STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495205	A. Building B. Wing	04/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
August Healthcare at Iliff	8000 Iliff Drive Dunn Loring, VA 22027

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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to develop a baseline care plan within 48 hours of admission to address skin impairment for one resident (Resident #2) in a survey sample of four residents. The findings included;For Resident #2, the staff failed to develop a baseline care plan within 48 hours of admission to identify and address a skin impairment that was present upon admission. Resident #2 was originally admitted on [DATE]. Diagnoses for Resident #2 included but were not limited to; Post infectious Viral encephalitis and encephalomyelitis, acute cerebral edema, intracranial space occupying lesion, persistent vegetative state, ventilator dependence, and an unstageable coccyx (later called sacrum by staff) pressure sore. Resident #2's admission Minimum Data Set (an assessment protocol) documented the Resident as completely dependent on 1-2 staff members for all Activities of Daily Living care. The Resident was incontinent of bowel and bladder and was vegetative, with no response to verbal or physical stimuli. A review of Resident #2's closed clinical record was conducted during the survey. Resident #2 discharged to the hospital on 1-24-26 and did not return to the facility. On 12-30-24 the first Admitting daily skin assessment documented existing pressure ulcer, sacrum only. A note was included which documented During physician assessment, the referred healed stage 2 on the sacrum per doctor is actually a mild skin maceration, and a birth mark is noted on his left side. The macerated area measured 5 cm long [centimeters] by 6 CM wide with no depth. On 1-1-25 the second Admitting daily skin assessment documented Skin maceration coccyx area measured 5 cm long [centimeters] by 6 CM wide with no depth. On 1-2-25 the third Admitting daily skin assessment documented admitted with Skin maceration sacrum with no measurement given. The review revealed no physician treatment orders for the pressure area from admission on [DATE] until 1-3-25. On 1-14-25 the dressing order was changed to Cleanse open area on the sacrum with wound cleanser, pat and dry, and apply Medi-honey and cover with dry dressing. The treatment was applied only on that day as the Resident was discharged to the hospital on that same day.On 1-9-25 a Weekly Skin Review was documented by staff. The document review revealed open area on sacrum, hydrofera in progress, no discomfort noted, Resident seen by doctor [name] on 1-8-25 during rounds The document went on to describe low air loss mattress, pressure ulcer unstageable, unchanged, moderate necrosis and slough tissue present, 5 cm long by 8 cm wide, no tunneling, no sign of infection, no change in treatment.On 4-6-26 a staff interview was conducted with the Pediatric Director RN B [Registered Nurse B]. RN B stated that she did remember the Resident as he was such a sad case. She went on to say when Resident#2 was admitted , the physician thought the pressure sore was acquired while hospitalized and was just beginning to break down and open on admission to the nursing facility. That's why the maceration was only in one spot and not covering the entire buttocks and genitalia of Resident #2.On 4-6-26 the Director of Nursing [DON] was interviewed and remembered the Resident. He stated that everyone knew that the wound was a DTI [deep tissue injury] and that it happened in the hospital. He was then asked if that was known, why did staff not obtain treatment orders or institute a care plan for the Resident upon admission. His response was I don't know.The comprehensive care plan was (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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reviewed and revealed that on 1-3-25, after orders for treatment were obtained from the physician 5 days after admission.The facility Administrator, and DON (Director of Nursing) were informed of the findings during an end-of-day de-briefing on 4-7-26, at approximately 4:30 p.m. The facility stated they had no further information to present at the time of exit.

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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 observation, staff interview, clinical record review, and facility document review, the facility staff failed to treat a pressure sore for one Resident (Resident #2) of the four (4) residents in the survey sample. The findings included;For Resident #2, the staff failed to provide a baseline treatment for what would reveal itself to be an unstageable sacral pressure sore from 12-30-24 through 1-3-25 (5 days). Resident #2 was originally admitted on [DATE]. The Resident was discharged to the hospital on 1-14-25 and did not return. Diagnoses for Resident #2 included but were not limited to; Post infectious acute Viral encephalitis and encephalomyelitis, acute cerebral edema, intracranial space occupying lesion, persistent vegetative state, ventilator dependence, and an unstageable coccyx (later called sacrum by staff) pressure sore. Resident #2's admission Minimum Data Set (an assessment protocol) documented the Resident as completely dependent on 1-2 staff members for all Activities of Daily Living care. The Resident was incontinent of bowel and bladder and was vegetative, with no response to verbal or physical stimuli. A review of Resident #2's clinical record was conducted during the survey. The review revealed no physician treatment orders for the pressure area from admission on [DATE] until 1-3-25. The 3 new orders were instituted on 1-4-25 by staff. They were for the following;Juven dietary supplement for wound healing 2 times per day.Weekly skin checks.Cleanse open area on the sacrum with wound cleanser, pat and dry, and apply hydrofera and cover with dry dressing.On 1-14-25 the dressing order was changed to Cleanse open area on the sacrum with wound cleanser, pat and dry, and apply Medi-honey and cover with dry dressing. The treatment was applied only on that day as the Resident was discharged to the hospital on that same day.On 12-30-24 the first Admitting daily skin assessment documented existing pressure ulcer, sacrum only. A note was included which documented During physician assessment, the referred healed stage 2 on the sacrum per doctor is actually a mild skin maceration, and a birth mark is noted on his left side. The macerated area measured 5 cm long [centimeters] by 6 CM wide with no depth. On 1-1-25 the second Admitting daily skin assessment documented Skin maceration coccyx area measured 5 cm long [centimeters] by 6 CM wide with no depth. On 1-2-25 the third Admitting daily skin assessment documented admitted with Skin maceration sacrum with no measurement given. On 1-9-25 a Weekly Skin Review was documented by staff. The document review revealed open area on sacrum, hydrofera in progress, no discomfort noted, Resident seen by doctor [name] on 1-8-25 during rounds The document went on to describe low air loss mattress, pressure ulcer unstageable, unchanged, moderate necrosis and slough tissue present, 5 cm long by 8 cm wide, no tunneling, no sign of infection, no change in treatment.On 4-6-26 a staff interview was conducted with the Pediatric Director RN B [Registered Nurse B]. RN B stated that she did remember the Resident as he was such a sad case. She went on to say when Resident#2 was admitted , the physician thought the pressure sore was acquired while hospitalized and was just beginning to break down and open on admission to the nursing facility. That's why the maceration was only in one spot and not covering the entire buttocks and genitalia of Resident #2.On 4-6-26 the Director of Nursing [DON] was interviewed and remembered the Resident. He stated that everyone knew that the wound was a DTI [deep tissue injury] and that it happened in the hospital. He was then asked if that was known, why did staff not obtain treatment orders or institute a care plan for the Resident upon admission. His response was I don't know.The care plan was reviewed and revealed that on 1-3-25, after orders for treatment were obtained from the physician, a baseline care plan with interventions was derived 5 days after admission.Treatment and Medication Administration records (TAR's/MAR's) as well as physician orders were reviewed and revealed that no treatment orders for the pressure ulcer were obtained from 12-30-24 until 1-3-25 and were not begun until 1-4-25.Facility policies were reviewed and it was revealed that weekly skin assessments were to be performed, and treatments obtained as needed. Wound evaluation documents were available in the clinical record, however, no treatments were (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	ordered and implemented for 5 days for a known admitted pressure ulcer. The facility Administrator, and DON (Director of Nursing) were informed of the findings during an end-of-day de-briefing on 4-7-26, at approximately 4:30 p.m. The facility stated they had no further information to present at the time of exit.