

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495099	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  12/31/2024
NAME OF PROVIDER OR SUPPLIER  Fairfax Rehabilitation and Nursing Center		STREET ADDRESS, CITY, STATE, ZIP CODE  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)
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on staff interview, clinical record review and facility document review, the facility staff failed to administer medications per the physician's orders for one of _ residents in the survey sample, resident # 2 (R2).</p> <p>The findings included:</p> <p>For R2 the facility staff failed to administer scheduled Gabapentin, a medication for nerve pain for three days after admission to the center.</p> <p>R2s diagnosis included but were not limited to, diabetes, muscle weakness, hypertension and depression.</p> <p>R2s minimum data set (MDS) assessment with an assessment reference date of 6/20/24 assigned the resident a brief interview for mental status (BIMS) score of 14 out of possible 15 indicating resident was cognitively intact. Further review of the MDS revealed that resident had rated their pain in the last five days as height as an 8 out of 10 on the pain scale. They indicated that their pain was frequent and had interfered with sleep over the last five days.</p> <p>R2s Discharge Summary from the hospital was reviewed. Listed under the heading Discharge Meds the document read in part, Gabapentin (neurontin) 300 mg cap (capsule) 300 mg oral every 8 hours and Oxycodone (immediate release) 5 mg tab (tablet) every 4 hours as needed for pain scale 4-6.</p> <p>The medication administration record (MAR) for R2 was reviewed. R2 was admitted to the center on 6/13/24. Gabapentin 300 mg every 8 hours was not put on the MAR until 6/14/24 and was scheduled to start at 8:00 AM 6/14/24. The MAR indicated the 8:00 AM dose and the 4:00 PM doses had been administered. For 6/15/24 all three doses were coded as 9, which according to the facility chart codes means, other/see nurses notes. On 6/16/24, the 12:00 AM dose and the 8:00 AM dose were documented with the chart code of 9. The 4:00 PM dose was checked off as given.</p> <p>The Orders-Administration progress notes were reviewed. On 6/15/24 at 12:30 AM a note read, Gabapentin (EPCS) Capsule 300 MG Give 1 capsule by mouth every 8 hours for Pain unable to give, awaiting delivery from pharmacy, (name omitted) NP informed, no new orders given. On 6/15/24 at 4:22 PM a note read, : Gabapentin (EPCS) Capsule 300 MG Give 1 capsule by mouth every 8 hours for Pain med not available. On 6/15/24 at 5:22 PM a note read, Gabapentin (EPCS) Capsule 300 MG Give 1 capsule by mouth every 8 hours for Pain</p> <p>(continued on next page)</p>

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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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Medication on order. See follow up communication mediprocity. Will administer as soon as delivered. RP (name omitted) made aware. On 6/16/24 at 12:53 AM a note read, Gabapentin (EPCS) Capsule 300 MG</p> <p>Give 1 capsule by mouth every 8 hours for Pain Did notify (name omitted) NP on 6/15/24 at 5:51 am of the need for the above medication script and for Oxycodone 5 mg po every 4 hours prn script, waiting for response from pharmacy if received both scripts or need. On 6/16/24 at 10:47 AM a note read, Gabapentin (EPCS) Capsule 300 MG Give 1 capsule by mouth every 8 hours for Pain unable to give at this time, waiting on delivery, (name omitted) NP informed, Notified pharmacy to verify if script received waiting response.</p> <p>Further review of all the progress notes was completed. The first documented complaint of pain was in a skilled progress note dated 6/15/24 at 4:23 PM that read in part, Pain: yes Non Pharmacological interventions provided: positioning with pillows Pharmacological interventions provided: scheduled medications. The pain scale on the MAR was marked with a 0 indicating no pain for all three shifts. There was no pain medication given according to the MAR. On 6/16/24 at 1:18 AM a note read, Pharmacy messaged back and stated that oxycodone will be in PM delivery today. we do not have a script for gabapentin. Also stated that oxycodone is in backup if needed prior to delivery after request if they can send it ASAP. On 6/16/24 at 3:08 AM a note read, Notified Pharmacy that Third Eye Health (name omitted) APN will be sending over a script to them for Gabapentin 300mg po every 8 hours pain and requested for them to notify us that the script was received and processed. On 6/16/24 at 3:53 AM the note read, Pharmscript confirmed they received script and processed for Gabapentin 300mg po every 8 hours pain (after not receiving it 1st time and requesting from (name omitted) APN from 3rd eye health to resend) - This can be obtained from Omnicel until supply of med comes in).</p> <p>On 12/30/24 at 1:50 PM this surveyor interviewed Licensed Practical Nurse (LPN) # 1. LPN # 1 had documented on 6/14/24 at 8:00 AM and 4:00 that R2 had been given scheduled Gabapentin. LPN # 1 stated when asked that they could not recall what medications they gave. They reviewed the MAR and stated, I signed it off so I must have given it. They did not recall an issue with pain or with obtaining medications.</p> <p>The night shift nurse who documented attempts to get the medication is no longer employed at the center.</p> <p>On 12/30/24 at 1:55 PM this surveyor interviewed the Nurse Practitioner (NP) who recalled R2 but did not recall an issue with getting Gabapentin.</p> <p>On 12/30/24 at 3:20 PM this surveyor interviewed the Director of Nursing (DON). When asked what time frame they would expect prescriptions to be obtained for narcotic medications they stated, We try to get them the same day. When asked if 4 days was a reasonable time frame to wait on a prescription for Gabapentin they stated, No, it shouldn't take that long.</p> <p>This concern was reviewed with the Administrator, DON and Regional Director of Clinical Services during an end of day meeting 12/30/24 at 3:35 PM</p> <p>On 12/31/24 at 9:37 PM this surveyor had a phone call with a pharmacy tech at the facility's contracted pharmacy. They stated that they received a prescription for Gabapentin 300 mg every 8 hours on 6/16/24 for R2. They stated the first card of medication was sent to the facility on the afternoon run 6/16/24 and that two doses for R2 were removed from the omnicell on 6/16/24.</p> <p>(continued on next page)</p>		

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F 0684  Level of Harm - Minimal harm or potential for actual harm  Residents Affected - Few	No further information was provided to the survey prior to the exit conference.