STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495099	A. Building B. Wing	10/23/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fairfax Rehabilitation and Nursing Center	10701 Main Street Fairfax, VA 22030

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 42353 Based on staff interview and clinical record review, the facility staff failed to follow the medical provider orders for 1 of 4 sampled residents (Resident #2). The findings included: For Resident #2, the facility staff failed to administer Amlodipine and Propranolol as ordered on 10/11/24. Amlodipine and Propranolol are used to treat high blood pressure. Resident #2's diagnosis list indicated diagnoses, which included, but not limited to Essential Hypertension, Hemiplegia and Hemiparesis following Cerebral Infarction, and Chronic Myeloid Leukemia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 10/04/24 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #2's current comprehensive person-centered care plan included a focus area stating the resident was at risk for cardiac complications secondary to hypertension with an intervention to administer medications as ordered. Resident #2's current provider orders included an order dated 9/30/24 for Amlodipine Besylate 5 mg by mouth one time a day for hypertension and an order dated 9/30/24 for Propranolol HCL 20 mg by mouth three times a day for hypertension. According to Resident #2's clinical record, Amlodipine and Propranolol were not administered on 10/11/24 at 8:00 AM. Nursing progress notes dated 10/11/24 at 8:33 AM and 8:34 AM documented the medications were held due to a blood pressure of 119/61. The provider orders for Amlodipine and Propranolol did not include directions to hold the medications due to blood pressure parameters. Surveyor reviewed Resident #2's clinical record and was unable to locate evidence of physician notification prior to holding the medications. On 10/23/24 at 2:25 PM, surveyor met with the [NAME] President of Operations, Administrator, and Director of Nursing (DON) and discussed the concern regarding staff failing to administer Amlodipine and Propranolol on 10/11/24. (continued on next page)

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/23/24 at 4:05 PM, surveyor spoke with the DON who stated the nurse held the medication based on nursing judgement due to the blood pressure but failed to notify the provider. The DON stated the nurse has been educated. No further information regarding this concern was presented to the surveyor prior to the exit conference on 10/23/24.

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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 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 Based on staff interview and clinical record review, the facility staff failed to provide enteral feeding as ordered by the medical provider for 1 of 4 sampled residents (Resident #1). The findings included: For Resident #1, the facility staff failed to provide an ordered bolus tube feeding. Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Acute Kidney Failure with Tubular Necrosis, End Stage Renal Disease, Hemiplegia and Hemiparesis following Cerebral Infarction, and Dysphagia following Cerebral Infarction. The minimum data set (MDS) with an assessment reference date (ARD) of 10/04/24 assigned the resident a Brief Interview for Mental Status (BIMS) summary score of 10 out of 15 indicating the resident was moderately cognitively impaired. Resident #1 was seen by Registered Dietitian (RD) #1 on 9/30/24. The assessment dated [DATE] at 10:09 AM read in part .rt [resident] reports >50 lbs. [pounds] weight loss in the past 6 months. Per transfer records, rt was on enteral nutrition support to encourage optimal nutrition intake . Recs [recommendations] Nepro 1.8 BOLUS 350 mls 5 times daily . A provider order for tube feeding 350 ml bolus 5 times a day was received on 9/30/24 at 11:22 AM; however, this order did not include the name of tube feeding formula. Despite this, the bolus feeding was signed off as being administered on 9/30/24 at noon as scheduled. This order was discontinued on 9/30/24 at 3:02 PM. A new tube feeding order was entered on 9/30/24 at 3:02 PM for Nepro 1.8 350 ml bolus 5 times a day to be administered at midnight, 8 AM, 12 PM, 5 PM, and 9 PM. However, the order was entered to begin the following day on 10/01/24 at 12 PM, leaving Resident #1 with no scheduled tube feeding to be provided for a period of 24 hours. According to Resident #1's September 2024 Medication Administration Record, the resident did not receive a bolus tube feeding on 9/30/24 at 5:00 PM. A nursing progress note dated 9/30/24 at 7:30 PM read in part Resident observed lying in [his/her] bed alert and oriented x 3 person, place and time, with confusion. Resident [adult children] [names omitted] were sitting [sic] the bedside . [adult child] requested [NAME] [sic] feeding for [their parent]. Order should start from 12 am. But [adult child] was expecting start Bolus as soon as possible. Called [on-call provider] . Continue with bolus feeds for tonight . (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A 9/30/24 8:55 PM on-call provider progress note read in part .newly admitted to the SNF [skilled nursing facility] and has orders for tube feeds. Per nurse, [he/she] is completely NPO [nothing by mouth]. [His/her] tube feed orders are set to start tomorrow. Per nurse, [he/she] is to receive Nepro 1.8 350 ml bolus 5x daily. Family is requesting to start the feeds tonight. [He/she] will need to receive the feeds at 2100 [9 PM] and midnight. Per nurse the 5x daily schedule is as follows: 8 am, 12 p, 5 p, 9 p, and 12 a .[he/she] was previously on overnight feeds .The tube feed orders were adjusted by dietary today .Plan .Continue with bolus feeds for tonight. Primary provider to address tube feed orders tomorrow . On 10/23/24 at 2:24 PM, surveyor met with the [NAME] President of Operations, Administrator, and the Director of Nursing (DON) and discussed the concern of Resident #1 missing the 9/30/24 5:00 PM tube feeding. No further information regarding this concern was presented to the surveyor prior to the exit conference on 10/23/24.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure residents were free of significant medication errors for 1 of 4 sampled residents (Resident #3). The findings included: For Resident #3, the facility staff failed to administer the oral antibiotic Levofloxacin on three (3) separate occasions as ordered by the medical provider. Resident #3's diagnosis list indicated diagnoses, which included, but not limited to Malignant Neoplasm of the Larynx and Dysphagia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/29/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #3 was seen by the physician on 10/08/24, the progress note read in part .The patient with pneumonia in the setting of chronic respiratory failure, status post tracheostomy with a history of cancer of the larynx. Complicated case with multiple comorbidities. At this point, we will complete a seven-day course of Levaquin [Levofloxacin]. Resident #3's comprehensive person-centered care plan included a focus area dated 10/09/24 stating the resident had developed pneumonia with an intervention for medications as ordered. A review of Resident #3's clinical record revealed the Levofloxacin (Levaquin) was not administered on 10/08/24, 10/10/24, and 10/12/24. An 10/08/24 10:37 PM nursing progress note documented the Levofloxacin was not administered due to awaiting meds to come from the pharmacy. An 10/10/24 6:50 PM nursing progress note documented the Levofloxacin was not available for administration. An 10/12/24 8:30 PM nursing progress note documented the Levofloxacin was pending from the pharmacy and the medication had been returned to the pharmacy from the facility. Surveyor requested and received the facility in-house medication supply list which indicated Levofloxacin 250 mg tablets and 500 mg tablets were available for administration. On 10/16/24, surveyor spoke with the pharmacy representative (PR) who provided documentation that a supply of 10 tablets of Levofloxacin 750 mg was delivered to the facility on [DATE] at 10:09 AM but the nurse at the time did not accept delivery of the medication and requested it be returned to the pharmacy. The PR also provided documentation of Levofloxacin being pulled from the in-house supply for Resident #3 on 10/09/24 and 10/11/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/16/24 at 1:00 PM, surveyor spoke with the Director of Nursing (DON) regarding the missed doses of Levofloxacin on 10/08/24, 10/10/24, and 10/12/24. The DON stated the nurses could have gotten the medication from the Omnicell (in-house supply) and she would have to find out why they did not obtain the medication. On 10/23/24 at 2:25 PM, surveyor met with the [NAME] President of Operations, Administrator, and DON and discussed the concern of staff failing to administer Resident #3's Levofloxacin on three (3) occasions. No further information regarding this concern was presented to the surveyor prior to the exit conference on 10/23/24.