STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/06/2021 through 04/08/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid survey was conducted 04/06/2021 through 04/08/2021. One complaint (VA00050781- unsubstantiated with no deficiencies), was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The Life Safety Code survey/report will follow. The census in this 145 bed facility was 130 at the time of survey. The survey sample consisted of 33 current resident record reviews and three closed records.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550	1. Corrective Action Certified Nursing Assistant #3 was re-educated on resident rights with an emphasis on assisting with meals in a dignified manner. Resident #101 suffered no ill effects from this deficient practice. 2. Other Potential Residents All residents have the potential to be affected by this deficient practice.	

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

Kathleen Robinson — LNHA — 5/4/2021

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

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that facility staff failed to serve lunch in a manner to promote resident dignity for one of 33 current residents in the survey sample, Resident # 101. CNA (certified nursing assistant) # 3 was observed standing next to Resident 101's bed, while feeding Resident # 101 their lunch meal. The findings include:	F 550	Continued From page 1 3. New Measures or Systemic Change The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will re-educate the Certified Nursing Assistant's on resident rights with an emphasis on assisting with meals in a dignified manner. 4. Monitoring The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will make rounds during meal time times to ensure resident's requiring assistance with meals are fed in a dignified manner. These rounds will be completed and documented as done daily for one week then three times weekly for an additional week, followed by two times weekly for an additional week, followed by one time per week for an additional two months. These results of these rounds will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021 RECEIVED MAY 07 2021 VDH/OLC	

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F 550	Continued From page 2 Resident # 101 was admitted to the facility with diagnoses that included but were not limited to: dementia [1], and malnutrition. Resident # 101's most recent MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 03/11/2020, coded Resident # 101 as unable to complete the BIMS [brief interview for mental status]. The "Staff Assessment for Mental Status" coded Resident # 101 as being moderately impaired for making daily decisions. Resident # 101 was coded as requiring extensive assistance of one staff member for eating. On 04/06/2021 at 2:32 p.m., an observation was conducted of CNA [certified nursing assistant] # 3 assisting Resident # 101 with their lunch. After CNA # 3 raised Resident # 101's bed and positioned the resident to an upright position, CNA # 3 opened containers and uncovered the food on Resident # 101's lunch try. CNA # 3 then stood next to the resident's bed and fed Resident # 101. On 04/07/2021 at 2:20 p.m., an interview was conducted with CNA # 3. When asked if they recalled feeding resident # 101, CNA #3 stated yes. When asked about their position while feeding Resident # 101, CNA # 3 stated, "I was standing." When asked if was dignified to feed someone while standing, CNA #3 stated no. When asked to describe the correct position when feeding a resident, CNA # 3 stated, "Sitting." On 04/06/2021 at approximately 11:30 a.m., the entrance conference for the survey was conducted with ASM [administrative staff	F 550		

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F 550	Continued From page 3 member] # 1, administrator and ASM # 2, the director of nursing. When asked what standards of practice the nursing staff follow ASM # 1 and ASM # 2 stated that they follow the facility's policies and procedures. The facility's policy "Meal Service" documented in part, "7. If patient requires assistance with eating, do not serve the tray until able to stay and provide assistance. Perform hygiene prior to assisting with eating. Sit next to the patient while assisting them to eat, rather than standing over them." On 04/07/2021 at approximately 4:55 p.m., ASM # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: [1] A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.	F 550		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview and clinical record review, it was	F 558	1. Corrective Action Resident #44 and # 49 suffered ill no effects from this deficient practice. 2. Other Potential Residents All residents have the potential to be affected by this deficient practice.	

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F 558	Continued From page 4 determined that the facility staff failed to provide accommodations of resident needs for two of 33 current residents in the survey sample, Residents # 44 and # 49. The facility staff failed to ensure the call bells [a device with a button that can be pushed to alert staff when assistance is needed] for Resident #44 and Resident #49's were maintained within reach for use. The findings include: 1. Resident # 44 was admitted to the facility with diagnoses that included but were not limited to: arthritis and dementia [1]. Resident # 44's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 02/04/2021, coded Resident # 44 as scoring a 9 [nine] on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 - being moderately impaired of cognition for making daily decisions. Resident # 44 was coded as requiring extensive assistance of one staff member for activities of daily living. Section G0400 "Functional Limitation in Range of Motion" coded Resident # 44 as "No impairment" of their upper extremities [shoulder, elbow, wrist, and hand] and "Impairment on both sides" of their lower extremities [hip, knee ankle, foot]. On 04/07/21 at 8:24 a.m., an observation of Resident # 44 revealed the resident lying in bed and the call bell on the floor to the right of Resident # 44. At this time an interview was conducted with Resident #44. When asked about the location of and their ability to use call bell, Resident # 44 stated that they can use it if they can reach it. On 4/7/21, at 8:26 a.m., observation revealed that	F 558	Continued From page 4 3. New Measures or Systemic Change The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will re-educate staff on the importance of ensuring the call bell is maintained within the reach of each resident. 4. Monitoring The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will make rounds on all three shifts to ensure the call bell is maintained within the reach of each resident. These rounds will be completed for each shift, documented and will occur as follows: daily for one week then three times weekly for an additional week, followed by two times weekly for an additional week, followed by one time per week for an additional two months. These results of these rounds will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

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F 558	Continued From page 5 CNA [certified nursing assistant] # 6 entered Resident # 44's room to provide a blanket to Resident # 44. Further observation at 8:27 a.m., revealed the blanket covering Resident # 44 and the call bell on the floor to the right of Resident # 44. On 04/07/21 at 9:20 a.m., and 10:50 a.m., observations of Resident # 44 revealed the resident lying in bed and the call bell on the floor to the right of Resident # 44. The comprehensive care plan for Resident # 44 dated 12/06/2020 documented in part, "Focus: At risk for falls due to unsteady gait and confusion. Date Initiated: 12/06/2020." Under "Interventions" it documented in part, "Reinforce need to call for assistance. Date Initiated: 12/06/2020." On 04/07/21 at 1:03 p.m., an interview was conducted with LPN [licensed practical nurse] # 2, regarding the positioning of call bells for residents. LPN # 2 stated, "The call bell is to be within reach at all times." 04/07/21 at 1:13 p.m., an interview was conducted with CNA [certified nursing assistant) # 6, regarding the positioning of call bells for residents. CNA # 6 stated, "So they can reach it." When asked how often the position of a call bell is checked, CNA # 6 stated, "You check it every time you go in [the resident's room]." When informed of the observation documented above on 04/07/21, at 8:26 a.m., CNA # 6 stated that they remembered getting Resident # 44 a blanket. When asked if they had checked the position of Resident # 44's call bell, CNA # 6 stated, "I didn't check for the call bell."	F 558		

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F 558	Continued From page 6	F 558		

On 04/06/2021 at approximately 11:30 a.m., the entrance conference for the survey was conducted with ASM [administrative staff member] # 1, administrator and ASM # 2, the director of nursing. When asked what standards of practice the nursing staff follow ASM # 1 and ASM # 2 stated that they follow the facility's policies and procedures.

The facility's policy "Call Light" documented in part, "6. Always position call light conveniently for use and within reach. A clip may be used to secure the light."

On 04/07/2021 at approximately 4:55 p.m., ASM # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings.

No further information was provided prior to exit.

References:
[1] A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.
2. The facility staff failed to maintain Resident #49's call bell within the residents reach for use. Observations revealed Resident #49 in bed and the call bell draped over the residents nightstand out of the residents reach for use.

Resident #49 was admitted to the facility on 2/10/2021 with diagnoses that included but were not limited to: cellulitis (inflammation of tissue especially that below the skin, characterized by redness, pain and swelling) (1) of both lower extremities, sarcopenia (age related muscle loss), and GERD (gastroesophageal reflux disease -

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F 558	Continued From page 7	F 558		

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) (3).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/16/2021, coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating the resident is cognitively intact to make daily decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating. Resident #49 was coded as having difficulty in his range of motion in both of his lower extremities.

Observation was made of Resident #49 in bed on 4/6/2021 at 12:49 p.m. The resident's call bell was observed draped over the bedside table, out of Resident #49's reach.

On 4/6/21 at 2:28 p.m., a second observation was made of Resident #49's call bell. The resident's call bell was observed draped over the nightstand out of the residents reach. An interview was conducted with Resident #49 at this time. When asked about the location of his call bell, Resident #49 stated, "It's probably on the floor as it's there sometimes." When asked how he would ask for help, Resident #49 stated, "He'd call out."

The comprehensive care plan dated 2/10/2021, documented in part, "Focus: At risk for falls due to unsteady gait and history of falls." The "Interventions" documented, "Reinforce need to call for assistance."

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F 558	Continued From page 8 An interview was conducted with CNA (certified nursing assistant) #2, on 4/7/2021 at 11:09 a.m., regarding positioning of resident call bells. CNA #2 stated it should be within the resident's reach. CNA #2 was asked if a call bell draped over a resident's night stand, would be within reach for a resident in bed that requires staff assistance getting in and out of the bed. CNA #2 stated, that no, it would not be in reach. On 4/7/2021, at 11:12 a.m., an interview was conducted with LPN (licensed practical nurse) #1, regarding positioning of resident call bells. LPN #1 stated it should be within the resident's reach. LPN #1 was asked if a call bell draped over a resident's night stand, would be within reach for a resident in bed that requires staff assistance getting in and out of the bed. LPN #1 stated, "No, it would not." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of this concern on 4/7/2021 at 4:54 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 111. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/natural/873.html. (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and	F 558		

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F 558	Continued From page 9 Chapman, page 243.	F 558		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to	F 656	1. Corrective Action A care plan has been developed and implemented for transmission based precautions for resident #336. A care plan has been developed and implemented for oxygen administration for resident #128. Resident #44 was given an incentive spirometer and a care plan has been developed and implemented for continuous positive airway pressure (C-PAP) and the incentive spirometer. 2. Other Potential Residents All residents have the potential to be affected by this deficient practice. 3. New Measures or Systemic Change The Director of Nursing, RN unit managers and/or RN supervisors will audit 100% of the care plans for residents with orders for transmission based precautions, supplemental oxygen use and continuous airway pressure to ensure all are care planned. The Director of Nursing, RN unit managers and/or RN supervisors will re-educate staff on transmission based precautions, supplemental oxygen use and continuous airway pressure. The need for a fully developed and implemented care plan will be included in this education.	

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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 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 # 44's use of the physician ordered C-PAP [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 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 observed sitting in a wheelchair in his room. On	F 656	Continued From page 10 4. Monitoring Three times weekly over the next 90 days the Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will report the findings of their visual checks that transmission based precautions, supplemental oxygen use and continuous airway pressure has been added to the care plans for all residents with orders. The compliance of these visual observations will be reported to the Administrator and to the QAPI Committee. 5. Completion Date May 18, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 656	Continued From page 11	F 656		

the outside of his door, signs designating the resident as on airborne and droplet isolation were observed. OSM (other staff member) #11, a physical therapist, was observed kneeling on the floor in front of the seated resident. OSM #11 was observed repeatedly touching the resident's legs, arms and shoulders. Observation revealed OSM #11's clothing was in direct contact with Resident #336, and the floor, multiple times. OSM #11 was wearing a mask, face shield, and gloves. However, he was not wearing an isolation gown.

A review of Resident #336's clinical record revealed the following physician's order, dated 3/30/21: "Airborne and Droplet Precaution for COVID-19 (3) Protocol."

A review of Resident #336's care plan dated 3/30/21 revealed no information related to infection control or isolation for COVID-19 observation.

On 4/7/21 at 3:53 p.m., LPN (licensed practical nurse) #4 was interviewed. She stated that the admitting nurse is responsible for creating a newly-admitted resident's baseline care plan, and that the MDS nurse is responsible for overseeing the development of the comprehensive care plan. LPN #4 stated the care plan is developed for each resident, with the purpose of meeting each individual resident's needs. When asked if physician ordered isolation precautions should be included on a resident's baseline care plan, LPN #4 stated they should.

On 4/8/21 at 8:25 a.m., RNs (registered nurses) #8 and #9, MDS coordinators, were interviewed. RN #8 stated the MDS coordinators develop the care plans based on information contained in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 12	F 656		

MDS, physicians' orders, and resident history. She stated various members of the care plan team complete portions of the MDS according to their specialties. She stated the facility does not wait the traditional 21 days to complete a comprehensive care plan. When asked if Resident #336's care plan dated 3/30/21 was a comprehensive care plan, RN #8 stated it was. When asked if isolation precautions should be included on a resident's care plan, RN #8 stated, "Yes."

No further information was provided prior to exit.

REFERENCES
(1) "Droplet Precautions are used to prevent the spread of pathogens that are passed through respiratory secretions and do not survive for long in transit. These droplets are relatively large particles that cannot travel through the air very far. They are transmitted through coughing, sneezing, and talking." This information is taken from the website https://www.cdc.gov/infectioncontrol/pdf/strive/PPE102-508.pdf.

(2) "Airborne precautions necessitate the prevention of infections and the use of available interventions in healthcare facilities to prevent the transmission of airborne particles. The airborne particles may remain localized to the room or move depending on the airflow. In some cases where there is inadequate ventilation, the airborne particle may remain in the hospital room and be inhaled by a newly admitted patient. The control and prevention of airborne transmission of infections are not simple. It requires the control of airflow with the use of specially designed ventilator systems, the practice of antiseptic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 13	F 656		

techniques, wearing personalized protection equipment (PPE), and performing basic infection prevention measures like hand washing. This activity reviews the techniques for minimizing the spread of airborne diseases and the role of the interprofessional team in maximizing airborne precautions to minimize the spread of disease." This information was taken from the website https://www.ncbi.nlm.nih.gov/books/NBK531468/#:~:text=Airborne%20precautions%20necessitate%20the%20prevention,move%20depending%20on%20the%20airflow.

(3) "Coronaviruses are a large family of viruses found in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the outbreak of respiratory illness in people first detected in Wuhan, China, has been named SARSCoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19." This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments.

2. Resident # 128 was admitted to the facility on 3/20/2021, with diagnoses that included cancer of the lung, high blood pressure, fractured ribs and depression. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date (ARD) of 3/25/2021, coded the resident as scoring a "14" on the BIMS (brief interview for mental status), score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. Section O - Special Treatments, Procedures and Programs coded the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 14	F 656		

resident as receiving oxygen while a resident in the facility.

The comprehensive care plan dated 3/20/2021, documented in part, "Focus: The resident has altered respiratory status with SOB r/t (related to) disease process [Lung CA {cancer}...recent rib fracture]." The "Interventions" documented in part, "Provide oxygen as ordered."

The physician order dated 3/20/2021, documented, "O2 (oxygen) @ (at) 2 liters per minute via N/C (nasal cannula - a plastic tubing that has two prongs that insert into the nose) every shift for SOB (shortness of breath)."

Observation was made of Resident #128 on 4/6/2021 at 1:00 p.m. She was resting in bed with her oxygen on via the nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was observed set at 2 liters per minute (LPM).

Observation was made of Resident #128 on 4/7/2021 at 12:15 p.m. Resident #128 had just had a window visit with her son and stated she was getting ready to go to radiation in a little bit. Resident #128 was observed with oxygen on via the nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was observed set at 3 LPM (liters per minute).

An interview was conducted with LPN (licensed practical nurse) # 3 on 4/7/2021 at 2:10 p.m., regarding the purpose of the comprehensive care plan. LPN #3 stated its how the care to that resident is provided. When asked if interventions on the comprehensive care plan should be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 15	F 656		

implemented, LPN #3 stated that it should be followed.

A review of the facility policy, "Interdisciplinary Care Planning," revealed, in part, "The facility must develop and implement a comprehensive person-centered care plan for each patient that includes measurable objectives and timeframes to meet a patient's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment."

ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 4/7/2021 at 4:54 p.m.

No further information was provided prior to exit.
3. The facility staff failed to develop a comprehensive care plan for Resident # 44's use of the physician ordered C-PAP [continuous positive airway pressure], with mask [1], and incentive spirometer [5].

Resident # 44 was admitted to the facility with diagnoses that included but were not limited to: obstructive sleep apnea [2] and respiratory failure [3] with hypoxia [4].

Resident # 44's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/06/2020, coded Resident # 44 as scoring a 9 [nine] on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 - being moderately impaired of cognition for making daily decisions. Section "O Special Treatments, Procedures and Programs" coded Resident # 44 as having a C-PAP "While a Resident."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 16 On 04/06/2021 at approximately 12:53 p.m., an observation of Resident # 44's room revealed a C-PAP mask on top of Resident # 44's dresser uncovered. Further observation of Resident #44's room failed to evidence an incentive spirometer. On 04/06/2021 at approximately 2:48 p.m., an observation of Resident # 44's room revealed a C-PAP mask on top of Resident # 44's dresser uncovered. Further observation of Resident #44's room failed to evidence an incentive spirometer. On 04/07/2021 at approximately 8:24 a.m., an observation of Resident # 44's room revealed a C-PAP mask laying on top of Resident # 44's dresser uncovered. Further observation of Resident #44's room failed to evidence an incentive spirometer. The physician's order dated 04/2021 for Resident # 44 documented, - "CPAP on at night and off in the AM [a.m.] and during the day while sleeping. Start Date: 02/17/2021." - "4/2021" documented, "Incentive Spirometer keep at bedside every day and evening shift for elevated CO2 [carbon dioxide. Frequency: every day and evening shift. Schedule Type: Everyday." The comprehensive care plan for Resident # 44 dated of 12/06/2020 failed to evidence documentation for the use of a C-PAP and failed to evidence documentation for the use of an incentive spirometer. The eTAR [electronic treatment administration record] for Resident # 44 dated April 2021	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 17 documented the above physician's orders. The eTAR further documented Resident # 44's use of the C-PAP on 04/06/2021, on the day and evening shifts and on 04/07/2021 2021, on the day and evening shifts. The eMAR further documented Resident # 44's use of an incentive spirometer on 04/06/2021 on the day and evening shifts and on 04/07/2021 on the day and evening shifts. On 04/07/21 at 12:58 p.m. an interview was conducted with LPN [licensed practical nurse] # 2, regarding the purpose of a resident's comprehensive care plan. LPN # 2 stated, "Tells you what to do for the patient." LPN # 2 was then asked to review Resident # 44's comprehensive care plan to determine if it addressed Resident # 44's use of a C-PAP and incentive spirometer. LPN # 2 and LPN # 3 reviewed Resident # 44's care and stated that it did not evidence documentation of Resident # 44's C-PAP or the use of an incentive spirometer. On 04/07/21 at 2:15 p.m., an interview was conducted with LPN # 3, interim unit manager. When asked about updating a resident's comprehensive care plan, LPN # 3 stated, "Any nursing staff can update the care plan and the unit manager will review the care plan to make sure that the care plan is accurate." When asked about the physician ordered C-PAP and incentive spirometer missing from Resident # 44's care plan, LPN # 3 stated that it was overlooked. On 04/06/2021 at approximately 11:30 a.m., the entrance conference for the survey was conducted with ASM [administrative staff member] # 1, administrator and ASM # 2, the director of nursing. When asked what standards	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 18 of practice the nursing staff follow ASM # 1 and ASM # 2 stated that they follow the facility's policies and procedures. On 04/07/2021 at approximately 4:55 p.m., ASM # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: [1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure) prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm. [2] Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html. [3] When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html. [4] Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hyp	F 656		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 656	Continued From page 19 oxia. [5] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.	F 656		
F 657 SS=E	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) Aregistered nurse with responsibility for the resident. (C) Anurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident'srepresentative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657	1. Corrective Action The care plan for resident #75's splint use has been reviewed and revised and a therapy evaluation was completed April 16, 2021. The care plan for resident #51's prostheses use has been reviewed and revised and he went for an appointment on April 20, 2021 to have his prostheses re-evaluated. No new orders were received. The care plan for resident #94's use of compression wraps has been reviewed revised. 2. Other Potential Residents All residents have the potential to be affected by this deficient practice. 3. New Measures or Systemic Change The Director of Nursing, RN unit managers and/or RN supervisors will audit 100% of the care plans for residents with orders for splints, prostheses and compression wraps to ensure all are care planned properly in accordance with current physician orders. The Director of Nursing, RN unit managers and/or RN supervisors will re-educate staff on the importance of physician ordered splints, prostheses and compression wraps being care planned and updated as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 20 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, clinical record review, facility document review and staff interview, it was determined facility staff failed to review and revise the comprehensive care plan for three of 33 current residents in the survey sample, (Resident #75, #51, and #94). The facility staff failed to review and revise the comprehensive care plans for Resident #75 to include the use of a physician ordered splint; for Resident #51 to include the use of bilateral lower extremity prostheses, and for Resident #94 to address the residents lower extremity edema and the use of physician ordered compression wraps to the residents bilateral feet and legs. The findings include: 1. The facility staff failed to review and revise the comprehensive care plan of Resident #75 to include the use of a wrist splint ordered by the physician. Resident #75 was admitted to the facility with diagnoses that included but were not limited to diabetes (1), dementia (2), and epilepsy (3). Resident #75's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/27/2021,coded Resident #75 as scoring a 6 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 6- being severely impaired for making daily decisions. Section G coded Resident #75 as requiring extensive assistance from two or more staff members for bed mobility and	F 657	Continued From page 20 4. Monitoring Three times weekly over the next 30 days then two times weekly over the following 30 days followed by one time weekly for an additional 30 days the Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will report the findings of their visual checks that splint and prostheses use and application of compression wraps has been care planned per physician orders. The compliance of these visual checks will be reported to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 21	F 657		

transfers. Section G coded Resident #75 as requiring extensive assistance from one person for dressing, eating, toilet use and personal hygiene. Section G coded Resident #75 as having functional limitation in range of motion to one side of the upper and lower extremity.

On 4/6/2021 at approximately 12:28 p.m., an observation was made of Resident #75 in their room in bed. Resident #75 appeared well groomed. Resident #75's hands were observed on top of the sheet. No splint was observed on Resident #75's right wrist or observed in sight in Resident #75's room. An interview was attempted at this time, with Resident #75 but could not be conducted due to their cognitive status.

Additional observations of Resident #75 on 4/6/2021 at 2:45 p.m., 4/7/2021 at 9:45 a.m., and 4/7/2021 at 1:10 p.m. failed to reveal a splint on Resident #75's right wrist.

The physician orders for Resident #75 documented in part, "Right wrist splint wear at all times. Order Status: Active, Order Date: 08/19/2020..."

The comprehensive care plan for Resident #75 documented in part, "ADL (activities of daily living) self care and mobility deficits related to physical limitations (left hemiplegia) (4) and cognitive impairment. Date Initiated: 08/10/2020, Revision on: 09/16/2020..." The care plan failed to evidence documentation for the use of a right wrist splint as ordered by the physician on 8/19/2020.

On 4/7/2021 at approximately 1:20 p.m., an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 22 interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated that they had never observed Resident #75 wear a splint on their right wrist and that splints were not really used on their unit. CNA #4 stated that when a resident required a splint they would see it on the care plan in the computer. CNA #4 stated that they 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. On 4/7/2021 at approximately 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that nurses or CNAs applied splints as ordered. LPN #2 stated that splints were ordered by the physician and also on the residents care plan. LPN #2 stated that it was documented in the progress notes if a resident refused to wear a splint as ordered and the physician and the responsible party was notified. LPN #2 reviewed Resident #75's medical record and stated that there was an order for a wrist splint to the right wrist at all times. LPN #2 stated that the splint should be addressed on the care plan and that the unit manager updated the care plans normally. On 4/7/2021 at approximately 1:32 p.m., an interview was conducted with LPN #3, interim unit manager. LPN #3 stated that any nurse could update the care plan. LPN #3 stated that the care plan provided staff with information on the overall plan of the patient's care. LPN #3 stated that splints were adaptive equipment and should be on the care plan. LPN #3 reviewed Resident #75's comprehensive care plan and stated that the right wrist splint was not addressed on the care plan and should be documented under the interventions on the ADL self care deficit care	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 23	F 657		

plan. LPN #3 reviewed the CNA kardex care plan and stated that the right wrist splint was not addressed on it either and should be added there as well.

On 4/8/2021 at approximately 10:00 a.m., an interview was conducted with OSM #9, occupational therapist. OSM #9 stated that they had provided therapy to Resident #75 in 2019. OSM #9 stated that they did not remember Resident #75 using a splint on the right wrist during therapy.

On 4/6/2021 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing stated that they used their policies and procedures as their standard of practice.

On 4/7/2021 at approximately 4:45 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for reviewing and revising the care plan.

On 4/8/2021 at approximately 10:28 a.m., ASM #1 provided via email, "Interdisciplinary Care Planning" dated "Updated 03/2018." The facility policy, "Interdisciplinary Care Planning" documented in part, "...The patient's care plan is a communication tool that guides members of the interdisciplinary healthcare team in how to meet each individual patient's needs. It also identifies the types and methods of care that the patient should receive... Interventions identify specific, individualized elements of care, provided by staff, which will help patients achieve their goals. Interventions are the instructions for delivering patient care and allow for continuity of care by staff. Just like goals, interventions are specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 24	F 657		

and measurable..." The policy further documented, "...The comprehensive care plan must describe the following: ... the services that are to be furnished to maintain the patient's highest practicable physical, mental, and psychosocial well-being..."

On 4/7/2021 at approximately 4:55 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Diabetes mellitus a chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

2. Dementia- a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

3. Epilepsy- a brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 25 2. The facility staff failed to review and revise the comprehensive care plan to include the use of bilateral lower extremity prostheses (1) for Resident #51. Resident #51 was admitted to the facility with diagnoses that included but were not limited to end stage renal disease (2), diabetes (3) and bilateral below the knee amputation (4). Resident #51's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/9/2021, coded Resident #51 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section G coded Resident #51, as requiring supervision from one staff member for bed mobility, dressing and eating and limited assistance of one person for transfers, toilet use and personal hygiene. Section G coded Resident #51 as having functional limitation in range of motion to both lower extremities. Section G coded Resident #51, as not walking during the assessment period and failed to evidence documentation of normal use of a limb prosthesis. On 4/6/2021 at approximately 11:45 a.m., an interview was conducted with Resident #51 in their room. Resident #51 was observed sitting in a manual wheelchair in their room. Two prosthetic legs were observed in the corner of Resident #51's room. An interview was conducted with Resident #51 at this time. When asked about the prosthetics, Resident #51 stated that he used to wear them a while ago when he received therapy. Resident #51 stated that he was taught how to put them on and had worked with therapy using the motorized wheelchair	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 26	F 657		

located in his room beside the window and with walking. Resident #51 stated that the right prosthetic did not fit properly and he was discharged from therapy because he was unable to wear the leg. Resident #51 stated that he had spoken to the previous social worker and the unit manager regarding setting up an appointment to get the prosthetic refitted but nothing had been set up. Resident #51 stated that the social worker left and that he had just stop using the other prosthetic leg because he could not use them both and just used the wheelchair. Resident #51 stated that he really wanted to attend therapy but they (staff) would not let him without the prosthetics on. Resident #51 stated that therapy had not looked at the prosthetics since he was discharged from them and that the nurses were left to arrange the repairs to the prosthetic with the clinic.

The comprehensive care plan for Resident #51 documented in part, "At risk for decline in ADLs (activities of daily living) & (and) mobility related to chronic disease process and BKAs (bilateral below the knee amputation). Date Initiated: 01/28/2019, Created on: 01/31/2018, Created by: [Name of staff member] Revision on: 08/31/2020..." Under "Interventions" it documented in part, "...Uses assistive/adaptive equipment such as use of wheelchair, sliding board for transfers. Date Initiated: 02/09/2018..." The comprehensive care plan failed to evidence documentation for the use of the leg prosthetics for Resident #51.

The "PT (physical therapy) Discharge Summary" dated "10/22/2018-11/27/2018" for Resident #51 documented in part, "...Pt (patient) now received his prosthesis for Bil (bilateral) LE's (lower

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 27	F 657		

extremities) on 9/24/18 and requirign [sic] skilled PT for prosthetic trainign [sic] with transfers and gait training. On eval (evaluation), Pt attempted several times to get the RLE (right lower extremity) prosthesis on, but unable to get it on. Pt able to get the LLE (left lower extremity) prosthesis on. On Eval. (evaluation) day [Name of prosthetic clinic] had adjsuted [sic] teh [sic] prosthesis, but cont (continues) to have difficulty with R LE (right lower extremity) prosthetic liner. Have left multiple messages with [Name of prosthetic clinic]. Pt has been donning prosthesis without teh [sic] while liner and standing and ambualting [sic]. Pt has met all of his goals. Awaiting [Name of prosthetic clinic] to fix the fit for R (right) prosthesis. Pt transferred to hosp (hospital) due to medical issues..."

The "Rehabilitation Screening" dated "01/18/19" for Resident #51 documented in part, "...Pt (patient) has orders for P.T. (physical therapy). Pt to receive skilled PT for prosthetic training only. He is MI (modified independent) with bed mobility & transfers as well as w/c (wheelchair) mobility. His R (right) LE (lower extremity) prosthetic sleeve (white) does not fit. [Name of prosthetic clinic] need to address it prior to patient being appropriate for skilled PT services. Pt and nursing aware. No skilled PT services warranted at this time..."

On 4/7/2021 at approximately 1:20 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated that they had never observed Resident #51 use his prosthetic legs and that as far as they knew he did not fit them properly so they were not used. CNA #4 stated that they reviewed resident care plans in the computer. CNA #4 stated that they

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 28 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. On 4/7/2021 at approximately 1:32 p.m., an interview was conducted with LPN (licensed practical nurse) #3, interim unit manager. LPN #3 stated that any nurse could update the care plan. LPN #3 stated that the care plan provided staff with information on the overall plan of the patient's care. LPN #3 stated that adaptive equipment should be on the care plan. LPN #3 stated that a while back there were issues with the [Name of prosthetic clinic] when trying to get Resident #51, an appointment to have his prosthesis looked at. LPN #3 stated that the last time they had spoken with anyone at the clinic, the person who had previously worked with Resident #51 no longer worked at the clinic. LPN #3 stated that OSM (other staff member) #8, physical therapist had spoken with the prosthetic clinic regarding the prosthesis problems in the past. LPN #3 stated that they did not know the status of setting up Resident #51 to have his prosthesis evaluated and they were not sure who was responsible for setting it up. LPN #3 stated that they would be glad to set up an appointment for Resident #51 at the [Name of prosthetic clinic] and would follow up with Resident #51. On 4/7/2021 at approximately 4:55 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. References: 1. Prosthesis - is a prosthesis is a device	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 29	F 657		

designed to replace a missing part of the body or to make a part of the body work better. Diseased or missing eyes, arms, hands, legs, or joints are commonly replaced by prosthetic devices. This information was obtained from the website: https://medlineplus.gov/ency/article/002286.htm

2. End-stage kidney disease - the last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm.

3. Diabetes mellitus is a chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

4. Amputation: Leg or foot amputation is the removal of a leg, foot or toes from the body. These body parts are called extremities. Amputations are done either by surgery orthey occur by accident or trauma to the body.

3. The facility staff failed to review and revise Resident #94's comprehensive care plan to address the care of the resident's edema and the use of physician ordered compression wraps to the residents bilateral feet and legs.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 30	F 657		

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).

The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/13/2021, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living.

A physician order for Resident #94, dated 4/4/2021 documented, "Compression wraps to both feet/legs (knee height) while awake for peripheral edema every day shift for edema."

Review of the comprehensive care plan for Resident #94, dated 3/9/2021, did not evidence documentation of the resident's edema or the use of the compression wraps to the residents bilateral feet and legs.

The "Treatment Administration Record (TAR)" documented, "Compression wraps to both feet/legs (knee height) while awake for peripheral edema every day shift for edema." The TAR documented the administration of the compression wraps on 4/4/2021 through 4/7/2021.

Observation was made of Resident #94 on 4/6/2021, at 3:12 p.m., revealed the resident sitting in a wheelchair at the bedside.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 31 Observation revealed her feet and ankles were swollen. An interview was conducted with Resident #94 at this time. When asked about her swollen ankles, the resident stated that the doctor change her medications around the other day but she doesn't remember what it was. Observation revealed grippy socks (socks with substance on the bottom to prevent slippage), on Resident #94's feet. A second observation was made on 4/7/2021 at 11:21 a.m. of the resident in her bed but the covers were off her feet. During an interview conducted at this time, Resident #94 stated the therapist (occupational therapist) was in the process of getting her up. The resident was noted to have grippy socks on her feet. When asked if the nurses had put on any other type of stocking or wraps on her legs since Sunday, Resident #94 pointed to her feet with the grippy socks on and stated that they were the only socks she's worn since she came to the facility. Her legs appeared to be swollen. An observation was made of Resident #94 on 4/7/2021 at 2:32 p.m. Resident #94 was sitting in her wheelchair with her legs elevated on her bed, with only grippy socks observed on her feet. An interview was conducted with LPN (licensed practical nurse) # 3 on 4/7/2021 at 2:10p.m. When asked who can update a comprehensive care plan, LPN #3 stated that any nursing staff can update a care plan as can any disciplines. When asked if new treatment orders should be care planned, LPN #3 stated that usually the managers go back and check those things, but yes, it should be care planned. When asked about the purpose of the comprehensive care	F 657		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 32 plan, LPN #3 stated its how the care to that resident is provided. An interview was conducted with RN (registered nurse) #6, the interim unit manager, on 4/7/2021 at approximately 2:45 p.m. The above order for compression wraps for Resident #94, was reviewed with RN #6. When asked if that order and the edema should be care planned, RN #6 stated that it should have that information on the care plan. ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 4/7/2021 at 4:54 p.m. No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 252. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.	F 657		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to	F 658	1. Corrective Action Resident #13, #74, and # 38 suffered no ill effects from this deficient practice. After learning this deficient practice Agency Nurse #7 and Nurse #2 were immediately re-educated. 2. Other Potential Residents All residents have the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 33 follow professional standards of practice for nursing documentation for one of six residents in the medication administration observation, (Resident #13), and for two other current residents in the survey sample, (Residents #74 and #38). RN (registered nurse) #7 an agency nurse used a facility nurse's computer name and password to sign of medications that she administered to Residents #13, during the medication pass observation, and used a facility nurse's computer name and password to sign of medications that she administered to Resident #74 and #38. The findings include: 1. An outside agency nurse used a facility nurse's computer username and password to sign off on medications given to Resident #13 on 4/7/21. Resident #13 was admitted to the facility on 7/10/19, and most recently readmitted on 6/4/20, with diagnoses including Multiple Sclerosis (1) and Parkinson's disease (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/4/21, Resident #13 was coded as cognitively intact for making daily decision, having scored 13 out of 15 on the BIMS (brief interview for mental status). On 4/7/21 at 9:15 a.m., during the medication administration observation, LPN (licensed practical nurse) #2 and RN (registered nurse) #7 were observed standing at the medication cart just outside Resident #13's room. A laptop computer was located on top of the medication cart. LPN #2 typed on the computer keyboard for a brief moment, and then walked away. RN #7	F 658	Continued From page 33 3. New Measures or Systemic Change The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will re-educate nursing staff on the importance of never sharing usernames and passwords. Staff were required to re-sign the acknowledgment of the Individual Confidentiality and Responsibility Agreement to ensure their understanding of this standard. 4. Monitoring The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will verify that the LPN or RN who is passing medications is actually the LPN or RN signing for the administration. This will be done by comparing the Medication Administration Record to the known assigned team of residents for that specific shift/date. This verification will occur three times each week on randomly selected shifts over the course of one month then two times each week for an additional month and once weekly for another month. These results of these audits will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 34 stepped up to the cart, checked the computer screen, and began to prepare the following medications for administration to Resident #13: - Tylenol (3) 650 mg (milligrams) tablets - Amlodipine (4) 5 mg tablet - Aspirin 81 mg tablet - Baclofen (5) 5 mg tablet - Colace (6) 100 mg tablet - Lexapro (7) 20 mg tablet - Miralax (8) 1 gram powder - Senna (9) 8.6 mg tablet - Multivitamin tablet - Vitamin C 1000 mg tablet - Iron (10mg) 325 mg tablet - Fluticasone (11) 50 mcg (micrograms) nasal spray - Vitamin D 100,000 IUs (international units) RN #7 was observed as she administered all of these medications to Resident #13. A review of Resident #13's MARs (medication administration records) for 4/7/21 at 9:00 a.m. revealed a block for each medication listed above. Each block contained a check mark and the initials of LPN #2. On 4/7/21 at 12:30 p.m., RN #7 was interviewed. When asked to look at Resident #13's MAR from the 9:00 medication administration, she pulled the electronic document up on the medication cart computer. Across the top of the computer screen, a banner stated: "Welcome [name of RN #7]." RN #7 was observed reviewing the MAR for Resident #13's medications administered at 9:00 a.m. that morning. When asked whose initials were in the blocks beside the medications she gave to Resident #13, RN #7 stated, "[LPN #2]'s." When asked if LPN #2 had administered those medications to Resident #13, RN #7 stated, "No. I	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 35	F 658		

did." When asked what LPN #2's initials in the blocks on the MAR beside the medications meant, RN #7 stated, "It looks like she gave the medications. But I did." When asked what happened, she stated she was an agency nurse, and that morning was her very first day working in the facility. She stated when she arrived for work, she was briefly oriented, but was told that she needed to "be on a med (medication) cart immediately because "state is in the building." RN #7 stated she did not have a computer username or password of her own, so LPN #2 signed in with her credentials, and instructed her to start administering medications under her name. When asked if she should be administering medications under any other nurse's username and password, RN #7 stated, "No. I know better."

On 4/7/21 at 1:53 p.m., LPN #2, was interviewed. She stated she does not have a formal role for any new staff, but that she tries to help agency nurses who are new. When asked if RN #7 had ever worked at the facility, she stated she did not think so. LPN #2 stated, "This is my first time seeing her. I have only worked here four months. I just got my license in June." LPN #2 was shown Resident #13's MAR for the 9:00 a.m. medications administered to the resident on 4/7/21, and was asked what the initials and check mark in each box meant. LPN #2 stated, "That is my sign off for [name of electronic medicalrecord software]." When asked if she administered the 9:00 a.m. medications to Resident #13, LPN #2 stated, "No. [RN #7] was using my password because she does not have a sign on." When asked if this is acceptable nursing practice, she stated it is not. She stated she could not remember who, but someone in management had told her it was okay for her to give RN #7 her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 36	F 658		

password because "state is in the building." LPN #2 stated it was wrong to share her computer credentials. LPN #2 stated, "If anything goes wrong, it's on me. It's not correct. I'm not the one who gave the medication." She stated she thought LPN #3, the interim unit manager, had told her to share her computer credentials so RN #7 could give medications.

On 4/7/21 at 2:05 p.m., LPN #3 was interviewed. She stated she is only the interim unit manager, and was "just covering" for the unit manager on the floor where Resident #13 resides. She stated her role with new nurses is to be a resource to answer questions, to give assistance, and to provide guidance. She stated the facility expects agency nurses to come in with experience with the electronic medical record software, and to be ready to work on the floor right away. When asked how an agency nurse receives computer sign on credentials, she stated she thought the request is made through the technology department. When asked what she would say to a new nurse who told her that the new nurse had been asked to administer medications but did not yet have computer sign on credentials, LPN #3 stated she would tell the nurse to go back and talk to HR (human resources). She stated she would never tell a new nurse to use another nurse's computer credentials. She stated it is not okay for a nurse to use another nurse's computer credentials because the MAR is a legal document, and is admissible in court.

On 4/7/21 at 2:46 p.m., OSM (other staff member) #10, the staffing coordinator, was interviewed. She stated her role with new agency nurses is all about scheduling. She stated anything regarding orientation and onboarding is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 37	F 658		

an HR function. She stated she met with RN #7 before 8:00 a.m. that morning. OSM #10 stated she accompanied RN #7 to meet with ASM (administrative staff member) #2, the director of nursing, just after 8:00 a.m. OSM #7 stated, "There was some question as to whether she would even need to work today." She stated ASM #2 instructed RN #7 to work on the second floor helping to pass out food trays, to make beds, and to help the CNAs (certified nursing assistants). She stated that once RN #7 got to the second floor, the unit manager on the first floor had made a change in assignments, and the result was that RN #7 was needed to administer medications on the second floor. When asked who is responsible for setting up RN #7 with her own computer username and password, OSM #10 stated, "HR [human resources]."

On 4/7/21 at 3:11 p.m., OSM #5, the human resources director, was interviewed. He stated new agency nurses generally receive a 1.5 hour orientation, which includes a review of policies and procedures, safety, security, emergency procedures, confidentiality of resident information, and abuse. He stated the orientation ends with a tour of the building, and the agency nurse is ready to begin work. He stated he requests computer credentials from the corporate technology department. OSM #5 stated he went through the usual agency nurse orientation process with RN #7. He stated he did not give her a tour of the building because "we were in a rush." He stated she was already familiar with the building because she had done nursing school clinical classes there. When asked about RN #7's computer access, OSM #5 stated, "It starts with me. I enter the request." He stated the access is usually completed within 30 minutes or so. He

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 38	F 658		

stated that, as of that moment, he still had not received computer access credentials for RN #7. He stated he had reached out to the corporate level at that point. He stated he did not know RN #7 had been administering medications without computer access. OSM #5 stated there was a breakdown in communication at the facility level, and there was also a communication breakdown at the corporate level.

On 4/7/21 at 4:03 p.m., ASM #2 was interviewed. When asked if a nurse should ever chart medication administration under another nurse's name, ASM #2 stated, "No. It is a violation. It is false information." She stated she tries to make sure things are coordinated between HR and new agency nurses. She stated her role is to make sure new agency nurses have the proper orientation, and have everything they need before they get to the floor to work with residents. She stated HR is responsible for obtaining the computer sign on credentials for new nurses. When asked if she was aware what had happened with RN #7, ASM #2 stated, "It is honestly a mistake. I told her to wait until she got her [computer] access." She stated that one of the unit managers was under the impression RN #7 already had computer access, and told her she could go ahead and administer medications. ASM #2 stated, "[RN #7] got on the cart without access." She stated LPN #2 is a relatively new nurse, and she does not really know the process. She stated LPN #2 logged in for RN #7.

On 4/7/21 at 4:54 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. Both were asked to clarify the facility's professional standard. ASM #1 and ASM #2 both verified that the facility uses its policies as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 39	F 658		

its standard for practice. A policy regarding staff computer logins was requested.

On 4/8/21 at 10:28 a.m., ASM #1 provided a 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.

The following quotation is found in Potter and Perry's Fundamentals of Nursing 6th edition (2005, p. 477): "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client medical record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive, and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice. Information in the client record provides a detailed account of the level of quality of care delivered to the clients." Potter and Perry (2005) also includes the following information: "As members of the health care team, nurses need to communicate information about clients accurately and in a timely, effective manner."

REFERENCES

(1) "Multiple sclerosis (MS) is a disease of the central nervous system. In MS the body's immune system attacks myelin, which coats nerve cells. Symptoms of MS include muscle weakness (often in the hands and legs), tingling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 40	F 658		

and burning sensations, numbness, chronic pain, coordination and balance problems, fatigue, vision problems, and difficulty with bladder control. People with MS also may feel depressed and have trouble thinking clearly." This information is taken from the website https://nccih.nih.gov/health/multiple-sclerosis.

(2) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families." This information is taken from the website https://medlineplus.gov/parkinsonsdisease.html.

(3) "Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body." This information is taken from the website https://medlineplus.gov/druginfo/meds/a681004.html.

(4) "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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 41	F 658		

to the heart). Amlodipine 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 taken from the website https://medlineplus.gov/druginfo/meds/a692044.html.

(5) "Baclofen is used to treat pain and certain types of spasticity (muscle stiffness and tightness) from multiple sclerosis, spinal cord injuries, or other spinal cord diseases. Baclofen is in a class of medications called skeletal muscle relaxants. Baclofen acts on the spinal cord nerves and decreases the number and severity of muscle spasms caused by multiple sclerosis or spinal cord conditions. It also relieves pain and improves muscle movement." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682530.html.

(6) "Docusate sodium (Colace) is a stool softener. Stool softeners are used on a short-term basis to relieve constipation by people who should avoid straining during bowel movements because of heart conditions, hemorrhoids, and other problems. They work by softening stools to make them easier to pass." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601113.html.

(7) "Escitalopram is used to treat depression in adults and children and teenagers 12 years of age or older. Escitalopram is also used to treat generalized anxiety disorder (GAD; excessive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 42	F 658		

worry and tension that disrupts daily life and lasts for 6 months or longer) in adults. Escitalopram is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It works by increasing the amount of serotonin, a natural substance in the brain that helps maintain mental balance." This information is taken from the website https://medlineplus.gov/druginfo/meds/a603005.html.

(8) "Polyethylene glycol 3350 is used to treat occasional constipation. Polyethylene glycol 3350 is in a class of medications called osmotic laxatives. It works by causing water to be retained with the stool. This increases the number of bowel movements and softens the stool so it is easier to pass." This information is taken from the website https://medlineplus.gov/druginfo/meds/a603032.html.

(9) "Senna is used on a short-term basis to treat constipation. It also is used to empty the bowels before surgery and certain medical procedures. Senna is in a class of medications called stimulant laxatives. It works by increasing activity of the intestines to cause a bowel movement." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601112.html.

(10) "Iron (ferrous fumarate, ferrous gluconate, ferrous sulfate) is used to treat or prevent anemia (a lower than normal number of red blood cells) when the amount of iron taken in from the diet is not enough. Iron is a mineral that is available as a dietary supplement. It works by helping the body to produce red blood cells." This information is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 43 taken from the website https://medlineplus.gov/druginfo/meds/a682778.html#:~:text=Iron%20(ferrous%20fumarate%2C%20ferrous%20gluconate,available%20as%20a%20dietary%20supplement. (11) "Nonprescription fluticasone nasal spray (Flonase Allergy) is used to relieve symptoms of rhinitis such as sneezing and a runny, stuffy, or itchy nose and itchy, watery eyes caused by hay fever or other allergies (caused by an allergy to pollen, mold, dust, or pets). Prescription fluticasone is also used to relieve symptoms of nonallergic rhinitis such as sneezing and runny or stuffy nose which are not caused by allergies . Prescription fluticasone nasal spray (Xhance) is used to treat nasal polyps (swelling of the lining of the nose). Fluticasone nasal spray should not be used to treat symptoms (e.g., sneezing, stuffy, runny, itchy nose) caused by the common cold. Fluticasone is in a class of medications called corticosteroids. It works by blocking the release of certain natural substances that cause allergy symptoms." This information is taken from the website https://medlineplus.gov/druginfo/meds/a695002.html. 2. An outside agency nurse used a facility nurse's computer username and password to sign off on medications given to Resident #74 on 4/7/21. 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	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 44 #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 - Vitamin B complex tablet - Calcitonin Solution 200 units (1) nose spray - Calcium Citrate 950 mg tablet - Folic Acid (2) 1 mg tablet - Multivitamin tablet - Norvasc (3) 10 mg tablet - Fish oil tablet - Senna (4) 8.6 mg tablet - Torsemide (5) 40 mg tablet - Vitamin D3 20 mcg (microgram) tablet On 4/7/21 at 12:30 p.m., RN #7 was interviewed. When asked to look at Resident #74's MAR from the 9:00 medication administration, she pulled the electronic document up on the medication cart computer. Across the top of the computer screen, a banner stated: "Welcome [name of RN #7]." RN #7 was observed reviewing the MAR for Resident #74's medications administered at 9:00 a.m. that morning. When asked whose initials were in the blocks beside the medications she gave to Resident #74, RN #7 stated, "[LPN #2]'s." When asked if LPN #2 had administered those medications to Resident #74, RN #7 stated, "No. I did." When asked what LPN #2's initials in the blocks on the MAR beside the medications meant, RN #7 stated, "It looks like she gave the medications. But I did." When asked what happened, she stated she was an agency nurse, and that morning was her very first day working in the facility. She stated when she arrived for work,	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 45	F 658		

she was briefly oriented, but was told that she needed to "be on a med (medication) cart immediately because "state is in the building." RN #7 stated she did not have a computer username or password of her own, so LPN #2 signed in with her credentials, and instructed her to start administering medications under her name. When asked if she should be administering medications under any other nurse's username and password, RN #7 stated, "No. I know better."

On 4/7/21 at 1:53 p.m., LPN #2, was interviewed. She stated she does not have a formal role for any new staff, but that she tries to help agency nurses who are new. When asked if RN #7 had ever worked at the facility, she stated she did not think so. LPN #2 stated, "This is my first time seeing her. I have only worked here four months. I just got my license in June." LPN #2 was shown Resident #74's MAR for the 9:00 a.m. medications administered to the resident on 4/7/21, and was asked what the initials and check mark in each box meant. LPN #2 stated, "That is my sign off for [name of electronic medical record software]." When asked if she administered the 9:00 a.m. medications to Resident #74, LPN #2 stated, "No. [RN #7] was using my password because she does not have a sign on." When asked if this is acceptable nursing practice, she stated it is not. She stated she could not remember who, but someone in management had told her it was okay for her to give RN #7 her password because "state is in the building." LPN #2 stated it was wrong to share her computer credentials. LPN #2 stated, "If anything goes wrong, it's on me. It's not correct. I'm not the one who gave the medication." She stated she thought LPN #3, the interim unit manager, had told her to share her computer credentials so RN

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 46 #7 could give medications. On 4/7/21 at 2:05 p.m., LPN #3 was interviewed. She stated she is only the interim unit manager, and was "just covering" for the unit manager on the floor where Resident #74 resides. She stated her role with new nurses is to be a resource to answer questions, to give assistance, and to provide guidance. She stated the facility expects agency nurses to come in with experience with the electronic medical record software, and to be ready to work on the floor right away. When asked how an agency nurse receives computer sign on credentials, she stated she thought the request is made through the technology department. When asked what she would say to a new nurse who told her that the new nurse had been asked to administer medications but did not yet have computer sign on credentials, LPN #3 stated she would tell the nurse to go back and talk to HR (human resources). She stated she would never tell a new nurse to use another nurse's computer credentials. She stated it is not okay for a nurse to use another nurse's computer credentials because the MAR is a legal document, and is admissible in court. On 4/7/21 at 2:46 p.m., OSM (other staff member) #10, the staffing coordinator, was interviewed. She stated her role with new agency nurses is all about scheduling. She stated anything regarding orientation and onboarding is an HR function. She stated she met with RN #7 before 8:00 a.m. that morning. OSM #10 stated she accompanied RN #7 to meet with ASM (administrative staff member) #2, the director of nursing, just after 8:00 a.m. OSM #7 stated, "There was some question as to whether she would even need to work today." She statedASM	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 47 #2 instructed RN #7 to work on the second floor helping to pass out food trays, to make beds, and to help the CNAs (certified nursing assistants). She stated that once RN #7 got to the second floor, the unit manager on the first floor had made a change in assignments, and the result was that RN #7 was needed to administer medications on the second floor. When asked who is responsible for setting up RN #7 with her own computer username and password, OSM #10 stated, "HR [human resources]." On 4/7/21 at 3:11 p.m., OSM #5, the human resources director, was interviewed. He stated new agency nurses generally receive a 1.5 hour orientation, which includes a review of policies and procedures, safety, security, emergency procedures, confidentiality of resident information, and abuse. He stated the orientation ends with a tour of the building, and the agency nurse is ready to begin work. He stated he requests computer credentials from the corporate technology department. OSM #5 stated he went through the usual agency nurse orientation process with RN #7. He stated he did not give her a tour of the building because "we were in a rush." He stated she was already familiar with the building because she had done nursing school clinical classes there. When asked about RN #7's computer access, OSM #5 stated, "It starts with me. I enter the request." He stated the access is usually completed within 30 minutes or so. He stated that, as of that moment, he still had not received computer access credentials for RN #7. He stated he had reached out to the corporate level at that point. He stated he did not know RN #7 had been administering medications without computer access. OSM #5 stated there was a breakdown in communication at the facility level,	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 658	Continued From page 48	F 658		

and there was also a communication breakdown at the corporate level.

On 4/7/21 at 4:03 p.m., ASM #2 was interviewed. When asked if a nurse should ever chart medication administration under another nurse's name, ASM #2 stated, "No. It is a violation. It is false information." She stated she tries to make sure things are coordinated between HR and new agency nurses. She stated her role is to make sure new agency nurses have the proper orientation, and have everything they need before they get to the floor to work with residents. She stated HR is responsible for obtaining the computer sign on credentials for new nurses. When asked if she was aware what had happened with RN #7, ASM #2 stated, "It is honestly a mistake. I told her to wait until she got her [computer] access." She stated that one of the unit managers was under the impression RN #7 already had computer access, and told her she could go ahead and administer medications. ASM #2 stated, "[RN #7] got on the cart without access." She stated LPN #2 is a relatively new nurse, and she does not really know the process. She stated LPN #2 logged in for RN #7.

On 4/7/21 at 4:54 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. Both were asked to clarify the facility's professional standard. ASM #1 and ASM #2 both verified that the facility uses its policies as its standard for practice. A policy regarding staff computer logins was requested.

On 4/8/21 at 10:28 a.m., ASM #1 provided a policy, "Individual Confidentiality and Responsibility" to the surveyor. A review of the policy revealed, in part: "Never reveal computer

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 658	Continued From page 49	F 658		

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 calcitonin 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 blood cells. A deficiency of this vitamin causes certain types of anemia (low red blood cell count)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682591.html.

(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). Amlodipine 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 taken from the website https://medlineplus.gov/druginfo/meds/a692044.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 658	Continued From page 50 (4) "Senna is used on a short-term basis to treat constipation. It also is used to empty the bowels before surgery and certain medical procedures. Senna is in a class of medications called stimulant laxatives. It works by increasing activity of the intestines to cause a bowel movement." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601112.html. (5) "Torsemide is used alone or in combination with other medications to treat high blood pressure. Torsemide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, or liver disease. Torsemide 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/a601212.html. 3. An outside agency nurse used a facility nurse's computer username and password to sign off on medications given to Resident #38 on 4/7/21. Resident #38 was admitted to the facility on 6/3/11 with diagnoses including dementia (1) and epilepsy (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/1/21, Resident #38 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status).	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 658	Continued From page 51 A review of Resident #38's MARs (medication administration records) for 4/7/21 at 9:00 a.m. revealed that she received the following medications: - Lasix (3) 20 mg (milligrams) tablet - Multivitamin tablet - Potassium 20 mEq (milliequivalent) tablet - Vitamin B12 tablet - Vitamin D3 tablet - Metoprolol (4) 50 mg tablet - Tramadol (5) 25 mg tablet On 4/7/21 at 12:30 p.m., RN #7 was interviewed. When asked to look at Resident #38's MAR from the 9:00 medication administration, she pulled the electronic document up on the medication cart computer. Across the top of the computer screen, a banner stated: "Welcome [name of RN #7]." RN #7 was observed reviewing the MAR for Resident #38's medications administered at 9:00 a.m. that morning. When asked whose initials were in the blocks beside the medications she gave to Resident #38, RN #7 stated, "[LPN #2]'s." When asked if LPN #2 had administered those medications to Resident #38, RN #7 stated, "No. I did." When asked what LPN #2's initials in the blocks on the MAR beside the medications meant, RN #7 stated, "It looks like she gave the medications. But I did." When asked what happened, she stated she was an agency nurse, and that morning was her very first day working in the facility. She stated when she arrived for work, she was briefly oriented, but was told that she needed to "be on a med (medication) cart immediately because "state is in the building." RN #7 stated she did not have a computer username or password of her own, so LPN #2 signed in with her credentials, and instructed her to start administering medications under her name.	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 658	Continued From page 52 When asked if she should be administering medications under any other nurse's username and password, RN #7 stated, "No. I know better." On 4/7/21 at 1:53 p.m., LPN #2, was interviewed. She stated she does not have a formal role for any new staff, but that she tries to help agency nurses who are new. When asked if RN #7 had ever worked at the facility, she stated she did not think so. LPN #2 stated, "This is my first time seeing her. I have only worked here four months. I just got my license in June." LPN #2 was shown Resident #38's MAR for the 9:00 a.m. medications administered to the resident on 4/7/21, and was asked what the initials and check mark in each box meant. LPN #2 stated, "That is my sign off for [name of electronic medicalrecord software]." When asked if she administered the 9:00 a.m. medications to Resident #38, LPN #2 stated, "No. [RN #7] was using my password because she does not have a sign on." When asked if this is acceptable nursing practice, she stated it is not. She stated she could not remember who, but someone in management had told her it was okay for her to give RN #7 her password because "state is in the building." LPN #2 stated it was wrong to share her computer credentials. LPN #2 stated, "If anything goes wrong, it's on me. It's not correct. I'm not the one who gave the medication." She stated she thought LPN #3, the interim unit manager, had told her to share her computer credentials so RN #7 could give medications. On 4/7/21 at 2:05 p.m., LPN #3 was interviewed. She stated she is only the interim unit manager, and was "just covering" for the unit manager on the floor where Resident #38 resides. She stated her role with new nurses is to be a resource to	F 658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 658	Continued From page 53	F 658		

answer questions, to give assistance, and to provide guidance. She stated the facility expects agency nurses to come in with experience with the electronic medical record software, and to be ready to work on the floor right away. When asked how an agency nurse receives computer sign on credentials, she stated she thought the request is made through the technology department. When asked what she would say to a new nurse who told her that the new nurse had been asked to administer medications but did not yet have computer sign on credentials, LPN #3 stated she would tell the nurse to go back and talk to HR (human resources). She stated she would never tell a new nurse to use another nurse's computer credentials. She stated it is not okay for a nurse to use another nurse's computer credentials because the MAR is a legal document, and is admissible in court.

On 4/7/21 at 2:46 p.m., OSM (other staff member) #10, the staffing coordinator, was interviewed. She stated her role with new agency nurses is all about scheduling. She stated anything regarding orientation and onboarding is an HR function. She stated she met with RN #7 before 8:00 a.m. that morning. OSM #10 stated she accompanied RN #7 to meet with ASM (administrative staff member) #2, the director of nursing, just after 8:00 a.m. OSM #7 stated, "There was some question as to whether she would even need to work today." She stated ASM #2 instructed RN #7 to work on the second floor helping to pass out food trays, to make beds, and to help the CNAs (certified nursing assistants). She stated that once RN #7 got to the second floor, the unit manager on the first floor had made a change in assignments, and the result was that RN #7 was needed to administer medications on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 658	Continued From page 54	F 658		

the second floor. When asked who is responsible for setting up RN #7 with her own computer username and password, OSM #10 stated, "HR [human resources]."

On 4/7/21 at 3:11 p.m., OSM #5, the human resources director, was interviewed. He stated new agency nurses generally receive a 1.5 hour orientation, which includes a review of policies and procedures, safety, security, emergency procedures, confidentiality of resident information, and abuse. He stated the orientation ends with a tour of the building, and the agency nurse is ready to begin work. He stated he requests computer credentials from the corporate technology department. OSM #5 stated he went through the usual agency nurse orientation process with RN #7. He stated he did not give her a tour of the building because "we were in a rush." He stated she was already familiar with the building because she had done nursing school clinical classes there. When asked about RN #7's computer access, OSM #5 stated, "It starts with me. I enter the request." He stated the access is usually completed within 30 minutes or so. He stated that, as of that moment, he still had not received computer access credentials for RN #7. He stated he had reached out to the corporate level at that point. He stated he did not know RN #7 had been administering medications without computer access. OSM #5 stated there was a breakdown in communication at the facility level, and there was also a communication breakdown at the corporate level.

On 4/7/21 at 4:03 p.m., ASM #2 was interviewed. When asked if a nurse should ever chart medication administration under another nurse's name, ASM #2 stated, "No. It is a violation. It is

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 658	Continued From page 55	F 658		

false information." She stated she tries to make sure things are coordinated between HR and new agency nurses. She stated her role is to make sure new agency nurses have the proper orientation, and have everything they need before they get to the floor to work with residents. She stated HR is responsible for obtaining the computer sign on credentials for new nurses. When asked if she was aware what had happened with RN #7, ASM #2 stated, "It is honestly a mistake. I told her to wait until she got her [computer] access." She stated that one of the unit managers was under the impression RN #7 already had computer access, and told her she could go ahead and administer medications. ASM #2 stated, "[RN #7] got on the cart without access." She stated LPN #2 is a relatively new nurse, and she does not really know the process. She stated LPN #2 logged in for RN #7.

On 4/7/21 at 4:54 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. Both were asked to clarify the facility's professional standard. ASM #1 and ASM #2 both verified that the facility uses its policies as its standard for practice. A policy regarding staff computer logins was requested.

On 4/8/21 at 10:28 a.m., ASM #1 provided a 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 658	Continued From page 56	F 658		

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/All-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.html.

(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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 658	Continued From page 57 medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682864.html. (5) "Tramadol is used to relieve moderate to moderately severe pain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a695011.html.	F 658		
F 659 SS=D	Qualified Persons CFR(s): 483.21(b)(3)(ii) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure respiratory services were provided by qualified persons in accordance with the written plan of care for one of 33 current residents in the survey sample, Resident #128. Resident #128 was removed from her oxygen concentrator by CNA (certified nursing assistant) #10, who then switched and connected the resident to a new oxygen concentrator and turned	F 659	1. Corrective Action Resident #128 suffered no ill effects from this deficient practice and Certified Nursing Assistant #10 was re-educated on performing tasks which fall within his scope of practice only upon learning of this deficient practice. 2. Other Potential Residents All residents who have orders for oxygen have the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 659	Continued From page 58 on the machine, which had a flow rate of 3 LPM (liters per minute) and not the physician ordered 2 LPM. CNA #10 is not qualified to remove residents from or place residents on an oxygen concentrator. The findings include: Resident # 128 was admitted to the facility on 3/20/2021 with diagnoses that included cancer of the lung, high blood pressure, fractured ribs and depression. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/25/2021, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. Resident #128 was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. Section O - Special Treatments, Procedures and Programs coded the resident as receiving oxygen while a resident in the facility. The physician order dated 3/20/2021, documented, "O2 (oxygen) @ (at) 2 liters per minute via N/C (nasal cannula - a plastic tubing that has two prongs that insert into the nose) every shift for SOB (shortness of breath)." Observation was made of Resident #128 on 4/6/2021 at 1:00 p.m. She was resting in bed with her oxygen on via the nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set at 2 LPM (liters per minute). Observation was made of Resident #128 on	F 659	Continued From page 58 3. New Measures or Systemic Change The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will re-educate nursing staff on the importance of only performing job tasks which are within their scope of practice. 4. Monitoring The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will verify that the MD ordered liters of oxygen flowing is correct for all residents using supplemental oxygen as follows: daily for one week then three times weekly for an additional week, followed by two times weekly for an additional week, followed by one time per week for an additional two months. These results of these rounds will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 659	Continued From page 59 4/7/2021 at 12:15 p.m. Resident #128 was observed with her oxygen on via the nasal cannula connected to an oxygen concentrator that was running. Further observation of the oxygen concentrator flow meter revealed that the oxygen was set at 3 LPM (liters per minute). An interview was conducted with RN (registered nurse) #5 on 4/7/2021 at 12:25 p.m., regarding the physician ordered flow rate of oxygen for resident #128. RN #5 reviewed the clinical record and stated the resident was to be on 2 LPM. RN #5 was asked to go to Resident 128's room to observe the residents oxygen flow rate. When asked if it was set at the correct rate, RN #5 stated that it wasn't and that the rate should be at 2 LPM. When asked if she had checked the oxygen concentrator that day, RN #5 stated she had looked at it earlier and it was at 2 LPM. RN #5, then stated, (name of CNA #10), the supply person, took and changed out the concentrator this morning. When asked if she had checked Resident #128's concentrator after that, RN #5 stated she had not. RN #5 proceeded to adjust the oxygen to the correct level. An interview was conducted with CNA (certified nursing assistant) #10, the person working in supply for the day, on 4/7/2021 at 1:36 p.m. When asked if he had taken a new oxygen concentrator into Resident #128's room on 4/7/2021, CNA #10 stated he had. CNA #10 stated they were having the yearly maintenance on the concentrators. When asked who set the resident's rate of oxygen on the concentrator when he brought it into the Resident #128's room, CNA #10 stated he just turned it on. When asked if he adjusted the rate of oxygen by the knob, CNA #10 stated he had not. CNA #10 stated he	F 659		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 659	Continued From page 60 told the nurse he changed out the concentrator. When asked if he noted the rate of oxygen that was on the machine, CNA #10 stated he had not. When asked if it was in his scope of practice to remove residents from an oxygen concentrator and place them on a new one, CNA #10 stated no, it was not. When asked if he was allowed to adjust the rate of oxygen, CNA #10 stated he was not. An interview was conducted with RN #6, the unit manager, on 4/7/2021 at 2:42 p.m. When asked if a CNA is able to remove and place a resident back on an oxygen concentrator, RN #6 stated, "They shouldn't." At this time RN #6 was informed of the above observation and interviews, RN #6 stated he (CNA #10) shouldn't have done that. The comprehensive care plan dated 3/20/2021, documented in part, "Focus: The resident has altered respiratory status with SOB r/t (related to) disease process [Lung CA {cancer}...recent rib fracture]." The "Interventions" documented in part, "Provide oxygen as ordered." The facility policy, "Oxygen Administration" documented in part, "Procedure: 1. Verify Physician's order...Preparation of Equipment: 3. For oxygen concentrator, plug in power cord, turn unit on and set flow meter to correct flow rate." "Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also	F 659		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 659	Continued From page 61 pertain to oxygen administration."(1) "Safety Alert: Oxygen Administration Set-up" was documented, "You do not administer oxygen. Tell the nurse when you finish setting up the oxygen administration system. The nurse turns on the oxygen, sets the flow rate, and applies the administration device."(2) ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 4/7/2021 at 4:54 p.m. No further information was provided prior to exit. (1) Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, (2) Mosby's Textbook for Long-Term Care Assistances, fourth edition, 2003, page 499.	F 659		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, clinical record review and facility document review, it was determined the facility staff failed to	F 684	1. Corrective Action Resident #94 was discharge home on April 15, 2021. The staff nurses who signed for the application of the wraps but did not apply them have been re-educated on the importance of following physician orders and disciplined for failure to do so. Resident #120 suffered no ill effects related to this deficient practice and #6 nurse re-educated on the importance of remaining with the resident until medication is fully administered. The care plan for resident #75's splint use has been reviewed and revised and a therapy evaluation was completed April 16, 2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 684	Continued From page 62 provide treatment and care in accordance with 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. 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. 3. The facility staff failed to apply a splint to Resident #75's right wrist as ordered by the physician. 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).	F 684	Continued From page 62 2. Other Potential Residents All residents have the potential to be affected by this deficient practice. 3. New Measures or Systemic Change The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will re-educate the nursing staff on the importance of remaining with each resident until they are certain they have successfully been administered all medications. The Director of Nursing, RN unit managers and/or RN supervisors will re-educate staff on the importance of following physician orders for physician ordered splints and compression wraps. 4. Monitoring The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will verify through visual observation that the MD ordered compression wraps and splints are in use for all residents with orders and that the nurse administering nebulizer treatments remains at bedside throughout the duration of the treatment as follows: daily for one week then three times weekly for an additional week, followed by two times weekly for an additional week, followed by one time per week for an additional two months. These results of these observations will be reported monthly to the Administrator and the QAPI Committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 63 The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/13/2021, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. Observation was made of Resident #94 on 4/6/2021, at 3:12 p.m., revealed the resident sitting in a wheelchair at the bedside. Observation revealed her feet and ankles were swollen. An interview was conducted with Resident #94 at this time. When asked about her swollen ankles, the resident stated that the doctor change her medications around the other day but she doesn't remember what it was. Observation revealed grippy socks (socks with substance on the bottom to prevent slippage), on Resident #94's feet. A second observation was made on 4/7/2021 at 11:21 a.m. of the resident in her bed but the covers were off her feet. During an interview conducted at this time, Resident #94 stated the therapist (occupational therapist) was in the process of getting her up. The resident was noted to have grippy socks on her feet. When asked if the nurses had put on any other type of stocking or wraps on her legs since Sunday, Resident #94 pointed to her feet with the grippy socks on and stated that they were the only socks she's worn since she came to the facility. Her legs appeared swollen. An observation was made of Resident #94 on 4/7/2021 at 2:32 p.m. Resident #94 was sitting in	F 684	Continued From page 63 5. Completion Date May 18, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 64	F 684		

her wheelchair with her legs elevated on her bed, with only grippy socks observed on her feet.

A physician order for Resident #94, dated 4/4/2021 documented, "Compression wraps to both feet/legs (knee height) while awake for peripheral edema every day shift for edema."

The "Treatment Administration Record (TAR)" documented, "Compression wraps to both feet/legs (knee height) while awake for peripheral edema every day shift for edema." The TAR documented the administration of the compression wraps on 4/4/2021 through 4/7/2021.

Review of the comprehensive care plan for Resident #94, dated 3/9/2021, did not evidence documentation of the resident's edema or the use of the compression wraps to the residents bilateral feet and legs.

An interview was conducted with RN (registered nurse) #5, the nurse caring for the resident on 4/7/2021 at approximately 2:35 p.m. RN #5 had already documented on the TAR the application of the compression wraps on Resident #94. When asked which compression wraps she used, RN #5 stated she would go get ace wraps out of the storage room and apply them. When asked if she would get new wraps each day, RN #5 stated the other staff must have thrown them away. RN #5 stated that therapy had just gotten her (Resident #94) up.

An interview was conducted with RN #6, the interim unit manager, on 4/7/2021 at approximately 2:45 p.m. The physician compression wrap order for Resident #94, was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 65	F 684		

reviewed with RN #6. RN #6 stated the nurse should let therapy know of the order. Therapy would come and wrap them [Resident #94's feet and legs up to the knees]. RN #6 was asked what staff do if the resident was up in a wheelchair . RN #6 stated the nurse either gets ace wraps or get a compression wrap from therapy. When asked if staff throw the ace wraps or compression wraps from therapy away each day, RN #6 stated the nurse could get TED stockings that are put on before they get out of bed and taken off when the go back to bed, but wouldn't throw them away unless soiled. RN #6 was made aware of the above observations and documentation related to Resident # 94's compression wraps.

The facility policy, "Physician Orders" and "Skin Practice Guide" did not address following the physician orders or the use of compression wraps.

On 4/6/2021 ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, stated the facility follows the facility polices as their standard of practice.

In "Fundamentals of Nursing" 6th edition, 2005; Patricia A. Potter and Anne Griffin Perry; Mosby, Inc; Page 419. "The physician is responsible for directing medical treatment. Nurses are obligated to follow physician's orders unless they believe the orders are in error or would harm clients."

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of this concern on 4/7/2021 at 4:54 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 684	Continued From page 66 No further information was provided prior to exit. (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 252. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. 2. The 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 pulling the nebulizer mask off his face multiple times during the treatment while unattended by staff. Resident #120 was admitted to the facility on 3/17/21 with diagnoses including advanced lung cancer. On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 3/22/21, Resident #120 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). On 4/6/21 at 1:53 p.m., Resident #120 was observed lying in his bed, with the head of the bed elevated. Resident #120 had oxygen being delivered through nasal cannula connected to an oxygen concentrator that was running. Resident #120 had a nebulizer mask over his nose and mouth. Steam was coming from the holes in the mask, indicating medication was being administered through the nebulizer mask. No staff members were present in the room. Resident #120 removed the mask from over his nose and mouth four times, each time for	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 684	Continued From page 67	F 684		

approximately ten to fifteen seconds. At 2:03 p.m., the steam was no longer observed coming from the holes in the mask, indicating no more medication was being administered through the nebulizer mask. At this time, the mask was resting partially over Resident #120's mouth and nose, and partially hanging off his face. At 2:12 p.m., LPN (licensed practical nurse) #6 entered the room. He removed the nebulizer mask, rinsed it off, and returned the mask to a storage bag on the resident's bedside table.

A review of Resident #120's clinical record revealed the following physician's order, dated 4/6/21: "Ipratropium-Albuterol Solution (2) 0.5-2.5 mg/3ml (milligrams per three milliliters) 1 vial inhale three times a day for SOB (shortness of breath)." A second physicians order, dated 4/6/21, documented, "Oxygen 2L (liters) [per minute] via nasal cannula. Every shift."

A review of Resident #120's MAR (medication administration record) revealed LPN #6's initials in the box for this medication administration, indicating he had administered the medication as ordered.

A review of Resident #120's comprehensive care plan, dated 3/22/21, did not include the newly physician ordered nebulizer treatment or oxygen.

On 4/6/21 at 2:21 p.m., LPN #6 was interviewed. When asked if he had initiated the nebulizer treatment earlier in the shift for Resident #120, he stated he had. When asked if he had made certain Resident #120 had received all of the medication, LPN #6 stated, "Well, usually we will keep an eye out. I will ask everyone to keep an eye on him, to let me know when he is finished."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 68	F 684		

When asked which specific staff he asked to "keep an eye" on the resident, LPN #6 stated that usually he asks the CNAs (certified nursing assistants). When asked if Resident #120 had received all of the nebulizer treatment, LPN #6 stated he thought so. LPN #6 stated, "We just got that order for him." When asked why it was important for Resident #120 to receive the nebulizer treatment, LPN #6 stated, "He has bad lungs. He needs the nebs (nebulizer) to help him breathe easier."

On 4/7/21 at 2:38 p.m., LPN (licensed practical nurse) #5 was interviewed. When asked a nurse's role in administering a nebulizer treatment, she stated the nurse is responsible for setting up the nebulizer with the correct medication, and for remaining with the resident for the duration of the treatment. When asked why this is important, LPN #5 stated, "You want to make sure the resident gets it all. You don't want them taking the mask off unless it's really necessary."

On 4/7/21 at 4:54 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. Both were asked to clarify the facility's professional standard. ASM #1 and ASM #2 both verified that the facility uses its policies as its standard for practice. A policy regarding medication administration was requested.

On 4/8/21 at 10:28 a.m., ASM #1 provided the policy, "Medication and Treatment Administration Guidelines." The policy contained no information related to a nurse remaining with a resident for the duration of a nebulizer treatment.

According to "Potter, Patricia A., and Anne Griffin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 69	F 684		

Perry. Fundamentals of Nursing: Concepts, Process, and Practice", 4th ed. St Louis: Mosby-Year Book, Inc., 1997: "... Medications of any sort should not be left unattended, and all patients should be observed taking the medication. This avoids the disposal, hoarding, abuse, or misuse of the medication, and assures the safety of the patient..."

No further information was provided prior to exit.

REFERENCES

(1) "A device used to turn a liquid into a fine spray." This information is taken from the website https://www.cancer.gov/publications/dictionaries/cancer-terms/def/nebulizer.

(2) "The combination of albuterol and ipratropium is used to prevent wheezing, difficulty breathing, chest tightness, and coughing in people with chronic obstructive pulmonary disease (COPD; a group of diseases that affect the lungs and airways) such as chronic bronchitis (swelling of the air passages that lead to the lungs) and emphysema (damage to the air sacs in the lungs). Albuterol and ipratropium combination is used by people whose symptoms have not been controlled by a single inhaled medication. Albuterol and ipratropium are in a class of medications called bronchodilators. Albuterol and ipratropium combination works by relaxing and opening the air passages to the lungs to make breathing easier." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601063.html.

3. The facility staff failed to apply a splint to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 70 Resident #75's right wrist as ordered by the physician. Resident #75 was admitted to the facility with diagnoses that included but were not limited to diabetes (1), dementia (2), and epilepsy (3). Resident #75's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/27/2021,coded Resident #75 as scoring a 6 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 6- being severely impaired for making daily decisions. Section G coded Resident #75 as requiring extensive assistance from two or more staff members for bed mobility and transfers. Section G coded Resident #75 as requiring extensive assistance from one person for dressing, eating, toilet use and personal hygiene. Section G coded Resident #75 as having functional limitation in range of motion to one side of the upper and lower extremity. On 4/6/2021 at approximately 12:28 p.m., an observation was made of Resident #75 in their room in bed. Resident #75's hands were observed on top of the sheet. No splint was observed on Resident #75's right wrist or observed in sight in Resident #75's room. An interview was attempted with Resident #75 but could not be conducted due to their cognitive status. Additional observations of Resident #75 on 4/6/2021 at 2:45 p.m., 4/7/2021 at 9:45 a.m., and 4/7/2021 at 1:10 p.m. failed to reveal a splint on Resident #75's right wrist. The physician orders for Resident #75 documented in part, "Right wrist splint wear at all	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 71	F 684		

times. Order Status: Active, Order Date: 08/19/2020..."

The comprehensive care plan for Resident #75 documented in part, "ADL (activities of daily living) self care and mobility deficits related to physical limitations (left hemiplegia) (4) and cognitive impairment. Date Initiated: 08/10/2020, Revision on: 09/16/2020..." Under "Interventions" it documented in part, "...Uses adaptive equipment (Gerichair). Date Initiated: 09/16/2020..."

Review of the nursing progress notes for Resident #75 failed to evidence documentation of Resident #75 wearing or refusing to wear the splint on the right wrist splint.

The eTAR (electronic treatment administration record) and eMAR (electronic medication administration record) for Resident #75 dated "4/1/2021-4/30/2021" failed to evidence documentation of Resident #75 wearing or refusing to wear the splint on the right wrist.

An "OT (occupational therapy) Discharge Summary" for Resident #75, dated "11/25/2019" failed to evidence documentation of the right wrist splint.

On 4/7/2021 at approximately 1:20 p.m., an interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated that they had never observed Resident #75 wear a splint on their right wrist and that splints were not really used on their unit. CNA #4 stated that when a resident required a splint they would see it on the care plan in the computer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 72 On 4/7/2021 at approximately 1:25 p.m., an interview was conducted with LPN (licensed practical nurse) #2. LPN #2 stated that nurses or CNAs applied splints as ordered. LPN #2 stated that splints were ordered by the physician and also on the residents care plan. LPN #2 stated that it was documented in the progress notes if a resident refused to wear a splint as ordered and the physician and the responsible party was notified. LPN #2 reviewed Resident #75's medical record and stated that there was an order for a wrist splint to the right wrist at all times. On 4/7/2021 at approximately 1:30 p.m., LPN #2 observed Resident #75 in their room. LPN #2 observed Resident #75's right hand and stated there was no splint on the right wrist. On 4/8/2021 at approximately 10:00 a.m., an interview was conducted with OSM #9, occupational therapist. OSM #9 stated that they had provided therapy to Resident #75 in 2019. OSM #9 stated that they did not remember Resident #75 using a splint on the right wrist during therapy. On 4/6/2021 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing stated that they used their policies and procedures as their standard of practice. On 4/7/2021 at approximately 4:45 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for splints. On 4/8/2021 at approximately 10:28 a.m., ASM #1 provided via email, "Braces/Splints" dated	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 73	F 684		

"Updated: 12/2009, 09/2018." The facility policy, "Braces/Splints" documented in part, "Purpose: To maintain functional range of motion, decrease muscle contractures and provide support and alignment for weakened limbs through use of braces and/or splints...Suggested Documentation: Care provided in POC (plan of care) or Progress note including completion of procedure and tolerance of procedure..."

The facility document "Resident Rights" documented in part, "Resident Rights, The resident has the following rights ... 34. To reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered..."

On 4/7/2021 at approximately 4:55 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.

No further information was provided prior to exit.

References:

1. Diabetes mellitus - a chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

2. Dementia is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 74 3. Epilepsy- a brain disorder that causes people to have recurring seizures. The seizures happen when clusters of nerve cells, or neurons, in the brain send out the wrong signals. People may have strange sensations and emotions or behave strangely. They may have violent muscle spasms or lose consciousness. This information was obtained from the website: https://medlineplus.gov/epilepsy.html.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care and services consistent with professional standards of practice, and the comprehensive person-centered care plan for three of 33 current residents in the survey sample, Residents #128, #44 and #73. 1. The facility staff failed to administer oxygen per the physician order and failed to follow professional standards of practice for the administration of oxygen for Resident #128.	F 695	1. Corrective Action Resident #128 suffered no ill effects from this deficient practice and Certified Nursing Assistant #10 was re-educated on performing tasks which fall within his scope of practice only upon learning of this deficient practice. Resident #44 suffered no ill effects from this deficient practice and was provided with a n new incentive spirometer and the appropriate staff were re-educated on the storage of the C-Pap in a sanitary manner. Resident #73 suffered no ill effects from this deficient practice and LPN #1 was re-educated on oxygen administration and care. 2. Other Potential Residents All residents who receive supplemental oxygen have the potential to be affected by this deficient practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 75 2. The facility staff failed to store Resident #44's CPAP (continuous positive airway pressure) mask in a sanitary manner and failed to provide the resident with a incentive spirometer for use as ordered by the physician. 3. The facility staff failed to provide respiratory services in a sanitary manner for Resident #73. Resident #73's nasal cannula oxygen tubing was observed on the floor on 4/6/21 at 12:40 PM during initial resident observation rounds. LPN (licensed practical nurse) #1 was observed wiping the nasal cannula with an alcohol wipe and placing it back on Resident #73. The findings include: 1. Resident # 128 was admitted to the facility on 3/20/2021 with diagnoses that included cancer of the lung, high blood pressure, fractured ribs and depression. The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 3/25/2021, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. Resident #128 was coded as requiring extensive assistance of one or more staff members for most of her activities of daily living. Section O - Special Treatments, Procedures and Programs coded the resident as receiving oxygen while a resident in the facility. The physician order dated 3/20/2021, documented, "O2 (oxygen) @ (at) 2 liters per minute via N/C (nasal cannula - a plastic tubing that has two prongs that insert into the nose) every shift for SOB (shortness of breath)."	F 695	Continued From page 75 3. New Measures or Systemic Change The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will re-educate nursing staff on the importance of supplemental oxygen administration, the importance of maintaining it in a sanitary manner, and the administrator of it as it relates to scope of practice. 4. Monitoring The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will verify that the MD ordered liters of oxygen flowing is correct for all residents using supplemental oxygen, the sanitary storage and care of all oxygen related supplies as follows: daily for one week then three times weekly for an additional week, followed by two times weekly for an additional week, followed by one time per week for an additional two months. These results of their findings will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 76	F 695		

The comprehensive care plan dated 3/20/2021, documented in part, "Focus: The resident has altered respiratory status with SOB r/t (related to) disease process [Lung CA {cancer}...recent rib fracture]." The "Interventions" documented in part, "Provide oxygen as ordered."

Observation was made of Resident #128 on 4/6/2021 at 1:00 p.m. She was resting in bed with her oxygen on via the nasal cannula connected to an oxygen concentrator that was running. The oxygen concentrator flow meter was set at 2 LPM (liters per minute).

Observation was made of Resident #128 on 4/7/2021 at 12:15 p.m. Resident had just had a window visit with her son and stated she was getting ready to go to radiation in a little bit. Resident #128 was observed with her oxygen on via the nasal cannula connected to an oxygen concentrator that was running. Further observation of the oxygen concentrator flow meter revealed that the oxygen was set at 3 LPM (liters per minute).

An interview was conducted with RN (registered nurse) #5 on 4/7/2021 at 12:25 p.m., regarding the physician rate of oxygen ordered for resident #128. RN #5 reviewed the clinical record and stated the resident was to be on 2 LPM. RN #5 was asked to go to Resident 128's room to observe the residents oxygen flow rate. When asked if it was set at the correct rate, RN #5 stated that it wasn't and that the rate should be at 2 LPM. When asked if she had checked the oxygen concentrator that day, RN #5 stated she had looked at it earlier and it was at 2 LPM. RN #5 then stated, (name of CNA #10), the supply person, took and changed out the concentrator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 77	F 695		

this morning. When asked if she had checked Resident #128's concentrator after that, RN #5 stated she had not. RN #5 proceeded to adjust the oxygen to the correct level.

An interview was conducted with CNA (certified nursing assistant) #10, the person working in supply for the day, on 4/7/2021 at 1:36 p.m. When asked if he had taken a new oxygen concentrator into Resident #128's room on 4/7/2021, CNA #10 stated he had. CNA #10 stated they were having the yearly maintenance on the concentrators. When asked who set the resident's rate of oxygen on the concentrator when he brought it into the Resident #128's room, CNA #10 stated he just turned it on. When asked if he adjusted the rate of oxygen by the knob, CNA #10 stated he had not. CNA #10 stated he told the nurse he changed out the concentrator. When asked if he noted the rate of oxygen that was on the machine, CNA #10 stated he had not. When asked if it was in his scope of practice to put residents on oxygen, CNA #10 stated no, it was not. When asked if he was allowed to adjust the rate of oxygen, CNA #10 stated he was not.

An interview was conducted with RN #6, the unit manager, on 4/7/2021 at 2:42 p.m. When asked if a CNA is able to remove and place a resident back on an oxygen concentrator, RN #6 stated, "They shouldn't." RN #6 was informed of the above observation and interviews, RN #6 stated he (CNA #10) shouldn't have done that.

The facility policy, "Oxygen Administration" documented in part, "Procedure: 1. Verify Physician's order...Preparation of Equipment: 3. For oxygen concentrator, plug in power cord, turn unit on and set flow meter to correct flow rate."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 78	F 695		

"Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."(1)

"Safety Alert: Oxygen Administration Set-up" was documented, "You do not administer oxygen. Tell the nurse when you finish setting up the oxygen administration system. The nurse turns on the oxygen, sets the flow rate, and applies the administration device."(2)

ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing, were made aware of the above concern on 4/7/2021 at 4:54 p.m.

No further information was provided prior to exit.

(1) Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122,
(2) Mosby's Textbook for Long-Term Care Assistants, fourth edition, 2003, page499.

2. The facility staff failed to store Resident # 44's C-PAP [continuous positive airway pressure] mask [1] in a sanitary manner and failed to provide Resident # 44 with an incentive spirometer [5] for use as ordered by the physician.

Resident # 44 was admitted to the facility with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 79	F 695		

diagnoses that included but were not limited to: obstructive sleep apnea [2] and respiratory failure [3] with hypoxia [4].

Resident # 44's most recent comprehensive MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 11/06/2020, coded Resident # 44 as scoring a 9 [nine] on the brief interview for mental status (BIMS) of a score of 0 - 15, 9 - being moderately impaired of cognition for making daily decisions. Under section "O Special Treatments, Procedures and Programs" coded Resident # 44 as having a C-PAP "While a Resident."

On 04/06/2021 at approximately 12:53 p.m., an observation of Resident # 44's room revealed a C-PAP mask on top of Resident # 44's dresser uncovered. Further observation of Resident #44's room, failed to evidence an incentive spirometer.

On 04/06/2021 at approximately 2:48 p.m., an observation of Resident # 44's room revealed a C-PAP mask on top of Resident # 44's dresser uncovered. Further observation of Resident #44's room, failed to evidence an incentive spirometer.

On 04/07/2021 at approximately 8:24 a.m., an observation by another surveyor of Resident # 44's room revealed a C-PAP mask on top of Resident # 44's dresser uncovered. Further observation of Resident #44's room, failed to evidence an incentive spirometer.

A physician's order dated 04/2021 for Resident # 44 documented, "CPAP on at night and off in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 80 AM [a.m.] and during the day while sleeping. Start Date: 02/17/2021." A second physician's order for Resident # 44 dated "4/2021" documented, "Incentive Spirometer keep at bedside every day and evening shift for elevated CO2 [carbon dioxide. Frequency: every day and evening shift. Schedule Type: Everyday." The comprehensive care plan for Resident # 44 dated of 12/06/2020 failed to evidence documentation for the use of a C-PAP or the use of an incentive spirometer. The eTAR [electronic treatment administration record] for Resident # 44 dated April 2021 documented the above physician's order for the CPAP. The eTAR further documented Resident # 44's use of the C-PAP on 04/06/2021 on the day and evening shifts and on 04/07/2021 2021 on the day and evening shifts. Further review of the eMAR [electronic medication administration record] for Resident # 44 documented the above physician's order for the use of the incentive spirometer, and documented Resident # 44's use of an incentive spirometer on 04/06/2021 on the day and evening shifts and on 04/07/2021 on the day and evening shifts. On 04/07/21 at 12:58 p.m. an observation of Resident # 44's room and interview was conducted with LPN [licensed practical nurse] # 2. When asked to describe the procedure for the storage of a C-PAP mask when not in use, LPN # 2 stated that it should be placed in a bag. When asked why the C-PAP should be placed in a bag, LPN # 2 stated, "You don't want dust or anything	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 81 on it." After entering Resident # 44's room and observing the C-PAP mask on top of the dresser uncovered, LPN # 2 stated that the mask was not stored in a sanitary manner. When asked to locate Resident # 44's incentive spirometer, LPN # 2 searched all the dresser drawers and all the compartments of Resident # 44's armoire [free standing closet]. LPN # 2 then stated that they could not locate the incentive spirometer. When asked why someone would use an incentive spirometer, LPN # 2 stated, "To expand your lungs." On 04/06/2021 at approximately 11:30 a.m., the entrance conference for the survey was conducted with ASM [administrative staff member] # 1, administrator and ASM # 2, the director of nursing. When asked what standards of practice the nursing staff follow ASM # 1 and ASM # 2 stated that they follow the facility's policies and procedures. The facility's policy "BiPAP /CPAP" Failed to evidence documentation for storage of the C- PAP mask when not in use." On 04/07/2021 at approximately 4:55 p.m., ASM # 1, administrator and ASM # 2, director of nursing, were made aware of the above findings. No further information was provided prior to exit. References: [1] Positive airway pressure (PAP) treatment uses a machine to pump air under pressure into the airway of the lungs. This helps keep the windpipe open during sleep. The forced air delivered by CPAP (continuous positive airway pressure)	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 82	F 695		

prevents episodes of airway collapse that block the breathing in people with obstructive sleep apnea and other breathing problems. This information was obtained from the website: https://medlineplus.gov/ency/article/001916.htm.

[2] Sleep apnea is a common disorder that causes your breathing to stop or get very shallow. Breathing pauses can last from a few seconds to minutes. They may occur 30 times or more an hour. This information was obtained from the website: https://medlineplus.gov/sleepapnea.html.

[3] When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

[4] Deficiency of oxygen reaching the tissues of the body. This information was obtained from the website: https://www.merriam-webster.com/dictionary/hypoxia.

[5] A device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how to take slow deep breaths. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000451.htm.

3. Resident #73's nasal cannula oxygen tubing was observed on the floor on 4/6/21 at 12:40 PM during initial resident observation rounds. LPN (licensed practical nurse) #1 was observed wiping the nasal cannula with an alcohol wipe and placing it back on Resident #73.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 83 Resident #73 was admitted to the facility on 8/26/17 with diagnoses that include but are not limited to: Congestive heart failure (characterized by circulatory congestion and retention of salt and water by the kidneys) (1), peripheral vascular disease (narrowing of blood vessels in the extremities due to plaque) (2) and atrial fibrillation (rapid/random contractions of the upper chambers of the heart) (3). Resident #73's most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 2/25/21, coded the resident as scoring 12 out of 15 on the BIMS (brief interview for mental status score), indicating the resident was moderately cognitively intact. The resident was coded as requiring extensive assistance in bed mobility, transfers, dressing, toileting, locomotion in room, bathing and personal hygiene; supervision in eating. On 4/6/21 at 12:40 PM, during the initial resident observation rounds, Resident #73's oxygen nasal cannula was observed on the floor beside her bed still attached to the oxygen concentrator. On 4/6/21 at 12:50 PM, LPN (licensed practical nurse) #1 was informed of Resident #73's oxygen cannula being on floor. LPN #1 stated, "I'll come to the room and put it back on her after I clean it." LPN #1 was then observed picking the nasal cannula and tubing up off the floor and then wiped the nasal cannula with an alcohol wipe and placed it back on Resident #73. When asked if wiping oxygen tubing and replacing it on the resident was the correct process, LPN #1 stated, "Yes, it is fine to do that."	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 695	Continued From page 84 A review of the physician's orders dated 7/9/20, documented in part, "Oxygen at 2 liters per minute via nasal cannula." A review of the nurse's progress note dated 4/6/21 at 3:04 PM, documented in part, "Resident continues on oxygen by nasal cannula at 2 liters per minute. Saturation steady and above 92%, no complaints of shortness of breath." Resident #73's care plan dated 11/29/17 with revision date of 3/8/21, documented in part, "Focus: At risk for respiratory problem related to chronic hypoxia. Interventions: Oxygen at 2 liters per minute via nasal cannula. Obtain pulse oximetry and report abnormal findings." An interview was conducted on 4/07/21 at 8:15 AM with RN (registered nurse) #2, the unit manager. When asked how oxygen tubing was managed, RN #2 stated, "We change it weekly or more often if needed." When asked if a nasal cannula and oxygen tubing fell onto floor, was the process followed for staff to wipe the nasal cannula off with alcohol and then place it back on resident, RN #2 stated, "We would trash that tubing and put new tubing on the resident." An interview was conducted on 4/8/21 at 7:43 AM with RN #1. RN #1 was asked about the process staff follows when a resident's oxygen tubing fell on the floor. RN #1 stated, "We would get new tubing and put on the resident." When asked if you would wipe down the tubing that had been on the floor with alcohol and put it back on the resident, RN #1 stated, "Oh no! We are not to do that. We change the tubing at least weekly and	F 695		

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 695	Continued From page 85 date it- usually on Monday." A review of Resident #73's TAR (treatment administration record) for March and April 2021, documented in part, "Change the oxygen tubing once weekly." The TAR documented Resident #73's nasal cannula and oxygen tubing as changed once weekly in March and April 2021. ASM (administrative staff member) #1, the administrator, and ASM #2 the director of nursing were informed of the finding on 4/7/21 at 5:00 PM. A review of the facility's "Respiratory: Oxygen Administration" policy dated 1/19, does not specify nasal cannula replacement. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 239. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 131. (3) Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 490.	F 695		
F 696 SS=D	Prostheses CFR(s): 483.25(j) §483.25(j) Prostheses The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, to wear and	F 696	1. Corrective Action Resident #51 went to his prostheses specialty appointment on April 20, 2021. Follow up is required in four to six weeks following the resident establishing a consistent routine of applying and wearing his shrinkers and prostheses.	

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 696	Continued From page 86 be able to use the prosthetic device. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, clinical record review, facility document review and staff interview, it was determined facility staff failed to provide prosthesis (1) services for one of 33 current residents in the survey sample, Resident #51. Resident #51 was unable to wear their right prosthetic leg due to an improper fit which was known by facility staff and not addressed. The findings include: Resident #51 was admitted to the facility with diagnoses that included but were not limited to end stage renal disease (2), diabetes (3) and bilateral below the knee amputation (4). Resident #51's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/9/2021, coded Resident #51 as scoring a 15 on the staff assessment for mental status (BIMS) of a score of 0 - 15, 15- being cognitively intact for making daily decisions. Section G coded Resident #51 requiring supervision from one staff member for bed mobility, dressing and eating and limited assistance of one person for transfers, toilet use and personal hygiene. Section G coded Resident #51 having functional limitation in range of motion to both lower extremities. Section G coded Resident #51 having not walked during the assessment period and failed to evidence documentation of normal use of limb prosthesis. On 4/6/2021 at approximately 11:45 a.m., an interview was conducted with Resident #51 in his room sitting in a manual wheelchair. Two prosthetic legs were observed in the corner of	F 696	Continued From page 86 2. Other Potential Residents All residents who have a prostheses have the potential to be affected by this deficient practice. 3. New Measures or Systemic Change The Director of Nursing, RN unit managers and/or RN supervisors will re-educate staff on the importance of encouraging resident to wear and offering assistance in donning prostheses to resident who have them. 4. Monitoring The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will verify through visual observations that residents with prosthesis are wearing them. These visual observations will occur daily for one week then three times weekly for an additional week, followed by two times weekly for an additional week, followed by one time per week for an additional two months. These results of these observations will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 696	Continued From page 87	F 696		

Resident #51's room. When asked about the prosthetics, Resident #51 stated that he used to wear them a while ago when he received therapy. Resident #51 stated that he was taught how to put them on and had worked with therapy using the motorized wheelchair located in his room beside the window and with walking. Resident #51 stated that the right prosthetic did not fit them properly and he was discharged from therapy because he was unable to wear the leg. Resident #51 stated that he had spoken to the previous social worker and the unit manager regarding setting up an appointment to get the prosthetic refitted but nothing had been set up. Resident #51 stated that the social worker left and that he had just stop using the other prosthetic leg because he could not use them both and just used the wheelchair. Resident #51 stated that he really wanted to attend therapy but they (staff) would not let him without the prosthetics on. Resident #51 stated that therapy had not looked at the prosthetics since he was discharged from their services and that the nurses were left to arrange the repairs to the prosthetic with the clinic.

The comprehensive care plan for Resident #51 documented in part, "At risk for decline in ADLs (activities of daily living) & (and) mobility related to chronic disease process and BKAs (bilateral below the knee amputation). Date Initiated: 01/28/2019, Created on: 01/31/2018, Created by: [Name of staff member] Revision on: 08/31/2020..." Under "Interventions" it documented in part, "...Uses assistive/adaptive equipment such as use of wheelchair, sliding board for transfers. Date Initiated: 02/09/2018..."

Review of the progress notes for Resident #51

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 696	Continued From page 88 failed to evidence documentation of communication with the prosthetic clinic. The "PT (physical therapy) Discharge Summary" dated "10/22/2018-11/27/2018" for Resident #51 documented in part, "...Pt (patient) now received his prosthesis for Bil (bilateral) LE's (lower extremities) on 9/24/18 and requirign [sic] skilled PT for prosthetic trainign [sic] with transfers and gait training. On eval (evaluation), Pt attempted several times to get the RLE (right lower extremity) prosthesis on, but unable to get it on. Pt able to get the LLE (left lower extremity) prosthesis on. On Eval. (evaluation) day [Name of prosthetic clinic] had adjsuted [sic] teh [sic] prosthesis, but cont (continues) to have difficulty with R LE (right lower extremity) prosthetic liner. Have left multiple messages with [Name of prosthetic clinic]. Pt has been donning prosthesis without teh [sic] while liner and standing and ambualting [sic]. Pt has met all of his goals. Awaiting [Name of prosthetic clinic] to fix the fit for R (right) prosthesis. Pt transferred to hosp (hospital) due to medical issues..." The "Rehabilitation Screening" dated "01/18/19" for Resident #51 documented in part, "...Pt (patient) has orders for P.T. (physical therapy). Pt to receive skilled PT for prosthetic training only. He is MI (modified independent) with bed mobility & transfers as well as w/c (wheelchair) mobility. His R (right) LE (lower extremity) prosthetic sleeve (white) does not fit. [Name of prosthetic clinic] need to address it prior to patient being appropriate for skilled PT services. Pt and nursing aware. No skilled PT services warranted at this time..." On 4/7/2021 at approximately 1:20 p.m., an	F 696		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 696	Continued From page 89	F 696		

interview was conducted with CNA (certified nursing assistant) #4. CNA #4 stated that they had never observed Resident #51 use their prosthetic legs and that as far as they knew they did not fit him properly so they were not used.

On 4/7/2021 at approximately 1:32 p.m., an interview was conducted with LPN (licensed practical nurse) #3, interim unit manager. LPN #3 stated that a while back there were issues with the [Name of prosthetic clinic] when trying to get Resident #51, an appointment to have their prosthesis looked at. LPN #3 stated that the last time they had spoken with anyone at the clinic, the person who had previously worked with Resident #51 no longer worked at the clinic. LPN #3 stated that OSM (other staff member) #8, physical therapist had spoken with the prosthetic clinic regarding the prosthesis problems in the past. LPN #3 stated that they did not know the status of setting up Resident #51 to have their prosthesis evaluated and they were not sure who was responsible for setting it up. LPN #3 stated that they would be glad to set up an appointment for Resident #51 at the [Name of prosthetic clinic] and would follow up with Resident #51.

On 4/7/2021 at approximately 3:00 p.m., a telephone interview was conducted with OSM #8, physical therapist. OSM #8 stated that they had provided therapy to Resident #51 when he came into the facility. OSM #8 stated that Resident #51 was admitted with bilateral below the knee amputations and the [Name of prosthetic clinic] was involved with making the prosthetics for them. OSM #8 stated that they worked with Resident #51 on standing and walking with the prosthetics. OSM #8 stated that one of the prosthetics would not lock all the way in and they

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 696	Continued From page 90	F 696		

had called the clinic for an outpatient appointment to have the prosthetic adjusted. OSM #8 stated that the prosthetic clinic had adjusted the prosthetic but somehow it did not work and they had reached out to them again. OSM #8 stated that Resident #51 was admitted to the hospital at that point and they had discontinued therapy and reached out to the nursing staff to follow up on the prosthetic adjustments. OSM #8 stated that when Resident #51 was readmitted to the facility they did not get a referral to see them again but they did follow up with nursing to set up the prosthetic adjustments. OSM #8 stated that when they discharged Resident #51 from therapy he was independent at wheelchair level for transferring and getting around in the wheelchair. OSM #8 stated that Resident #51 had stopped using the prosthetics and said that one side wasn't fitting correctly and was getting in their way so they did not feel like putting it on.

On 4/6/2021 at approximately 11:30 a.m., ASM (administrative staff member) #1, the administrator and ASM #2, the director of nursing stated that they used their policies and procedures as their standard of practice.

On 4/7/2021 at approximately 4:45 p.m., a request was made to ASM (administrative staff member) #1, the administrator for the facility policy for prosthetics.

On 4/8/2021 at approximately 10:28 a.m., ASM #1 provided via email, "Stump/Prosthesis Care" dated "01/2011."

The facility policy, "Stump/Prosthesis Care" documented in part, "...Prosthesis Care: ...3. Inspect prosthetic device for smooth edges and

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 696	Continued From page 91 verify straps are in good repair. Report abnormalities or complaints about prosthesis fit or functioning to therapist and/or physician..." The facility document "Resident Rights" documented in part, "Resident Rights, The resident has the following rights ... 34. To reside and receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered..." On 4/7/2021 at approximately 4:55 p.m., ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings. No further information was provided prior to exit. References: 1. Prosthesis- a prosthesis is a device designed to replace a missing part of the body or to make a part of the body work better. Diseased or missing eyes, arms, hands, legs, or joints are commonly replaced by prosthetic devices. This information was obtained from the website: https://medlineplus.gov/ency/article/002286.htm 2. End-stage kidney disease- the last stage of chronic kidney disease. This is when your kidneys can no longer support your body's needs. This information was obtained from the website: https://medlineplus.gov/ency/article/000500.htm. 3. Diabetes mellitus - a chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:	F 696		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 696	Continued From page 92 https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm. 4. Amputation: Leg or foot amputation is the removal of a leg, foot or toes from the body. These body parts are called extremities. Amputations are done either by surgery or they occur by accident or trauma to the body.	F 696		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to ensure residents' that require dialysis, receive services, consistent with professional standards of practice for one of thirty-three residents in the survey sample, Resident #436. The facility staff failed to evidence ongoing communication and collaboration with the dialysis facility for Resident #436, during her Monday/Wednesday/Friday dialysis treatments. The findings include: Resident #436 was admitted to the facility on 3/26/21 with diagnoses that included but were not limited to: end stage renal disease (ESRD) (final stage of irreversible kidney disease) (1), COVID-19 (coronavirus 19) (2) and atrial fibrillation (rapid/random contractions of the upper	F 698	1. Corrective Action - Dialysis Resident #436 suffered no ill effects from this deficient practice. 2. Other Potential Residents All dialysis residents have the potential to be affected by this deficient practice. 3. New Measures or Systemic Change The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will re-educate licensed nursing staff on the importance of using the established communication tools (binder and dialysis communication forms).	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 698	Continued From page 93 chambers of the heart) (3). The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 3/31/21, coded the resident as scoring a 11 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was cognitively moderately impaired. In Section G (functional status)- the resident was coded as requiring extensive assistance for bed mobility, transfer, dressing, toilet use, personal hygiene and bathing; supervision for eating. In Section O (special procedures) - the resident was coded "Yes" as receiving dialysis while a resident. A review of the physician's orders dated 3/26/21, documented in part, "Patient is on hemodialysis [mechanical purification of the blood as a substitute for normal kidney function] every Monday, Wednesday and Friday". A review of nursing progress notes revealed the following documentation: - 3/29/21 at 10:45 AM, "Resident left for dialysis." - 3/31/21 at 6:00 AM, "Resident left for dialysis in stable condition." - 4/2/21 at 4:59 PM, "Resident left for dialysis. Shunt left upper arm intact with no bleeding, bruit and thrill present." - 4/6/21 at 1:08 AM, "Resident came back from dialysis at 5:15 PM." - 4/7/21 at 10:30 AM, "Resident left for dialysis." Review of Resident #436's dialysis communication book revealed there were no communication forms from the facility to the dialysis center for the dates of 3/29/21, 3/31/21, 4/2/21 and 4/5/21. There was one	F 698	Continued From page 93 4. Monitoring The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will review the dialysis communication binder for each resident who receives dialysis to ensure compliance with communication is occurring as follows: three times per week for one week then two times weekly for an additional week, followed by once weekly for an additional two weeks. After this month of increased reviews, the dialysis communication binder will be reviewed monthly for an additional 60 days. The results of these reviews will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 698	Continued From page 94	F 698		

communication form dated 4/7/21. Resident #436 receives dialysis Monday/Wednesday/Friday dialysis treatments since 3/29/21 for a total of five dialysis visits, with four communication forms missing.

A review of Resident #436's comprehensive care plan dated 3/29/21, documented in part, "The Focus: dated 11/13/19 "Renal insufficiencies related to acute renal failure. The Interventions: dialysis three times a week, Monday, Wednesday and Friday. Send meal with the resident".

On 4/8/21 at 8:05 AM and interview was conducted with RN (registered nurse) #1. When asked the purpose of the dialysis communication forms, RN #1 stated, "They are to provide current information to the dialysis center about vital signs, medications and any changes. The dialysis center provides information back to us regarding treatment outcomes for that day." When asked where the additional forms would be found, RN #1 stated, "I don't know where they are. I'll call the dialysis company and they will send them."

On 4/8/21 at 8:30 AM, ASM (administrative staff member) #1, the administrator was made aware of the concern regarding communication with the dialysis center for Resident #436 and that per RN #1; the dialysis company would be sending information.

On 4/8/21 at 11:00 AM, the dialysis communication binder for Resident #436 was provided. The information from the dialysis company regarding Resident #436's treatment on 4/7/21 was present, but no evidence of the four missing communication sheets from the facility dated 3/29/21, 3/31/21, 4/2/21 and 4/5/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 95 On 4/8/21 at 11:30 AM, ASM #1, the administrator, and ASM #2 the director of nursing were informed of the finding. The facility's contract with the dialysis facility, documented in part, "Facility shall ensure that all appropriate medical, social, administrative, and other information accompany all designated residents at the time of transfer to the center. This information, shall include, but is not limited to, where appropriate, the following: appropriate medical records, including history of the designated resident's illness, treatment presently being provided to the designated resident including medications, any changes in patient's condition and any other information that will facilitate the adequate coordination of care as reasonably determined by the center." No further information was provided prior to exit. References: 1. Barron Dictionary of Medical Terms, 7th edition, Rothenberg and Kaplan, page 498. 2. This information was obtained fromthe following website: www.CDC.gov. 3. Barron Dictionary of Medical Terms,7th edition, Rothenberg and Kaplan, page 54.	F 698		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal,	F 812	1. Corrective Action All food items identified during this survey as not being properly stored were discarded.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 812	Continued From page 96 state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by thefacility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, it was determined the facility staff failed to store and serve food in a sanitary manner in the kitchen. The findings include: Observation was made of the freezer. A box of frozen biscuit was open and the plastic bag inside the box was observed open exposing the contents to air and contamination. On the top shelf a disposable tin container of sweet potato casserole was observed with the lid to the container not secured exposing the casserole to air. Further observation of the lid revealed it was labelled with the date of 10/8/2020. OSM #7 stated that he didn't even know why that was in the freezer. A box of gluten free glazed donuts was observed on the shelf in the freezer. The box was opened and the plastic wrapper around the donuts, was also opened to air and contamination. There was no date indicating	F 812	Continued From page 96 2. Other Potential Residents All residents have the potential to be affected by this deficient practice. 3. New Measures or Systemic Change All dietary staff employees were re-educated on proper and sanitary food storage and service by the Food Services Director. 4. Monitoring The Food Services Director and/or Registered Dietician will perform an inspection of the kitchen to ensure food items are properly stored in a sanitary manner weekly for one month then monthly for an additional two months. The results of these inspections will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 812	Continued From page 97	F 812		

when the box was opened. When asked if the box should be open with the plastic opened to air, OSM #7 stated, no it should be closed after opening. When asked when the donuts were opened, OSM #7 stated he couldn't tell when as the box was not dated when opened. OSM #7 was asked if they had a resident in house that was receiving the gluten free food; OSM #7 stated they haven't had a gluten free diet for a few weeks now.

Observation was made of an oven on the far wall of the kitchen. It was in use. It was opened and brown material was noted on the racks and the oven doors. When asked when it was last cleaned, OSM #7 stated about a week and a half ago. He further stated that the other oven is broken and they are awaiting another oven so it's the only oven in use. When asked if it was in need of a cleaning, OSM #7 stated, yes it needed to be cleaned.

Review of the policy, "Storage of Food" documented in part, "10. Label opened foods following date marking guidelines. 14. Seal and label open frozen foods. 15. Discard food that has exceeded the expiration date or when use-by-date is unclear."

Review of the policy, "Labeling Food and Date Marking" documented, "Foods are labeled following delivery, preparation or opening to identify the item and to provide date, time and or temperature information. The identification of the date of preparation and the day by which the food is to be used or consumed is often referred to as date marking."

ASM (administrative staff member) #1, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 812	Continued From page 98 administrator, and ASM #2, the director of nursing, were made aware of this concern on 4/7/2021 at 4:54 p.m. No further information was provided prior to exit.	F 812		
F 814 SS=F	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility staff failed to maintain the dumpster area in a sanitary manner to prevent pests. Approximately four clear gloves were noted on the ground around the dumpsters and bits of paper trash was observed on the ground throughout the area around the dumpsters The findings include: Observation was made of the dumpster area on 4/7/2021 at 8:49 a.m. accompanied by other staff member (OSM) #7, the dietary manager. There were three metal dumpsters. One for cardboard and two for trash. Approximately four clear gloves were noted on the ground around the dumpsters. When asked which department uses the clear gloves, OSM #7 stated that they are used throughout the facility. There were bits of paper trash throughout the area around the dumpster's. The trash did not appear to be fresh as it had dirt and mud on it. When asked whose responsibility is it to keep the area clean, OSM#7 stated it's both the kitchen and housekeeping	F 814	1. Corrective Action The area surrounding the dumpster was swept clean by the housekeeping director and staff during survey. On Tuesday, April 20, 2021 the provider of waste management for the facility placed a lock on the dumpster to ensure no wildlife could get in. 2. Other Potential Residents No residents were affected by this deficient practice. 3. New Measures or Systemic Change The Housekeeping Supervisor or designee in his absence will inspect the area surrounding the dumpsters to ensure proper disposal of all trash twice daily over the next 90 days. In addition, the Administrator will do random visual checks of this area weekly over the next 60 days. 4. Monitoring The results of the inspections surrounding the dumpster area will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 814	Continued From page 99 staff. OSM #7 informed this surveyor that they had a raccoon problem. He stated that the one dumpster had metal closing doors and the other had plastic closing doors. He stated the raccoons get in the one with plastic closing doors. The policy, "Housekeeping Manual Standards & Policies" documented in part, "Entrances, Sidewalks, Dumpster and Driveway Cleaning: Inspect areas daily. Sweep daily. Clean all interior and exterior area when spills occur...Sweep sidewalks, dumpster and delivery areas with a hard bristle 30-inch push broom. Sweep debris into trash container." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were made aware of this concern on 4/7/2021 at 4:54 p.m. The ASM #1 presented a document on 4/8/2021 at 8:00 a.m. of an email sent by a member of their corporate office to the trash contractor , dated 2/9/2021, that documented, "We need the 8 yard trash container change out to metal door. We are having raccoons getting into the trash container. No further information was provided prior to exit.	F 814		
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent	F 842		

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 842	Continued From page 100 agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained	F 842	1. Corrective Action Resident #13, #74, and #38 suffered no ill effects from this deficient practice. After learning of this incident Registered Nurse (RN) #7 and Licensed Practical Nurse (LPN) #2 were re-educated on the importance of maintaining an accurate medical record. 2. Other Potential Residents All residents have the potential to be affected by this deficient practice. 3. New Measures or Systemic Change The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will re-educate all licensed nursing staff on the importance maintaining an accurate medical record. 4. Monitoring The Director of Nursing and/or registered nurse (RN) unit managers and/or RN supervisors will make random visual observations during medication administration times to ensure that the nurse administering the medication is in fact the nurse signed into the system. These random visual observations will occur as follows: three times per week for two weeks then two times weekly for an additional two weeks, followed by once weekly for an additional 60 days. The results of these rounds will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 842	Continued From page 101 for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to maintain an accurate clinical record for one of six residents in the medication administration observation, Resident #13; and for two other current residents in the survey sample, Residents #74 and #38. The MARs (medication administration record) for Resident #13, #74 and #38 inaccurately documented the wrong staff as administering medications to the residents on 4/7/21 at 9:00 a.m. The findings include: 1. Resident #13's MAR (medication	F 842		

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 842	Continued From page 102	F 842		

administration record) for 4/7/21 for 9:00 a.m. medications was inaccurate.

Resident #13 was admitted to the facility on 7/10/19, and most recently readmitted on 6/4/20, with diagnoses including Multiple Sclerosis (1) and Parkinson's disease (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 1/4/21, she was coded as being cognitively intact for making daily decision, having scored 13 out of 15 on the BIMS (brief interview for mental status).

On 4/7/21 at 9:15 a.m., during the medication administration observation) LPN (licensed practical nurse) #2 and RN (registered nurse) #7 were observed standing at the medication cart just outside Resident #13's room. A laptop computer was located on top of the medication cart. LPN #2 typed on the computer keyboard for a brief moment, and then walked away. RN #7 stepped up to the cart, checked the computer screen, and began to prepare the following medications for administration to Resident #13:

- Tylenol (3) 650 mg (milligrams) tablets
- Amlodipine (4) 5 mg tablet
- Aspirin 81 mg tablet
- Baclofen (5) 5 mg tablet
- Colace (6) 100 mg tablet
- Lexapro (7) 20 mg tablet
- Miralax (8) 1 gram powder
- Senna (9) 8.6 mg tablet
- Multivitamin tablet
- Vitamin C 1000 mg tablet
- Iron (10mg) 325 mg tablet
- Fluticasone (11) 50 mcg (micrograms) nasal spray
- Vitamin D 100,000 IUs (international units)

RN #7 was observed as she administered all of

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 842	Continued From page 103 these medications to Resident #13. A review of Resident #13's MARs (medication administration records) for 4/7/21 at 9:00 a.m. revealed a block for each medication listed above. Each block contained a check mark and the initials of LPN #2. On 4/7/21 at 12:30 p.m., RN #7 was interviewed. When asked to look at Resident #13's MAR from the 9:00 medication administration, she pulled the electronic document up on the medication cart computer. Across the top of the computer screen, a banner stated: "Welcome [name of RN #7]." On 4/7/21 at 12:30 p.m., RN #7 was interviewed. When asked to look at Resident #13's MAR from the 9:00 medication administration, she pulled the electronic document up on the medication cart computer. Across the top of the computer screen, a banner stated: "Welcome [name of RN #7]." RN #7 was observed reviewing the MAR for Resident #13's medications administered at 9:00 a.m. that morning. When asked whose initials were in the blocks beside the medications she gave to Resident #13, RN #7 stated, "[LPN #2]'s." When asked if LPN #2 had administered those medications to Resident #13, RN #7 stated, "No. I did." When asked what LPN #2's initials in the blocks on the MAR beside the medications meant, RN #7 stated, "It looks like she gave the medications. But I did." When asked what happened, she stated she was an agency nurse, and that morning was her very first day working in the facility. She stated when she arrived for work, she was briefly oriented, but was told that she needed to "be on a med (medication) cart immediately because "state is in the building." RN #7 stated she did not have a computer username or password of her own, so LPN #2 signed in with	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 842	Continued From page 104	F 842		

her credentials, and instructed her to start administering medications under her name. When asked if Resident #13's MAR was accurate, RN #7 stated it was not.

On 4/7/21 at 1:53 p.m., LPN #2, was interviewed. She stated she does not have a formal role for any new staff, but that she tries to help agency nurses who are new. When asked if RN #7 had ever worked at the facility, she stated she did not think so. She stated: "This is my first time seeing here. I have only worked here four months. I just got my license in June." LPN #2 was shown Resident #13's MAR for the 9:00 a.m. medications on 4/7/21, and was asked what the initials and check mark in each box meant. LPN #2 stated, "That is my sign off for [name of electronic medical record software]." When asked if she administered the 9:00 a.m. medications to Resident #13, LPN #2 stated, "No. [RN #7] was using my password because she does not have a sign on." When asked if Resident #13's MAR was accurate, LPN #2 stated it was not.

On 4/7/21 at 4:03 p.m., ASM #2 was interviewed. When asked if a nurse should ever chart medication administration under another nurse's name, she stated: "No. It is a violation. It is false information." ASM #2 stated it was her understanding that LPN #2 logged in for RN #7 during the morning medication observation.

On 4/7/21 at 4:54 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. Both were asked to clarify the facility's professional standard. ASM #1 and ASM #2 both verified that the facility uses its policies as its standard for practice. A policy regarding accurate computer logins was requested.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 842	Continued From page 105 On 4/8/21 at 10:28 a.m., ASM #1 provided a 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." The following quotation is found in Lippincott's Fundamentals of Nursing 5th edition (2007, page 237): "The client record serves as a legal document of the client's health status and care received ..... Because nurses and otherhealthcare team members cannot remember specific assessments or interventions involving a client years after the fact, accurate and complete documentation at the time of care is essential. The care may have been excellent, but the documentation must prove it." No further information was provided prior to exit. REFERENCES (1) "Multiple sclerosis (MS) is a disease of the central nervous system. In MS the body's immune system attacks myelin, which coats nerve cells. Symptoms of MS include muscle weakness (often in the hands and legs), tingling and burning sensations, numbness, chronic pain, coordination and balance problems, fatigue, vision problems, and difficulty with bladder control. People with MS also may feel depressed and have trouble thinking clearly." This information is taken from the website https://nccih.nih.gov/health/multiple-sclerosis.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 106	F 842		

(2) "Parkinson's disease (PD) is a type of movement disorder. It happens when nerve cells in the brain don't produce enough of a brain chemical called dopamine. Sometimes it is genetic, but most cases do not seem to run in families." This information is taken from the website https://medlineplus.gov/parkinsonsdisease.html.

(3) "Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, and reactions to vaccinations (shots), and to reduce fever. Acetaminophen may also be used to relieve the pain of osteoarthritis (arthritis caused by the breakdown of the lining of the joints). Acetaminophen is in a class of medications called analgesics (pain relievers) and antipyretics (fever reducers). It works by changing the way the body senses pain and by cooling the body." This information is taken from the website https://medlineplus.gov/druginfo/meds/a681004.html.

(4) "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). Amlodipine 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 taken from the website https://medlineplus.gov/druginfo/meds/a692044.h

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 107 tml. (5) "Baclofen is used to treat pain and certain types of spasticity (muscle stiffness and tightness) from multiple sclerosis, spinal cord injuries, or other spinal cord diseases. Baclofen is in a class of medications called skeletal muscle relaxants. Baclofen acts on the spinal cordnerves and decreases the number and severity of muscle spasms caused by multiple sclerosis or spinal cord conditions. It also relieves pain and improves muscle movement." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682530.html. (6) "Docusate sodium (Colace) is a stool softener. Stool softeners are used on a short-term basis to relieve constipation by people who should avoid straining during bowel movements because of heart conditions, hemorrhoids, and other problems. They work by softening stools to make them easier to pass." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601113.html. (7) "Escitalopram is used to treat depression in adults and children and teenagers 12 years of age or older. Escitalopram is also used to treat generalized anxiety disorder (GAD; excessive worry and tension that disrupts daily life and lasts for 6 months or longer) in adults. Escitalopram is in a class of antidepressants called selective serotonin reuptake inhibitors (SSRIs). It worksby increasing the amount of serotonin, a natural substance in the brain that helps maintainmental balance." This information is taken from the website	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 842	Continued From page 108 https://medlineplus.gov/druginfo/meds/a603005.html. (8) "Polyethylene glycol 3350 is used to treat occasional constipation. Polyethylene glycol 3350 is in a class of medications called osmotic laxatives. It works by causing water to be retained with the stool. This increases the number of bowel movements and softens the stool so it is easier to pass." This information is taken from the website https://medlineplus.gov/druginfo/meds/a603032.html. (9) "Senna is used on a short-term basis to treat constipation. It also is used to empty the bowels before surgery and certain medical procedures. Senna is in a class of medications called stimulant laxatives. It works by increasing activity of the intestines to cause a bowel movement." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601112.html. (10) "Iron (ferrous fumarate, ferrous gluconate, ferrous sulfate) is used to treat or prevent anemia (a lower than normal number of red blood cells) when the amount of iron taken in from the diet is not enough. Iron is a mineral that is available as a dietary supplement. It works by helping the body to produce red blood cells." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682778.html#:~:text=Iron%20(ferrous%20fumarate%2C%20ferrous%20gluconate,available%20as%20a%20dietary%20supplement. (11) "Nonprescription fluticasone nasal spray (FlonaseAllergy) is used to relieve symptoms of	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 842	Continued From page 109 rhinitis such as sneezing and a runny, stuffy, or itchy nose and itchy, watery eyes caused by hay fever or other allergies (caused by an allergy to pollen, mold, dust, or pets). Prescription fluticasone is also used to relieve symptoms of nonallergic rhinitis such as sneezing and runny or stuffy nose which are not caused by allergies . Prescription fluticasone nasal spray (Xhance) is used to treat nasal polyps (swelling of the lining of the nose). Fluticasone nasal spray should not be used to treat symptoms (e.g., sneezing, stuffy, runny, itchy nose) caused by the common cold. Fluticasone is in a class of medications called corticosteroids. It works by blocking the release of certain natural substances that cause allergy symptoms." This information is taken from the website https://medlineplus.gov/druginfo/meds/a695002.html. 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	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 842	Continued From page 110 - Vitamin B complex tablet - Calcitonin Solution 200 units (1) nose spray - Calcium Citrate 950 mg tablet - Folic Acid (2) 1 mg tablet - Multivitamin tablet - Norvasc (3) 10 mg tablet - Fish oil tablet - Senna (4) 8.6 mg tablet - Torsemide (5) 40 mg tablet - Vitamin D3 20 mcg (microgram) tablet On 4/7/21 at 12:30 p.m., RN #7 was interviewed. When asked to look at Resident #74's MAR from the 9:00 medication administration, she pulled the electronic document up on the medication cart computer. Across the top of the computer screen, a banner stated: "Welcome [name of RN #7]." RN #7 was observed reviewing the MAR for Resident #74's medications administered at 9:00 a.m. that morning. When asked whose initials were in the blocks beside the medications she gave to Resident #74, RN #7 stated, "[LPN #2]'s." When asked if LPN #2 had administered those medications to Resident #74, RN #7 stated, "No. I did." When asked what it LPN #2's initials in the blocks on the MAR beside the medications meant, RN #7 stated, "It looks like she gave the medications. But I did." When asked what happened, she stated she was an agency nurse, and that morning was her very first day working in the facility. She stated when she arrived for work, she was briefly oriented, but was told that she needed to "be on a med (medication) cart immediately because "state is in the building." RN #7 stated she did not have a computer username or password of her own, so LPN #2 signed in with her credentials, and instructed her to start administering medications under her name. When asked if Resident #74's MAR was	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 842	Continued From page 111	F 842		

accurate, she stated it was not.

On 4/7/21 at 1:53 p.m., LPN #2, was interviewed. She stated she does not have a formal role for any new staff, but that she tries to help agency nurses who are new. When asked if RN #7 had ever worked at the facility, she stated she did not think so. LPN #2 stated, "This is my first time seeing her. I have only worked here four months. I just got my license in June." LPN #2 was shown Resident #74's MAR for the 9:00 a.m. medications administered to the resident on 4/7/21, and was asked what the initials and check mark in each box meant. LPN #2 stated, "That is my sign off for [name of electronic medicalrecord software]." When asked if she administered the 9:00 a.m. medications to Resident #74, LPN #2 stated, "No. [RN #7] was using my password because she does not have a sign on." When asked if Resident #74's MAR was accurate, LPN #2 stated it was not.

On 4/7/21 at 4:03 p.m., ASM #2 was interviewed. When asked if a nurse should ever chart medication administration under another nurse's name, ASM #2 stated, "No. It is a violation. It is false information." She stated it was her understanding that LPN #2 logged in for RN #7 during the morning medication observation.

On 4/7/21 at 4:54 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. Both were asked to clarify the facility's professional standard. ASM #1 and ASM #2 both verified that the facility uses its policies as its standard for practice. A policy regarding staff accurate computer logins was requested.

On 4/8/21 at 10:28 a.m., ASM #1 provided a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 112	F 842		

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 calcitonin 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 blood cells. A deficiency of this vitamin causes certain types of anemia (low red blood cell count)." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682591.html.

(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). Amlodipine 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 113 taken from the website https://medlineplus.gov/druginfo/meds/a692044.html. (4) "Senna is used on a short-term basis to treat constipation. It also is used to empty the bowels before surgery and certain medical procedures. Senna is in a class of medications called stimulant laxatives. It works by increasing activity of the intestines to cause a bowel movement." This information is taken from the website https://medlineplus.gov/druginfo/meds/a601112.html. (5) "Torsemide is used alone or in combination with other medications to treat high blood pressure. Torsemide is used to treat edema (fluid retention; excess fluid held in body tissues) caused by various medical problems, including heart, kidney, or liver disease. Torsemide 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/a601212.html. 3. Resident #38's MAR (medication administration record) for 4/7/21 for 9:00 a.m. medications was inaccurate. Resident #38 was admitted to the facility on 6/3/11 with diagnoses including dementia (1) and epilepsy (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/1/21, Resident #38 was coded as being severely cognitively impaired for making daily decisions, having	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 842	Continued From page 114 scored three out of 15 on the BIMS (brief interview for mental status). A review of Resident #38's MARs (medication administration records) for 4/7/21 at 9:00 a.m. revealed that she received the following medications: - Lasix (3) 20 mg (milligrams) tablet - Multivitamin tablet - Potassium 20 mEq (milliequivalent) tablet - Vitamin B12 tablet - Vitamin D3 tablet - Metoprolol (4) 50 mg tablet - Tramadol (5) 25 mg tablet On 4/7/21 at 12:30 p.m., RN #7 was interviewed. When asked to look at Resident #38's MAR from the 9:00 medication administration, she pulled the electronic document up on the medication cart computer. Across the top of the computer screen, a banner stated: "Welcome [name of RN #7]." RN #7 was observed reviewing the MAR for Resident #38's medications administered at 9:00 a.m. that morning. When asked whose initials were in the blocks beside the medications she gave to Resident #38, RN #7 stated, "[LPN #2]'s." When asked if LPN #2 had administered those medications to Resident #38, RN #7 stated, "No. I did." When asked what it LPN #2's initials in the blocks on the MAR beside the medications meant, RN #7 stated, "It looks like she gave the medications. But I did." When asked what happened, she stated she was an agency nurse, and that morning was her very first day working in the facility. She stated when she arrived for work, she was briefly oriented, but was told that she needed to "be on a med (medication) cart immediately because "state is in the building." RN #7 stated she did not have a computer username	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 115	F 842		

or password of her own, so LPN #2 signed in with her credentials, and instructed her to start administering medications under her name. When asked if Resident #38's MAR was accurate, she stated it was not.

On 4/7/21 at 1:53 p.m., LPN #2, was interviewed. She stated she does not have a formal role for any new staff, but that she tries to help agency nurses who are new. When asked if RN #7 had ever worked at the facility, she stated she did not think so. LPN #2 stated, "This is my first time seeing her. I have only worked here four months. I just got my license in June." LPN #2 was shown Resident #38's MAR for the 9:00 a.m. medications administered to the resident on 4/7/21, and was asked what the initials and check mark in each box meant. LPN #2 stated, "That is my sign off for [name of electronic medical record software]." When asked if she administered the 9:00 a.m. medications to Resident #38, LPN #2 stated, "No. [RN #7] was using my password because she does not have a sign on." When asked if Resident #38's MAR was accurate, LPN #2 stated it was not.

On 4/7/21 at 4:03 p.m., ASM #2 was interviewed. When asked if a nurse should ever chart medication administration under another nurse's name, ASM #2 stated, "No. It is a violation. It is false information." She stated it was her understanding that LPN #2 logged in for RN #7 during the morning medication observation.

On 4/7/21 at 4:54 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. Both were asked to clarify the facility's professional standard. ASM #1 and ASM #2 both verified that the facility uses its policies as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 116	F 842		

its standard for practice. A policy regarding staff accurate computer logins was requested.

On 4/8/21 at 10:28 a.m., ASM #1 provided a 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) "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/All-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,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 117 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.html. (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 medications to treat heart failure. Metoprolol is in a class of medications called beta blockers. It works by relaxing blood vessels and slowing heart rate to improve blood flow and decrease blood pressure." This information is taken from the website https://medlineplus.gov/druginfo/meds/a682864.html. (5) "Tramadol is used to relieve moderate to moderately severe pain." This information is taken from the website https://medlineplus.gov/druginfo/meds/a695011.html.	F 842		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880	1. Corrective Action Resident #336 and #38 suffered no ill effects related to this deficient practice. The physical therapist (PT) and Registered Nurse (RN) who failed to follow facility infection control standards were re-educated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 118 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880	Continued From page 118 2. Other Potential Residents All residents have the potential to be affected by this deficient practice. 3. New Measures or Systemic Change The Infection Preventionist, Director of Nursing and/or registered nurse (RN) unit managers/supervisors will re-educate all healthcare professionals regarding transmission – based precautions, to include which personal protective equipment (PPE) is required and the proper cleaning of reusable equipment. 4. Monitoring The Infection Preventionist, Director of Nursing and/or RN unit managers and/or RN Supervisors will make focused infection control rounds daily for one week. Following this week, the focused infection control rounds will be completed two times weekly for another week then one time weekly for an additional week. Following this three-week increase in focused infection control rounding, the rounds will continue monthly for another two months. These results of these focused infection control rounds will be reported monthly to the Administrator and the QAPI Committee. 5. Completion Date May 18, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MANORCARE HEALTH SERVICES-FAIR OAKS	12475 LEE JACKSON MEMORIAL HIGHWAY FAIRFAX, VA 22033

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F 880	Continued From page 119 disease or infected skin lesions from direct contact with residents or their food, ifdirect contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to follow infection control practices for two of 33 current residents in the survey sample, (Residents #336 and #38). A physical therapist failed to wear an isolation gown into Resident #336's room when he was providing treatment to the resident. The resident had a physician's order for droplet and airborne isolation precautions and the facility staff failed to sanitize an unclean blood pressure cuff before using it on Resident #38. The findings include: 1. Resident #336 was admitted to the facility on 3/30/21 with diagnoses including history of a stroke and right side paralysis. Resident #336 had not been admitted to the facility long enough	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 880	Continued From page 120	F 880		

for an MDS (minimum data set) to be completed. On the admission nursing assessment dated 3/30/21, Resident #336 was documented as being, "alert and oriented X 3 [person, place, and time]."

On 4/06/21 at 1:56 p.m., Resident #336 was observed sitting in a wheelchair in his room. On the outside of his door, signs designating the resident as on airborne and droplet isolation were observed. OSM (other staff member) #11, a physical therapist, was observed kneeling on the floor in front of the seated resident. OSM #11 repeatedly touched the resident's legs, arms and shoulders. Observation revealed OSM #11's clothing was in direct contact with Resident #336, and the floor, multiple times. OSM #11 was wearing a mask, face shield, and gloves. However, he was not wearing an isolation gown.

A review of Resident #336's clinical record revealed the following physician's order, dated 3/30/21: "Airborne (1) and Droplet Precaution (2) for COVID-19 (3) Protocol."

A review of Resident #336's care plan dated 3/30/21 revealed no information related to infection control or isolation for COVID-19 observation.

On 4/7/21 at 2:32 p.m., OSM #11 was interviewed. When asked what isolation equipment he wore in Resident #336's room on 4/6/21, OSM #1 stated, "Gloves and my masks." When asked if he wore an isolation gown, he stated he did not. He stated the resident is not positive for COVID-19, and is only on isolation precautions because he is a relatively new admission. OSM #11 stated he works at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 880	Continued From page 121	F 880		

hospital most of the time, and only part time at the facility. He stated at the hospital, the isolation gown is optional for residents on COVID-19 observation. OSM #11 stated he is not sure that the gown is required at the facility. OSM #11 stated, "It may be that it is just suggested."

On 4/7/21 at 2:38 p.m., LPN (licensed practical nurse) #5 was interviewed. When asked what isolation equipment should be worn by staff caring for residents who are on observation for COVID-19, LPN #5 stated, "Gowns, gloves, masks, and face shields." She stated these are required because residents may have COVID-19.

On 4/7/21 at 3:53 p.m., LPN #4 was interviewed. When asked what isolation equipment should be worn by staff caring for residents who are on observation for COVID-19, LPN #4 stated, "Airborne and droplet." She stated the staff providing direct care for these residents should wear a gown, face mask, face shield, and gloves.

On 4/7/21 at 4:03 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. When asked what isolation equipment should be worn by staff caring for residents who are on observation for COVID-19, ASM #2 stated staff should wear a gown, gloves, mask and face shield.

A review of the facility document, "Personal Protective Equipment Usage Guide," revealed, in part: "Personal Protective Equipment Type: Gown...When to Use: When providing care or services within 6 (six) feet of patients with suspected or confirmed COVID-19 in transmission-based precautions including new admissions for 14-day quarantine period."

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 880	Continued From page 122 On 4/7/21 at 4:54 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. No further information was provided prior to exit. REFERENCES (1) "Droplet Precautions are used to prevent the spread of pathogens that are passed through respiratory secretions and do not survive for long in transit. These droplets are relatively large particles that cannot travel through the air very far. They are transmitted through coughing, sneezing, and talking." This information is taken from the website https://www.cdc.gov/infectioncontrol/pdf/strive/PPE102-508.pdf. (2) "Airborne precautions necessitate the prevention of infections and the use of available interventions in healthcare facilities to prevent the transmission of airborne particles. The airborne particles may remain localized to the room or move depending on the airflow. In some cases where there is inadequate ventilation, the airborne particle may remain in the hospital room and be inhaled by a newly admitted patient. The control and prevention of airborne transmission of infections are not simple. It requires the control of airflow with the use of specially designed ventilator systems, the practice of antiseptic techniques, wearing personalized protection equipment (PPE), and performing basic infection prevention measures like hand washing. This activity reviews the techniques for minimizing the spread of airborne diseases and the role of the interprofessional team in maximizing airborne precautions to minimize the spread ofdisease."	F 880		

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 880	Continued From page 123 This information was taken from the website https://www.ncbi.nlm.nih.gov/books/NBK531468/#:~:text=Airborne%20precautions%20necessitate%20the%20prevention,move%20depending%20on%20the%20airflow. (3) "Coronaviruses are a large family of viruses found in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the outbreak of respiratory illness in people first detected in Wuhan, China, has been named SARSCoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19." This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments 2. The facility staff failed to sanitize an unclean blood pressure cuff before using it on Resident #38. Resident #38 was admitted to the facility on 6/3/11 with diagnoses including dementia (1) and epilepsy (2). On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 2/1/21, Resident #38 was coded as being severely cognitively impaired for making daily decisions, having scored three out of 15 on the BIMS (brief interview for mental status). On 4/7/21 at 11:39 a.m., RN (registered nurse)#7 was observed entering the hallway from a resident's room. She was holding a portable blood pressure cuff. She placed the blood pressure cuff on top of the medication cart, and	F 880		

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	495217	A. BUILDING _____ B. WING _____	C 04/08/2021

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F 880	Continued From page 124 sanitized her hands with alcohol-based sanitizing gel. She rolled the cart to the door of Resident #38's room. She picked up the blood pressure cuff and entered Resident #38's room. RN #7 then used the blood pressure cuff to take Resident #38's blood pressure. She exited Resident #38's room, placed the blood pressure cuff on top of the medication cart, and sanitized her hands with alcohol-based sanitizing gel. On 4/7/21 at 12:30 p.m., RN #7 was interviewed. When asked if she had cleaned the blood pressure cuff between resident use before taking Resident #38's blood pressure, RN #7 stated, "Oh no. I did not." When asked if this is something that should be done, RN #7 stated, "Yes. I usually do. It's my first day here. I did not have anything to use to wipe it down." When asked why it is important to sanitize vital sign equipment between residents, RN #7 stated this is one way to prevent the spread of bacteria and germs between residents. On 4/7/21 at 2:38 p.m., LPN (licensed practical nurse) #5 was interviewed. When asked what should be done with vital sign equipment such as a blood pressure cuff between residents, LPN #5 stated the vital sign equipment should be sanitized. She stated this is an infection control concern. On 4/7/21 at 3:53 p.m., LPN #4 was interviewed. When asked what should be done with vital sign equipment such as a blood pressure cuff , between residents, LPN #4 stated it should be sanitized. She stated the facility provides sanitizing wipes for this purpose. LPN #4 stated the sanitizing wipes are usually located on the medication carts.	F 880		

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F 880	Continued From page 125 On 4/7/21 at 4:03 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated vital sign equipment should be cleaned with sanitizing wipes between residents. ASM #2 stated the wipes are necessary to kill bacteria and avoid cross contamination. On 4/7/21 at 4:54 p.m., ASM #1, the administrator, and ASM #2 were informed of these concerns. A review of the facility policy, "Cleaning and Disinfecting Product Guide," revealed, in part: "Micro-Kill Bleach Germicidal Wipes: Nursing - reusable non-dedicated patient care equipment in between patients (e.g. [for example] vital sign monitors, BP cuffs." No further information was provided prior to exit. 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496217	A. BUILDING _____ B. WING _____	C 04/08/2021

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MANORCARE HEALTH SERVICES-FAIR OAKS	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 BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 126 https://www.ninds.nih.gov/Disorders/All-Disorders/Epilepsy-Information-Page.	F 880		