STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manassas Health and Rehab Center	8575 Rixlew Lane Manassas, VA 20109

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to dispose of refuse properly. The facility staff failed to maintain a clean dumpster area during the facility task- kitchen observation 1/20/26 at 11:50 AM. The findings include: On 1/20/26 at 11:50 AM, an observation was conducted in the dumpster area outside of the kitchen. On the left side of the dumpster on the ground there were blue and white gloves and plastic straw.An interview was conducted on 1/20/26 at 1:10 PM with OSM #1, the dining services director. When asked about the findings, OSM #1 stated, we only wear black gloves. I will talk with housekeeping about it. It sounds like trash from the facility.On 1/21/26 at 11:00 AM ASM (administrator staff member) #1, the administrator was informed of the above concerns.The facility does not have a policy related to the dumpster.No further information was provided prior to exit.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement the comprehensive care plan for two of 43 residents in the survey sample, Resident #6 and Resident #35.The findings include:1. For Resident #6 (R6), the facility staff failed to implement the comprehensive care plan to administer pain medication as ordered. Pain level parameters for the administration of Hydromorphone (1) were not followed during administration during dates in December 2025 and January 2026. The comprehensive care plan for R6 documented in part, Patient has pain or potential for pain. Date Initiated: 11/07/2025. Under Interventions it documented in part, Administer pain medication as ordered. Report s/s (signs/symptoms) potential negative side effects. Date Initiated: 11/07/2025 . Report breakthrough pain and/or unrelieved pain for further assessment and treatment. Date Initiated: 11/07/2025.On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date of 12/17/2025, the resident scored 14 out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. Section J documented R6 receiving scheduled and as needed pain medication and having almost constant pain.On 1/20/2026 at 2:57 PM, an interview was conducted with R6 who stated that they had chronic pain and took medication every four hours as needed. R6 stated that the medication helped when they had knee pain. The physician orders for R6 documented in part, Hydromorphone HCl Tablet 4 MG (milligram) Give 1 tablet by mouth every 4 hours as needed for severe pain 8-10. Hold for sedation/confusion. Order Date: 12/09/2025.Review of the electronic medication administration record (eMAR) dated 12/1-12/31/2025 for R6 documented administration of the Hydromorphone 4mg on 44 occasions for pain levels between zero and seven.Review of the eMAR dated 1/1-1/31/2026 for R6 documented administration of the Hydromorphone 4mg on 23 occasions for pain levels between zero and seven.On 1/22/2026 at 11:48 AM, an interview was conducted with licensed practical nurse (LPN) #9 who stated that the purpose of the care plan was to individualize the care of the resident and provide a reference for nursing to have for that resident. She stated that the care plan should be implemented because they wanted the residents to feel comfortable with their care and for their safety. LPN #9 stated that when a resident complained of pain they went and assessed the pain level, offered non-pharmacological interventions first and if they were not effective they looked at pain medication orders. She stated that when an as needed pain medication had pain level parameters they administered them when the pain level was within the parameters. LPN #9 stated that if the resident requested the medication for a pain level lower than the parameter that was set in the orders they would need to speak with the physician because the medications may need to be adjusted to better control their pain. The facility policy Comprehensive Care Planning Process dated 2017 failed to evidence guidance on implementing the comprehensive care plan. On 1/22/2026 at 3:30 PM, administrative staff member (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.Reference:(1) Hydromorphone is used to relieve severe pain. Hydromorphone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682013.html2. For Resident #35 (R35), the facility staff failed to implement the comprehensive care plan to offer ambulation daily. The comprehensive care plan for R35 documented in part, [R35] Demonstrates the need for ADL (activities of daily living) assistance, has history of CVA (cerebrovascular accident) with left sided weakness. Date Initiated: 08/24/2024. Revision on: 11/06/2025. Under Interventions it documented in part, Offer to assist with ambulation daily. Date Initiated: 12/11/2025 .On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 10/24/2025, the resident scored 15 out of (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. The assessment documented use of a wheelchair and walking not attempted due to the residents medical condition or safety concerns. It documented no therapy services received during the assessment period.On 1/20/2026 at 2:05 PM, an interview was conducted with R35 who stated that they had recently been discharged from physical therapy (PT). R35 stated that their insurance had stopped the therapy, but they had been walking with therapy using their walker and since then, they had not been walking anymore. R35 stated that they were told that the CNAs (certified nursing assistants) would walk behind them with a wheelchair and assist them to walk using the walker, but the CNAs did not have time to do it. R35 stated that it took 15 minutes to do that and the staff do not have time for that. R35 stated that they were concerned that they would lose the mobility they had gained working with PT if they did not get up and walk around like they were supposed to. Review of the physical therapy discharge summary documented therapy services from 12/22-12/30/2025 with extent of progress documented as Patient continues to require Min A (minimal assistance) for STS (sit to stand) from w/c (wheelchair), once upright able to perform transfers and ambulation with CGA/SBA (contact guard assist/stand-by assist). Under follow-up care recommended it documented, SNF (skilled nursing facility) care. Review of the ADL documentation for R35 from 1/1/2026-1/21/2026 documented in part, How the resident walks 10 feet AFTER standing up with or without assistive device (anywhere except in therapy). It failed to evidence ambulation or a refusal to ambulate on 1/5/2026, 1/8/2026, 1/10/2026, 1/12/2026, 1/15/2026 and 1/18/2026.Review of the clinical record failed to evidence any refusals to ambulate on the dates listed above. On 1/21/2026 at approximately 5:00 PM, a request was made to administrative staff member (ASM) #1, the administrator for evidence that R35 was assisted to ambulate or offered to ambulate daily from 1/1-1/21/2026.On 1/22/2026 at 8:53 AM, ASM #1 provided the ADL documentation listed above which failed to evidence ambulation on the dates listed above. On 1/22/2026 at 10:50 AM, an interview was conducted with other staff member (OSM) #14, physical therapist (PT) who stated that they worked with R35 in December 2025. She stated that they did an FMP (functional maintenance plan) for R35, and the nursing staff are supposed to ambulate R35 50-150 feet with the hemi-walker and gait belt and following behind the resident with their wheelchair. She stated that it was not safe for R35 to walk by themselves and they had put in the plan for R35 to walk at least once a day because they would benefit walking to maintain their ability to walk and because R35 wanted to do it. OSM #14 stated that the facility did not have a restorative nursing program and the assigned CNAs should be walking R35 as recommended to maintain mobility. On 1/22/2026 at 11:04 AM, an interview was conducted with certified nursing assistant (CNA) #8 who stated that the Kardex showed them recommendations from PT for residents ambulation. She stated that when a resident had recommended ambulation from PT it could be done anytime depending on the instructions given by therapy and how often the resident was to be ambulated. On 1/22/2026 at 11:48 AM, an interview was conducted with licensed practical nurse (LPN) #9 who stated that the purpose of the care plan was to individualize the care of the resident and to give a reference to nursing about the residents care. She stated that the care plan should be implemented to respect the residents choices and for safety purposes. LPN #9 stated that prior to discharge from therapy, education was completed with the nurses and the CNAs by the therapist on what follow up care was to be provided for that resident. She stated that the follow up recommendations were documented on the care plan and the CNAs had access to the Kardex which were implemented from the care plan. LPN #9 stated that they followed the therapy recommendations so that the residents did not lose what they had gained in therapy. On 1/22/2026 at approximately 12:00 PM, a request was made to ASM #1, the administrator for the FMP (functional maintenance plan) for R35.On 1/22/2026 at 2:40 PM, ASM #2, the director of nursing stated that they did not have an FMP for R35, but they had continued to offer to ambulate them every day. She stated that there were times when R35 refused to walk or did not want to get out of bed and those instances should be documented. On 1/22/2026 at 3:30 PM, ASM #1, (continued on next page)

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	495038	A. Building B. Wing	01/22/2026

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	the administrator and ASM #2, the director of nursing were made aware of the findings.No further evidence was provided prior to exit.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical review, the facility staff failed to provide activities to promote the highest level of wellbeing for three of 43 residents in the survey sample, Residents #24, #17, and #72.The findings include:1. For Resident #24 (R24), the facility staff failed to provide activities to promote the resident's highest level of wellbeing in December 2025 and January 2026.On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 10/2/25, R24 was coded as having both short term and long term memory problems. She was coded as preferring the following activities: snacks between meals, reading books/newspapers/magazines, listening to music, and doing things with groups of people. On 1/20/26 at 12:57 p.m., R24 was observed sitting up in bed in her room on the memory care unit. The resident was being fed by a staff member who was seated in a chair next to the bed. On 1/20/26 at 2:43 p.m., R24 was observed sitting up in bed with her eyes open, looking around the room. There was no music playing in the room. At 3:02 p.m., OSM (other staff member) #7, the activities director, began a word and [NAME] activity in the memory care day room. There was no observation of any staff member attempting to invite R24 to the activity. At 3:06 p.m., R24 was sitting up in bed, eyes open, looking around the room. There was no music playing in the room.On 1/20/26 at 11:00 a.m., observation was made in the day room in the memory care unit. Several residents were seated around the room and two residents were independently ambulating around the day room, as well as up and down the hallway. No activity was occurring.A review of the facility's activities calendar for 1/20/26 revealed one activity in the morning (music) and one activity in the afternoon (Getting Creative). This review also revealed one activity on 1/21/26, an exercise activity at 11:00 a.m. This was the only activity listed in the memory care unit on 1/21/26.A review of the larger activities calendar for December 2025 and January 2026 revealed some days with two planned activities on the memory care unit, and some days with only one activity designated for the memory care unit.A review of R24's December 2025 and January 2026 (through 1/19/26) activity participation records revealed that she was in bed and therefore did not participate in any group activity on 31 different days. This review revealed no information at all for seven days. This review revealed no evidence of any attempts by the facility staff to provide individual activities matching R24's assessed activity interests on any day that she did not participate in group activities on the memory care unit.On 1/21/226 at 2:10 p.m., OSM #7 was interviewed. She stated the memory care unit is her area, and that she is the primary person who plans and implements activities on this unit. When asked what sources she uses to plan activities on the memory care unit, she stated she relies on training she received and from a website to which she subscribes. She stated this website has a section geared towards residents with dementia. She stated she is aware that some residents do not like to get up early in the morning for groups, and that there are some people who enjoy exercise. She stated there is usually music playing in the day room all the time. She stated she tries to include different types of activities (crafts, exercise, music, BINGO) in hopes of meeting everyone's needs, but acknowledged this is difficult to do, especially on the memory care unit. She stated she tries to plan two activities each day on the memory care unit, and this usually leaves her time to do one-on-one activities for residents. She stated: I like to drop in and see them one-on one. She stated she did not have any documentation for any one-on-one resident activities for any resident on the memory care unit. She stated the 11:00 a.m. activity that was on the calendar for the memory care unit on 1/21/26 should not have been on the calendar. She stated there was no memory care activity that morning because she was involved in taking other residents on an outing. She stated she would be willing to go over there and do some things with them when she returned from the outing. On 1/21/26 at 5:27 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. ASM #3 stated the company had (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	recently undertaken a new initiative to improve activities in all of its facilities.A review of the facility policy, Activities Program, Implementation, revealed, in part: The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and individual activities.An overall assessment of each resident.and the physical and mental condition of the residents is necessary when planning activities.The activities calendar shall be implemented as written. Cancellations will be noted on the calendar and during morning announcements.No additional information was provided prior to exit.2. For Resident #17 (R17), the facility staff failed to provide activities to promote the resident's highest level of wellbeing in December 2025 and January 2026.On the most recent comprehensive MDS (minimum data set), a significant change assessment with an ARD (assessment reference date) of 11/28/25, R17 was coded as having no short term or long term memory problems, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was, however, coded as having Alzheimer's disease. She was coded as preferring listening to music, being around animals, going outside, and participating in religious services for activities.On 1/20/26 at 1:01 p.m., R17 was observed independently transferring from her wheelchair to sit on the side of her bed in her room on the memory care unit. On 1/20/26 at 3:02 p.m., OSM (other staff member) #7, the activities director, began a word and [NAME] activity in the memory care day room. At 3:08 p.m., R17 was sitting on the side of her bed in her room.On 1/20/26 at 11:00 a.m., observation was made in the day room in the memory care unit. Several residents were seated around the room and two residents were independently ambulating around the day room, as well as up and down the hallway. No activity was occurring.A review of the facility's activities calendar for 1/20/26 revealed one activity in the morning (music) and one activity in the afternoon (Getting Creative). This review also revealed one activity on 1/21/26, an exercise activity at 11:00 a.m. This was the only activity listed in the memory care unit on 1/21/26.A review of the larger activities calendar for December 2025 and January 2026 revealed some days with two planned activities on the memory care unit, and some days with only one activity designated for the memory care unit.A review of R17's December 2025 and January 2026 (through 1/19/26) activity participation records revealed that she either refused or was in bed and therefore did not participate in any group activity on 41 different days. This review revealed no information at all for five days. This review revealed no evidence of any attempts by the facility staff to provide individual activities matching R17's assessed activity interests on any day that she did not participate in group activities on the memory care unit.On 1/21/226 at 2:10 p.m., OSM #7 was interviewed. She stated the memory care unit is her area, and that she is the primary person who plans and implements activities on this unit. When asked what sources she uses to plan activities on the memory care unit, she stated she relies on training she received and from a website to which she subscribes. She stated this website has a section geared towards residents with dementia. She stated she is aware that some residents do not like to get up early in the morning for groups, and that there are some people who enjoy exercise. She stated there is usually music playing in the day room all the time. She stated she tries to include different types of activities (crafts, exercise, music, BINGO) in hopes of meeting everyone's needs, but acknowledged this is difficult to do, especially on the memory care unit. She stated she tries to plan two activities each day on the memory care unit, and this usually leaves her time to do one-on-one activities for residents. She stated: I like to drop in and see them one-on one. She stated she did not have any documentation for any one-on-one resident activities for any resident on the memory care unit. She stated the 11:00 a.m. activity that was on the calendar for the memory care unit on 1/21/26 should not have been on the calendar. She stated there was no memory care activity that morning because she was involved in taking other residents on an outing. She stated she would be willing to go over there and do some things with them when she returned from the outing. On 1/21/26 at 5:27 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. ASM #3 (continued on next page)

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	495038	A. Building B. Wing	01/22/2026

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated the company had recently undertaken a new initiative to improve activities in all of its facilities.No additional information was provided prior to exit.3. For Resident #72 (R72), the facility staff failed to provide activities to promote the resident's highest level of wellbeing in December 2025 and January 2026.On the most recent comprehensive MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 1/20/25, R72 was coded as being severely cognitively impaired. She was coded as preferring the following activities: keeping up with the news, going outside when the weather is good, and participating in religious services for activities. On the following dates and times, R72 was observed in her bed in the memory care unit: 1/20/26 at 12:54 p.m. and 3:02 p.m.; and 1/21/26 at 8:00 a.m., 11:34 a.m., and 4:08 p.m.A review of the facility's activities calendar for 1/20/26 revealed one activity in the morning (music) and one activity in the afternoon (Getting Creative). This review also revealed one activity on 1/21/26, an exercise activity at 11:00 a.m. This was the only activity listed in the memory care unit on 1/21/26.A review of the larger activities calendar for December 2025 and January 2026 revealed some days with two planned activities on the memory care unit, and some days with only one activity designated for the memory care unit.A review of R72's December 2025 and January 2026 (through 1/19/26) activity participation records revealed that she was in bed and therefore did not participate in any group activity on 32 different days. This review revealed no information at all for two days. This review revealed no evidence of any attempts by the facility staff to provide individual activities matching R72's assessed activity interests on any day that she did not participate in group activities on the memory care unit.On 1/21/226 at 2:10 p.m., OSM #7 was interviewed. She stated the memory care unit is her area, and that she is the primary person who plans and implements activities on this unit. When asked what sources she uses to plan activities on the memory care unit, she stated she relies on training she received and from a website to which she subscribes. She stated this website has a section geared towards residents with dementia. She stated she is aware that some residents do not like to get up early in the morning for groups, and that there are some people who enjoy exercise. She stated there is usually music playing in the day room all the time. She stated she tries to include different types of activities (crafts, exercise, music, BINGO) in hopes of meeting everyone's needs, but acknowledged this is difficult to do, especially on the memory care unit. She stated she tries to plan two activities each day on the memory care unit, and this usually leaves her time to do one-on-one activities for residents. She stated: I like to drop in and see them one-on one. She stated she did not have any documentation for any one-on-one resident activities for any resident on the memory care unit. She stated the 11:00 a.m. activity that was on the calendar for the memory care unit on 1/21/26 should not have been on the calendar. She stated there was no memory care activity that morning because she was involved in taking other residents on an outing. She stated she would be willing to go over there and do some things with them when she returned from the outing. On 1/21/26 at 5:27 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of operations, were informed of these concerns. ASM #3 stated the company had recently undertaken a new initiative to improve activities in all of its facilities.No additional information was provided prior to exit.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interview, and facility document review, it was determined that the facility staff failed to maintain the kitchen in a sanitary manner. The findings include: On 1/20/26 at 10:55 AM, an observation was conducted in the kitchen with the following findings: walk-in refrigerator #1, opened and undated five-pound bag of hash browns; walk-in refrigerator #2, one half chicken salad sandwich dated (prep 1/16/26 at 1:39 PM, expires 1/18/26 at 1:39 PM). An interview was conducted with OSM #1, the dining services director as the tour was being conducted, asked about opened and undated hash browns as well as the expired chicken salad sandwich OSM #1 stated, they should not be in there. I am throwing both of them out now. On 1/21/26 at 11:00 AM ASM (administrator staff member) #1, the administrator was informed of the above concerns.A review of the facility's Safe Food and Supply Storage policy revealed, Leftover prepared foods must be stored in approved containers, zip lock bags or wrapped with plastic wrap, be labeled as to contents and dated with a ?Use By' date. Opened packages must be securely closed and product identified.It is the center policy to ensure all dry goods will be appropriately stored in accordance with guidelines of the FDA (Food Drug Administration) Food Code. The Dining Services Director or designee ensures that all packaged and canned food items shall be kept clean, dry and properly sealed.No further information was provided prior to exit.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure dignity for one of 43 residents in the survey sample, Resident #133. The findings include:For Resident #133 (R133), the facility staff failed to ensure the resident's incontinence brief was not exposed and visible from the hall. R133 was admitted to the facility on [DATE]. A nursing admission assessment signed by a nurse on 1/13/26 documented R133 was only oriented to self. On 1/20/26 at 12:45 p.m., R133 was observed lying in bed, only wearing an incontinence brief. The resident was visible from the hall. On 1/20/26 at 2:25 p.m., 1/21/26 at 3:55 p.m., and 1/22/26 at 10:41 a.m., R133 was observed lying in bed with a gown pulled above the resident's waist. The resident's incontinence brief was exposed and visible from the hall. On 1/22/26 at 10:54 a.m., an interview was conducted with CNA (Certified Nursing Assistant) #8 (the CNA caring for R133). CNA #8 stated she had pulled the resident's gown down three times that morning, but the resident continued to pull the gown up. CNA #8 stated if a resident has clothes, she dresses the resident every day. CNA #8 stated R133 was moved to a different room because of COVID and did not have clothes in the current room. CNA #8 stated she could obtain clothes from R133's old room and try to put the clothes on the resident. On 1/22/26 at 11:49 a.m., an interview was conducted with LPN (Licensed Practical Nurse) #9. LPN #9 stated if she wore an incontinence brief, she would not want it to be exposed because she would feel very embarrassed. On 1/22/26 at 3:48 p.m., ASM (Administrative Staff Member) #1 (the Administrator), and ASM #2 (the Director of Nursing) were made aware of the above concern. On 1/22/26 at 5:02 p.m., an interview was conducted with ASM #2. ASM #2 stated she followed up with nursing staff and the social services assistant. ASM #2 stated staff had asked R133's daughter to bring the resident's clothes to the facility but she had not done so because she was sick. ASM #2 stated the CNAs said R133 did not have clothes and kicks the sheets off. ASM #2 stated on this date (after the above interviews), a CNA went to the laundry department to see if there were any clothes that would fit R133. The facility did not provide a policy regarding dignity.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495038	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Manassas Health and Rehab Center	8575 Rixlew Lane Manassas, VA 20109

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on clinical record review, staff interview and facility document review, it was determined that the facility staff failed to ensure all discharge needs were met prior to discharge from the facility for one of 43 residents in the survey sample, Resident #136.The findings include:For Resident #136 (R136), the facility staff failed to ensure needed durable medical equipment (DME), a bedside commode, was delivered to the residents home prior to discharging them from the facility to reside independently in a multi-level home with a bathroom located up 13 steps on the second level when they were unable to negotiate stairs. On the admission minimum data set (MDS), with an assessment reference date (ARD) of 12/12/2023, R136 was assessed as requiring partial/moderate assistance for bathing, upper body dressing, and standing from a sitting position, requiring substantial/maximal assistance of a helper for toileting and lower body dressing. Toilet transfers and walking were not attempted due to medical condition or safety concerns. The assessment coded R136 as frequently incontinent of bowel and bladder, having frequent severe pain, and utilizing scheduled and as needed pain medications. It documented the resident having a fall in the last month prior to admission with a major surgery during the 100 days prior to admission.The social services admission assessment dated [DATE] documented in part, .[R136] is adjusting to her new environment thus far. She arrived after 10:00 pm last night, 12/6/23, so her true adjustment is unknown at this time. There are no family supports in the area . Potential barriers/needs to meeting expressed goals (include physical barriers such as stairs, level of supervision/assistance available, location, lack of resources, etc.) Lives alone. 13 steps to bathroom level of home. No supervision. no family supports . Social Services staff will arrange home health, PT/OT/ST/Nurse/Aide (physical therapy/occupational therapy/speech therapy) and any equipment needed at discharge .The safe transition meeting for R136 dated 12/7/2023 documented attendance of the social worker, unit manager, rehab representative, business office manager, activities assistant and the resident. It further documented, .Patient's Transition Expectations: Return to home alone . Potential Barriers: Potential barriers to safe transition to desired destination (including financial/copay concerns, family/community support availability, etc.): Lives alone, 13 steps to bathroom on 2nd. level. No family in the area .A letter dated 2/5/2024 to the facility and R136 documented denial of appeals of the decision of Medicare Non-Coverage with services ending on 1/28/2024.The OT discharge summary for R136 dated 1/31/2024 documented in part, .Toilet transfer: Discharge (1/31/2024) Supervision or touching assistance . Discharge Recommendations: Home health services, Remove throw rugs, Remove environmental barriers, Assistive device for safe functional mobility. Elevated toilet seat/3 in 1 commode, shower bench (unpadded/over tub edge), Grab bars, Assistance w/ADLs (activities of daily living) and Lifeline for safety .The PT discharge summary for R136 dated 1/31/2024 documented in part, .Discharge Recommendations: Patient requires supervision for all bed mobility and transfer .The progress notes documented in part,- 1/19/2024 15:15 (3:15 PM) Social Services Note. Note Text: [R136] received her NOMNC (notice of Medicare non-coverage) with LCD (last covered day) 1/22/2024 and D/C (discharge) 1/23/2024. The appeal process was reviewed and the Livanta number given, [phone number] to be called by noon 01/21/2024. [R136] stated she is still not yet ready, unable to put any weight on her leg, and her other leg has become weak, so she plans to appeal once again.- 1/25/2024 18:55 (6:55 PM) Social Services Note. Note Text: [R136] was given and signed her NOMNC with LCD 1/28/2024 and DC 1/29/2024. Appeal information was provided. Appeal by noon 1/27/2024 by calling Livanta @ [phone number]. [R136] stated she would be appealing again, her wounds are not healing, and she is doing better in therapy.- 1/29/2024 09:53 (9:53 AM) Social Services Note. Note Text: [R136] lost her appeal Saturday, Jan. 27th. Liability begins today, 1/29/2024. She has filed a second level appeal.- 01/31/2024 14:58 (2:58 PM) Social Services note. LATE ENTRY Note Text: [R136] is (continued on next page)

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	495038	A. Building B. Wing	01/22/2026

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	being discharged [DATE]. Writer has attempted to order oxygen and a bedside commode, due to her bathroom being on the second floor of her home and her inability to walk or climb stairs. [R136] does not qualify for oxygen, as her O2 (oxygen) stats [sic] are above 90 with room air.- 2/1/2024 08:55 (8:55 AM) Nurse Practitioner Note . Pt to be discharged to home with home health and skilled nursing. Course at [Name of facility] included PT/OT, medication monitoring and pain management. In stable condition for discharge. RX (prescription) was provided to assigned nurse. Spent over 55 min on discharge planning, coordination, and education, coordinating DME with SW, assessing the pt, writing prescriptions and documentation . Recent discharge from a facility following Right knee replacement and wound management. The patient is unable to leave home because he/she is unable to negotiate stairs leading outside his/her home due to endurance, weakness or dyspnea .- 2/1/2024 12:35 (12:35 PM) Note Text : Resident discharged home, took all personal belongings including remaining medications.- 2/2/2024 11:32 (11:32 AM) Note Text : Home health was set up through [Name of home health agency], where she will receive PT/OT/Nursing and an Aide.The Notice of Transfer or Discharge for R136 documented an effective date of transfer home on 2/1/2024 due to The transfer or discharge is appropriate because your health has improved sufficiently that you no longer need the services provided by this center . The notice was dated as written on 1/25/24 with R136's name written on it. On 1/22/2026 at approximately 7:43 AM, administrative staff member (ASM) #1, the administrator, provided a printed copy of a chat between the facility and the DME provider for R136. The chat documented the social worker at the facility creating the order for the 3 in 1 bedside commode on 1/31/2024 at 5:11 PM with the order accepted by the DME provider on 1/31/2024 at 6:38 PM. The chat documented the order pending further review on 1/31/2024 at 6:59 PM and the DME company attempting to contact the resident on 2/1/2024 at 12:06 PM. A note from the DME company dated 2/1/2024 at 12:58 PM documented We contacted the patient/family. We are awaiting a callback to discuss financial obligation and delivery. We will continue our outreach if we do not hear back in a timely fashion. We just wanted to provide a quick update. Thank you! The next note was cancellation of the order on 3/27/2024 at 10:33 AM.ASM #1 also provided a fax from the home health agency which documented an email chain between staff at the home health agency. The first email dated 2/1/2024 at 10:50 AM sent the referral and eligibility form for review, the second email documented them leaving a message at 2:00 PM and to attempt to call again later. The third email documented staff calling again at 4:36 PM and the fourth email documented speaking with R136 at 4:59PM on 2/5/2024. It documented, I spoke to pt (patient) at 4:59pm. She fell at home when she was DC (discharged) on 2/1 and went to the emergency room. She refused to go back to [Name of facility] so she was admitted to [Name of other facility] I shared that we would be happy to provide her HH (home health) services upon her DC. This will be a canceled referral. Thanks .The information provided by ASM #1 failed to evidence the bedside commode delivery to R136's home prior to them being discharged from the facility.On 1/22/2026 at 9:31 AM, an interview was conducted with other staff member (OSM) #10, the social services assistant who stated that she remembered R136. She stated that R136 had received a NOMNC and filed an appeal but had lost. OSM #10 stated that she had discussed with therapy about what DME R136 was going to need to go home with and had set up home health services. She stated that she had ordered a 3 in 1 commode for R136 that therapy had recommended for them. OSM #10 stated that she was not aware that the DME company had called R136 or that they had gone to the hospital. She stated that she had ordered everything prior to R136 going home and sometimes it was delivered to the home. She stated that R136 may have had a copay and that may have been the reason that it was not delivered. OSM #10 stated that they could only do what was required of them to do and that was why the 3 in 1 commode was ordered. She stated that they tried to make sure DME was delivered prior to discharge but they were at the mercy of the insurance. She stated that if the resident lived alone with no family and were dependent, they tried to let the home health agency know to expedite the service and that it should be documented in their notes if it were done for R136. OSM #10 stated that it was difficult for her because they were at the (continued on next page)

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	495038	A. Building B. Wing	01/22/2026

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mercy of the insurance, but maybe she could have notified APS (adult protective services) that the resident was going home alone and dependent on someone for care. She stated that they could not go to each persons home to make sure they were safe and it was unfortunate because she did not know R136 had fallen. On 1/22/2026 at 2:43 PM, an interview was conducted with OSM #9, rehab director who stated that they did not remember R136. OSM #9 stated that the physical therapist and occupational therapist who worked with R136 during their stay no longer worked at the facility. She stated that she had reviewed the PT and OT discharge summaries for R136 and they were non-weight bearing to the right leg throughout their stay at the facility. She stated that at discharge, R136 was unable to bear weight on the right leg and was not able to go up or down stairs. OSM #9 stated that the discharge plan was for a bedside commode at home that was recommended by therapy, and it was set up by the social worker. She stated that R136 would have performed better if their weight bearing status had changed but the orthopedic physician had not allowed them to put weight on that leg. OSM #9 stated that R136 needed supervision at the time of discharge, but she could not determine by the notes whether it was constant or not. OSM #9 stated that therapy recommended the DME, but social services were the ones who set up and ensured that everything was in place at the time of discharge.On 1/22/2026 at 11:48 AM, an interview was conducted with licensed practical nurse (LPN) #9 who stated that she did not remember R136. She stated that when a resident was discharged home they provided patient teaching and educated the caregiver. She stated that therapy played a part in determining when a resident was ready for discharge and what DME was needed at home. LPN #9 stated that if a resident required assistance or if there were concerns regarding DME not being at home prior to discharge, she would speak with the social worker and physician to let them know that she did not feel that it was safe to discharge the resident. She stated that they could do peer to peer reviews but unfortunately the insurance usually made the decision. On 1/22/2026 at 3:30 PM, ASM #1, the administrator and ASM #2, the director of nursing were made aware of the concern.No further information was provided prior to exit.

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	495038	A. Building B. Wing	01/22/2026

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to provide ADL (activities of daily living) care for one of 43 residents in the survey sample, Resident #133. The findings include:For Resident #133 (R133), the facility staff failed to dress the resident in clothes on 1/20/26, 1/21/26, and 1/22/26. R133 was admitted to the facility on [DATE]. A nursing admission assessment signed by a nurse on 1/13/26 documented R133 was only oriented to self. On 1/20/26 at 12:45 p.m., R133 was observed lying in bed, only wearing an incontinence brief. The resident was visible from the hall. On 1/20/26 at 2:25 p.m., 1/21/26 at 3:55 p.m., and 1/22/26 at 10:41 a.m., R133 was observed lying in bed with a gown pulled above the resident's waist. The resident's incontinence brief was exposed and visible from the hall. On 1/22/26 at 10:54 a.m., an interview was conducted with CNA (Certified Nursing Assistant) #8 (the CNA caring for R133). CNA #8 stated she had pulled the resident's gown down three times that morning, but the resident continued to pull the gown up. CNA #8 stated if a resident has clothes, she dresses the resident every day. CNA #8 stated R133 was moved to a different room because of COVID and did not have clothes in the current room. CNA #8 stated she could obtain clothes from R133's old room and try to put the clothes on the resident. On 1/22/26 at 3:48 p.m., ASM (Administrative Staff Member) #1 (the Administrator), and ASM #2 (the Director of Nursing) were made aware of the above concern. On 1/22/26 at 5:02 p.m., an interview was conducted with ASM #2. ASM #2 stated she followed up with nursing staff and the social services assistant. ASM #2 stated staff had asked R133's daughter to bring the resident's clothes to the facility but she had not done so because she was sick. ASM #2 stated the CNAs said R133 did not have clothes and kicks the sheets off. ASM #2 stated on this date (after the above interviews), a CNA went to the laundry department to see if there were any clothes that would fit R133. The facility policy titled, ADL Care of Patients documented, It is the policy of this Center to provide ADL care for patients to ensure all ADL needs are met daily .2. Patients will be dressed in clean clothing .

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	495038	A. Building B. Wing	01/22/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement interventions to prevent a decrease in mobility for one of 43 residents in the survey sample, Resident #35.The findings include:For Resident #35 (R35), the facility staff failed to ambulate as recommended by physical therapy and care plan interventions to prevent a decrease in mobility.On the most recent minimum data set (MDS), a quarterly assessment with an assessment reference date (ARD) of 10/24/2025, the resident scored 15 out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. The assessment documented use of a wheelchair and walking not attempted due to the residents medical condition or safety concerns. It documented no therapy services received during the assessment period.On 1/20/2026 at 2:05 PM, an interview was conducted with R35 who stated that they had recently been discharged from physical therapy (PT). R35 stated that their insurance had stopped the therapy, but they had been walking with therapy using their walker and since then they had not been walking anymore. R35 stated that they were told that the CNAs (certified nursing assistants) would walk behind them with a wheelchair and assist them to walk using the walker, but the CNAs did not have time to do it. R35 stated that it took 15 minutes to do that and the staff do not have time for that. R35 stated that they were concerned that they would lose the mobility they had gained working with PT if they did not get up and walk around like they were supposed to. Review of the physical therapy discharge summary documented therapy services from 12/22-12/30/2025 with extent of progress documented as Patient continues to require Min A (minimal assistance) for STS (sit to stand) from w/c (wheelchair), once upright able to perform transfers and ambulation with CGA/SBA (contact guard assist/stand-by assist). Under follow-up care recommended it documented, SNF (skilled nursing facility) care. The comprehensive care plan for R35 documented in part, [R35] Demonstrates the need for ADL (activities of daily living) assistance, has history of CVA (cerebrovascular accident) with left sided weakness. Date Initiated: 08/24/2024. Revision on: 11/06/2025. Under Interventions it documented in part, Offer to assist with ambulation daily. Date Initiated: 12/11/2025 .Review of the ADL documentation for R35 from 1/1/2026-1/21/2026 documented in part, How the resident walks 10 feet AFTER standing up with or without assistive device (anywhere except in therapy). It failed to evidence ambulation or a refusal to ambulate on 1/5/2026, 1/8/2026, 1/10/2026, 1/12/2026, 1/15/2026 and 1/18/2026.Review of the clinical record failed to evidence any refusals to ambulate on the dates listed above. On 1/21/2026 at approximately 5:00 PM, a request was made to administrative staff member (ASM) #1, the administrator for evidence that R35 was assisted to ambulate or offered to ambulate daily from 1/1-1/21/2026.On 1/22/2026 at 8:53 AM, ASM #1 provided the ADL documentation listed above which failed to evidence ambulation on the dates listed above. On 1/22/2026 at 10:50 AM, an interview was conducted with other staff member (OSM) #14, physical therapist (PT) who stated that they worked with R35 in December 2025. She stated that they did an FMP (functional maintenance plan) for R35, and the nursing staff are supposed to ambulate R35 50-150 feet with the hemi-walker and gait belt and following behind the resident with their wheelchair. She stated that it was not safe for R35 to walk by themselves and they had put in the plan for R35 to walk at least once a day because they would benefit walking to maintain their ability to walk and because R35 wanted to do it. OSM #14 stated that the facility did not have a restorative nursing program and the assigned CNAs should be walking R35 as recommended to maintain mobility. On 1/22/2026 at 11:04 AM, an interview was conducted with certified nursing assistant (CNA) #8 who stated that the Kardex showed them recommendations from PT for residents ambulation. She stated that when a resident had recommended ambulation from PT it could be done anytime depending on the instructions given by therapy and how often the resident was to be ambulated. On 1/22/2026 at 11:48 AM, an interview (continued on next page)

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	495038	A. Building B. Wing	01/22/2026

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F 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was conducted with licensed practical nurse (LPN) #9 who stated that prior to discharge from therapy, education was completed with the nurses and the CNAs by the therapist on what follow up care was to be provided for that resident. She stated that the follow up recommendations were documented on the care plan and the CNAs had access to the Kardex which were implemented from the care plan. LPN #9 stated that they followed the therapy recommendations so that the residents did not lose what they had gained in therapy. On 1/22/2026 at approximately 12:00 PM, a request was made to ASM #1, the administrator for the FMP (functional maintenance plan) for R35.On 1/22/2026 at 2:40 PM, ASM #2, the director of nursing stated that they did not have an FMP for R35, but they had continued to offer to ambulate them every day. She stated that there were times when R35 refused to walk or did not want to get out of bed and those instances should be documented. No policy was provided on prevention of decrease in mobility in residents.On 1/22/2026 at 3:30 PM, ASM #1, the administrator and ASM #2, the director of nursing were made aware of the findings.No further evidence was provided prior to exit.

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on resident interview, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to implement a complete pain management program for one of 43 residents in the survey sample, Resident #6.The findings include:For Resident #6 (R6), the facility staff failed to follow pain level parameters for the administration of hydromorphone (1). On the most recent minimum data set (MDS), a significant change assessment with an assessment reference date of 12/17/2025, the resident 14 out of 15 on the brief interview for mental status (BIMS) assessment, indicating they were cognitively intact for making daily decisions. Section J documented R6 receiving scheduled and as needed pain medication and having almost constant pain.On 1/20/2026 at 2:57 PM, an interview was conducted with R6 who stated that they had chronic pain and took medication every four hours as needed. R6 stated that the medication helped when they had knee pain. The physician orders for R6 documented in part, Hydromorphone HCl Tablet 4 MG (milligram) Give 1 tablet by mouth every 4 hours as needed for severe pain 8-10. Hold for sedation/confusion. Order Date: 12/09/2025.Review of the electronic medication administration record (eMAR) dated 12/1-12/31/2025 for R6 documented administration of the Hydromorphone 4mg on 44 occasions for pain levels between zero and seven.Review of the eMAR dated 1/1-1/31/2026 for R6 documented administration of the Hydromorphone 4mg on 23 occasions for pain levels between zero and seven.The comprehensive care plan for R6 documented in part, Patient has pain or potential for pain. Date Initiated: 11/07/2025. Under Interventions it documented in part, Administer pain medication as ordered. Report s/s potential negative side effects. Date Initiated: 11/07/2025 . Report breakthrough pain and/or unrelieved pain for further assessment and treatment. Date Initiated: 11/07/2025.On 1/22/2026 at 11:48 AM, an interview was conducted with licensed practical nurse (LPN) #9 who stated that when a resident complained of pain they went in and assessed the pain level, offered non-pharmacological interventions first and if they were not effective they looked at pain medication orders. She stated that when an as needed pain medication had pain level parameters they administered them when the pain level was within the parameters. LPN #9 stated that if the resident requested the medication for a pain level lower than the parameter they would need to speak with the physician because the medications may need to be adjusted to better control their pain.The facility policy Pain Management revised 3/13/2025 documented in part, The center must ensure that pain management is provided to patients that require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the patient's goals and preferences . Center employees will notify the medical practitioner, if the patient's pain is not controlled by the current treatment regimen . On 1/22/2026 at 3:30 PM, administrative staff member (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.Reference:(1) Hydromorphone is used to relieve severe pain. Hydromorphone is in a class of medications called opiate (narcotic) analgesics. It works by changing the way the brain and nervous system respond to pain. This information was obtained from the website: https://medlineplus.gov/druginfo/meds/a682013.html