON MEMORIAL HII FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 842	policy, "Individual Cor Responsibility" to the policy revealed, in pa credentials to anyone including employees of to access [electronic in under my credentials. The following quotation Fundamentals of Nurs 237): "The client reco- document of the client received Because team members cannot assessments or intervi- years after the fact, and documentation at the The care may have be documentation must put No further information REFERENCES (1) "Multiple sclerosis central nervous system immune system attact nerve cells. Symptomic weakness (often in the	m., ASM #1 provided a infidentiality and surveyor. A review of the rt: "Never reveal computer Never allow others, or other workforce members medical record software] " on is found in Lippincott's sing 5th edition (2007, page rd serves as a legal t's health status and care nurses and otherhealthcare of remember specific rentions involving a client occurate and complete time of care is essential. He en excellent, but the prove it." (MS) is a disease of the	F				
	vision problems, and control. People with M and have trouble think information is taken from	S also may feel depressed ing clearly." This					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		TE SURVEY MPLETED
		495217	B. WING_			C 4/08/2021
00-1000 01-1000	ROVIDER OR SUPPLIER	S-FAIR OAKS	STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033		ΡE	4/00/2021
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		(EACH CORRECTIVE ACTION	OVIDER'S PLAN OF CORRECTION H CORRECTIVE ACTION SHOULD BE REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 842	(2) "Parkinson's dise movement disorder. in the brain don't prochemical called dopa genetic, but most cas families." This inform website https://medlineplus.go (3) "Acetaminophen moderate pain from I menstrual periods, cotoothaches, backach vaccinations (shots), Acetaminophen may pain of osteoarthritis breakdown of the lini Acetaminophen is in analgesics (pain reliereducers). It works by senses pain and by coinformation is taken if https://medlineplus.go tml. (4) "Amlodipine (Noncombination with othe blood pressure in aduolder. It is also used angina (chest pain) a (narrowing of the blood to the heart). Amlodigmedications called callowers blood pressure vessels so the heart hard. It controls ches supply of blood to the taken from the websit	ase (PD) is a type of It happens when nerve cells duce enough of a brain Imine. Sometimes it is ses do not seem to run in ation is taken from the It what is used to relieve mild to neadaches, muscle aches, olds and sore throats, es, and reactions to and to reduce fever. also be used to relieve the (arthritis caused by the ng of the joints). It changing the way the body sooling the body." This from the website It who website It who website It was and children 6 years and to treat certain types of and coronary artery disease and vessels that supply blood bine is in a class of alcium channel blockers. It the by relaxing the blood does not have to pump as to pain by increasing the the heart." This information is	F8	42		

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495217	B. WING		C 04/08/2021			
	ROVIDER OR SUPPLIER ARE HEALTH SERVICI	ES-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLÉTION			
F 842	types of spasticity (relightness) from multinjuries, or other spirin a class of medical relaxants. Baclofen and decreases their muscle spasms causpinal cord condition improves muscle mediaken from the websity://medlineplus.grtml. (6) "Docusate sodium Stool softeners are relieve constipation straining during bow heart conditions, helproblems. They work them easier to pass from the website https://medlineplus.grml. (7) "Escitalopram is adults and children a age or older. Escital generalized anxiety worry and tension the for 6 months or long in a class of antidepiserotonin reuptake in increasing the amousubstance in the bra	d to treat pain and certain muscle stiffness and iple sclerosis, spinal cord nal cord diseases. Baclofen is tions called skeletal muscle acts on the spinal cordnerves number and severity of sed by multiple sclerosis or ins. It also relieves pain and overment." This information is	F 842					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		TE SURVEY
			A. SOILL	A. BUILDING			_
		495217	B. WING				C 4/08/2021
	ROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		1	TREET ADDRESS, CITY, STATE, ZIP CODE 2475 LEE JACKSON MEMORIAL HIGHWAY AIRFAX, VA 22033		100/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	ix	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	 E NTE	(X5) COMPLETION DATE
	tml. (8) "Polyethylene glycoccasional constipation is in a class of medical laxatives. It works by the with the stool. This into bowel movements and easier to pass." This into website https://medlineplus.gov.tml. (9) "Senna is used on constipation. It also is before surgery and ce Senna is in a class of stimulant laxatives. It is of the intestines to cau. This information is tak https://medlineplus.gov.ml. (10) "Iron (ferrous fum ferrous sulfate) is used (a lower than normal in when the amount of iron tenough. Iron is a midietary supplement. It to produce red blood cotaken from the website https://medlineplus.gov/tml#:~:text=Iron%20(fer Oferrous%20gluconate, addietary%20supplement.	ashort-term basis to treat used to empty the bowels ration medical procedures. medications called works by increasing activity use a bowel movement." en from the website artate, ferrous gluconate, it to treat or prevent anemia umber of red blood cells) on taken in from the diet is sineral that is available as a works by helping the body ells." This information is druginfo/meds/a682778.h rous%20fumarate%2C%2 available%20as%20a%20 it.	F	842			
	(11) "Nonprescription fl (FlonaseAllergy) is use	uticasone nasal spray					

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495217	B. WING	B. WING		С	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	<u> </u>	4/08/2021	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRE- (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 842	rhinitis such as sneed itchy nose and itchy, fever or other allergic pollen, mold, dust, or fluticasone is also us nonallergic rhinitis sustuffy nose which are Prescription fluticason used to treat nasal pothe nose). Fluticason used to treat symptom runny, itchy nose) ca Fluticasone is in a classor corticosteroids. It work certain natural substate symptoms." This inforwebsite	zing and a runny, stuffy, or watery eyes caused by hay es (caused by an allergy to	F 8	42			
	2. Resident #74's MAR (medication administration record) for 4/7/21 for 9:00 a.m. medications was inaccurate. Resident #74 was admitted to the facility on 12/1/17, and most recently readmitted on 2/5/19, with diagnoses including heart failure and history of a stroke. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/27/21, Resident #74 was coded as having no cognitive impairment for making daily decisions. A review of Resident #74's MARs (medication administration records) for 4/7/21 at 9:00 a.m. revealed that she received the following medications: - Aspirin 81 mg (milligram) tablet						

PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A, BUILDING			(X3) DATE SURVEY COMPLETED			
			1 6				C	
		495217	B. WING					
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		-1/00/2021	-
MANORC	ARE HEALTH SERVICES	S-FAIR OAKS		1:	2475 LEE JACKSON MEMORIAL HIGHWAY			1
				F.	AIRFAX, VA 22033			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	7
PREFIX TAG			PREFI. TAG	- 1	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	COMPLETION DATE	
F 842	Continued From page	110	F	842				
İ	- Vitamin B comp	lex tablet						ı
		ion 200 units (1) nose spray						
į	 Calcium Citrate 	950 mg tablet						ı
	- Folic Acid (2) 1			- 1				١
	 Multivitamin tab 							ı
	- Norvasc (3) 10 i	ng tablet						ı
	- Fish oil tablet							l
İ	- Senna (4) 8.6 m							l
	- Torsemide (5) 40							l
İ	- Vitamin D3 20 m	ncg (microgram) tablet						ĺ
İ	On 4/7/21 at 12:30 p.m., RN #7 was interviewed.							l
ĺ	When asked to look at	Resident #74's MAR from	-					ľ
	the 9:00 medication ad	lministration, she pulled the		- 1			· i	l
	electronic document u	p on the medication cart						ĺ
	computer. Across the	top of the computer screen,					1	l
	a banner stated: "Weld	come [name of RN #7]," RN						l
	#7 was observed revie	wing the MAR for Resident						l
	#74's medications adn	ninistered at 9:00 a.m. that						ı
İ	morning. When asked	whose initials were in the						l
	blocks beside the med	ications she gave to						ı
-	Resident #/4, RN #/ s	stated, "[LPN #2]'s." When	1	ľ				ı
	asked if LPN #2 had a							ĺ
1	did " When asked who	nt #74, RN #7 stated, "No. I t it LPN #2's initials in the						
ĺ	blocks on the MAR be:	t it LF14 #2 S initialS in the	-					ĺ
	meant RN #7 stated "	'It looks like she gave the						
İ	medications. But I did.	" When asked what						ļ
	happened, she stated	she was an agency nurse,					i I	
	and that morning was h	ner very first day working in					1	
	the facility. She stated	when she arrived for work.						
1	she was briefly oriented	d, but was told that she					<u> </u>	
į,	needed to "be on a me	d (medication) cart						
] i	immediately because ":	state is in the building," RN						
;	#7 stated she did not h	ave a computer username						
	or password of her own	i, so LPN #2 signed in with						
	her credentials, and ins	structed her to start						
1:	administering medication	ons under her name.						
	When asked if Residen	it #74's MAR was						

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

Event (D: OKNR11

Facility ID: VA0153

If continuation sheet Page 111 of 127



STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B WING	B. WING			С	
NAME OF D	ROVIDER OR SUPPLIER	450217	D. WING			04/	/08/2021	
	ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY 12475 LEE JACKSON N FAIRFAX, VA 22033				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
	accurate, she stated On 4/7/21 at 1:53 p.r She stated she does any new staff, but the nurses who are new, ever worked at the fathink so. LPN #2 states seeing her. I have on I just got my license is Resident #74's MAR medications administ 4/7/21, and was aske mark in each box memy sign off for [name software]." When ask 9:00 a.m. medication stated, "No. [RN #7] to because she does not asked if Resident #74 #2 stated it was not. On 4/7/21 at 4:03 p.m. When asked if a nurs medication administration administration administration administration and the morning medication that LF during the morning medicality's professional	it was not. m., LPN #2, was interviewed. not have a formal role for at she tries to help agency When asked if RN #7 had acility, she stated she did not ted, "This is my first time ally worked here four months. in June." LPN #2 was shown for the 9:00 a.m. tered to the resident on ad what the initials and check ant. LPN #2 stated, "That is a of electronic medical record ted if she administered the s to Resident #74, LPN #2 was using my password but have a sign on." When It's MAR was accurate, LPN m., ASM #2 was interviewed. e should ever chart ation under another nurse's d, "No. It is a violation. It is the stated it was her PN #2 logged in for RN #7 redication observation. m., ASM #1, the tim #2 were informed of the were asked to clarify the standard. ASM #1 and ASM	F	342				
	its standard for practic accurate computer log	ne facility uses its policies as ce. A policy regarding staff gins was requested. m., ASM #1 provided a				į		

NAME OF PROVIDER OR SUPPLIER A95217 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE		
04/08/		
1 STREET ADDRESS THE VIDEOUS	OVIDER OR SUPP	
MANORCARE HEALTH SERVICES-FAIR OAKS 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	RE HEALTH SI	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CORRE	(EACH DE	
F 842 Continued From page 112 policy, "Individual Confidentiality and Responsibility" to the surveyor. A review of the policy revealed, in part. "Never reveal computer credentials to anyone Never allow others, including employees or other workforce members to access [electronic medical record software] under my credentials." No further information was provided prior to exit. REFERENCES (1) "Nasal calcitorin is a newly approved treatment for established osteoporosis. Nasal calcitonin is safe, preventative, and may increase bone mass in the lumbar spine." This information is taken from https://pubmed.ncbi.nlm.nih.gov/9001161/. (2) "Folic acid is used to treat or prevent folic acid deficiency. It is a B-complex vitamin needed by the body to manufacture red blod cells. A deficiency of this vitamin causes certain types of anemia (low red blod cell count)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682591.h tml. (3) "Amlodipine (Norvasc) is used alone or in combination with other medications to treat high blood pressure in adults and children 6 years and older. It is also used to treat certain types of angina (chest pain) and coronary artery disease (narrowing of the blood vessels that supply blood to the heart). "Minodipine is in a class of medications called calcium channel blockers. It lowers blood pressure by relaxing the blood vessels so the heart does not have to pump as hard. It controls chest pain by increasing the supply of blood to the heart." This information is	colicy, "Individed Responsibility colicy reveale credentials to including employ access [elevander my credentials to further information in the companies of the heart). Amilodipination without the companies of the heart. Amilodipination with the heart of the heart. Amilodipination with the heart.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		ATE SURVEY	
		495217	B. WING			С	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWA FAIRFAX, VA 22033		04/08/2021	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD B. REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE CROSS-REFER		OULD BE	(X5) COMPLETION DATE	
F 842	taken from the webs https://medlineplus.gtml. (4) "Senna is used of constipation. It also is before surgery and of Senna is in a class of stimulant laxatives. If of the intestines to constitute the intestines to constipation is the intestines to constitute the intestines the in	ite gov/druginfo/meds/a692044.h In a short-term basis to treat s used to empty the bowels tertain medical procedures. If medications called t works by increasing activity ause a bowel movement." Isken from the website ov/druginfo/meds/a601112.ht	F	342			
	Resident #38 was ad 6/3/11 with diagnose epilepsy (2). On the r data set), a quarterly (assessment reference #38 was coded as be) for 4/7/21 for 9:00 a.m.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	B WING	B. WING			С		
NAME OF P	ROVIDER OR SUPPLIER	430211	D. WING			04	1/08/2021		
, , , , , , , , , , , , , , , , , , ,	NOVIDER OR SUFFEIER				STREET ADDRESS, CITY, STATE, ZIP CODE				
MANORC	ARE HEALTH SERVICE	S-FAIR OAKS		'	12475 LEE JACKSON MEMORIAL HIGHWAY				
	····			1	FAIRFAX, VA 22033				
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX TAG	REGULATORY OR	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI. TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE		
F 842	- Commod From page 114		F	842					
	scored three out of 1	5 on the BIMS (brief							
	interview for mental s								
		·					1		
	A review of Resident	#38's MARs (medication							
	administration record	ls) for 4/7/21 at 9:00 a.m.							
	revealed that she red	eived the following							
	medications:	-							
	- Lasix (3) 20 mg	g (milligrams) tablet]		
	 Multivitamin tal 								
		nEq (milliequivalent) tablet							
	- Vitamin B12 tal						1		
	- Vitamin D3 tabl								
	- Metoprolol (4) 5								
	- Tramadol (5) 2	5 mg tablet				i			
	On 4/7/21 at 12:30 p.	m., RN #7 was interviewed.					i i		
	When asked to look a	at Resident #38's MAR from					 		
-		dministration, she pulled the				1			
	electronic document	up on the medication cart							
	computer. Across the	top of the computer screen,					ĺ		
	a banner stated: "We	come [name of RN #7]." RN							
	#7 was observed revi	ewing the MAR for Resident							
	#38's medications ad	ministered at 9:00 a.m. that							
	morning. When asked	whose initials were in the							
	blocks beside the me	dications she gave to							
		stated, "[LPN #2]'s." When	-						
	asked if LPN #2 had a	administered those							
	medications to Reside	ent #38, RN #7 stated, "No. I							
	did." When asked wha	at it LPN #2's initials in the		ļ					
	blocks on the MAR be	eside the medications							
	meant, RN #7 stated,	"It looks like she gave the							
	medications. But I did	." When asked what					1		
	happened, she stated	she was an agency nurse,					ŀ		
-	and that morning was	her very first day working in							
	the facility. She stated	when she arrived for work,				!			
	she was briefly oriente	ed, but was told that she					1		
1	needed to "be on a me	ed (medication) cart		J			ŀ		
İ	immediately because	"state is in the building." RN		- 1					
	#7 stated she did not I	nave a computer username							

PRINTED: 04/19/2021 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X	3) DATE SURVEY	
- In		- IDENTIFICATION NOMBERS	A. BUILD	A. BUILDING		COMPLETED	
		495217	B. WING			С	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E ZIR CODE	04/08/2021	
				12475 LEE JACKSON MEMOR	•		
MANORC	MANORCARE HEALTH SERVICES-FAIR OAKS			FAIRFAX, VA 22033	CIAL HIGHWAT		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES							
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	(X5) COMPLETION DATE	
F 842	Continued From page	115	F	342			
	her credentials, and in	tions under her name. ent #38's MAR was					
	She stated she does any new staff, but that nurses who are new." ever worked at the fact think so. LPN #2 state seeing her. I have on! I just got my license in Resident #38's MAR to medications administed 4/7/21, and was asked mark in each box meany sign off for [name software]." When asked 9:00 a.m. medications stated, "No. [RN #7] we because she does not ever who are software she does not be supported by the stated of the stated o	a., LPN #2, was interviewed. The that have a formal role for the tries to help agency when asked if RN #7 had boility, she stated she did not ed, "This is my first time by worked here four months. In June." LPN #2 was shown for the 9:00 a.m. ared to the resident on the what the initials and check each. LPN #2 stated, "That is not electronic medical recorded if she administered the sto Resident #38, LPN #2 was using my password to thave a sign on." When the state of the					
	When asked if a nurse medication administration name, ASM #2 stated false information." She understanding that LP during the morning medical three concerns. Both facility's professional states.	tion under another nurse's , "No. It is a violation. It is e stated it was her N #2 logged in for RN #7 edication observation.					

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

Event ID: OKNR11

Facility ID: VA0153

If continuation sheet Page 116 of 127



AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495217	8. WING			C 04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHW FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENT	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)				(X5) COMPLETION DATE	
F 842	its standard for prace accurate computer in accurate computer in the policy, "Individual Composition," Individual Composition, "Individual Composition, "Individual Composition, access [electronic under my credentials to anyon including employees to access [electronic under my credentials." No further information in the composition of the properties of	tice. A policy regarding staff ogins was requested. I.m., ASM #1 provided a policy and a surveyor. A review of the part: "Never reveal computer eNever allow others, or other workforce members a medical record software] s." In was provided prior to exit. In was provided prior to	F	842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495217	B. WING _		C 04/08/2021
	PROVIDER OR SUPPLIER ARE HEALTH SERVICES	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033	04/06/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DÉFICIENCIES / MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 842	including heart, kidne Furosemide is in a cla diuretics ('water pills') kidneys to get rid of u from the body into the taken from the websit https://medlineplus.go tml. (4) "Metoprolol is used with other medications pressure. It also is use pain) and to improve s Metoprolol also is use medications to treat he a class of medications works by relaxing bloch heart rate to improve to blood pressure." This the website	y, and liver disease. ass of medications called . It works by causing the nneeded water and salt aurine." This information is e v/druginfo/meds/a682858.h	F 8	42	
F 880 SS=E	ml. Infection Prevention & CFR(s): 483.80(a)(1)(2) §483.80 Infection Con The facility must establinfection prevention ar designed to provide a comfortable environment.	in." This information is e e e e e e e e e e e e e e e e e e e	F 88	1. Corrective Action Resident #336 and #38 suffered no ill effects related to this deficient practic The physical therapist (PT) and Regis Nurse (RN) who failed to follow facility infection control standards were re- educated.	e. stered

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495217	B. WING_		С	
NAME OF D	ROVIDER OR SUPPLIER	430217	3. WING		04/08/2021	
NAME OF F	KOVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MANORC	ARE HEALTH SERVICES	-FAIR OAKS		12475 LEE JACKSON MEMORIAL HIGHWAY		
			i	FAIRFAX, VA 22033		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE					
F 880	F 880 Continued From page 118 F 880 Continued			Continued From page 118		
	program. The facility must estal and control program (a minimum, the follow §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visitor providing services und arrangement based up conducted according to accepted national start §483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveill possible communicable infections before they persons in the facility; (ii) When and to whom communicable disease reported; (iii) Standard and transto be followed to preve (iv) When and how isol resident; including but (A) The type and durat depending upon the in involved, and (B) A requirement that	m 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 indards; standards, policies, and ogram, which must include, ance designed to identify le diseases or can spread to other in possible incidents of e or infections should be smission-based precautions ent spread of infections; ation should be used for a not limited to:		2. Other Potential Residents All residents have the potential to be affected by this deficient practice. 3. New Measures or Systemic Chan The Infection Preventionist, Director Nursing and/or registered nurse (RN managers/supervisors will re-educate healthcare professionals regarding transmission – based precautions, to include which personal protective equipment (PPE) is required and the cleaning of reusable equipment. 4. Monitoring The Infection Preventionist, Director Nursing and/or RN unit managers an RN Supervisors will make focused in control rounds daily for one week. Following this week, the focused infecontrol rounds will be completed two weekly for another week then one time weekly for an additional week. Follow this three-week increase in focused infection control rounding, the rounds continue monthly for another two monthese results of these focused infection rounds will be reported monthed the Administrator and the QAPI Communication.	of) unit e all proper of d/or fection times ne wing s will nths. ion	
		under which the facility es with a communicable				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495217	B. WING _	8. WING		C 04/08/2021	
	ROVIDER OR SUPPLIER ARE HEALTH SERVICE	S-FAIR OAKS		STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SH			CROSS-REFERENCED TO THE APPR	ULD BE	(X5) COMPLETION DATE	
F 880	contact with resident contact will transmit to (vi)The hand hygiene by staff involved in di §483.80(a)(4) A syste identified under the facorrective actions take §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual remains a facility will condulted and update the This REQUIREMENT by: Based on observation document review, and was determined that follow infection controcurrent residents in the (Residents #336 and failed to wear an isola #336's room when he the resident. The resifor droplet and airborn the facility staff failed pressure cuff before updated to the facility staff failed pressure cuff before updat	kin lesions from direct s or their food, ifdirect he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the en by the facility. the, store, process, and to prevent the spread of view. act an annual review of its ir program, as necessary. is not met as evidenced an, staff interview, facility d clinical record review, it the facility staff failed to old practices for two of 33	F 84	80			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		IDENTIFICATION NUMBER:		LE CONSTRUCTION	1' '	(X3) DATE SURVEY COMPLETED C	
		495217	B. WING			04/08/2021	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 880	for an MDS (minimum on the admission in 3/30/21, Resident #being, "alert and oritime]." On 4/06/21 at 1:56 observed sitting in a the outside of his diresident as on airboubserved. OSM (otliang physical therapist, of floor in front of the repeatedly touched shoulders. Observed clothing was in dire and the floor, multiple wearing a mask, far However, he was in A review of Resider revealed the following 3/30/21: "Airborne for COVID-19 (3) P A review of Resider and infection control or observation. On 4/7/21 at 2:32 printerviewed. When equipment he wore 4/6/21, OSM #1 sta When asked if he was time."	um data set) to be completed. ursing assessment dated 336 was documented as iented X 3 [person, place, and p.m., Resident #336 was a wheelchair in his room. On bor, signs designating the borne and droplet isolation were her staff member) #11, a was observed kneeling on the seated resident. OSM #11 the resident's legs, arms and ation revealed OSM #11's ct contact with Resident #336, ble times. OSM #11 was ce shield, and gloves. ot wearing an isolation gown. at #336's clinical record and physician's order, dated by information related to disolation for COVID-19 a.m., OSM #11 was asked what isolation in Resident #336's room on ated, "Gloves and my masks." avore an isolation gown, he	F 88				
	interviewed. When equipment he wore 4/6/21, OSM #1 sta When asked if he w stated he did not. Hositive for COVID-precautions because	asked what isolation in Resident #336's room on ted, "Gloves and my masks."					

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						С	
		495217	B. WING_			04/08/2021	
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP COD 12475 LEE JACKSON MEMORIAL HIGH FAIRFAX, VA 22033	E		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		BY FULL PREFIX (FACH CORRECTIVE ACTION SHOULD		SHOULD BE	(X5) COMPLETION DATE	
F 880	hospital most of the tithe facility. He stated gown is optional for nobservation. OSM #1 the gown is required stated, "It may be that On 4/7/21 at 2:38 p.m nurse) #5 was intervisional for residents w COVID-19, LPN #5 si masks, and face shie required because residents worn by staff caring for observation for COVII "Airborne and droplet providing direct care if wear a gown, face material with the direct interviewed. When as equipment should be	and only part time at at the hospital, the isolation esidents on COVID-19 1 stated he is not sure that at the facility. OSM #11 t it is just suggested." 1., LPN (licensed practical ewed. When asked what hould be worn by staff tho are on observation for sated, "Gowns, gloves, Ids." She stated these are dents may have COVID-19. 1., LPN #4 was interviewed. Ilation equipment should be or residents who are on D-19, LPN #4 stated, "She stated the staff for these residents should isk, face shield, and gloves. 1., ASM (administrative staff ctor of nursing, was ked what isolation worn by staff caring for	F8				
	ASM #2 stated staff's mask and face shield. A review of the facility Protective Equipment part: "Personal Protective GownWhen to Use: services within 6 (six) suspected or confirme	document, "Personal Usage Guide," revealed, in tive Equipment Type: When providing care or feet of patients with d COVID-19 in recautions including new					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	(X3) DATE SURVEY COMPLETED		
		IDENTIFICATION NUMBER:	A. BUILD	A. BUILDING			
					С		
495217		8. WING	8. WING		04/08/2021		
NAME OF PROVIDER OR SUPPLIER			-		STREET ADDRESS, CITY, STATE, ZIP CODE		
MANOPCADE HEALTH SERVICES TAIR CAVE				١.	12475 LEE JACKSON MEMORIAL HIGHWAY		
MANORCARE HEALTH SERVICES-FAIR OAKS				ı	FAIRFAX, VA 22033		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID		PROVIDER'S PLAN OF CORRECTION		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREF	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
F 880	Continued From page 122		F	880			
	On 4/7/21 at 4:54 p.m	n ASM #1. the					
		M #2 were informed of					
	these concerns.						
	No further information	was provided prior to exit.					
	REFERENCES						
	(1) "Droplet Precautio						
	spread of pathogens t	hat are passed through					ł !
	respiratory secretions	and do not survive for long					
	in transit. These dropl						
6	particles that cannot travel through the air very						l i
	far. They are transmitt						
i	sneezing, and talking.						
1	from the website https://www.cdc.gov/ir						
	E102-508.pdf.			*:		[
	(2) "Airborne precaution						
	prevention of infection	s and the use of available					
	interventions in health	care facilities to prevent the					
	transmission of airborr	ne particles. The airborne					
	particles may remain le	ocalized to the room or		,			
i	move depending on the	e airflow. In some cases					
	where there is inadequalithorne particle may	remain in the hospital room					
	and he inhaled by a ne	ewly admitted patient. The					
	control and prevention	of airborne transmission of					
	infections are not simp	le. It requires the control of				į	
	airflow with the use of						
	ventilator systems, the	practice of antiseptic					
	techniques, wearing pe	ersonalized protection					.0
	equipment (PPE), and	performing basic infection					
		ike hand washing. This					1
	activity reviews the tec	hniques for minimizing the					
	spread of airborne dise	eases and the role of the					
	interprofessional team	in maximizing airborne				1	
	precautions to minimiz	e the spread ofdisease."				ŀ	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495217	B. WING				
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS			STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			04/08/2021	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 880	F 880 Continued From page 123		F8	80			
	https://www.ncbi.nlm. #:~:text=Airborne%20	taken from the website nih.gov/books/NBK531468/ Oprecautions%20necessitate on,move%20depending%20o				SV SV	
	found in many differe including camels, cat of coronavirus identification outbreak of respirator detected in Wuhan, CSARSCoV-2. (Forme 2019-nCoV.) The discSARS-CoV-2 has been information was obtain	en named COVID-19." This ined from the website: .gov/health/in-the-news-coro					
	-	led to sanitize an unclean efore using it on Resident					
	6/3/11 with diagnoses epilepsy (2). On the r data set), a quarterly (assessment reference #38 was coded as be	•					
	was observed enterin resident's room. She blood pressure cuff. S	was holding a portable					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		495217	B. WING _			C 04/08/2021
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP CO 12475 LEE JACKSON MEMORIAL HIG FAIRFAX, VA 22033		
(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 ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	sanitized her hands vigel. She rolled the cail #38's room. She pick cuff and entered Resisted then used the blood president #38's blood Resident #38's room, cuff on top of the mediate her hands with alcohologophic for the hands with alcohologop	with alcohol-based sanitizing into the door of Resident and up the blood pressure dent #38's room. RN #7 pressure cuff to take pressure. She exited placed the blood pressure dication cart, and sanitized obl-based sanitizing gel. In RN #7 was interviewed. In the company of th	F 84	80		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING			COMPLETED		
		495217 B.		B. WING			C	
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 04	/08/2021	
MANORO	ARE UEALTH CERVIO	TO FAID OAKO			2475 LEE JACKSON MEMORIAL HIGHWAY			
MANURU	ARE HEALTH SERVIC	S-FAIR OAKS			AIRFAX, VA 22033			
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		I	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF CORRECTIVE ACTION SHOULD DEFICIENCY)			(X5) COMPLETION DATE	
F 880	Continued From page 125		F	880				
	member) #2, the dirinterviewed. She sta should be cleaned we residents. ASM #2 so necessary to kill bac contamination. On 4/7/21 at 4:54 p. administrator, and A these concerns. A review of the facility Disinfecting Product "Micro-Kill Bleach Greusable non-dedication of the state of the st	eteria and avoid cross						
	REFERENCES (1) "Dementia is a gradient function. This of affects memory, the and behavior." This website https://medlineplus.g. (2) "The epilepsies a disorders ranging from and disabling, to one benign. In epilepsy, the state of the state	radual and permanent loss of occurs with certain diseases. inking, language, judgment, information is taken from the gov/ency/article/000746.htm. are a spectrum of brain om severe, life-threatening as that are much more the normal pattern of						
	neuronal activity bed strange sensations, sometimes convulsion	comes disturbed, causing emotions, and behavior or ons, muscle spasms, and se." This information is taken						

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		495217 B. WING			C 04/08/2021		
NAME OF PROVIDER OR SUPPLIER MANORCARE HEALTH SERVICES-FAIR OAKS				STREET ADDRESS, CITY, STATE, ZIP CODE 12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 880	Continued From page 126 https://www.ninds.nih.gov/Disorders/All-Disorders /Epilepsy-Information-Page.		F 84	80			

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