STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495424	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Manassas Health & Rehabilitation Center	14935 Holly Knoll Lane Gainesville, VA 20155

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide required documents at the time of discharge for one of 12 residents in the survey sample, Resident #2.The findings include:For Resident #2 (R2), the facility staff failed to provide a written notice of bed hold to the resident or Resident Representative (RR) and failed to provide continuity of clinical care documents to the receiving hospital on 2/28/26.A review of R2's clinical record revealed that she was discharged to the hospital on 2/28/26 at approximately 10:30 p.m.Further review of R2's clinical record failed to reveal evidence that the resident (or Resident Representative) was notified in writing of the reasons for the discharge and no evidence that the facility provided clinical documentation regarding the resident's care plan goals and other information to the receiving hospital.On 4/8/26 at 7:05 a.m., the [NAME] President of Operations stated there was no bed hold or continuity of clinical care information for R2 on 2/28/26.On 4/8/26 at 8:52 a.m., LPN (licensed practical nurse) #9 was interviewed. She stated she communicates the critical clinical information to the receiving hospital by phone. She stated she also prints the resident's code status, medical history, allergies, vital signs, and other relevant information from the past seven days. She stated ordinarily she gives this paperwork to the EMS (emergency medical service personnel) to be handed over to the emergency room staff. She stated all of this is documented in the change of condition report in the electronic medical record.On 4/8/26 at 10:48 a.m., the Director of Nursing, Regional Director of Clinical Services, and [NAME] President of Operations were notified of these concerns.A review of the facility policy, Patient Transfer, revealed, in part: A Patient Transfer Form (eINTERACT) should be sent with the patient when transporting to a hospital or acute care setting.The Patient Transfer Form (eINTERACT) is completed by a licensed nurse when the patient is being transferred to the hospital for care and services. Generate the chart for the last 7 days and provide information to the receiving facility.A review of the facility policy, Bed Reserve, revealed, in part: Whenever any patient.is transferred from the Health and Rehabilitation Center is admitted for overnight hospitalization/observation.the patient and or the responsible representative (or hospital) must pay to hold the bed if the patient wishes to ensure that he/she can return to the bed he/she has been occupying.To make this arrangement, the patient and/or responsible representative must (1) promptly complete and sign a formal ?Voluntary Bed Retention Agreement' and (2) provide private payment to the Health and Rehabilitation Center for the requested days. This arrangement can be made at the time of transfer, or by the close of the business day on which the hospitalization occurs, but no later than 10:00 a.m. on the day following the hospitalization.No additional 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

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide care in a timely manner to prevent serious injury and/or death to two of 12 residents in the survey sample, Residents #1 and #2, resulting in the identification of immediate jeopardy.The findings include:1. For Resident #1 (R1), on [DATE], the facility staff failed to assess and accurately identify signs and symptoms of sepsis (1) and to transfer the resident to the hospital in a timely manner. The resident's significant change of condition was identified on [DATE] at 7:30 a.m., the resident was not transferred to the local hospital for treatment until approximately 12:30 p.m., and the resident died at the hospital at 3:37 p.m. from sepsis. The delay in treatment put the resident at high risk of serious injury or death.R1 was admitted to the facility on [DATE] with diagnoses that included surgical repair of a hip fracture. On the admission MDS (minimum) assessment with an ARD (assessment reference date) of [DATE], he was coded as having no cognitive impairment, having scored 15 out of 15 on the BIMS (Brief Interview for Mental Status). He was coded as having no concerns with making his needs known or communicating. A review of provider and nursing assessments revealed R1 was consistently alert and oriented to person, place, time, and situation. R1 had a provider's order that he was a full code. A review of R1's clinical record revealed the following sequence of events: On [DATE] at approximately 11:00 p.m., R1 was documented as having no physical concerns; his blood pressure was 127/65, and no concerns were documented regarding his neurological status. On [DATE] at 6:27 a.m., the weekend on-call licensed provider was contacted about the resident's low blood pressure (documented as 84/49). The on-call provider ordered a hold on the resident's aspirin and medications to treat high blood pressure, a test for blood in the resident's stool, and hourly blood pressure checks. On [DATE] at 7:30 a.m., R1's blood pressure was recorded as 80/41, he was unresponsive to verbal stimuli, and his oxygen saturation was 84% on room air. R1's neurological status of being unresponsive never changed throughout the day. The resident's PCP (primary care physician) was notified and he gave orders for IV (intravenous) fluids to be given at 100 ml/hr (milliliters per hours). At 8:00 a.m., R1's blood pressure was 82/38 and O2 saturation was 93% on oxygen at 4 lpm (liters per minute). At 9:30 a.m., the PCP ordered additional IV fluids . At 10:00 a.m., R1's blood pressure was 85/43 and his heart rate was 132; his O2 saturation was 85-90% on 5 lpm. IV fluids continued. At 11:08 a.m., R1's blood pressure was 79/40 and his O2 saturation was 99% on 8 lpm. At 12:00 noon, R1's blood pressure was 81/41. The PCP gave an order for the resident to be transferred to the hospital.A review of the EMS (emergency medical services) call record revealed the facility placed a call for assistance with R1 on [DATE] at 12:23 p.m. This review revealed the following: Primary Impression: Sepsis.Signs and Symptoms Hypotension (low blood pressure) Primary.A review of R1's death certificate revealed his time of death at the hospital as 3:37 p.m., and sepsis as the resident's cause of death.On [DATE] at 9:27 a.m., LPN (licensed practical nurse) #1 was interviewed. LPN #1 worked the night shift taking care of R1 from 11:00 p.m. on [DATE] until 7:30 a.m. on [DATE]. He stated he had no memory of R1 or of any of the events that occurred around R1's change in condition between [DATE] and [DATE]. He stated he did not have access to the facility's electronic medical record and could not provide additional information.On [DATE] at 9:43 a.m., LPN #2 was interviewed. She was assigned to R1 on [DATE] from 7:00 a.m. until the resident was sent to the hospital. She stated she did not remember the resident or these events. After reviewing R1's progress notes, most of which were written by her, she stated it looked like she contacted the PCP. She stated that at the current time, she did not remember why she called the PCP instead of the weekend on-call provider. She stated that she told the PCP about R1's condition and vital signs, and she followed the orders the PCP gave (to administer IV fluids at 100 ml/hr and to continue to monitor the resident). She stated it was not her place to determine whether the PCP's orders were appropriate; it was her job to follow the orders. She stated that although she documented (continued on next page)

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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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	multiple times that the resident was unresponsive during her entire shift she did not remember anything about this. She stated she believed the PCP ordered the IV fluids in an effort to increase the resident's blood pressure. She stated she continued to monitor the resident's vital signs and to report them to the PCP, as was evidenced in the progress notes. She stated she believed she reported all vital signs and the resident's neurological status to the PCP each time she spoke with him. She stated she did not question the provider's orders, and she continued to follow the physician's orders and the facility protocol. During the interview, LPN #2 was given a scenario of a resident with low blood pressure, loss of consciousness, and decreasing respiratory status, and she was asked to identify what was likely to have been happening to the resident. She did not identify sepsis as a likely outcome. She added that as a nurse, she is only able to follow the physician's order. She stated: I can't just do something on my own. I cannot judge his decision. I cannot send the resident to the ER (emergency room) on my own. I always need an order. She stated she did not know who the facility's medical director was at that time or who it is at the present time.On [DATE] at 10:06 a.m., R1's Nurse Practitioner (NP) was interviewed. She stated the resident had at least one previous episode of low blood pressure, and her thinking was that the resident may have had some slight internal bleeding. She stated the resident had previously declined additional iv fluids to treat the low blood pressure, and she had ordered an iron supplement to boost the resident's red blood cell function. She stated every time she saw R1, the resident was alert, oriented, and talkative. The NP was not a part of any of the communication regarding R1's change in condition between [DATE] and [DATE]. She reviewed the clinical record, and stated it was too hard for her to know or to speculate if she would have done anything differently if she had been contacted. She stated: It's so hard. It depends on who's calling you and what information you are given. She stated that by the time the 10:00 a.m. vital signs were recorded, she would have been highly suspecting that the resident had sepsis. She stated sepsis is a life-threatening medical emergency and must be treated immediately, and that the window of time for successful treatment is very small.On [DATE] at 12:27 p.m., the PCP was interviewed. Before the surveyor could inform the PCP of which patient would be discussed, the PCP stated : First, I don't remember anything about this patient. He stated one of the facility nurses had already called him to alert him of the questions that were being asked about R1, and he had already reviewed the whole thing. He stated he did not remember anything about this resident, and he could not remember anything about any of the information he was given throughout the morning of [DATE]. He added: I wasn't even supposed to be working. I was not even on call that day. He explained that sometimes the nurses call him even when he is not on call, and he responds to the information he is given. He said that most likely the information he was given was only about the resident's blood pressure. He stated that he did not remember anyone telling him anything about the resident being unresponsive. He explained that these communications with the staff were two years ago and he was trying to put the events together based solely on the clinical record. He reiterated: I don't remember anything about the calls. Nothing. He stated if a nurse believes a resident should be sent to the ER, he has no problem with that. He stated: I tell them they are there, I am not. He completed the interview by saying if he had known the resident was unconscious and that his respiratory status was declining, he would have sent him to the ER immediately.On [DATE] at 10:25, the Director of Nursing (DON) was interviewed. She stated that sepsis has been a hot topic for decades for nurses. She stated that the nursing standard in this facility is for nurses to be able to recognize early signs and symptoms of sepsis and to take immediate action. She stated it would be very hard to say R1 was transferred to the hospital in timely manner. She stated the facility nurses have always had autonomy in using their nursing judgment to send a resident to the hospital even without a provider's order. She stated she could not speculate on the action of the PCP on [DATE].Reference(1) Sepsis is your body's overactive and extreme response to an infection. Sepsis is a life-threatening medical emergency. Without quick treatment, it can lead to tissue damage, organ failure, and even death.It's important to get medical care right away if you think you might have sepsis or if your infection is not getting better (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	or is getting worse. This information is taken from the website https://medlineplus.gov/sepsis.html?_gl=1*nte9oy*_ga*MTk0MjYwOTg2NS4xNzc2MDk1NTQ4*_ga_7147EPK Sepsis is diagnosed through a medical assessment performed by a healthcare provider.They diagnose sepsis using physical findings, such as: Fever, Increased heart rate, Low blood pressure, Trouble breathing.Research shows that rapid, effective sepsis treatment includes: Giving appropriate treatment, including antibiotics, as soon as possible, Maintaining blood flow to organs, Sometimes surgery is required to remove tissue damaged by the infection. Healthcare providers should treat sepsis as soon as possible. This information is taken from the website https://www.cdc.gov/sepsis/about/index.html.2. For Resident #2 (R2), the facility staff failed to assess and accurately identify signs and symptoms of sepsis and to transfer the resident to the hospital in a timely manner. The resident's significant change of condition was identified on [DATE] at 9:00 p.m. and the resident was not transferred to the local hospital for treatment until approximately 10:30 p.m. that same evening. The delay in treatment put the resident at high risk for serious injury or death.On the most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of [DATE], R2 was coded as having no cognitive impairment, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as having no concerns with being understood or with understanding others. A review of provider and nursing assessments revealed R2 was consistently alert and oriented to person, place, time, and situation. R2 had a provider's order that she was a full code.A review of R2's clinical record revealed the following sequence of events: On [DATE] at 8:30 p.m., the resident was documented as alert, responsive, talking, and answering questions with facility staff. On [DATE] at 9:00 p.m., a CNA (certified nursing assistant) reported to the nurse that the resident's condition had changed. LPN (licensed practical nurse) #3 assessed the resident, whose blood pressure was 78/46, and who was documented to be in acute distress, including being lethargic and having respiratory congestion with labored breathing and intermittent gasping. On [DATE] at 9:52 p.m., LPN #3 contacted the on-call licensed provider service, who gave an order for the resident to be transferred to the hospital. The resident was sent to the emergency room around 10:30 p.m. on [DATE], per the facility documentation.The CNA who identified a change in R2's condition was not available for interview during the survey.On [DATE] at 1:41 p.m., LPN #3 was interviewed. She stated she did not know R2 very well at all. She stated she was told in report that the resident was ordinarily alert and oriented, and she remembered talking with the resident, including an exchange of light-hearted questions and answers at the beginning of her shift. She stated she identified R2's condition as possible sepsis. However, she was not allowed to send the resident to the hospital without a physician's order. She stated: We have to talk to the provider before sending them out. She stated she could not explain why she waited almost an hour between assessing the resident and contacting the provider.On [DATE] at 10:25, the Director of Nursing (DON) was interviewed. She stated that sepsis has been a hot topic for decades for nurses. She stated that the nursing standard in this facility is for nurses to be able to recognize early signs and symptoms of sepsis and to take immediate action. She stated it would be very hard to say R2 was transferred to the hospital in timely manner. She stated the facility nurses have always had autonomy in using their nursing judgment to send a resident to the hospital even without a provider's order.R2's hospital records were requested but not provided prior to the conclusion of the survey.A review of the facility policy, Significant Change of Condition, revealed, in part: A licensed nurse will assess the patient for signs and symptoms of change of condition.Potentially life-threatening conditions require nursing assessment critical thinking skills to determine whether a patient should be transferred to an acute care setting.This decision will be made by a licensed nurse when the patient's condition is so acute that time does not permit waiting for provider's response.The facility's deficient practice placed all residents in the facility at risk of serious injury and death due to a lack of identification of sepsis and delay in treatment. This resulted in a determination of Immediate Jeopardy (IJ), cited at level four isolated beginning on [DATE].On [DATE] at 1:15 p.m., the DON and Regional Director of Clinical (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Services (RDCS) were informed of these concerns, and informed that the facility was in immediate jeopardy.On [DATE] at 4:00 p.m., the facility's IJ Removal Plan was accepted by the SA (state agency) supervisor.Facility Removal PlanCorrective Action for those residents found to be affected by the deficient practice:1. Resident 1 and Resident 2 were sent out to the hospital and no longer reside in the facility.Corrective Actions taken for residents with potential to be affected by deficient practice:2. All residents have the potential to be affected by the deficient practice. All current residents will have their vitals obtained and reviewed by a Licensed Nurse who is educated on signs and symptoms of Sepsis to assess an emergent medical need.Systemic Changes put into place to ensure the deficient practice does not recur: 3. The Interdisciplinary Team (Director of Nursing, Assistant Director of Nursing, Director of Social Work, Dietary Manager, Business Office Manager, Director of Housekeeping and Laundry, Human Resources, Rehab Director and Unit Managers) will be educated by the Regional Director of Clinical Services on identification of change in condition and early identification of sepsis. The licensed nursing staff will be educated on the change of condition policy and signs and symptoms of sepsis as outlined by the CDC to include sending residents to the hospital in an emergent situation. [NAME] President of Operations will educate Medical Director on duties and responsibilities. Staff will not be allowed to work until educated, and all new licensed nursing staff will be educated upon hire. Monitoring of corrective action to ensure the deficient practice does not recur. 4.The DON or designee will review unplanned discharges 5 times a week for 4 weeks then weekly for 4 weeks to identify timely identification in change in condition, sepsis, and timely return to hospital, and following physician orders.5. The facility will be complete with a plan for removal of the Immediate Jeopardy on [DATE] at 11:59pm.On [DATE] at 6:30 a.m., the survey team began verification of the facility's removal plan. This verification process included staff interviews on all elements of the removal plan (interviews conducted with staff from all three shifts and with the medical director), and review of the facility's credible evidence. The survey team verified that the facility completed the removal plan on [DATE] at 11:59 p.m. Once the immediate jeopardy was removed, the scope and severity was reduced to a level three, isolated.No additional information was provided prior to exit.

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Obtain a doctor's order to admit a resident and ensure the resident is under a doctor's care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide physician supervision for one of 12 residents in the survey sample, Resident #1. The findings include:For Resident #1 (R1), the facility physician failed to provide adequate physician oversight and direction related to a significant change in condition on 9/1/24.R1 was admitted to the facility on [DATE] with diagnoses that included surgical repair of a hip fracture. On the admission MDS (minimum) assessment with an ARD (assessment reference date) of 8/16/24, he was coded as having no cognitive impairment, having scored 15 out of 15 on the BIMS (Brief Interview for Mental Status). He was coded as having no concerns with making his needs known or communicating. A review of provider and nursing assessments revealed R1 was consistently alert and oriented to person, place, time, and situation. R1 had a provider's order that he was a full code. A review of R1's clinical record revealed the following sequence of events: On 8/31/24 at approximately 11:00 p.m., R1 was documented as having no physical concerns; his blood pressure was 127/65, and no concerns were documented regarding his neurological status. On 9/1/24 at 6:27 a.m., the weekend on-call licensed provider was contacted about the resident's low blood pressure (documented as 84/49). The on-call provider ordered a hold on the resident's aspirin and medications to treat high blood pressure, a test for blood in the resident's stool, and hourly blood pressure checks. On 9/1/24 at 7:30 a.m., R1's blood pressure was recorded as 80/41, he was unresponsive to verbal stimuli, and his oxygen saturation was 84% on room air. R1's neurological status of being unresponsive never changed throughout the day. The resident's PCP (Primary Care Physician) was notified and he gave orders for IV (intravenous) fluids to be given at 100 ml/hr (milliliters per hours). At 8:00 a.m., R1's blood pressure was 82/38 and O2 saturation was 93% on oxygen at 4 lpm (liters per minute). At 9:30 a.m., the PCP ordered additional IV fluids. At 10:00 a.m., R1's blood pressure was 85/43 and his heart rate was 132; his O2 saturation was 85-90% on 5 lpm. IV fluids continued. At 11:08 a.m., R1's blood pressure was 79/40 and his O2 saturation was 99% on 8 lpm. At 12:00 noon, R1's blood pressure was 81/41. The PCP gave an order for the resident to be transferred to the hospital.A review of the EMS (emergency medical services) call record revealed the facility placed a call for assistance with R1 on 9/1/24 at 12:23 p.m. This review revealed the following: Primary Impression: Sepsis (1).Signs and Symptoms Hypotension (low blood pressure) Primary.A review of R1's death certificate revealed his time of death at the hospital as 3:37 p.m., and sepsis as the resident's cause of death.On 4/7/26 at 9:43 a.m., LPN #2 was interviewed. She was assigned to R1 on 9/1/24 from 7:00 a.m. until the resident was sent to the hospital. She stated she did not remember the resident or these events. After reviewing R1's progress notes, most of which were written by her, she stated it looked like she contacted the PCP. She stated that at the current time, she did not remember why she called the PCP instead of the weekend on-call provider. She stated that she told the PCP about R1's condition and vital signs, and she followed the orders the PCP gave (to administer iv fluids at 100 ml/hr and to continue to monitor the resident). She stated it was not her place to determine whether the PCP's orders were appropriate; it was her job to follow the orders. She stated that although she documented multiple times that the resident was unresponsive during her entire shift she did not remember anything about this. She stated she believed the PCP ordered the iv fluids in an effort to increase the resident's blood pressure. She stated she continued to monitor the resident's vital signs and to report them to the PCP, as was evidenced in the progress notes. She stated she believed she reported all vital signs and the resident's neurological status to the PCP each time she spoke with him. She stated she did not question the provider's orders, and she continued to follow the physician's orders and the facility protocol. During the interview, LPN #2 was given a scenario of a resident with low blood pressure, loss of consciousness, and decreasing respiratory status, and she was asked to identify what was likely to have been happening to the resident. She did not identify sepsis as a likely (continued on next page)

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F 0710 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	outcome. She added that as a nurse, she is only able to follow the physician's order. She stated: I can't just do something on my own. I cannot judge his decision. I cannot send the resident to the ER (emergency room) on my own. I always need an order. She stated she did not know who the facility's medical director was at that time or who it is at the present time.On 4/7/26 at 12:27 p.m., the PCP was interviewed. Before the surveyor could inform the PCP of which patient would be discussed, the PCP stated : First, I don't remember anything about this patient. He stated one of the facility nurses had already called him to alert him of the questions that were being asked about R1, and he had already reviewed the whole thing. He stated he did not remember anything about this resident, and he could not remember anything about any of the information he was given throughout the morning of 9/1/24. He added: I wasn't even supposed to be working. I was not even on call that day. He explained that sometimes the nurses call him even when he is not on call, and he responds to the information he is given. He said that most likely the information he was given was only about the resident's blood pressure. He stated that he did not remember anyone telling him anything about the resident being unresponsive. He explained that these communications with the staff were two years ago and he was trying to put the events together based solely on the clinical record. He reiterated: I don't remember anything about the calls. Nothing. He stated if a nurse believes a resident should be sent to the ER, he has no problem with that. He stated: I tell them they are there, I am not. He completed the interview by saying if he had known the resident was unconscious and that his respiratory status was declining, he would have sent him to the ER immediately.On 4/8/26 at 10:08 a.m., the PCP contacted the survey team. He asked if there was any way this [regulatory finding] could be reversed. He stated he was confident that the nursing staff did not tell him about R1's altered level of consciousness and declining respiratory status. He did not respond to concerns about how he could specifically remember what was or was not shared with him by the nurse during phone calls on 9/1/24 if he, as he stated the previous day, remembered nothing about the resident or the sequence of events other than what was included in the record. The PCP was reminded that the clinical record contained consistent documentation of all of the resident's vital signs and neurological status at each entry during the morning of 9/1/24.On 4/8/26 at 10:25, the Director of Nursing (DON) was interviewed. She stated that sepsis has been a hot topic for decades for nurses. She stated that the nursing standard in this facility is for nurses to be able to recognize early signs and symptoms of sepsis and to take immediate action. She stated it would be very hard to say R1 was transferred to the hospital in timely manner. She stated the facility nurses have always had autonomy in using their nursing judgment to send a resident to the hospital even without a provider's order. She stated she could not speculate on the actions of the PCP on 9/1/24.On 4/8/26 at 10:48 a.m., the DON, Regional Director of Clinical Services, and [NAME] President of Operations were notified of these concerns. At this time, the [NAME] President of Operations stated the facility did not have a policy regarding physician services/supervision.No additional information was provided prior to exit.Reference(1) Sepsis is your body's overactive and extreme response to an infection. Sepsis is a life-threatening medical emergency. Without quick treatment, it can lead to tissue damage, organ failure, and even death.It's important to get medical care right away if you think you might have sepsis or if your infection is not getting better or is getting worse. This information is taken from the website https://medlineplus.gov/sepsis.html?_gl=1*nte9oy*_ga*MTk0MjYwOTg2NS4xNzc2MDk1NTQ4*_ga_7147EPK Sepsis is diagnosed through a medical assessment performed by a healthcare provider.They diagnose sepsis using physical findings, such as: Fever, Increased heart rate, Low blood pressure, Trouble breathing.Research shows that rapid, effective sepsis treatment includes: Giving appropriate treatment, including antibiotics, as soon as possible, Maintaining blood flow to organs, Sometimes surgery is required to remove tissue damaged by the infection. Healthcare providers should treat sepsis as soon as possible. This information is taken from the website https://www.cdc.gov/sepsis/about/index.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495424	A. Building B. Wing	04/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lake Manassas Health & Rehabilitation Center	14935 Holly Knoll Lane Gainesville, VA 20155

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, physician interview, facility document review, and clinical record review, the facility staff failed to provide competent nursing staff for two of twelve residents in the survey sample, Residents #1 and #2.The findings include:1. For Resident #1 (R1), the facility nursing staff failed to demonstrate competence to recognize and respond to a significant change in condition, including signs and symptoms consistent with sepsis (1).R1 was admitted to the facility on [DATE] with diagnoses that included surgical repair of a hip fracture. On the admission MDS (minimum) assessment with an ARD (assessment reference date) of 8/16/24, he was coded as having no cognitive impairment, having scored 15 out of 15 on the BIMS (Brief Interview for Mental Status). He was coded as having no concerns with making his needs known or communicating. A review of provider and nursing assessments revealed R1 was consistently alert and oriented to person, place, time, and situation. R1 had a provider's order that he was a full code. A review of R1's clinical record revealed the following sequence of events: On 8/31/24 at approximately 11:00 p.m., R1 was documented as having no physical concerns; his blood pressure was 127/65, and no concerns were documented regarding his neurological status. On 9/1/24 at 6:27 a.m., the weekend on-call licensed provider was contacted about the resident's low blood pressure (documented as 84/49). The on-call provider ordered a hold on the resident's aspirin and medications to treat high blood pressure, a test for blood in the resident's stool, and hourly blood pressure checks. On 9/1/24 at 7:30 a.m., R1's blood pressure was recorded as 80/41, he was unresponsive to verbal stimuli, and his oxygen saturation was 84% on room air. R1's neurological status of being unresponsive never changed throughout the day. The resident's PCP (primary care physician) was notified and he gave orders for IV (intravenous) fluids to be given at 100 ml/hr (milliliters per hours). At 8:00 a.m., R1's blood pressure was 82/38 and O2 saturation was 93% on oxygen at 4 lpm (liters per minute). At 9:30 a.m., the PCP ordered additional iv fluids. At 10:00 a.m., R1's blood pressure was 85/43 and his heart rate was 132; his O2 saturation was 85-90% on 5 lpm. IV fluids continued. At 11:08 a.m., R1's blood pressure was 79/40 and his O2 saturation was 99% on 8 lpm. At 12:00 noon, R1's blood pressure was 81/41. The PCP gave an order for the resident to be transferred to the hospital.A review of the EMS (emergency medical services) call record revealed the facility placed a call for assistance with R1 on 9/1/24 at 12:23 p.m. This review revealed the following: Primary Impression: Sepsis.Signs and Symptoms Hypotension (low blood pressure) Primary.A review of R1's death certificate revealed his time of death at the hospital as 3:37 p.m., and sepsis as the resident's cause of death. On 4/7/26 at 9:43 a.m., LPN #2 was interviewed. She was assigned to R1 on 9/1/24 from 7:00 a.m. until the resident was sent to the hospital. She stated she did not remember the resident or these events. After reviewing R1's progress notes, most of which were written by her, she stated it looked like she contacted the PCP. She stated that at the current time, she did not remember why she called the PCP instead of the weekend on-call provider. She stated that she told the PCP about R1's condition and vital signs, and she followed the orders the PCP gave (to administer iv fluids at 100 ml/hr and to continue to monitor the resident). She stated it was not her place to determine whether the PCP's orders were appropriate; it was her job to follow the orders. She stated that although she documented multiple times that the resident was unresponsive during her entire shift she did not remember anything about this. She stated she believed the PCP ordered the iv fluids in an effort to increase the resident's blood pressure. She stated she continued to monitor the resident's vital signs and to report them to the PCP, as was evidenced in the progress notes. She stated she believed she reported all vital signs and the resident's neurological status to the PCP each time she spoke with him. She stated she did not question the provider's orders, and she continued to follow the physician's orders and the facility protocol. During the interview, LPN #2 was given a scenario of a resident with low blood pressure, (continued on next page)

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	loss of consciousness, and decreasing respiratory status, and she was asked to identify what was likely to have been happening to the resident. She did not identify sepsis as a likely outcome. She added that as a nurse, she is only able to follow the physician's order. She stated: I can't just do something on my own. I cannot judge his decision. I cannot send the resident to the ER (emergency room) on my own. I always need an order. She stated she did not know who the facility's medical director was at that time or who it is at the present time.On 4/8/26 at 10:25, the Director of Nursing (DON) was interviewed. She stated that sepsis has been a hot topic for decades for nurses. She explained that new nurses should come to the facility with a basic understanding of sepsis, but that she does not always find this to be the case. She added: It is scary. She stated that the nursing standard in this facility is for nurses to be able to recognize early signs and symptoms of sepsis and to take immediate action. She added that newly hired nurses all receive some training in identifying sepsis when they are first hired, and that all staff receive refresher training on sepsis annually. She stated it would be very hard to say R1 was transferred to the hospital in timely manner. She stated the facility nurses have always had autonomy in using their nursing judgment to send a resident to the hospital even without a provider's order. On 4/8/26 at 10:48 a.m., the DON, Regional Director of Clinical Services, and [NAME] President of Operations were notified of these concerns. At this time, the [NAME] President of Operations stated the facility did not have a policy regarding competent nursing staff.No additional information was provided prior to exit.Reference(1) Sepsis is your body's overactive and extreme response to an infection. Sepsis is a life-threatening medical emergency. Without quick treatment, it can lead to tissue damage, organ failure, and even death.It's important to get medical care right away if you think you might have sepsis or if your infection is not getting better or is getting worse. This information is taken from the website https://medlineplus.gov/sepsis.html?_gl=1*nte9oy*_ga*MTk0MjYwOTg2NS4xNzc2MDk1NTQ4*_ga_7147EPK Sepsis is diagnosed through a medical assessment performed by a healthcare provider.They diagnose sepsis using physical findings, such as: Fever, Increased heart rate, Low blood pressure, Trouble breathing.Research shows that rapid, effective sepsis treatment includes: Giving appropriate treatment, including antibiotics, as soon as possible, Maintaining blood flow to organs, Sometimes surgery is required to remove tissue damaged by the infection. Healthcare providers should treat sepsis as soon as possible. This information is taken from the website https://www.cdc.gov/sepsis/about/index.html.2. For Resident #2 (R2), the facility nursing staff failed to demonstrate competence to recognize and respond to a significant change in condition, including signs and symptoms consistent with sepsis.A review of R2's clinical record revealed the following sequence of events: On 2/28/26 at 8:30 p.m., the resident was documented as alert, responsive, talking, and answering questions with facility staff. On 2/28/26 at 9:00 p.m., a CNA (certified nursing assistant) reported to the nurse that the resident's condition had changed. LPN (licensed practical nurse) #3 assessed the resident, whose blood pressure was 78/46, and who was documented to be in acute distress, including being lethargic and having respiratory congestion with labored breathing and intermittent gasping. On 2/28/26 at 9:52 p.m., LPN #3 contacted the on-call licensed provider service, who gave an order for the resident to be transferred to the hospital. The resident was sent to the emergency room around 10:30 p.m. on 2/28/26, per the facility documentation.On 4/7/26 at 1:41 p.m., LPN #3 was interviewed. She stated she did not know R2 very well at all. She stated she was told in report that the resident was ordinarily alert and oriented, and she remembered talking with the resident, including an exchange of light-hearted questions and answers at the beginning of her shift. She stated she identified R2's condition as possible sepsis. However, she was not allowed to send the resident to the hospital without a physician's order. She stated: We have to talk to the provider before sending them out. She stated she could not explain why she waited almost an hour between assessing the resident and contacting the provider.On 4/8/26 at 10:25, the Director of Nursing (DON) was interviewed. She stated that sepsis has been a hot topic for decades for nurses. She explained that new nurses should come to the facility with a basic (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	understanding of sepsis, but that she does not always find this to be the case. She added: It is scary. She stated that the nursing standard in this facility is for nurses to be able to recognize early signs and symptoms of sepsis and to take immediate action. She added that newly hired nurses all receive some training in identifying sepsis when they are first hired, and that all staff receive refresher training on sepsis annually. She stated it would be very hard to say R2 was transferred to the hospital in timely manner. She stated the facility nurses have always had autonomy in using their nursing judgment to send a resident to the hospital even without a provider's order. On 4/8/26 at 10:48 a.m., the DON, Regional Director of Clinical Services, and [NAME] President of Operations were notified of these concerns.No additional information was provided prior to exit.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement an effective QAPI (Quality Assurance/Performance Improvement) process for one of one facility.The findings include:The facility failed to implement its QAPI plan following an incident in which a resident, who was displaying signs and symptoms of sepsis (1), was not transferred to the hospital in a timely manner.On 9/1/24 at 6:27 a.m., the weekend on-call licensed provider was contacted about the resident's low blood pressure (documented as 84/49). The on-call provider ordered a hold on the resident's aspirin and medications to treat high blood pressure, a test for blood in the resident's stool, and hourly blood pressure checks. On 9/1/24 at 7:30 a.m., R1's blood pressure was recorded as 80/41, he was unresponsive to verbal stimuli, and his oxygen saturation was 84% on room air. R1's neurological status of being unresponsive never changed throughout the day. The resident's PCP (primary care physician) was notified and he gave orders for IV (intravenous) fluids to be given at 100 ml/hr (milliliters per hours). At 8:00 a.m., R1's blood pressure was 82/38 and O2 saturation was 93% on oxygen at 4 lpm (liters per minute). At 9:30 a.m., the PCP ordered additional iv fluids. At 10:00 a.m., R1's blood pressure was 85/43 and his heart rate was 132; his O2 saturation was 85-90% on 5 lpm. IV fluids continued. At 11:08 a.m., R1's blood pressure was 79/40 and his O2 saturation was 99% on 8 lpm. At 12:00 noon, R1's blood pressure was 81/41. The PCP gave an order for the resident to be transferred to the hospital.A review of the EMS (emergency medical services) call record revealed the facility placed a call for assistance with R1 on 9/1/24 at 12:23 p.m. This review revealed the following: Primary Impression: Sepsis.Signs and Symptoms Hypotension (low blood pressure) Primary.A review of R1's death certificate revealed his time of death at the hospital as 3:37 p.m., and sepsis as the resident's cause of death.On 4/8/26 at 10:25, the Director of Nursing (DON) was interviewed. She stated that sepsis has been a hot topic for decades for nurses. She stated that the nursing standard in this facility is for nurses to be able to recognize early signs and symptoms of sepsis and to take immediate action. She stated it would be very hard to say R1 was transferred to the hospital in timely manner. She stated that she could not find specific evidence that the sequence of events surrounding R1's discharge from the facility was reviewed by the QAPI committee, or that a quality improvement plan was ever considered following R1's delay in treatment. She stated that the staff participates in a weekly risk management meeting, which is considered to be a part of the facility's QAPI process, during which all the previous week's discharges are discussed. However, she could not locate any evidence that this had occurred following R1's discharge on [DATE]. She stated she was not aware that any sort of action plan had been developed or implemented regarding R1's situation. She added the facility has improvements to be made in this regard.A review of the facility policy, QAPI, revealed, in part: The Administrator is responsible for directing the Center's Quality Assurance/Performance Improvement Program and for implementing a Quality Assurance/Performance Improvement Plan that focuses on Center specific indicators that measure quality of care, quality of life and patient choice. The QAPI plan will systematically identify actual or potential areas of risk or deficiency that will proactively pursue ongoing performance improvement.The QAPI committee is scheduled to meet a minimum of quarterly. The care and service standards of the Center are continuously tracked, reviewed, analyzed, monitored, and improved by the committee.In addition to Center established indicators and surveys, the Administrator and the QAPI committee are responsible for targeting and monitoring specific services and/or operational areas of ongoing studies within the Center.These are identified as a priority for high risk, high volume, or problem prone processes .or opportunities for improving dimensions of performance.On 4/8/26 at 10:48 a.m., the DON, Regional Director of Clinical Services, and [NAME] President of Operations were notified of these concerns. No additional information was provided prior to exit.Reference(1) Sepsis is your body's overactive and extreme response to an infection. Sepsis is a life-threatening medical (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	emergency. Without quick treatment, it can lead to tissue damage, organ failure, and even death.It's important to get medical care right away if you think you might have sepsis or if your infection is not getting better or is getting worse. This information is taken from the website https://medlineplus.gov/sepsis.html?_gl=1*nte9oy*_ga*MTk0MjYwOTg2NS4xNzc2MDk1NTQ4*_ga_7147EPK Sepsis is diagnosed through a medical assessment performed by a healthcare provider.They diagnose sepsis using physical findings, such as: Fever, Increased heart rate, Low blood pressure, Trouble breathing.Research shows that rapid, effective sepsis treatment includes: Giving appropriate treatment, including antibiotics, as soon as possible, Maintaining blood flow to organs, Sometimes surgery is required to remove tissue damaged by the infection. Healthcare providers should treat sepsis as soon as possible. This information is taken from the website https://www.cdc.gov/sepsis/about/index.html.