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	06/27/2025

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to notify the Ombudsman of transfer or discharge for 2 of 41 residents and failed to provide the receiving entity with proper documentation upon transfer for 1 of 41 residents. (Resident #155, #138, and #434) The findings were: 1. For Resident #155, the facility staff failed to notify the ombudsman of the resident's discharge on [DATE]. Resident #155's minimum data set (MDS) assessment with an assessment reference date of 05/19/25 was signed as completed on 05/23/25. Resident #155's brief interview for mental status summary score was documented as a 15 out of 15; this indicated intact cognition. Resident #155's clinical record was reviewed and indicated the resident was discharged home with home health services on 06/07/25. The Discharge Instructions/Post Discharge Plan of Care - V6 document read the resident's discharge status/facility was Home. The summary/discharge arrangements read in part, Resident will discharge on [DATE] due to an insurance cut. Medical equipment arrangements included a hospital bed with home health arrangements made for in-home physical therapy, occupational therapy, registered nurse and home health aide. Discharge instructions were given to the resident. The clinical record included documentation Resident #155 filed an appeal for discharge. Social services assistant (Other Staff #6) was interviewed on 06/26/25 at approximately 10:15 a.m. Other Staff #6 reported and provided written documentation the appeal was denied and Resident #155 discharged home on [DATE] rather than filing a second appeal. On 06/25/25 the director of nursing (DON) was asked for evidence the ombudsman was provided with notification of Resident #155's discharge. The DON responded the facility staff does not notify the ombudsman of planned discharges, only discharges that were against medical advice (AMA) and discharges to a hospital. On 06/26/26 at 4:04 p.m. during a meeting with the director of nursing, administrator, vice president of operations, regional MDS coordinator, and two regional nurse consultants (RNC #1 and #2), the concern with the ombudsman not being notified of Resident #155's discharge was discussed. No further information was provided prior to the exit conference. (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. For resident #434 (R434), the facility staff failed to provide the receiving entity with proper documentation upon transfer to the hospital and failed to provide the resident with bed hold information. On 6/24/2025 this surveyor interviewed R434 at bedside. They stated they were readmitted to the facility on [DATE] after a brief hospitalization. I had pneumonia and sepsis they said. I didn't know I was sick. The ambulance showed up to get me and took out. I guess it was a good thing though. R434's minimum data set (MDS) assessment with an assessment reference date of 3/28/25 was reviewed and assigned the resident a brief interview for mental status score (BIMS) of 12 out of possible 15, indicating the possibility of mild cognitive impairment. A progress note dated 6/14/25 by the on-call physician service read in part, per nurse patient reported chest pain and SOB (shortness of breath) around 720 am EST patient seen with nurse Per nurse patient points to anterior chest as location of chest pain. Per nurse lungs clear on exam and HR (heart rate) 123 with regular rhythm on palpation. Patient states she has been having chest pain for awhile. States the chest pain is constant, point to her left axilla where pain starts and moves to her mid chest. States the pain feels like a pressure. States SOB started last night and worse this morning. Admits to dizziness and nausea. States nausea present earlier and now gone. The document went on to read, Transfer to Emergency Department via 911 RE: chest pain/SOB/dizziness/nausea -Nitroglycerin 0.4mg PO 1tab q5min prn Chest pain x 3 doses, first dose now Disposition : Transfer to Emergency Department .' An einteract SBAR summary for providers dated 6/19/2025 at 7:35 AM read in part, Change in Condition Nursing observations, evaluation, and recommendations are:While on rounds, resident reported to writer I am experiencing chest pain 6/10, on assessment pain is non-radiating, crackles auscultated to base of R lung, respiration is labored at 27/min, heart rate 122bpm, SpO2 88% (baseline). Writer administered O2 2L/M nasal canula for SOB. Writer contacted thirdeye clinician (name omitted). Orders issued to transfer resident to ED via 911, administer Nitroglycerin 0.4mg PO 1 TAB Q5min PRN for chest pain X3 doses, first dose STAT. Primary Care Provider Feedback : Primary Care Provider responded with the following feedback: A. Recommendations: Transfer resident to Emergency Department via 911 for Chest Pain/SOB/dizziness/nausea. Administer Nitroglycerin 0.4 mg PO 1 TAB Q5min PRN for chest pain X3 doses, first dose STAT. This surveyor was unable to locate any documentation of what the facility provided to the hospital upon R434's transfer. On 6/25/2025 at 3:15 PM this surveyor asked the Regional Director of Clinical Services to provide any evidence that the hospital received the proper information and documentation when resident was sent out and for evidence of the resident being given information about the bed hold policy. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/26/2025 the Regional Director of Clinical Services stated they could find no evidence for R434 that the hospital was provided with the proper documentation or that the resident received the bed hold information prior to the discharge on [DATE]. The policy entitled, Bed Reserve Process, was provided and read in part, The Admissions Director will ensure the proper documentation is executed for any patient discharge desiring to voluntarily reserve a bed. 06/27/2025 12:28 PM the survey team met with the Administrator, Director of Nursing, Regional Director of Clinical Services and the Regional [NAME] President of Operations. This concern was discussed at that time. No further information was provided prior to the exit conference. 2. For Resident #138 the facility staff failed to notify the office of the local long-term care ombudsman of a transfer/discharge that occurred on 1/26/25. Resident #138's diagnosis list indicated diagnoses that included, but were not limited to, Chronic Obstructive Pulmonary Disease, Dementia, Anxiety Disorder, Traumatic Brain Injury, Other Specified Disorders of Brain, Anxiety Disorder, Epilepsy, Depression, and Weakness. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/1/25 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the clinical record indicated Resident #138 was transferred to the hospital on 1/26/25. Surveyor requested evidence of notification of the transfer/discharge to the local long-term care ombudsman. On 6/26/25 at 12:47 PM, this surveyor was provided with the ombudsman notifications for January 2025 and Resident #138 was not on the list. The vice president of operations and the social worker both agreed the ombudsman was not notified of Resident #138's transfer/discharge. This concern was discussed on 6/26/25 at 6:04 PM at the end of day meeting with the administrator, vice president of operations, director of nursing, regional nurse consultant #1, and regional nurse consultant #2. Surveyor requested and received a facility policy titled, Notice of Transfer/Discharge which read in part, .7. Provide designated copies of the completed .Notice of Transfer/Discharge form to each of those specified on the form, which includes the Ombudsman .9. Once the document has been scanned into .complete a Social Work and Discharge Planning Progress Note confirming the following .b. Date the notice was sent to the Ombudsman and the method by which it was sent . No further information was provided to the survey team prior to exit on 6/27/25.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility staff failed to store food in accordance with professional standards for food service safety in the facility kitchen. The findings included: The facility staff failed to discard out of date perishable food items, failed to store food preparation pans clean, failed to promptly discard unused food items, failed to utilize beard restraints for male dietary aides, and failed to ensure foods were stored at safe temperatures. On 6/24/25 at 9:39 AM, surveyor entered facility kitchen for an initial tour with dietary manager-other staff #9 (OS#9) and regional dietary manager-other staff #11 (OS#11). Surveyor observed three reach-in refrigerators in the kitchen food prep area. The thermometer on refrigerator #1 was 50 degrees, no food items were present in the refrigerator. Refrigerator #2 had a sign on the door which read, Out of Order and inside was one tray of peaches in individual bowls with no lids, one tray of pudding in individual bowls with lids, and one tray of a small salad containing cucumber slices in souffle cups with no lids. OS#9 informed surveyor the refrigerator had been out of order for the past month. Surveyor inquired if the food in the refrigerator had been in there for a month and OS#9 stated no, that was from dinner last night, staff did not throw it away. During the observation other staff #20 (OS#20) came to the refrigerator and took out the tray of peaches. Surveyor inquired what she was doing with the peaches and OS#20 informed surveyor she was going to put lids on them. Surveyor inquired why she was putting lids on them, and she stated to, serve. OS#9 then stated, No, she is throwing them away. OS#20 then proceeded to throw the bowls of fruit into the large trash can nearby. OS#20 then removed the tray of salads and tray of pudding from the refrigerator and discarded the salads and took the bowls of pudding to the dish washing area. Surveyor observed refrigerator #3 to be at 36 degrees and empty. Surveyor observed an ice cream standing freezer to be at 40 degrees, all of the ice cream was observed to be frozen. Surveyor observed an ice cream floor freezer with two sliding doors on the top of the unit. No thermometer could be located in the freezer. A box of clear strawberry ice cream cups was observed on top of the other boxes of ice creams. All the strawberry ice cream cups were observed to be soft, melted, and separated-with the strawberry syrup on the bottom of the cups and a foamy pink liquid on top within the cups. OS#9 stated it has been extremely hot in the kitchen, and they had no air. Surveyor observed fans throughout the kitchen space. OS#9 threw the case of strawberry ice cream cups away. The temperature logs on top of the freezer documented the freezer at 10 degrees that morning. The walk-in refrigerator was observed, and 3 bags of cilantro were observed in a box on a bottom shelf. The cilantro appeared wilted in each bag and each bag had a BB (best by) date of 6/20/25. OS#9 discarded the cilantro. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The walk-in freezer was observed, and a large bag of diced chicken was found to be soft with crystalized ice inside the bag. It was not firm to the touch. OS#9 discarded the chicken. Surveyor observed 1 large food pan and 2 small food pans with visible, crusty, light-brown substances on them, stacked in the clean dish area. OS#11 removed the pans and gave them to a dietary aide to re-wash. Surveyor observed the dry storage area, and a bottle of sparkling cider was located on the 2nd shelf with a BB date of 5/5/24. OS#9 discarded the cider. These concerns were discussed at the end of day meeting on 6/24/25 at 5:48 PM with the administrator, regional vice president of operations, director of nursing, and regional nurse consultant #1. On 6/26/25 at 11:05 AM, surveyor entered the facility kitchen for additional observations and met with OS#9, OS#11, and other staff #13. Surveyor observed four male dietary aides and OS#13 without beard restraints. OS#9 provided all the men with beard restraints and informed surveyor it is her expectation for them to always wear beard restraints. No further information was provided to the survey team prior to exit on 6/27/25.

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the facility is licensed under applicable State and local law and operates and provides services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards. Based on staff interview and facility document review, the facility staff failed to act with accepted professional standards and principles that apply to professionals providing services to the facility. The findings included: The facility administration failed to operate and provide services with accepted professional standards and principles that apply to professionals providing services to the facility as related to an outstanding balance owed to a contracted staffing agency for services rendered from May 19, 2023, through September 29, 2023. On 6/24/25, this surveyor spoke with regional vice president of operations and requested information pertaining to a staffing agency that the facility owed an outstanding balance to over $911,000.00. On 6/25/25 at 9:15 AM regional vice president of operations informed surveyor he located a lawsuit from a staffing agency that is suing the facility. He provided surveyor with a copy of Complaint for Damages served on 6/17/25, a copy of the staffing agency/facility contract, and a copy of the outstanding balance due indicated on an invoice dated 6/9/25. The Staffing Agreement contract dated 11/19/21 read in part, .Whereas, the parties desire by entering into this Agreement to make it possible for [staffing agency name omitted] to provide staffing services of temporary healthcare personnel .to the CLIENT (facility) in consideration of mutually agreed upon rate fee, and; wherein this Agreement sets forth the rights, duties and obligations and expectations of the parties in reference .3.1 .Client understands Agency invests substantial resources in recruitment, screening, training and other administrative expenses in connection with the placement of this assignment .3.9 Remit payment for services upon receipt of invoice .4. [NAME] Procedures .4.1 [Staffing agency name omitted] will submit billing invoices along with copies of the facilities authorized .timecards for payment weekly for services rendered. 4.2 These weekly invoices will be paid by the Client upon receipt and not to exceed (45) days. Invoices not paid within (45) days are considered past-due and will be charged a finance charge of one and half (1.5%) percent per month on the unpaid balance (annual percentage of 18%) or the maximum interest rate allowed by law, whichever is lower .6.1 The provisions of this agreement may be modified only by mutual agreement of the parties. No modification shall be binding unless it is in writing and signed by the party against whom enforcement or modification is sought .7.1 Each party agrees to indemnify and hold the other .harmless from all claims, suits, judgments and demands arising from the indemnifying party's negligent and/or intentional acts and omissions in the performance of the duties prescribed by this Agreement. Each party shall give the other immediate written notice of any claim, suit or demand which may be subject to this provision. This provision shall survive the termination of the Agreement .9.2 If an Event of Default by Client occurs, in addition to the right to terminate this Agreement, [staffing agency name omitted] may seek any other remedy available to it in law or in equity on account of such default. Additionally, any amounts due for Services Provided by [staffing agency name omitted] shall be immediately paid to [staffing agency name omitted] upon notice . A review of the Staffing Service Rates as of November 19, 2021, were are follows: (continued on next page)

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F 0836 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	CNA (certified nursing assistant)-approved hourly rate: $35.00 LPN (licensed practical nurse)-approved hourly rate: $56.00 RN (registered nurse)-approved hourly rate: $73.00 The Staffing Services Rate Agreement was signed by the staffing agency and representative of the facility on 11/22/21. Surveyor reviewed the invoice from the staffing agency and the invoice revealed from 5/19/23 through 9/29/23, the past due balances were forwarded each billing cycle. The total due with interest owed reflected on the invoice as $1,108,655.21. The Complaint for Damages with a served date of 6/17/25 read in part, .4. On or about November 19, 2021, Plaintiff (staffing agency) and Defendant (facility) entered into a Staffing Agreement, which provided that the Plaintiff would supply certain skilled workers to provide Defendant with temporary healthcare personnel, in exchange for the Defendant's payment of Plaintiff's invoices .6. The Contract also provided the Defendant would compensate [Plaintiff] for services rendered, whereas payment shall be made in accordance with attached [staffing agency name omitted] Service Rate Schedule .The Contract further provided that the Defendant would remit payment for services upon receipt of invoice .7 .beginning in May 2023, the Defendant came to be in arrears with respect to payment of Plaintiff's invoices. For the period of May 19, 2023, through September 29, 2023, the Defendant failed and refused to pay invoices issued for services provided by the Plaintiff and became indebted to the Plaintiff in the amount of $911,257.26 .8. The terms of the Contract further provide that Plaintiff is entitled to interest on unpaid balances in the amount of one-and one-half percent (1.5%) per month for each month that the unpaid invoice remains past due .9. In spite of demands for payment by the Plaintiff, Defendant has failed to pay the foregoing amount, which remains outstanding . This concern was discussed at the pre-exit meeting on 6/27/25 at 12:28 PM with the administrator, director of nursing, vice president of operations, regional nurse consultant #1, and regional nurse consultant #2. Surveyor requested but did not receive a facility policy for accounts payable. No further information was presented to the survey team prior to exit on 6/27/25.