STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495197	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belvoir Woods Health Care Center at the Fairfax	9160 Belvoir Woods Pkwy Fort Belvoir, VA 22060

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 0574 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The resident has the right to receive notices in a format and a language he or she understands. Based on observation, resident interview, and staff interview it was determined that the facility staff failed to inform the residents of the location for the contact information for the State Survey Agency and the State Long-Term Care Ombudsman program.The findings include:During an observation of the third floor on 3/11/2026 at approximately 9:30 am, the list of names, addresses (mailing and email), and telephone numbers of the State licensure office, and the Office of the State Long-Term Care Ombudsman program information was observed to be posted behind the concierge's desk on the wall, inaccessible to the residents. No other signage with the required information was hung on the third floor.During the Resident Council Meeting on 3/11/2026 at approximately 11:07 am, 10 out of 10 residents were unable to identify where the list of names, addresses (mailing and email), and telephone numbers of the State licensure office, and the Office of the State Long-Term Care Ombudsman program information was located. They were unaware that they had the right to file a complaint with the State licensure office or with the State Long-Term Care Ombudsman.At approximately 11:53 am, after the meeting, the Activities Director (AD) took Residents #18 and Resident #39 to see the location of the Ombudsman Information. Both stated they didn't know the information was posted in that location. Concierge #2 stated that residents must ask for the information and phone numbers if they need them, and during the 5 years she has worked at the facility, no one has asked her for them. The AD stated that there is another copy outside her office on the 2nd Floor for Assisted Living.During the end-of-day meeting on 3/13/2026 at approximately 11:30 am, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Administrator were informed of the above. The administrator stated that the Activity Director hands out cards with the Ombudsman's information from time to time, and the Ombudsman does rounds.

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

Printed: 06/05/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026
NAME OF PROVIDER OR SUPPLIER Belvoir Woods Health Care Center at the Fairfax		STREET ADDRESS, CITY, STATE, ZIP CODE 9160 Belvoir Woods Pkwy Fort Belvoir, VA 22060	

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F 0575 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Post a list of names, addresses, and telephone numbers of all pertinent State agencies and advocacy groups and a statement that the resident may file a complaint with the State Survey Agency. Based on observation, resident interview, and staff interview it was determined that the facility staff failed to post the required State Survey Agency, the State licensure office, and the Office of the State Long-Term Care Ombudsman program information in a place that is accessible to all residents.The findings include:During an observation of the third floor on 3/11/2026 at approximately 9:30 am, the list of names, addresses (mailing and email), and telephone numbers of the State licensure office, and the Office of the State Long-Term Care Ombudsman program information was observed to be posted behind the concierge's desk on the wall, inaccessible to the residents. No other signage with the required information was hung on the third floor.During the Resident Council Meeting on 3/11/2026 at approximately 11:07 am, 10 out of 10 residents were unable to identify where the list of names, addresses (mailing and email), and telephone numbers of the State licensure office, and the Office of the State Long-Term Care Ombudsman program information was located. They were unaware that they had the right to file a complaint with the State licensure office or with the State Long-Term Care Ombudsman.At approximately 11:53 am, after the meeting, the Activities Director (AD) took Residents #18 and #39 to see the Ombudsman Information location. The residents were positioned in their wheelchairs in front of the concierge's desk, and the Activities Director walked over to the information desk, pointed to the sign, and explained its contents. Residents #18 and #39 were unable to see the information on the signage from their position. Concierge #2 stated that the residents are not allowed behind the desk. Concierge #2 also stated the residents must ask for the information and phone numbers if they need it, and during the 5 years of her working for the facility, no one has asked her for it. Concierge #2 stated they keep the door to the dining room behind the desk locked so residents cannot go behind the desk. The AD stated that there is another copy outside her office on the 2nd Floor for Assisted Living.During the end-of-day meeting on 3/13/2026 at approximately 11:30 am, the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Administrator were informed of the above. The administrator stated that the Activity Director hands out cards with the Ombudsman information from time to time, and the Ombudsman does come and do rounds.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of clinical records, the facility staff failed review and revise the person-centered care plan for 4 for 38 residents (Resident #7, #10, #11 and #43), in the survey sample.1. The facility staff failed to review and revise Resident #7's care plan to include an election of hospice services with an admission to hospice services on 3/8/26.Resident #7 was initially admitted to the facility on [DATE], after an acute care hospital stay. The residents' current diagnoses included Alzheimer's disease, heart failure, and diabetes. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/22/2025, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 3 out of 15. This indicated that Resident #7's cognitive abilities for daily decision-making were severely impaired. A review of the active care plan, with a target date of 3/26/26, failed to identify a care plan addressing the residents' admission to hospice services. The nurse's notes revealed the clinical staff had been working with the resident's Power-of-Attorney since 2/4/26 because of her decrease in oral intake, episodes of MASD, and an overall decline noted by staff. The resident was admitted to hospice services on 3/8/26. On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, but they did not. The facility's team nodded in agreement with the non-compliance. 2. The facility's staff failed to review and revise Resident #10's care plan to include a fall from the bed to the fall mat on 3/13/26, and to develop interventions for episodes of orthostatic hypotension. Resident #10 was admitted to the facility on [DATE] after an acute care hospital stay. The residents' diagnoses included diabetes, high blood pressure with episodes of orthostatic hypotension, and impaired mobility and self-care secondary to Fusion of the lumbar spine. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 1/6/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 5 out of 15. This indicated that Resident #10's cognitive abilities for daily decision-making were severely impaired. A review of the active care plan with a target date of 6/17/26 failed to reveal a care plan that addressed the resident's fall on 3/13/26, and the resident's care plan failed to address that the resident had a diagnosis of hypertension but experienced episodes of orthostatic hypotension. The nurse's notes revealed the resident experienced an unwitnessed fall on 3/13/26, and on 3/17/26, it was not documented on the care plan. The 3/13/26 fall nurse's note stated that no changes to the care plan were needed. An interview was conducted with the Rehabilitation Director on 3/11/26 at 10:00 AM. The Rehab Director stated the resident was unable to tolerate therapy, was resistant to sitting up on the side of the bed or wheelchair, had episodes of low blood pressure, stated ill-feeling while sitting up, and would vomit. On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, but they did not. The facility's team nodded in agreement with the non-compliance. 3. The facility staff failed to review and revise Resident #11's care plan to include intolerance to the use of a hearing aid and dentures.Resident #11 was admitted to the facility on [DATE] after an acute care hospital stay following a new L1 compression fracture and a right 11th rib fracture secondary to a fall. The residents' diagnoses included vascular dementia, mild protein-calorie malnutrition, and a hearing loss. The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/5/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 0 out of 15. This indicated that Resident #11's cognitive abilities for daily decision-making were severely impaired. The MDS assessment at B0200. Hearing has minimal difficulty.A review of the active care plan, with a target date of 5/2/26, failed to document that the resident did not tolerate her dentures and hearing aid. A (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	care plan intervention stated that the resident requires assistance with applying, removing, and cleaning her denture.Over the course of the survey, 3/10/26 through 3/13/26 and 3/16/26 through 3/18/26, the resident was seen without dentures at each visit, and she was observed putting foods she was unable to chew well in the napkins on the tray. It was also observed that the resident was experiencing extreme difficulty communicating with the speaker due to her inability to hear what was said. On 3/17/26 at approximately 11:25 AM, the private duty sitter stated that the resident's son said it was okay for the resident not to wear the dentures and hearing aid because, on multiple occasions, she had removed both appendages and thrown them in the trash can. On 3/17/26 at approximately 2:05 PM, the concern was addressed with the DON. The DON stated that she was unaware of the concern, but the private sitter shared the same information with her, and she would follow up with the resident's son. On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, but they did not. The facility's team nodded in agreement with the non-compliance. 4. The facility staff failed to review and revise Resident #43's care plan to reflect that he does not receive hospice services.Resident #43 was admitted to the facility on [DATE] after an acute care hospital stay. The residents' diagnoses include atrial fibrillation, stage 4 chronic kidney disease, and heart failure. The annual Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/12/2025, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident #43's cognitive abilities for daily decision-making were intact. A review of the active care plan, with a target date of 6/5/26, stated that the resident was receiving hospice services for multiple problems. A nutrition note dated 3/10/25 revealed that the resident was discharged from hospice services on 3/4/25. On 3/17/26 at approximately 2:05 PM, the concern was addressed with the DON. The DON stated that the resident was no longer receiving hospice services. On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, but they did not. The facility's team nodded in agreement with the non-compliance.

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident and staff interviews and a review of the clinical record, the facility staff failed to provide the necessary activities of daily living (ADLs) for 4 dependent residents (Resident #16, Resident #67, Resident #49 and Resident #45) of the 38 residents in the survey sample. 1.The facility staff failed to provide at least 2 showers a week and to wash the residents' hair since admission. Resident #16 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included repeated falls and unsteadiness on feet. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 03/04/26 was coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 12 out of 15. This indicated that Resident #16's cognitive abilities for daily decision-making were intact. The resident's personal care plan dated 2/26/26 with a focus on bathing had a Goal specifying resident will gain increased functional ability to be able to complete her own bathing. Some interventions included It is very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath; the resident requires a shower/tub chair for bathing, the resident's shower/tub chair will be kept clean and available as needed and stored when not in use. An interview was conducted with Resident #16 on 03/11/2026 at approximately 12:09 pm. Resident #16 said that the staff was counting on her to ask for showers. The resident mentioned that I thought that I had shower days. The resident also said that she's been taking baths with a basin. The resident also said when she's home, she likes to wash her hair when she takes showers. The resident also said I've been using wash clothes to run through my hair. I told my aide today that I wanted to take a shower. I don't refuse showers I love showers. A review of the Activity of Daily Living (ADL) document for February 2026 revealed that the resident had showers scheduled for Wednesday and Saturdays during the 7:00 am to 3:00 pm shift. The ADL documentation dated 2/28/26 was coded as 01, meaning shower/bathe self. A review of the Activity of Daily Living (ADL) document for March 2026 revealed that the resident had showers scheduled for Wednesday and Saturdays during the 3:00 pm to 11:00 pm shift. The ADL documentation dated 3/07/26 was marked (NA). On 3/13/26 at approximately 11:00 am., during the end of day meeting with the administrator, the Director of Nursing (DON) and Assistant Director of Nursing (ADON) concerning showers. The ADON said that shower preferences are based on what's best for the resident. The ADON also said that Resident #16 was getting showers on Monday and Saturdays from 3:00 pm to 11:00 pm but voiced yesterday that she prefers daytime showers. The ADON also stated that showers were not documented for the resident. 2. The facility staff failed to provide at least 2 showers a week since admission. Resident #67 was initially admitted to the facility on [DATE] due to a right intertrochanteric femur fracture. The residents' current diagnoses included repeated falls and unsteadiness on feet. The admission minimum data set (MDS) assessment with an assessment reference date (ARD) of (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3/8/2026 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of the possible 15. This indicated Resident #67 cognitive abilities for daily decision making were intact. The resident's personal care plan dated 3/2/2026 read that resident requires partial/moderate assistance bathing. In section GG (Functional Abilities and Goals) the resident was coded as requiring required partial/moderate assistance with showering/bathing. During an observation and interview with Resident #67 on 3/12/2026 at approximately 11:02 am Resident #67 stated he went to the shower room and received a shower for the first time this morning since admission. Resident #67 stated It was a very thorough washing, and it made him feel clean and great. Resident reports that his preference is showers. Resident stated staff have not bathed him before today in the shower room or in bed, but he has been able to shave, use a washcloth to wipe himself down and brush his teeth in the bathroom. During an interview on 3/12/2026 at approximately 11:28 am Certified Nursing Assistant (CNA) #6 stated that staff document a shower or a refusal in the computer system in the medical record. CNA #6 states that there is a set schedule for each side of each hallway. Showers/baths are also provided if the family or resident requests a shower/bath or if there is an accident/need for a shower/bath. CNA #6 states the shower schedule is on the board in each of the rooms and staff ask the residents what time they want to get a shower/bath. During an observation and interview on 3/12/2026 at approximately 11:34 am Resident #67's board did not have his shower/bath days listed. Licensed Practical Nurse (LPN) #6 was in the room and states that some residents have them scheduled on the board and others do not but that the schedule is in the CNA computers. LPN #6 confirmed that Resident #67's shower/bath schedule is Monday and Thursdays on the 7:00 am-3:00 pm shift. A review of the Activity of Daily Living (ADL) document for March 2026 revealed that the resident had showers scheduled for Monday and Thursdays on the 7am-3pm shift. The ADL documentation reflected the resident received his first shower/bath on 3/12/26 which was coded as 04, supervision or touching assistance. A review of the Activity of Daily Living (ADL) document for March 2026 revealed that the resident had showers scheduled for Monday and Thursdays on the 3:00 pm to 11:00 pm shift, as needed. The ADL documentation dated 3/03/26 was marked (NA). At the end of day meeting on 3/13/2026 the DON (Director of Nursing), ADON (Assistant Director of Nursing), and Administrator were informed of the above. The DON, ADON, and Administrator were given the opportunity to provide any additional information. No further information or documentation was provided. 3. The facility staff failed to give showers/tub baths to Resident #49. Resident #49 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included Alzheimer's dementia and paroxysmal atrial fibrillation. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/25/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 3 out of 15. This indicated that Resident #49's cognitive abilities for daily decision-making were severely impaired. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In section GG0130. Self-Care: the resident was coded as dependent with toileting hygiene, shower/bathe self, and lower body dressing; requires substantial/maximal assistance with eating, upper body dressing, personal hygiene, and putting on/taking off footwear; and partial/moderate assistance with oral hygiene. The resident's person-centered care plan, dated 2/19/26, included a problem titled Bathing. The goal stated is that I will gain increased functional ability to be able to complete my own bathing task through the next review date, 5/15/26. The interventions include requiring substantial/maximal assistance with bathing, and it is very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. On 3/11/26 at 12:15 PM, Resident #49 was observed in bed with oily flat hair, and her skin was observed to have patches of dry, rough skin on her face. The resident was unable to state whether she was receiving showers/tub baths. On 3/13/26 at 11:45 AM, Resident #49 was observed in bed again. The resident was observed again with oily flat hair, rough skin, and an offensive odor. An interview was conducted with Family Member #2, who was seated in the room. He stated that the resident's hair had not been washed for weeks. He stated that the resident would be admitted to an assisted living facility on 3/17/26 and that he would ensure the resident's hair was washed and that she looked good upon admission to the new facility. A review of the resident's bathing records revealed the resident refused showers/tub baths on 3/4/26 and 3/11/26. On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, but they did not. 4. The facility staff failed to educate Resident #45 so she would accept showers. Resident #45 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included severe hyponatremia secondary to SIADH and soft tissue swelling along the dorsum of the wrist. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/26/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 15 out of 15. This indicated that Resident # 45's cognitive abilities for daily decision-making were intact. In section GG0130. Self-Care: the resident required substantial/maximal assistance with shower/bathe self, lower-body dressing, putting on/taking off footwear, and toileting hygiene; partial/moderate assistance with personal hygiene, upper-body dressing, and setup or clean-up assistance with eating and personal hygiene. The resident's person-centered care plan, with a revision date of 2/20/26, included a problem titled Bathing. The goal stated that I will gain increased functional ability to complete the bathing task by the next review date. The interventions included: I require substantial/maximal assistance with bathing, and it is very important to the resident to choose between a tub bath, shower, bed bath, or sponge bath. Resident #45 was observed on 3/10/26 with multiple scabs on her arms and legs. The resident's hair (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on a review of the Quality Assurance and Performance Improvement (QAPI) program, the facility staff failed to identify failed systems. The findings included:On 3/18/26 at approximately 11:30 AM, an interview was conducted with the Administrator (ADM) regarding any specific care areas or services the committee had identified as not functioning well, or that had failed. Information comes from data collected from the 5-star report, Resident Council meetings, grievances, families, residents, and the Interdisciplinary Team members. The ADM further stated that falls, pressure ulcers, and a newly developed process related to transcription errors were current systems they had identified and were ongoing. The three areas identified during the survey were not identified by the facility's staff and were not presented to the QAPI team. Throughout the survey conducted 3/10/26 through 3/13/26 and 3/16/26 through 3/18/26, three system failures were identified. They were Activities of Daily Living, specifically showers/tub baths, reviews and revisions of person-centered care plans, and maintaining a safe, clean, comfortable, and homelike environment. Several dependent residents were identified as not receiving showers and/or tub baths. Observations were made of dependent residents with oily hair, scaly skin, and body odor; a few complained of not receiving showers or having their hair washed. A review of showers and/or tub baths was conducted, and the documentation revealed that residents did not receive regular full-body baths, primarily showers or tub baths. Resident person-centered care plans were reviewed for all sampled residents, and a pattern was identified, that they were not reviewed and revised on an ongoing basis as the resident improved or deteriorated. Resident rooms were also identified as a failed system, as many were not safe, clean, comfortable, and/or homelike. There was one room with ongoing heating concerns, and the resident stated they had been cold several nights. Over 15 other rooms had walls that required painting or had torn wallpaper and exposed wallboards. An interview was conducted with the Assistant Engineer (AE) on 3/18/26 at 1:15 PM, during which he acknowledged the problem and outlined what they would do to correct it going forward. On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, but they did not.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation and interviews, the facility staff failed to ensure that two (2) residents (Resident #18 and Resident #5) in the survey sample of 38 residents lived in a comfortable, homelike environment.The findings include: 1. The facility staff failed to ensure the Resident #18 remained comfortable and warm in her room, room [ROOM NUMBER] B. Resident #18 was originally admitted to the facility on [DATE] after an acute care hospital stay and readmitted on [DATE]. The current diagnoses included: Chronic Kidney DS, stage 3B, and Neuralgia and Neuritis, Unspecified. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/14/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated that Resident #18's cognitive abilities for daily decision making were intact. The resident's personal care plan dated 5/08/25 read that the resident would make their own decisions and have no memory loss. A Goal set for the resident was to maintain current memory recall and the ability to make their own self-care decisions. Some resident interventions include allowing the resident to make her own self-care decisions daily, keeping herself informed of current events, and encouraging me to attend activities of her choice. On 03/11/2026 at approximately 11:07 am, a meeting was held with residents and two members of the survey team. Resident #18, who lived in room [ROOM NUMBER]B, said she was experiencing ongoing temperature issues in her room. The resident said that maintenance was informed, but has not fixed the issue. The resident said that her room is cold. A review of the Resident Council Meeting notes revealed that a grievance was on file on 1/08/26 by Resident #18. The grievance document stated that maintenance fixed the issue, with no further complaints. However, the Grievance concerned the common areas rather than specific rooms. On 03/12/2026 at approximately 12:39 pm, an interview was conducted with Resident #16. Upon entering the resident's room, the radiator was heard chirping. The resident stated, Feels on the cold side. The resident was observed still in bed, covered with blankets, and with several blankets/throws on her chair. The resident said it wasn't as cold today as it was last night, but she snuggled up with her extra blankets then. On 03/17/2026 at approximately 12:24 pm, a brief interview was conducted with the resident concerning her room temperature. The resident stated she's very satisfied because someone from maintenance came by the other day to fix it. The resident said, The room feels warm. On 03/17/2026 at approximately 6:56 pm, the resident reported the room being cold. The administrator said the staff will be trained to Turn up the residents' heat. On 03/18/2026 at approximately 10:33 am, an interview was conducted with the Maintenance Engineer (ME). The ME said the unit (Packaged Terminal Air Conditioners/PTAC) must be switched from heat to cold, but he switched it from cold to heat. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belvoir Woods Health Care Center at the Fairfax	9160 Belvoir Woods Pkwy Fort Belvoir, VA 22060

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 03/18/2026 at approximately 10:38 am, the resident was observed in bed. The resident said she thought she was going to freeze last night because she hadn't had heat in her room since yesterday. The engineer appeared shortly thereafter and was asked to check the room temperature. The ME portable thermometer read 71.9 degrees Fahrenheit (71.9F). The ME also said that the room temperature was 69F on yesterday. On 03/18/26 at approximately 11:27 am, the ME informed the surveyor that he was en route to the resident's room to set up a temporary portable heating unit. On 03/18/2026 at approximately 12:19 pm, a portable heater was observed in the resident's room with the temperature set to 75F. Warm air was circulating in the room set to 75 F. On 3/18/2026, a brief interview was conducted with Certified Nursing Assistant (CNA) #1. CNA #1 said that this morning, the resident mentioned she was cold last night, so she gave her two blankets. On 3/18/2026 at approximately 4:45 pm, a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and two Corporate Consultants. The above findings were discussed with the administrative staff. 2. The facility staff failed to maintain a homelike environment for Resident #5. Resident #5 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included atrial fibrillation and chronic venous insufficiency. The significant change Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/9/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 3 out of 15. This indicated that Resident # 5's cognitive abilities for daily decision-making were severely impaired. On 3/13/26 at approximately 12:10 PM, Resident #5 was observed in bed. She stated that she did not feel well but was unable to say exactly what was bothering her. The resident's personal belongings were scattered around the room, on top of the bedside table, in the chair, and on the over-the-bed table. The wall behind the bed had torn wallpaper. The resident was asked whether she was alright with her personal belongings not being put away and with the torn wallpaper beside her bed. Resident #5 stated it was her preference to have her belongings stored and that she would like to have the wall repaired. An interview was conducted with the Assistant Engineer (AE) on 3/18/26 at approximately 1:15 PM. The AE stated that they had identified many rooms that require the accent walls to be repaired, but they had not completed many because the resident would need to move out of the room for the wall repair. The AE stated that the direct care staff was tearing the walls when the beds were moved. The AE stated that, going forward, they would work directly with nursing to ensure the rooms were available for the wall work to be completed. On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the (continued on next page)

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	495197	A. Building B. Wing	03/18/2026

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, and the DON stated that nursing is responsible for ensuring that a resident's personal belongings are stored appropriately.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and a review of clinical records, the facility staff failed to accurately transcribe a medication order for 1 of 38 residents (Resident 32) in the survey sample.The findings included: Resident #32 was admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included Right 5th finger osteomyelitis/septic arthritis requiring IV therapy, congestive heart failure, and atrial fibrillation. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 3/5/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 11 out of 15. This indicated that Resident # 32's cognitive abilities for daily decision-making were moderately impaired. Resident #32 was discharged from the hospital and admitted to the facility on [DATE] with an order for Apixaban Oral Tablet 2.5 MG. Give one tablet by mouth twice daily. A new order was written on 3/13/26 at 3:56 PM for Apixaban Oral Tablet 2.5 MG. Give 12.5 mg by mouth twice daily, beginning on 3/14/26. On 3/14/26, a nurse signed off on the administration of 12.5 mg of Apixaban. The physician's progress note dated 3/13/26 at 2:55 PM stated that the resident presented with left leg swelling, minimal difference between the right and left, and some redness, which was new per the resident. The note further stated that the resident had an ultrasound to rule out a blood clot. The results were negative. On 3/17/26 at approximately 11:30 AM, an interview was conducted with the Assistant Director of Nursing (ADON) regarding the change in Resident #32's Apixaban Oral Tablet 2.5 mg from 2.5 mg twice daily to 12.5 mg twice daily. The ADON stated the nurse who transcribed the order mistakenly changed the Apixaban Oral Tablet 2.5 mg dosage twice daily to 12.5 mg twice daily. The ADON stated that the Apixaban Oral Tablet 2.5 mg, give 12.5 mg was signed off as administered on 3/14/26, but the nurse stated she only administered one 2.5 mg tablet because she didn't notice the dosage change equaled 5 tablets instead of one tablet. The ADON also stated they validated that the 4 additional tablets had not been administered based on the tablet count. The ADON stated that an audit of the resident's medications was conducted, and it revealed that the 12.5 mg tablet was for the new order obtained on 3/13/26 for Aldactone (a diuretic), not Apixaban. The ADON concluded that the 12.5 mg of Apixaban was never administered, the order was clarified, and returned to Apixaban Oral Tablet 2.5 mg twice daily. The ADON stated that the problem had been traced to a transcription error and that in-service training related to this error had begun. On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, but they did not. Apixaban is also used to prevent stroke and blood clots in patients with certain heart rhythm problem (eg, nonvalvular atrial fibrillation). It is also used to treat or reduce the risk of venous thromboembolism (VTE) after receiving at least 5 days of medicine to treat blood clots. Apixaban is a factor Xa inhibitor, an anticoagulant. It works by decreasing the clotting ability of the blood and helps preventing harmful clots from forming in the blood vessels. (Apixaban (oral route) - Side effects & dosage - Mayo Clinic)

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and a review of clinical records, the facility staff failed to provide the necessary care to prevent the development of a sacral stage 3 pressure ulcer in 1 of 38 residents in the survey sample (Resident #7), constituting harm. The findings included: Resident #7 was initially admitted to the facility on [DATE], after an acute care hospital stay. The residents' current diagnoses included Alzheimer's disease, heart failure, and diabetes. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 12/22/2025, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 3 out of 15. This indicated that Resident #7's cognitive abilities for daily decision-making were severely impaired. In section GG0130. Self-Care: the resident was coded as requiring set-up assistance with eating and oral hygiene; supervision or touch assistance with personal hygiene; substantial/maximal assistance with toileting, showers/bathes, lower body dressing, and putting on and taking off footwear; and partial/moderate assistance with upper body dressing. In section GG0170. Mobility: the resident was coded as requiring substantial/maximal assistance with rolling left and right, sitting to lying, lying to sitting, sitting to standing, chair-to-bed transfers, and transfers to the shower or tub. The person-centered care plan dated 9/14/24, which stated that the resident had a potential for impaired/compromised skin integrity with a need for preventative care related to bilateral lower extremity edema and incontinence. The goal stated the resident would be monitored for compromised skin integrity through the next review date, 6/17/26. The interventions included observing chair/bed-bound resident for redness to pressure areas - buttocks, lower back, shoulders, elbow, hip, and heels. Notify the nurse of any redness. Encourage and assist with turning and positioning. Assist the resident to bed during the day to promote pressure relief and assist with repositioning as needed. The use of a low-air-loss mattress in the bed was added 2/25/26. On 3/11/26 at approximately 3:50 PM, Resident #7 was observed sitting in her wheelchair in her room. She was observed in the room, seated in a wheelchair, at approximately 11:00 AM. On 3/12/26, Resident #7 was observed in bed at approximately 9:15 AM with the breakfast meal before her. She was observed at 11:07 AM out of bed in the wheelchair, with the Certified Nursing Assistant (CNA) #4 propelling her towards the dining room. The resident was again observed at approximately 4:30 PM in her wheelchair in her room. On 3/18/26 at approximately 11:00 AM, Resident #7 was observed in the wheelchair sitting in her room. CNA #4 was observed making the bed. The CNA stated that Resident #7 is out of bed daily before 11:00 AM because her spouse wishes the resident to have lunch in the dining room. A review of the nurse's notes revealed that on 2/4/26 at 2:39 PM, the resident had a weekly skin assessment completed with no skin issues noted. The note further stated that barrier cream was in use on both buttocks as a preventative measure secondary to incontinence. A nurse's note dated 2/11/26 at 10:08 AM stated that the resident received a head-to-toe weekly skin assessment, and moisture-associated skin damage (MASD) was observed on the sacrum. A nurse's note dated 2/18/2026 3:01 PM stated that the weekly skin assessment was completed, and the resident continued with MASD to the sacrum. On 2/22/2026 10:52 PM, a nurse's note stated that the resident had an open wound to the sacrum. The open wound measured 2 centimeters (cm) x 2 centimeters. The open wound was not staged during this assessment; it was cleaned with normal saline and covered. The wound care physician's progress note dated 2/24/26 stated that this was the first visit with the resident, and the etiology of the sacral wound was pressure. The sacral pressure ulcer measured a length of 2.0 cm by a width of 1.5 cm by a depth of 0.2. The pressure ulcer was identified as a stage 3, presented with 100% granulation tissue and moderate serous drainage. The treatment orders were for calcium alginate with honey. The wound care physician stated that, given the resident's overall condition, further decline was anticipated, and the pressure ulcer was unavoidable. The Nurse Practitioner also documented on this date that the resident's wound was viewed as unavoidable due to her bedbound status, limited mobility, poor oral (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intake, and documented weight loss. The resident was observed with no encouragement or assistance from staff with meals.The wound care physician's progress note dated 3/3/26 stated that the sacral pressure ulcer had decreased in size and measured 1.2 cm by 1.2 cm by 0.2 cm. The treatment remained the same, as well as the offloading and repositioning. On 3/10/26, the sacral pressure ulcer was reassessed by the wound care physician, and again it had decreased in size. It measured 0.8 cm by 0.7 cm by 0.2 cm. The treatment remained the same, and the recommendation was to offload pressure and reposition the resident per the facility's protocol. On 3/17/26, the sacral pressure ulcer was reassessed by the wound care physician. The wound continued to decrease in size. It measured 1.2 cm by 0.4 cm by 0.2 cm. An interview was conducted with the Director of Nursing (DON) on 3/17/26 at approximately 1:00 PM. The DON stated that the wound care physician had reassessed the resident's sacral pressure ulcer, and it was expected to be resolved any day now because it responded well to treatment. The resident's daily observation of remaining in the wheelchair for more than 7 hours was discussed with the DON, and the DON stated that the direct care staff had assured her that they shift the resident's weight when she is seated in the wheelchair. The DON didn't state whether the nursing team had educated the Responsible Party and/or Power of Attorney about the need to offload pressure to promote healing of the ulcer and prevent the development of additional pressure ulcers.On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, but they did not. Bedsores are injuries to the skin and the tissue below the skin that are due to pressure on the skin for a long time. Bedsores most often arise on skin that covers bony areas of the body, such as the heels, ankles, hips, and tailbone. The people who are most at risk of bedsores have medical conditions that keep them from changing positions or moving. Or they spend most of their time in a bed or a chair. (Bedsores (pressure ulcers) - Symptoms and causes - Mayo Clinic)

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	495197	A. Building B. Wing	03/18/2026

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on an interview with Family Member #1, staff interviews, and a review of clinical records, the facility staff failed to provide adequate assistance during incontinence care to prevent a fall for 1 of 38 residents in the survey sample (Resident #10). The findings included: Resident #10 was admitted to the facility on [DATE] after an acute care hospital stay. The residents' diagnoses included diabetes, high blood pressure with episodes of orthostatic hypotension, and impaired mobility and self-care secondary to Fusion of the lumbar spine. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 1/6/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 5 out of 15. This indicated that Resident #10's cognitive abilities for daily decision-making were severely impaired. An interview was conducted with the Rehabilitation Director on 3/11/26 at 10:00 AM. The Rehab Director stated the resident was unable to tolerate therapy, was resistant to sitting up on the side of the bed or wheelchair, had episodes of low blood pressure, reported feeling ill while sitting up, and would vomit. Prior to the 3/6/26 fall, the resident didn't have a resistance problem in the care plan. On 3/13/26 at approximately 11:45 AM, Family Member # 1 stated that the resident had fallen from the bed to the floor, and that staff were working to transfer her back to the bed. A review of the nurse's notes revealed that the resident had experienced a witnessed fall on 3/6/26 at 4:30 AM, while a Certified Nursing Assistant (CNA) was providing incontinence care. The nurse's note further stated that the resident was resisting care, tried to get out of bed, and slid off the bed to the floor. The resident required two staff members to assist her back onto the bed. An interview was conducted with the Director of Nursing (DON) on 3/17/26 at 4:40 PM regarding interventions the CNA should have instituted to prevent the fall on 3/6/26. The DON stated that the CNA should have stopped care when the resident became resistant, reminded the resident that she required assistance getting out of bed, ensured the resident was safe, and later reapproached the resident. On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, but they did not.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, and clinical record review, it was determined that the facility staff failed to provide the resident with a bedside urinal upon request from the resident for 1 resident (Resident #67) out of 38 residents in the survey sample.The findings Include:Resident #67 was initially admitted to the facility on [DATE] due to a right intertrochanteric femur fracture. The residents' current diagnoses included repeated falls and unsteadiness on their feet.The admission minimum data set (MDS) assessment, with an assessment reference date (ARD) of 3/8/2026, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of the possible 15. This indicated that Resident #67's cognitive abilities for daily decision making were intact.The resident's personal care plan dated 3/2/2026 read that the resident requires partial/moderate assistance with toilet use and the use of incontinent briefs, and is able to make self-care decisions daily.In section GG (Functional Abilities and Goals), the resident was coded as requiring substantial/maximal assistance with bed-to-chair transfers and toilet transfers and partial/moderate assistance with toileting hygiene. In section H (Bladder and Bowel), read that the resident is occasionally incontinent.During an observation on 3/11/2026 at approximately 12:01 pm, Resident #67 asked CNA #8 (Certified Nursing Assistant) to have his urinal at his bedside. CNA #8 stated that he could not have one at his bedside and needed to use the call bell to ask for assistance with using the urinal in the bathroom.Observation of room [ROOM NUMBER]-B on 3/11/2026 at approximately 2:13 pm, there was no urinal at Resident #67's bedside. Resident #67's urinal was in a bag in the bathroom. The resident stated he was not provided with a urinal.During an interview on 3/11/2026 at approximately 2:14 pm, CNA #8 stated that Resident #67 transfers with supervision, and sometimes he needs assistance depending on the day. When asked about the bedside urinal, CNA #8 stated they don't usually provide a bedside urinal due to infection control. They would place the urinal in the bathroom in a bag for the resident to use, and the resident would be educated to use the call light to request assistance with using the urinal.During an interview on 3/11/2026 at approximately 2:24 pm, CNA #6 stated that if a resident is unable to transfer to the urinal independently, they would stay at the resident's bedside upon request to prevent falls. If the resident can walk, then the urinal would be left in a bag in the bathroom.Observation of room [ROOM NUMBER]-B on 3/12/2026 at approximately 10:38 am, there was no urinal at Resident #67's bedside. Resident #67's urinal was in a bag in the bathroom. The resident stated he was not provided with a urinal.During an interview on 3/12/2026 at approximately 10:40 am, LPN #6 (Licensed Practical Nurse) stated that the staff usually have residents who cannot transfer independently to the urinals. The residents are allowed to have them at the bedside. Staff use them to prevent falls, and it is better for residents to have them close by, so they don't impulsively get up. LPN #6 was informed that Resident #67 was requesting a urinal for his bedside.During an interview on 3/12/2026 at approximately 11:02 am, Resident #67 stated that he never received the urinal he was requesting for his bedside and that he sure could have used one.Observation of room [ROOM NUMBER]-B on 3/12/2026 at approximately 1:50 pm, there was no urinal at Resident #67's bedside. Resident #67's urinal was in a bag in the bathroom. The resident stated he was not provided with a urinal.Observation of room [ROOM NUMBER]-B on 3/13/2026 at approximately 9:54 am, there was no urinal at Resident #67's bedside. Resident #67's urinal was in a bag in the bathroom. The resident stated he was not provided with a urinal.During the end-of-day meeting on 3/13/2026 at approximately 11:45 am, the DON (Director of Nursing), ADON (Assistant Director of Nursing), and Administrator were informed of the observations and interviews. The ADON stated that the resident could have a bedside urinal if he was able to use it and that there is no policy regarding bedside urinals. No additional information was provided.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on information obtained during the medication administration observation, staff interviews, and a review of facility documents, the facility staff failed to ensure that the medication label was not altered from the pharmacy-printed label. The findings included:On 3/12/26 at 1:00 pm, during the medication administration observations with Licensed Practical Nurse (LPN) #3, the label on the Benzonatate 100 mg capsules medication card was noted to have a handwritten 8 covering the previous hourly instructions for administration, such as 4 hours and 12 hours. A review of the physician's order summary revealed that on 2/19/26, an order was received for Benzonatate 100 mg, 1 capsule by mouth every three hours as needed (PRN) for cough. This order was changed on 2/20/26 to Benzonatate 100 mg every eight hours PRN for cough. On 3/11/26, the order was changed to Benzonatate 100 mg, 1 capsule by mouth three times a day for cough for 5 days. The pharmacy instructions further said to use the PRN medication on hand. On 03/12/26 at 1:00 pm, an interview was conducted with LPN #3 regarding the handwritten 8 covering the previous hourly instructions. LPN #3 stated that the order had been changed from PRN to scheduled doses, and the pharmacy's instructions were for the facility staff to use the on-hand medication until the new medication card was received. On 3/13/26 at 11:30 am, an interview was conducted with the Director of Nursing (DON). The DON stated that the staff nurses' expectations are to follow the policy. A review of the facility's policy titled Medication and Medication Labels 3.7, dated January 2025. In section 6a, the policy stated: If the prescriber's directions for use change or the label is inaccurate, the nurse may place a 'direction change. ' Change of order-check chart' or similar label on the container indicating there is a change in directions for use, taking care not to cover important label information. On 3/18/25 at approximately 4:45 pm, a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, [NAME] President of Operations, and the Corporate Nurse Consultant. The above findings were conveyed to the administrative team, who made no comments and voiced no concerns.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews and a review of the clinical record, the facility staff failed to have a hospice-coordinated plan of care for 1 of 38 residents (Resident #5), in the survey sample. The findings included: Resident #5 was initially admitted to the facility on [DATE] after an acute care hospital stay. The residents' current diagnoses included atrial fibrillation and chronic venous insufficiency.The significant change Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/9/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 3 out of 15. This indicated that Resident # 5's cognitive abilities for daily decision-making were severely impaired. An interview was conducted with Certified Nursing Assistant (CNA) #6 on 3/13/26 at approximately 12:20 PM. CNA #6 stated she had never seen a hospice aide provide any services to Resident #5. She further stated that a male nurse was observed visiting the resident approximately twice per week. A care plan problem dated 2/4/26 stated that Resident #5 was admitted to hospice services for end-of-life care related to senile degeneration of the brain. The goal was to receive uninterrupted supportive services through the next review date. The interventions included coordinating all residents' needs, communicating any changes to hospice, and educating the resident, family, responsible party, and caregivers about changing needs and the need for additional hospice services. An interview was conducted with the Director of Nursing (DON) on 3/12/26 at approximately 11:40 AM. The DON stated that the hospice admission paperwork, the care plan, and visit notes were likely in the resident's paper chart. A review of the paper charts resulted in no hospice documents. Therefore, the services the hospice agency would provide, when and how those services would be provided, the communication process, and when or why the nursing facility staff should contact the hospice agency were not available in the facility. On 3/13/26, the hospice documents were provided. They had been faxed to the facility on 3/12/26 at 4:53 PM. The hospice documents stated that the resident was admitted for hospice services on 1/29/26 for senile degeneration of the brain. On 3/18/26 at approximately 4:00 PM, the above information was conveyed to the Administrator, the DON, ADON, and two corporate consultants. An opportunity was offered for the Team to provide additional information, but they did not. The facility's team nodded in agreement with the non-compliance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495197	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belvoir Woods Health Care Center at the Fairfax	9160 Belvoir Woods Pkwy Fort Belvoir, VA 22060

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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. Based on information received during the infection control task, and staff interviews, the facility staff failed to document each staff member's COVID-19 information. The findings included:On 3/12/26 at 2:00 pm information for investigation of the staff COVID 19 task was provided by the Human Resource Manager (HRM). The HRM stated that they had no documentation for the employees with longevity, but all new hires initial the Orientation Acknowledgement form that says they were given COVID -19 education. The HRM could not provide the education which was acknowledged by initials for two of two selected new hires. On 3/13/26 at 11:23 am the HR manager provided their Infectious disease COVID-19 preparedness and response plan as the education. Also, the HRM was unable to provide education or documentation that all staff had been offered the COVID-19 vaccine. At 1:00 pm the HRM stated going forward they would institute a new process. The new process would document that all staff received education and would be offered the COVID -19 vaccine. On 3/18/26 at approximately 4:45 pm, a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and two Corporate Consultants. The above findings were conveyed to the administrative team, and the overall Director of the facility stated that going forward they would review the requirements and develop a plan for staff COVID-19 vaccines.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495197	A. Building B. Wing	03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Belvoir Woods Health Care Center at the Fairfax	9160 Belvoir Woods Pkwy Fort Belvoir, VA 22060

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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 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, and staff interviews, the facility's staff failed to ensure that the call bell was accessible to one (1) of 38 residents in the survey sample (Resident #72). The findings include: Resident #72 was originally admitted to the facility 3/04/26 and after an acute care hospital stay and readmitted on [DATE]. The current diagnoses included; Wedge compression fracture of fourth lumbar vertebra and Subsequent encounter for fracture with routine healing.The 5-day assessment Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 03/11/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated Resident #72's cognitive abilities for daily decision making were intact.On 3/12/26 at approximately 10:45 am, an interview was conducted with Resident #72 concerning his care. The resident was observed lying in bed with his head raised slightly to approximately 45 degrees; his call bell was observed on the floor beside his bed. During the interview, the resident was observed drinking water and wasting a small to moderate amount on his shirt. The resident asked if he could get something to wipe off the water from his shirt and chest. The resident was asked to use his Call Bell (CB) for assistance, but said that he couldn't find it. The resident had also mentioned that he had a fall last night, I hit the bell, but no one came. I was trying to pull the curtain and fell on my left side.The call bell timeline was as follows on 3/12/26:At 10:45 am, the call bell observed on the floor beside the resident's bed was not accessible.At 10:55 am, call the bell in the same location.At 11:14 am, Certified Nursing Assistant (CNA) #2 was observed entering the resident's room, picking up his CB, and placing it at the bedside. CNA #2 said that she does resident rounds every 15 minutes.On 3/18/26 at approximately 4:45 pm, a final interview was conducted with the Administrator, Director of Nursing, Assistant Director of Nursing, and two Corporate Consultants. The above findings were discussed with the administrative staff. The administrator said that she had not been made aware of the issue.