PRINTED: 04/04/2022 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495038	B. WING		03/10/2022	
	ROVIDER OR SUPPLIER  AS HEALTH AND REHAL	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE COMPLETION	
F 000	INITIAL COMMENTS	3	F 00	00		
F 558 SS=D	survey was conducted 03/10/2022. One corsubstantiated) was is survey. Corrections a with 42 CFR Part 48. Requirements. The Laurvey/report will follow the consisted of 42 currectors and the time of the consisted of 42 currectors are closed record review. Reasonable Accomm CFR(s): 483.10(e)(3) Services in the facility accommodation of repreferences except wendanger the health other residents. This REQUIREMENT by:  Based on observation interview, facility docrecord review, it was failed to place a call 46 residents in the services.  The findings include:	20 certified bed facility was a survey. The survey sample ant Resident reviews and four s. nodations Needs/Preferences with to reside and receive with reasonable esident needs and when to do so would or safety of the resident or Γ is not met as evidenced on, staff interview, resident ument review and clinical determined the facility staff bell within reach for one of urvey sample, Resident determined the facility staff bell within reach for one of urvey sample, Resident	F 58	The statements made in the follow plan of correction are not an admis and do not constitute an agreement the alleged deficiencies nor the reproduction of the alleged deficiencies in support of the alleged deficiencifacility sets forth the following plan correction to remain in compliance federal and state regulations. The has taken or will take the actions so in the plan of correction. The follow plan of correction constitutes the factors of the state of t	esion to ont with corted on cited es. The of with all facility et forth	
	Resident #103 was a	dmitted to the facility on		allegation of compliance. All allege	-	
LABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE .	TITLE	(X6) DATE	

Electronically Signed 03/23/2022

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) DATE SURVEY COMPLETED		
		495038	B. WING _			03/	10/2022
	ROVIDER OR SUPPLIER  AS HEALTH AND REHAE	CENTER		STREET ADDRESS, CITY, 8575 RIXLEW LANE MANASSAS, VA 2010			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)	<b>I</b>	(X5) COMPLETION DATE
F 558	2/18/22 with diagnose and neuropathy. Res MDS (minimum data Medicare assessmen reference date of 2/2 scoring 15 out of 15 of for mental status) scowas not cognitively in coded the resident as assistance with bed rhygiene; total dependence oded the resident as bowel and for bladde.  A review of the comp 2/18/22 revealed, in particular falls related to recent Orient patient to roo bathroom. Encourag assistance with need.  On 3/8/22 at 8:05 AM was noted to be on the roommate's bed. being delivered to Reapproximately 8:15 AM was in the same local the two beds.  An interview was con AM with Resident #10 her call bell, Residen on the floor. It is on the floor. It is on the floor of the bed.	es that include pneumonia ident #103's most recent set) assessment, a five day it, with an assessment 4/22, coded the resident as on the BIMS (brief interview ore, indicating the resident inpaired. MDS Section G is requiring extensive staff mobility, transfers, dressing, dence for bathing. Section H is frequently incontinent for r.  The ensive care plan dated part, "FOCUS: At risk for history of falls at home orm, call bell, lighting and it to use call bell for s."  If, Resident #103's call bell for seldent #103 at M.  M. Resident #103's call bell tion, on the floor between ducted on 3/8/22 at 10:05  O3. When asked if she had it #103 stated, "It's probably the floor frequently because	F 5	deficiencies cited corrected by the  1. Resident splaced within real bedside immedia reported. Reside in facility.  2. Any resident call light secured A 100% audit of be conducted to secured and with 3. The Directo will re-educate a of accessibility to 4. Director of Naudit 10 resident accessibility and week for 4 week report findings to any variances accessibility.	or of Nursing or designed all staff on the important or call light by resident. Nursing or designee with the per unit for call light of securement to bed 5x and weekly for 8	des g ach. will ee ace ill c a eks;	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495038	B. WING		03/	/10/2022
	ROVIDER OR SUPPLIER  AS HEALTH AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 558	room, and was aske Resident #103's call is on the floor." Whe should be located, O within the resident's it and give it back to floor." OSM #2 was and cord with an ant back to the resident.  On 3/8/22 at 10:15 A conducted with LPN When asked if she h #103's morning med "Yes, I gave her the see the call bell on tilt should not be on tilt should not sh	entered Resident #103's d about the location of bell. OSM #2 stated, "Yes, it en asked where the call bell DSM #2 stated, "It should be reach. I'm just going to wipe her, it should not be on the observed wiping the call bell ibacterial wipe, and giving it  MM, an interview was (licensed practical nurse) #2. ad administered Resident ications, LPN #2 stated, morning meds but did not he floor. I'm sorry about that.	F 55	8		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING			03/	10/2022
	ROVIDER OR SUPPLIER  AS HEALTH AND REHAB	CENTER		85	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE IANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 558 F 656 SS=E	and Timely Response which revealed, "The assure the facility is a call light at each residenting facility to allow assistance. With each resident's room or ba call light is within read secured, as needed."  No further information	videspread."  y's "Call Lights: Accessibility e" policy dated 6/1/2021, purpose of this policy is to adequately equipped with a dent's bedside, toilet and w residents to call for th interaction in the throom, staff will ensure the ch of the resident and		5558 656			4/19/22
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that indo objectives and timefra medical, nursing, and needs that are identif assessment. The con- describe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that a under §483.24, §483.2 provided due to the re- under §483.10, includ- treatment under §483.3	cility must develop and hensive person-centered sident, consistent with the th at §483.10(c)(2) and cludes measurable ames to meet a resident's a mental and psychosocial ied in the comprehensive inprehensive care plan must g - are to be furnished to attain ent's highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required i.25 or §483.40 but are not esident's exercise of rights thing the right to refuse					

l ' '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING _	<del></del>	0;	3/10/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	•	
		HAD OFFITED		8575 RIXLEW LANE		
MANASSA	AS HEALTH AND RE	HAB CENTER		MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL 'OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 656	Continued From p	page 4	F 6	56		
	rehabilitative serv	rices the nursing facility will It of PASARR				
	recommendations findings of the PA rationale in the re (iv)In consultation resident's represe (A) The resident's desired outcomes (B) The resident's future discharge. whether the resid community was a local contact agerentities, for this properties of the polar, as appropriate requirements set section.	s. If a facility disagrees with the SARR, it must indicate its sident's medical record.  In with the resident and the entative(s)-  Is goals for admission and s.  Is preference and potential for Facilities must document ent's desire to return to the ssessed and any referrals to noices and/or other appropriate				
	interview, clinical document review, facility staff failed comprehensive or in the survey sam #56 and # 103.  The findings inclusion. The facility states the facility states oxygen at two little Resident # 45 was diagnoses that inchronic obstructive.	are plan for five of 46 residents uple, Residents #45, #24, # 64, and the control of the control		1. Resident #45□s compres plan was implemented to en oxygen is administered at the prescribed rate. Resident #3 comprehensive care plans wimplemented to ensure regular communication and coordinated dialysis center. Resident #64 longer resides in the center.  2. All residents have the plans and the feature of care plan implement conducted to ensure that oxygen communication and call light are carried out in accordance comprehensive person-centiplan.  3. The DON or designee with prescribed at the position of the plans implements the plans implements the plans implements of the	sure that le physician 24 and #56 \( \) 24 and #56 \( \) sere alar ation with the 4 and #103 no otential to be actice. A 100% tation will be ygen, dialysis t accessibility le with ered care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495038	B. WING _			03/	10/2022
	ROVIDER OR SUPPLIER  AS HEALTH AND REHAE	3 CENTER		857	REET ADDRESS, CITY, STATE, ZIP CODE 75 RIXLEW LANE ANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	quarterly assessmen reference date) of 01 scored 15 out of 15 of for mental status), incognitively intact for its Section "O Special Thrograms" coded Re Therapy" while a residulying in bed receiving Observation of the floconcentrator revealed three liters per minute.  The physician order if documented, "O2 (oxper minute) via (by) rhours as needed for Order Date: 02/19/20  The comprehensive of dated 09/04/2021 documented of the comprehensive of the com	t with an ARD (assessment /17/2022, the resident on the BIMS (brief interview dicating the resident is making daily decisions. reatments, Procedures and sident # 45 for "Oxygen ident.  Disciplinately 1:36 p.m., an ent # 45 revealed they were an oxygen by nasal cannula. The procedure is oxygen flow rate of each oxygen by nasal cannula. The procedure is oxygen flow rate of each oxygen by nasal cannula. The procedure is oxygen by nasal cannula.	F6	856	the nursing staff on implementing the resident □s comprehensive person-centered care plan.  4. Director of Nursing or designee(s) conduct an audit of 10 resident care pl to ensure implementation of oxygen, communication with dialysis center and placing call light within resident □s read as per resident care plan and standard practice weekly for 12 weeks and repofindings to QAPI committee.  5. Date of compliance is 4/19/2022	ans d ch ls of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495038	B. WING _			03/	/10/2022	
	ROVIDER OR SUPPLIER  AS HEALTH AND REHAE	3 CENTER		8575 RIX	ADDRESS, CITY, STATE, ZIP CODE KLEW LANE ISAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 656	Continued From page	e 6	F6	556				
	(related to) COPD, A 09/04/2021Provided Initiated: 09/04/2021 On 03/09/2022 at approbation of Resided oxygen concentrator conducted with LPN 4. When asked how rate on an oxygen con "The liter line goes the When asked to read Resident # 45's oxygoread the flow meter a minute." After review Resident # 45's oxygoread the describe the care plan, LPN # 4 story taking care of the rescomprehensive care respiratory care LPN	proximately 12:55 p.m., an ent # 45's flow meter on their						
	On 03/09/2022 at app (administrative staff r administrator and AS	proximately 5:00 p.m., ASM member) # 1, interim SM # 2, director of clinical aware of the above findings.						
	Care Planning Proce	y document "Comprehensive ess" was conducted. This cally direct that the care plan aplemented.						
	No further information	n was provided prior to exit.						
	2. The facility staff fa	ailed implement Resident #						

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	MULTIPLE CONSTRUCTION  JILDING		(X3) DATE SURVEY COMPLETED		
		495038	B. WING _		0	03/10/2022		
	ROVIDER OR SUPPLIER	HAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109				
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE		
F 656	24's comprehensicommunication will Resident # 24 was diagnoses include stage renal diseas (minimum data sean ARD (assessm 12/23/2022, the rethe BIMS (brief intindicating the resimaking daily decis Treatments, Proce Resident # 24 for  The physician's or documented in paas follows: 1) [Nar Number of Dialysi Tues-Thurs-Sat 4/Dialysis Transport Company]. 6) Chapate 08/10/2021.'  The comprehensive dated 08/10/2021 [Resident # 24] had dialysis Date Initia with dialysis center ordered. Communication of the faci Forms" for Reside evidence docume signs on 01/03/02 and temperature or signature or 01/03/02 and temperature or 01/03/02 and	th the dialysis center. Is admitted to the facility with ad but were not limited to: end se [2]. On the most recent MDS t), a quarterly assessment with lent reference date) of esident scored 15 out of 15 on terview for mental status), dent is cognitively intact for sions. Section "O Special edures and Programs" coded "Dialysis" while a resident.  Indeed the sheet for Resident # 24 ort, Resident receives Dialysis me, Address and Phone is Center]. Dialysis Days: Indeed to Dialysis Medical DX: ESRD 5) is (company): [Name of the sheet in part, "Focus: as Renal Disease requiring the sheet of the sheet in part, "Focus: as Renal Disease requiring the sheet of the sheet in part, "Focus: as Renal Disease requiring the sheet of the sheet in part, "Focus: as Renal Disease requiring the sheet of the sheet in part, "Focus: as Renal Disease requiring the sheet of t	F6	556				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING			03	/10/2022
	ROVIDER OR SUPPLIER  AS HEALTH AND REHA	B CENTER	•	8575 RIX	ADDRESS, CITY, STATE, ZIP CODE LEW LANE SAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIEN	CTATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 656	On 03/09/2022 at apinterview was condustaff member) # 2, coasked what portions facility was responsistated, "The resident (blood pressure, restemperature), and the reviewing the facility Forms" for Resident 2 was asked if the formation of care, tells us asked if Resident # was implemented to communication with dates listed above, and the formation of the kidneys can no long (and other types of of the kidneys when information was obtattoneys://medlineplus.com/100707.htm.	opproximately 4:05 p.m. an acted with ASM (administrative lirector of nursing. When of the dialysis sheets the able for completing, ASM # 2 at's name, date, vital signs apiration, pulse, and the nurse's signature. After a stransfer and Treatment are # 24 as dated above, ASM # forms were completed. ASM # forms were completed. ASM # forms were to describe the an, ASM # 2 stated, "It's a stated what we have to do." When 24's comprehensive care plan	F	656			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495038	B. WING _			03/	10/2022
	VIDER OR SUPPLIER  HEALTH AND REHAL	3 CENTER		8	STREET ADDRESS, CITY, STATE, ZIP CODE B575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
is both first to contain the c	ody's needs. This is on the website: ttps://medlineplus.g  The facility staff facomprehensive care ialysis services for Interest of the state of the services for Interest of the services for mental services for eating the look back of the services of the clinical services of the clinical services of the complete of the services of	can no longer support your information was obtained ov/ency/article/000500.htm.  ailed to implement the plan for coordination with Resident #64.  Imitted to the facility on diagnoses of but not limited diabetes, dialysis, and se. On the most recent MDS a 5-day assessment with an eference Date) of 2/7/22, the out of 15 on the BIMS (brief status, indicating the resident inpaired for making daily ent was coded as requiring g and extensive assistance activities of daily living. The as receiving dialysis services period.  all record revealed a ed 2/2/22 for, "Resident inalysis Days: Monday,	F	656			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495038	B. WING	·····		3/10/2022	
	ROVIDER OR SUPPLIER  AS HEALTH AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO. 8575 RIXLEW LANE MANASSAS, VA 20109	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	revealed "Transfer a were to be complete being sent to dialysis following information address, provider, di allergies, current me height, weight, and s 3/4/22, 3/7/22 and 3 complete the communication to th dated 3/9/22 did have documented but did documented.  On 3/10/22 at 7:45 A conducted with RN 4 asked the purpose obook, she stated it is resident's status, es weight. When asked completed, was the with the required info stated they were not documented to community with dialysis, was the stated it was not.  On 3/10/22 at 8:25 A Staff Member) the D notified of the finding dialysis forms that we that the facility community center, she stated the have been completed of the care plan, she	sis communication book nd Treatment Forms" that d for Resident #64 prior to s. This form included the name, date, facility, agnosis, code status, dical condition, vital signs, skin condition. The dates of /9/22, the facility did not unication forms for the and current weight for the dialysis center. The form the the blood pressure only not have complete vital signs	F 65	56			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		495038	B. WING _			03/10/2022	
	ROVIDER OR SUPPLIER	B CENTER	•	STREET ADDRESS, CITY, STATE, ZIP C 8575 RIXLEW LANE MANASSAS, VA 20109	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 656	Continued From pag	e 11	F 6	656			
		n was being followed g communication data for the ited it was not.					
		ximately 10:15 AM, ASM #1, as made aware of the					
	No further information the survey.	n was provided by the end of					
		ailed to implement the plan for coordination with Resident #56.					
	10/20/21 and had the to diabetes, end stage On the most recent I quarterly assessmen Reference Date) of 12 out of 15 on the Emental status, indica moderately cognitive decisions. The resid limited to extensive a activities of daily living as receving dialysis a period.	dmitted to the facility on e diagnoses of but not limited ge renal disease, and dialysis. MDS (Minimum Data Set), a set with an ARD (Assessment 1/26/22, the resident scored a BIMS (brief interview for ting the resident was sely impaired for making daily lent was coded as requiring assistance for all areas of ag. The resident was coded services during the look back					
	1 * *	red 10/22/21 for, "Resident Dialysis Days: Mon-Wed-Fri					
	A review of the comprevealed one dated	orehensive care plan 10/20/21 for, "[Resident #56]					

	OF DEFICIENCIES CORRECTION			(X3) DATE SURVEY COMPLETED	
		495038	B. WING		03/10/2022
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109	·
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION
F 656	with Dialysis center ordered. Communic regularly via pre/postary via pre/posta	requiring dialysisCoordinate for dialysis treatments as ate with dialysis provider	F 65		
	completed, was dial required information were not. When ask communicating predialysis center was was not.  On 3/10/22 at 8:25 \( \) Staff Member) the E notified of the findin dialysis forms that we that the facility commenter, she stated the	ysis center provided with the they needed, she stated they need if the care plan for treatment notes with the being followed, she stated it  AM, ASM #2, (Administrative Director of Nursing, was gs. When asked if the vere incomplete evidenced municated with the dialysis nat the dialysis forms should ed. When asked the purpose			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE (X6)			(X3) DATE SURVEY COMPLETED			
		495038	B. WING _		٥	3/10/2022
	ROVIDER OR SUPPLIER	AB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	Continued From pa	ge 13	F 6	56		
	have to do, everything asked if the care plant dialysis communicated she stated it was not on 3/10/22 at approach the Administrator, with findings.	e stated "It tells us what we ing about the resident." When an was being followed for tion data for the above dates, bt.  Eximately 10:15 AM, ASM #1, was made aware of the				
	_	ailed to implement the e plan for the call light for				
	2/18/22 with diagnol limited to, pneumon #103's most recent assessment, a five with an assessment coded the resident as BIMS (brief interview the resident was not Section G coded the extensive assistance transfers, dressing, bathing. Section H of frequently incontine A review of the come 2/18/22 revealed, in falls related to receilOrient patient to receil	admitted to the facility on uses that include, but are not use and neuropathy. Resident MDS (minimum data set) day Medicare assessment, at reference date of 2/24/22, as scoring 15 out of 15 on the w for mental status), indicating use cognitively impaired. MDS are resident as requiring the use of staff for bed mobility, hygiene; total dependence for coded the resident as unt for bowel and for bladder.  Apprehensive care plan dated in part, "FOCUS: At risk for int history of falls at home oom, call bell, lighting and use to use call bell for				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495038	B. WING _			03/10/2022	
	ROVIDER OR SUPPLIER  AS HEALTH AND REHAE	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP 8575 RIXLEW LANE MANASSAS, VA 20109	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE	
F 656	Continued From page	e 14	F 6	656			
	AM with Resident #10 her call bell, Resident on the floor. It is on to it slides off of the bed.  An interview was con AM with OSM (other therapist in Resident was asked about the call bell, OSM #2 stat When asked where to located, OSM #2 stat resident's reach. I'm it back to her, it shou #2 observed sanitized gave it back to the resident's reach. I'm it back to her, it shou #2 observed sanitized gave it back to the resident's reach. I'm it back to her, it shou #2 observed sanitized gave it back to the resident's reach. I'm it back to the resident's reach. I'm it back to her, it shou #2 observed sanitized gave it back to the resident's reach. I'm it back to the resident's reach. I'm it back to the resident's reach.	ducted on 3/8/22 at 10:07 staff member) #2, a physical #103's room. When OSM #2 location of Resident #103's ted, "Yes, it is on the floor." ne call bell should be ed, "It should be within the just going to wipe it and give ld not be on the floor." OSM d the call bell and cord, and sident.  M, an interview was					
	When asked if she ha #103's morning medi "Yes, I gave her the r see the call bell on the It should not be on the An interview was con approximately 1:10 P asked the purpose of stated, "It is to outline resident." When ask implemented if the in implemented. LPN #3 implemented."  On 3/9/22 at 4:58 PM member) #1, the inte						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING		03/10/2022	
	ROVIDER OR SUPPLIER  AS HEALTH AND REHAE	CENTER	8	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 656		n was provided prior to exit.	F 656			
F 695 SS=D	Respiratory/Tracheose CFR(s): 483.25(i)  § 483.25(i) Respirato tracheostomy care are The facility must ensure needs respiratory care care and tracheal succare, consistent with practice, the compreheare plan, the resider and 483.65 of this suffilial REQUIREMENT by:  Based on observation record review, and fawas determined that respiratory services a orders for one of 46 msample, Resident #4  The findings include:  Facility staff failed to oxygen flow rate at 2 to the physician's ord  Resident #45 was ac diagnoses that include chronic obstructive proon the most recent Median quarterly assessment reference date) of 01 scored 15 out of 15 or	ry care, including and tracheal suctioning. Use that a resident who e, including tracheostomy etioning, is provided such professional standards of the survey person-centered and the survey standards and preferences, appart.  The is not met as evidenced and the survey of the survey it facility document review, it facility staff failed to provide according to the physician's esidents in the survey 5.	F 695	<ol> <li>Resident #45□s Oxygen flow rate adjusted to two liters per minute via na cannula as per physician□s order.</li> <li>Any resident receiving supplement oxygen is at risk to be affected by this deficient practice. A 100% audit of residents receiving supplemental oxygwill be conducted to ensure flow rate being administered according to physician□s order.</li> <li>The DON or designee will re-educt nursing staff on Respiratory Care related to administration of supplemental oxygwas per physician□s order.</li> <li>Director of Nursing or designee with conduct an audit of 25% of residents receiving supplemental oxygen 3x per week x 4 weeks, then weekly x 4, then monthly x 1, and report findings to QAF committee with any variances addressed.</li> <li>Date of compliance is 4/19/2022</li> </ol>	sal tal en ate ed en II	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING		03/10/2022	
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 8575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETION	
F 695	cognitively intact for Section "O Special To Programs" coded Read Therapy" while a result on 03/08/22 at approbate of the filter	making daily decisions. Treatments, Procedures and esident # 45 for "Oxygen cident.  Doximately 1:36 p.m., an lent # 45 revealed they were goxygen by nasal cannula. The cow meter on the oxygen end an oxygen flow rate of the lent # 45 revealed they were goxygen by nasal cannula. The cow meter on the oxygen end an oxygen flow rate of the lent # 45 revealed they were goxygen by nasal cannula. The cow meter on the oxygen end an oxygen flow rate of the lent # 45 revealed they were goxygen by nasal cannula. The lent # 45 revealed they were goxygen by nasal cannula. The lent # 45 revealed they were goxygen by nasal cannula. The lent # 45 revealed they were goxygen by nasal cannula. The lent # 45 revealed they were goxygen by nasal cannula. The lent # 45 revealed they were goxygen by nasal cannula. The lent # 45 revealed they were goxygen by nasal cannula.	F 69	5		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING_			03/	10/2022
	ROVIDER OR SUPPLIER	CENTER		8	STREET ADDRESS, CITY, STATE, ZIP CODE 1575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	observation of Reside oxygen concentrator, conducted with LPN (4. When asked how rate on an oxygen con "The liter line goes the When asked to read to Resident # 45's oxygen read the flow meter a minute." After review Resident # 45's oxygen Resident # 4	proximately 12:55 p.m., an ent # 45's flow meter on their and an interview was licensed practical nurse) # they read the oxygen flow neentrator LPN # 4 stated, rough the middle of the ball." the oxygen flow rate on en concentrator, LPN # 4 and stated, "Three liters per ing the physician's order for en administration LPN # 4 wo liter per minute."	F	695			
F 698 SS=E	orders LPN # 4 stated hyperventilate."  The "User Manual" by [Name of Oxygen Codocumented in part, "prescribed setting by of the flow meter until line marking the specton 03/09/2022 at app (administrative staff in administrator and ASI services, were made.  No further information Dialysis	/ [Name of Manufacturer] for ncentrator] for Resident # 45 6. Adjust the flow to the turning the knob at the top the ball is centered on the ific flow rate."	F	698			4/19/22
33-E	§483.25(I) Dialysis. The facility must ensu	ure that residents who we such services, consistent					

	DE DEFICIENCIES CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495038	B. WING		03/10/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	·
MANACCA	AS HEALTH AND REHAE	CENTER		8575 RIXLEW LANE	
WANASSA	AS REALIN AND RENAL	CENTER		MANASSAS, VA 20109	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 698	Continued From page	e 18	F 69	8	
	with professional star	ndards of practice, the			
	-	on-centered care plan, and			
	the residents' goals a	and preferences.			
	This REQUIREMENT	Γ is not met as evidenced			
	by:				
		riew, facility document review		It is noted that facility staff failed	
		view, it was determined that		provide dialysis care coordination ar	
	_	to provide care and service		services for a complete dialysis prog	
		sis [1] program for three of		for resident #24, #64, and #56. Dialy	
		ırvey sample, Residents #		books updated to include communic	
	24, # 64 and # 56.			with Dialysis center. Resident #64 n	o
	The findings includes			longer resides in facility.	voio
	The findings include:			2. Any resident who receives Dialy treatment has the potential to be affective.	
	1 The facility staff fa	iled to maintain accurate		if the facility fails to provide a comple	
	_	ding Resident #24's care		dialysis program and ensure there is	
		er for January 2022 through		effective communication between	'
	March 2022.	or for barraary 2022 amough		facilities. 100% audit of all residents	who
				receive dialysis will be conducted to	
	Resident # 24 was a	dmitted to the facility with		ensure the center has implemented	
		out were not limited to: end		effective dialysis communication pro	
	stage renal disease [	2]. On the most recent MDS		for these residents.	
	(minimum data set),	a quarterly assessment with		3. The Director of Nursing or design	jnee
	an ARD (assessment	reference date) of		will educate licensed nurses and clir	nical
	12/23/2022, the resid	lent scored 15 out of 15 on		nurse leaders on dialysis policy inclu	ıding
	,	view for mental status),		communication.	
	_	nt is cognitively intact for		4. Director of Nursing or designee	
		ns. Section "O Special		audit dialysis residents to ensure dia	-
		res and Programs" coded		program and dialysis communication	
		ring received dialysis while a		books are current and up to date 3x	
	resident.			x 4, weekly x 4 then monthly x1. Fin	-
	The physician's arda	r sheet for Posidont # 24		will be reviewed in QAPI, and varian addressed.	UE3
		r sheet for Resident # 24 'Resident receives Dialysis		5. Compliance date 4/19/2022.	
	as follows: 1) [Name,			5. Compliance date 4/13/2022.	
		Center]. Dialysis Days:			
	_	alysis Medical DX: ESRD 5)			
	Dialysis Transport (c				
		ime: 10:55am (a.m.). Start			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495038	B. WING			03/	10/2022
	ROVIDER OR SUPPLIER	3 CENTER	·	8	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE MANASSAS, VA 20109		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 698	dated 08/10/2021 do [Resident # 24] has fidialysis Date Initiated with dialysis center for ordered. Communicate regularly via pre/post Initiated: 08/10/2021.  Review of the facility Forms" for Resident evidence documentate signs on 01/03/0221 and temperature on 0 signature on 01/03/0.01/13/0221, 01/18/2.02/05/2021, 03/01/2.001/13/0222 at appinterview was conducted staff member) # 2, diasked what portions facility was responsite stated, "The resident (blood pressure, respectemperature), and the reviewing the facility' Form" for Resident # 2 was asked if the focus asked if the focus asked what complete for the forms to be considered to the nurse that complete Then facility's policy "Hemodialysis. Communication of the forms to policy "Hemodialysis. Communication of the forms to policy "Hemodialysis. Communication of the facility's policy "Hemodialysis. Communication of the facility of the facility's policy "Hemodialysis. Communication of the facility of the facility's policy "Hemodialysis. Communication of the facility of the facilit	care plan for Resident # 24 cumented in part, "Focus: Renal Disease requiring d: 08/10/2021Coordinate or dialysis treatments as the with dialysis provider a treatment notesDate "  Is "Transfer and Treatment # 24's dialysis failed to tion of the following: all vital and 01/08/2021; respiration 01/11/2021 and the nurse's 221, 01/08/2021, 01/127/2021, 021, 01/25/2021, 01/27/2021, 021 and 03/05/2021.  Proximately 4:05 p.m. an obted with ASM (administrative rector of nursing. When of the dialysis sheets the oble for completing, ASM # 2 is name, date, vital signs objection, pulse, and an enurse's signature." After a Transfer and Treatment 24 as dated above, ASM # rms were complete. ASM # an asked why it was important ompleted ASM # 2 stated, anges in the resident and eted the form."	F	698			
		ommunicate to the dialysis					

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIF IDENTIFICATION NUMBER: A. BUILDING		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495038	B. WING		03/10/2022
	ROVIDER OR SUPPLIER  AS HEALTH AND REHA	B CENTER	8	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE IANASSAS, VA 20109	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODER (CROSS-REFERENCED TO THE APPRODE)	JLD BE COMPLÉTION
F 698	format, such as a di other form, that will b. Physician/treatme and vital signs"  On 03/09/2022 at all # 1, interim administ clinical services, we findings.  No further information References: [1] Dialysis treats er removes waste from kidneys can no long (and other types of of the kidneys when information was obthttps://medlineplus.go/00707.htm.  [2] The last stage of is when your kidney body's needs. This from the website:	c communication or written alysis communication form or include, but not limit itself to: ent orders, laboratory values, oproximately 5:00 p.m., ASM trator and ASM # 2, director of the made aware of the above on was provided prior to exit.  Ind-stage kidney failure. It is a your blood when your er do their job. Hemodialysis dialysis) does some of the job they stop working well. This ained from the website: gov/ency/patientinstructions/0  I chronic kidney disease. This is can no longer support your information was obtained	F 698		
	2. The facility staff communication and and services for Reand the dialysis cen	coordination of dialysis care sident #64 between the facility			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			, ,	(X3) DATE SURVEY COMPLETED	
		495038	B. WING		,	03/10/2022	
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 8575 RIXLEW LANE MANASSAS, VA 20109	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 698	kidney disease. On (Minimum Data Set), ARD (Assessment Resident scored a 15 interview for mental was not cognitively in decisions. The resident was not cognitively in decisions. The resident was coded a during the look back. A review of the clinic physician's order data receives Dialysis	abetes, dialysis, and chronic the most recent MDS, a 5-day assessment with an deference Date) of 2/7/22, the out of 15 on the BIMS (brief status, indicating the resident impaired for making daily dent was coded as requiring grand extensive assistance activities of daily living. The as receiving dialysis services period.  all record revealed a ded 2/2/22 for, "Resident Dialysis Days: Monday, day"  sis communication book and Treatment Forms that do for Resident #64 prior to a. This form included the control of the facility, agnosis, code status, dical condition, vital signs, skin condition. On 3/4/22, the facility did not complete the services for the required vital signs for communication to the form dated 3/9/22 did have only documented but did not signs documented.	F 69	98			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION		X3) DATE SURVEY COMPLETED	
		495038	B. WING		03	/10/2022	
	ROVIDER OR SUPPLIER  AS HEALTH AND REHA	AB CENTER	85	TREET ADDRESS, CITY, STATE, ZIP CODE 575 RIXLEW LANE ANASSAS, VA 20109	DDE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 698	with the required inf stated they were not stated they were not on 3/10/22 at 8:25. Staff Member) the Enotified of the findin dialysis forms that we that the facility come center, she stated the state of the state	dialysis center was provided formation they needed, she it.  AM, ASM #2, (Administrative Director of Nursing, was gs. When asked if the vere incomplete evidenced municated with the dialysis hat the dialysis forms should ed.  prehensive care plan 1/31/22 for, "[Resident #64] requiring dialysisCoordinate for dialysis treatments as cate with dialysis provider st treatment notes."  eximately 10:15 AM, ASM #1, was made aware of the con was provided by the end of failed to evidence coordination of dialysis care sident #56 between the facility	F 698				
	10/20/21 and had the limited to, diabetes, dialysis. On the modulate Data Set), a quarter (Assessment Reference of the limited to the limited that the limited to, diabetes, dialysis. On the modulation of the limited to, diabetes, dialysis.	Indirection of the facility on the diagnoses of, but not the end stage renal disease, and the strecent MDS (Minimum of the strecent with an ARD the ence Date) of 1/26/22, the 2 out of 15 on the BIMS (brief					

* *		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495038	B. WING		,	03/10/2022	
	ROVIDER OR SUPPLIER  AS HEALTH AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  8575 RIXLEW LANE  MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 698	was moderately cog daily decisions. The requiring limited to e areas of activities of coded as receiving of look back period.  A review of the clinic physician's order daireceives Dialysis	status, indicating the resident nitively impaired for making resident was coded as xtensive assistance for all daily living. The resident was lialysis services during the sal record revealed a ted 10/22/21 for, "Resident Dialysis Days: Mon-Wed-Friay, Friday)."  sis communication book and Treatment Forms that d for Resident #64 prior to se. This form included the rame, date, facility, agnosis, code status, dical condition, vital signs, skin condition. On 3/9/22, 2, 2/28/22, 2/23/22, 2/14/22, ty did not complete the se for the required vital signs or communication to the	F 69	98			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495038	B. WING_		03	3/10/2022	
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE  8575 RIXLEW LANE  MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC'  X (EACH CORRECTIVE ACTION SHOU  CROSS-REFERENCED TO THE APPR  DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
r continue of the continue of	that the facility committeenter, she stated that have been completed. A review of the comprevealed one dated 10 has Renal Disease revith Dialysis center for dered. Communicate egularly via pre/post 20 has 10/22 at approximate the Administrator, was indings.  No further information he survey. Resident Records - Icc CFR(s): 483.20(f)(5), 8483.20(f)(5) Resident in the facility may not resident-identifiable to accordance with a congress not to use or congress to the extent the odo so.	s. When asked if the pre incomplete evidenced unicated with the dialysis at the dialysis forms should be the dialysis forms as the with dialysis provider treatment notes."  I mately 10:15 AM, ASM #1, as made aware of the should be the dialysis formation that is the dialysis formation that is the public. I lease information that is the public of		342		4/19/22	

STATEMENT OF DEFICIENCIES ( AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495038	B. WING		03/10/2022	
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE B575 RIXLEW LANE MANASSAS, VA 20109	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOLE CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION	
F 842	all information contained regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, paraproperations, as permin with 45 CFR 164.506 (iv) For public health neglect, or domestic activities, judicial and law enforcement pur purposes, research purposes, resear	nented; le; and ganized  cility must keep confidential ned in the resident's records, n or storage method of the n release is- or their resident e permitted by applicable law;  syment, or health care tted by and in compliance b; activities, reporting of abuse, violence, health oversight d administrative proceedings, poses, organ donation purposes, or to coroners, funeral directors, and to avert ealth or safety as permitted e with 45 CFR 164.512.  cility must safeguard medical gainst loss, destruction, or  Il records must be retained e required by State law; or ne date of discharge when ent in State law; or ars after a resident reaches	F 842			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING		03	3/10/2022
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  8575 RIXLEW LANE  MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 842	(iii) The comprehensi provided; (iv) The results of any and resident review of determinations condutive (v) Physician's, nurse professional's progret (vi) Laboratory, radio services reports as restricted as the services it was determined as the services as t	ye plan of care and services y preadmission screening evaluations and ucted by the State; e's, and other licensed ss notes; and logy and other diagnostic equired under §483.50. To is not met as evidenced eterview, clinical record ment review and staff ermined that the facility failed te and accurate clinical residents in the survey	F 84:	1. It is noted that facility failed to maintain a complete and accurate A (Activities of Daily Living- showers) for resident #42.  2. Any resident is at risk to be affe by this deficient practice. A 100% a ADL Shower documentation accurate conducted.  3. The Director of Nursing or desi will educate Certified Nursing Aides (CNAs) and nurses on maintain an accurate record of Shower docume to accurately reflect the resident.  4. Director of Nursing or designed audit shower documentation of 10 residents per unit 3x week x 4, weethen monthly x1. Findings will be rein QAPI, and variances addressed.  5. Compliance date 4/19/2022.	record ected udit of cy will gnee ntation e with kly x 4	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495038	B. WING			3/10/2022	
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CO. 8575 RIXLEW LANE MANASSAS, VA 20109		<u></u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 842	showers on Tuesday they were not offered Resident #42 stated on some days, but not the comprehensive part, "[Resident #42] ADL assistance as res/p (status post) Lt. (amputation), also old Generalized weakned Incontinence, pain ar 06/26/2020"  The "Documentation 2/1/2022-2/28/2022 bathing/shower document bathing/shower area 2/25/2022. The area blank.  On 3/10/2022 at 9:45 conducted with CNA #3. CNA #3 stated the provided twice a week computer. CNA #3 should be documentation if a rest the building, or received the ADL documentation was caring for the rest the bath or shower.  On 3/10/2022 at 10:00 conducted with LPN	that he was scheduled for s and Fridays and at times I, and he was not sure why. that he did refuse showers of always.  Care plan documented in demonstrates the need for elated to impaired mobility, left) AKA (above the knee //healed Rt (right) AKA. ss, altered balance, and glaucoma Date Initiated:  Survey Report" dated was reviewed for mentation. The report failed	F 84				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		` IDENTIFICATION NUMBER:		MULTIPLE CONSTRUCTION  IILDING		(X3) DATE SURVEY COMPLETED	
		495038	B. WING _	<del></del>	0	3/10/2022	
NAME OF PROVIDER OR SUPPLIER  MANASSAS HEALTH AND REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CO 8575 RIXLEW LANE MANASSAS, VA 20109			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 842	not document the car those dates. LPN #6 indicated the charting. The facility policy "Do Record" dated 6/1/21 resident's medical reaccurate representation of the resident and in provide a picture of the through complete, and documentationLice interdisciplinary team all assessments, obsprovided in the reside accordance with state On 3/10/2022 at application of the reside accordance with state of administrative staff resident administrator and AS were made aware of	ably meant that the CNAs did the or the refusal of care on a stated that the blanks grows not complete.  Social complete of complete of the actual experiences of the actual experiences of the actual experiences of the enough information to the resident's progress of the actual experiences of the enough information to the resident's progress of the actual experiences of the enough information to the resident's progress of the enough information to the enough information to the resident's progress of the enough information to the	F8	42			