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	02/04/2026

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on staff interview, clinical record review and facility document review, the facility staff failed to ensure appropriate interventions were implemented for resident safety for (1) one of (4) four sampled residents, Resident #1, resulting in harm. Resident #1 sustained a fall during transfer resulting in a subarachnoid hemorrhage and subsequent death. The findings included:Resident #1's diagnosis list indicated diagnoses that included, but were not limited to, metabolic encephalopathy, type 2 diabetes mellitus with diabetic kidney disease, congestive heart failure, unspecified dementia, end stage renal disease, arteriovenous fistula, unspecified lack of coordination, and muscle weakness. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 11/25/25, assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of Resident #1's clinical record disclosed the following documentation: A progress note dated 1/19/2026 read in part, . 08:50 (8:50 AM) .Resident fell during Transfer from bed to chair with CNA (certified nursing assistant) assistance while preparing to go for dialysis in Resident room. Resident assessed immediately and found lying in a supine position on the floor. Noted with skin tear to the right upper eye. [provider name omitted] notified and order given to send resident to the ER (emergency room) . A progress note dated 1/19/26 read in part, .01/19/2026 17:15 (5:15 PM) .Health Status Note.Phone call was made to.Hospital Trauma/ICU (intensive care unit) for follow up status on resident. Charge nurse on the unit [name omitted] mentioned resident has been admitted with a diagnosis of Brain Bleed. A review of Resident #1's comprehensive person-centered care plan disclosed a focus which read in part, .requires assistance with their activities of daily living due to chronic disease. Interventions related to the focus read in part, .2 person assist transfer. On 2/3/26 at 5:05 PM, the facility administrator stated the facility had completed a plan of correction (POC) for this incident, and he provided the POC and the facility synopsis of events files. On 2/4/26 at 12:27 PM, an interview was conducted with Registered Nurse (RN) #2 via phone conversation and RN#2 stated she was Resident #1's nurse on the day of the incident and that Resident #1 was on the dialysis schedule for that day (1/19/26) and the resident was a 2-person assist for transfers. RN#2 recalled instructing CNA#1 to get assistance to transfer Resident #1 and then a few minutes later CNA#1 came to her and said Resident #1 was on the floor. RN#2 stated she went to the resident's room and observed the resident lying on the floor and bleeding from a laceration to her right eyebrow. RN#2 stated she checked Resident #1's vital signs and the nursing supervisor entered the room and then went and called 911 immediately. A review of the facility synopsis of events dated 1/19/26, read in part, . (Resident #1) sustained a fall while staff were transferring her. (Resident #1) was transferred to the hospital. Per the hospital notes, (Resident #1) sustained a subarachnoid hemorrhage (a life-threatening type of stroke caused by bleeding into the space between the brain and the surrounding membrane (subarachnoid space). It is commonly characterized by a sudden, severe thunderclap headache, (continued on next page)

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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F 0689 Level of Harm - Actual harm Residents Affected - Few	often caused by a ruptured aneurysm or trauma). (Resident #1) passed away at the hospital.Incident Type: Allegation of Neglect.Location of Incident: Resident's room.Employee Involved: [employee name omitted-for purposes of this survey the employee has been identified as CNA#1] .(CNA#1) has been placed on suspension pending investigation. CNA #1 was unavailable for interview as they were no longer employed by the facility at the time of the survey. A review of witness statement #3 dated 1/20/26, provided by CNA#1 via phone conversation with the administrator and director of nursing, read in part, .How was the patient when you first saw them? .She was normal for the shift, have not worked with her before.2. Do you know how to check the patient's transfer status? .Yes, in the cardex [sic] (Kardex-a concise, quick-reference system used primarily to summarize essential, real-time patient data like medications, treatments, allergies, and care plans, facilitating communication and continuity of care across shifts, separate from the full patient chart).Did you call for help? .No, I was told she was a 1-person assist and did not need further assistance.4. How did you transfer the patient.? .Was sitting at the edge of the bed. Placed left leg between her (Resident #1's) legs. Used left arm around her body under her right arm. Used right arm to grab pants. Transferred her to the wheelchair. When repositioning her in the chair she fell.5. What happened immediately following the fall, what did you do/tell? .Rushed to get the nurses. Who then began to assess the resident. A review of the ER report dated 1/19/26 read in part, .presenting to the emergency department with a fall prior to arrival. Per EMS, the patient lives at the nursing facility and they were moving her out of bed when she fell. They note that she fell from about 3 feet up and hit the right side of her head.They note the patient had episode of vomiting on route.Subdural hematoma.the patient was admitted and handed off to ICU (intensive care unit.CT (Computed Tomography scan, a noninvasive, painless medical imaging procedure that uses specialized X-ray equipment and computer algorithms to produce detailed, 3D, and cross-sectional slice images of bones, blood vessels, and soft tissues) of the head showed.1. Large, acute right-sided subdural hemorrhage with prominent mass effect, right to left midline shift, effacement of basilar cisterns and probable early uncal herniation (a critical radiological finding, indicating a life-threatening emergency caused by high pressure inside the skull that is forcing brain tissue to shift out of its normal position. This situation requires immediate neurosurgical intervention to prevent permanent brain damage or death). 2. Smaller, acute left-side subdural hematoma. 3. Scattered subarachnoid hemorrhage (a, often non-aneurysmal, bleeding event in the subarachnoid space - the area between the brain and its surrounding membrane (arachnoid mater) - that appears in multiple, disjointed areas on imaging).Patient will be admitted to the ICU. A review of hospital neurosurgery notes dated 1/19/26 read in part, .10:55 AM.p/w (presented with) larged {sic} R (right) holohemispheric subdural hematoma in the setting of fall from bed at SNF (skilled nursing facility), + head strike.The patient's [family member name omitted] was contacted to discuss goals of care and management options.Discussed w (with) [family member name omitted] regarding pt (patient) clinical picture.Pt [family member] understands pt significant head injury and is actively dying.[family member] confirmed she does not want any surgical interventions however she does want pt to be on life support until she arrives bedside.would like everything done until she arrives to hospital and confirmed she is currently 5 hours away. Pt full code and will update family if pt continues to decline for further end of life discussions. A review of the facility synopsis of events final report dated 1/27/26 read in part, .Per the hospital notes, (Resident #1) sustained a subarachnoid hemorrhage. (Resident #1 passed away at the hospital.Employee action initiated or taken: CNA#1 has been terminated.Upon investigation, we found the resident did fall.During the investigation, the CNA had access to the resident's transfer status and signed off on the KARDEX acknowledging that she knew what the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	transfer status was. (Resident #1) was listed as a 2-person assist, but the CNA transferred her by herself. Based on the facts within the investigation, we are substantiating this [facility synopsis of events]. The CNA involved has been terminated. This concern was discussed on 2/4/26 at 8:20 AM in a meeting with the administrator, vice president of operations, regional nurse consultant, interim director of nursing, and director of nursing in-training. The administrative team concluded that deficient practice was identified and had been corrected. The POC had a completion date of 1/23/26 and read as follows: Corrective Action: Immediate Response: Resident #1 was assessed for pain and a skin assessment was performed. Laceration noted to R (right) eyebrow. Provider was called and notified. RP (responsible party) was called multiple times and message left. Resident was sent to the hospital with EMS (emergency medical services). All residents requiring a two-person assist or mechanical lift have the potential to be affected. A 100% audit was done of all residents having a transfer status in the care plan and put into the Kardex. Root Cause Analysis: Failure to follow the resident's care plan requiring a two-person assist for transfers, resulting in a fall with a subsequent death. Identification of Deficient PracticeHow will corrective action be accomplished for those residents having potential to be affected by the same deficient practice: On 1/20/26 an audit of all residents having a transfer status in the care plan/Kardex was performed by the administrative nursing staff to ensure that the care plans and Kardex are accurate. Any issues identified were corrected. Systemic Changes: On 1/21/26 the DON/designee began education with all nursing staff on safe transfer techniques, use of gait belts and mechanical lifts and to stop and seek help. On 1/21/26 the DON/designee began educating all staff on abuse and neglect. On 1/21/26 the DON/designee began educating all nursing staff on following care plan/Kardex for all transfer levels, stop the transfer if adequate assistance is not available, and a two-person transfer may not be completed by one staff member under any circumstances. On 1/21/26 the DON/designee began educating all nursing staff to check Kardex for transfer status if someone is a 2 person assist they need to be always with 2 people. Provision of how the facility plans to monitor its performance to make sure that solutions are sustained: The DON/designee will audit CNAs on how to check and access the Kardex on 6 CNAs 5 times per week for 8 weeks. The DON/designee will conduct random audits of 15 resident transfers per week to ensure they were transferred according to their care plan for 4 weeks. The DON/designee will audit all falls related to transfer to ensure the care plan was followed related to transfer status for 4 weeks. The DON/designee will audit all new residents for accurate transfer status to ensure all care plans are updated accordingly 5 times a week for 8 weeks. Completion Date Projection: 3/18/26 Credible Evidence Review:A review of the credible evidence for the POC on 2/4/26 found the audits and education to be complete. The interim director of nursing provided evidence of care plans, Kardex demonstration, and transfer status education is provided during orientation for new hires prior to working with the residents independently. Ongoing monitoring was also confirmed. Observations: On 2/4/26 at 9:37 AM, CNA#2 and CNA#3 were observed conducting a two-person transfer with Resident #4. No issues were identified. On 2/4/26 at 9:40 AM, CNA #2 and CNA#3 were observed conducting a two-person mechanical lift transfer with Resident #5. No issues were identified. Interviews: On 2/4/26, an interview was conducted with registered nurse #1 (RN#1) and RN#1 stated that she is educating new hires during orientation and orients them on the care plan/Kardex and what to look for. She is also educating on utilization of gait belts and enforcement of not transferring a two-person transfer unless two people are present. RN#1 stated she is assisting with the weekly audits and denied any transfer-related falls since the incident occurred. On 2/4/26, an interview was conducted with certified nursing assistants #2, #3, #4, #5, and #6 and they all concurred they had received education on resident transfers, care plans, (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	and Kardex review. All the CNAs verbalized the correct protocol implemented for safe transfers of the residents. On 2/4/26, registered nurses #1 and #2, and licensed practical nurses #1, #2, and #3 were interviewed and all the nurses concurred they had received education on resident transfers, care plan and Kardex review. All the nurses verbalized the correct protocol implemented for safe transfers of the residents and they all concurred they assist CNAs for two-person transfers when needed, identify transfer status of new residents, and observe CNAs for proper transfer assistance. No further information was provided prior to exit on 2/4/26. This is a past non-compliance deficiency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to maintain an infection prevention and control program to provide a safe, sanitary, environment and help prevent the development and transmission of communicable disease and infection for 1 of 4 sampled residents, Resident #7. The findings included:For Resident #7 the facility staff failed to identify the need for gowns as part of the required PPE (personal protective equipment) prior to entering an EBP (enhanced barrier precaution) room. Resident #7's diagnosis list indicated diagnoses that included, but were not limited to, end stage renal disease, type 2 diabetes with chronic kidney disease, and dependence on renal dialysis. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/21/25 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. On 2/4/26 at 11:00 AM, this surveyor observed an EBP sign on Resident #7's door, which read in part, .requires use of gown.during high-contact patient care activities as defined.transferring. Two certified nursing assistants (CNAs) were observed transferring Resident #7 from a geri-chair to the bed. Both of the CNAs were observed to be wearing gloves. Both CNAs were not observed to be wearing gowns. This surveyor spoke with certified nursing assistant #2 (CNA#2) and he informed this surveyor he usually wears a gown. This surveyor stepped out into the hallway to observe the EBP sign again and spoke with licensed practical nurse #4 (LPN#4) and asked her to clarify if the CNAs should be donning gowns. LPN #4 reviewed the EBP sign on the door and agreed that the two CNAs should be donning gowns when working with Resident #7. This surveyor inquired of certified nursing assistant #7 (CNA#7) why a gown was not donned and CNA#7 informed this surveyor she was just helping with the transfer. A review of Resident #7's clinical record disclosed the following documentation: A medical provider orders with a start date of 1/20/26 read in part, .Enhanced Barrier Precautions every shift for Enhanced Barrier Precautions HD (hemodialysis). A review of the person-centered comprehensive care plan disclosed a focus that read in part, .ENHANCED BARRIER PRECAUTIONS: the resident required Enhanced Barrier Precautions related to AV Fistula to Right forearm ((Arteriovenous Fistula in the right forearm is a surgically created abnormal connection between an artery and a vein, specifically designed to act as a reliable, long-term access point for hemodialysis in patients with kidney failure). The interventions related to the focus read in part, .appropriate PPE per policy.Isolation precautions per order. This concern was discussed with the regional vice president of operations (VPO) on 2/4/26 at approximately 11:30 AM. Surveyor requested and received a facility policy titled, Enhanced Barrier Precautions (EBPs) with an effective date of 3/26/24, which read in part, .Employees providing high-contact care activities will follow Enhanced Barrier Precautions for patients who meet the criteria.1. May be indicated for patients:.with indwelling medical devices.3. EBPs require the use of gown.by staff during high-contact patient care activities as defined below:.c. Transferring. No further information was provided to this surveyor prior to exit on 2/4/26.