STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495217	A. Building B. Wing	10/08/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fair Oaks Health & Rehabilitation	12475 Lee Jackson Memorial Highway Fairfax, VA 22033

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on review of facility's documentation and staff interview, it was determined that the facility failed to promote and enhance each resident's right to a dignified existence and being respected for one of eleven residents in the survey sample, Resident #11 (R11).The findings include:R11 was admitted to the facility on [DATE] with diagnosis that included but were not limited to dementia, osteoarthritis and metabolic encephalopathy.The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 9/10/25, coded the resident as scoring a 06 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was severely cognitively impaired. A review of the comprehensive care plan dated 1/22/25 revealed, FOCUS: Resident prefers toparticipate in activities such as BINGO and Group activities. INTERVENTIONS: All staff to converse with him while providing care. On 10/7/25 at 8:28 AM, during medication administration, observation, RN (registered nurse) #1 stated, I just got here. I don't usually work up here. I don't know these residents well or where all their medications are. I am only prn (as needed). I usually work at the hospital.On 10/7/25 at approximately 1:00 PM, observed RN #1 enter R11's room. RN #1 was observed to not be wearing a name tag. When asked his name, RN #1 felt for name tag and then stated, Oh, it dropped off when I was in the break room. When asked how the residents and families are able to identify him without a name badge, RN #1 stated, Oh, they are all long residents, and they know us. RN #1 went to first floor to obtain name badge from break room. On 1/7/25 at 1:15 PM, R11 was sitting in room in his wheelchair. When asked if he knew the male nurse's name R11 stated, No, I do not, and he was not wearing a name badge either. RN #1 was asked if the name tag is part of their uniform, RN #1 stated yes, it is. When asked if no name tag/identification having visible to the resident was demonstrating dignity and respect for the resident, RN #1 stated, no, it is not.On 10/8/25 at 8:45 AM, an interview was conducted with LPN (licensed practical nurse) 1, the second floor unit manager. When asked what identification staff should wear, LPN #1 stated, they should wear their identification badges/name tags as it is part of their uniform. On 10/8/25 at 11:40 AM, ASM (administrative staff member) 1, the administrator, ASM #2, director of nursing and ASM #3, the regional director of clinical operations was made aware of the findings.A review of the facility's Resident Rights policy reveals, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem.No further information was provided prior to exit.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to place a call bell within a resident's reach for one of 11 residents in the survey sample, Resident #6.The findings include:For Resident #6 (R6), the facility staff failed to place the resident's call bell within reach on 10/6/25 and 10/7/25.On the following dates and times, R6 was observed sitting up and/or lying in bed. At all of these times, R6's call bell was clipped to the bottom sheet more than halfway down the length of the bed, out of the resident's reach: 10/6/25 at 11:17 a.m. and 4:17 p.m.; 10/7/25 at 8:01 a.m. and 8:21 a.m. At 8:21 a.m., RN (registered nurse) #1 went into R6's room, stood beside the resident and spoke to him, and did not place the call bell within R6's reach before RN #1 left the room.On the most recent MDS (minimum data set), a quarterly assessment dated [DATE], R7 was coded as being severely cognitively impaired. He was coded as having range of motion impairment in both arms, and as requiring the assistance of staff for bed mobility. On 10/7/25 at 3:55 p.m., CNA (certified nursing assistant) #2 was interviewed. She stated a resident's call bell should be placed within a resident's reach at all times. She stated this was for the resident's safety in case he needed to call a staff member.On 10/8/25 at 8:10 a.m., LPN (licensed practical nurse) #2, a unit manager, was interviewed. She stated call bells should be within reach of a resident at all times. She explained this is the quickest way for a resident to alert staff if he/she needs assistance.On 10/8/25 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were informed of these concerns.A review of the facility policy Answering the Call Light revealed, in part: The facility will maintain a functional call light system and will make all reasonable efforts to ensure timely responses to the resident's requests and needs .When the resident is in bed or confined to a chair be sure the call light is within easy reach of the resident.No additional information was provided prior to exit.

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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. Based on observation, staff interview, and facility document review, the facility staff failed to maintain a clean, comfortable, home like environment in two of two facility elevators.The findings include:On 10/7/25 at 7:58 a.m. and 12:15 p.m., both facility elevators were observed. Both elevators had large wall surface scrapes and indentations, and the floors on both elevators contained visible areas of dirt and grime. On 10/7/25 at 1:03 p.m., OSM (other staff member) #1, the regional director of maintenance, and ASM (administrative staff member) #1, the administrator, observed both elevators and were interviewed about the condition of the elevators. Both staff members agreed the elevator walls needed cleaning and painting, and the elevator floors needed to be stripped and cleaned. Both staff members agreed that the elevators were used throughout the day and evening by multiple residents, and the elevators did not provide the residents with a clean, home like environment. ASM #1 stated he would begin correcting this immediately.On 10/7/25 at 4:53 p.m., ASM #1, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations, were notified of these concerns.A review of the facility policy Homelike Environment revealed, in part: Residents will be provided with a safe, clean, comfortable and homelike environment .The facility staff and management maximizes, to the extent possible, the characteristics of the facility that reflect a personalized, homelike setting. These characteristics include .clean, sanitary and orderly equipment.No additional information was provided prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. Based on staff interview and clinical record review, the facility staff failed to complete an accurate MDS (minimum data set) for one of 11 residents in the survey sample, Resident #4.The findings include:For Resident #4 (R4), the facility staff failed to code an MDS accurately regarding the resident's level of consciousness.A review of R4's quarterly MDS with an ARD (assessment reference date) of 9/19/25 revealed he was coded as being in a persistent vegetative state with no discernable consciousness. As a result of this code in Section B, there were no responses to any of the questions in Sections C (cognition), D (Mood), or E (behaviors). A review of R4's previous quarterly MDS with an ARD of 6/19/25 revealed the resident was not in a vegetative state. A review of R4's progress notes corroborated the findings that the resident was not in a vegetative state at any point during his stay at the facility. On 10/8/25 at 7:46 a.m., LPN (licensed practical nurse) #2, the MDS coordinator who completed both of R4's MDS assessments, was interviewed. After reviewing both of R4's quarterly MDS assessments, she stated she made an error in coding on the 9/19/25 assessment. She explained that she miscoded the answer to the question about R4's level of consciousness in Section B, and thereby eliminated the need to answer the subsequent questions in Section B, and all questions in Sections C, D, and E. She stated she remember R4 well, and he was never in a persistent vegetative state while he was at the facility. She stated she uses the RAI (resident assessment instrument) manual that is published by CMS (Centers for Medicare/Medicaid Services) as her guide for completing accurate MDS assessments. A review of the RAI manual dated October 2024 revealed, in part: Section B .The intent of items in this section is to document whether the resident is comatose, the resident's ability to hear (with assistive hearing devices, if they are used), understand, and communicate with others, and the resident's ability to see objects nearby in their environment .Coding Instructions .Code 0, no: if a diagnosis of coma or persistent vegetative state is not present during the 7-day look-back period. Continue to B0200, Hearing .Code 1, yes: if the record indicates that a physician, nurse practitioner or clinical nurse specialist has documented a diagnosis of coma or persistent vegetative state that is applicable during the 7-day look-back period. Skip to GG0100, Prior Functioning: Everyday Activities.On 10/8/25 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were informed of these concerns.No additional information was provided prior to exit.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. Based on staff interview, facility document review, and clinical record review, the facility staff failed to notify a physician of a resident's blood sugar level according to the physician's order for one of 11 residents in the survey sample, Resident #3.The findings include:For Resident #3 (R3), the facility staff failed to notify the physician when the resident's blood sugar was greater than 200 on multiple occasions in June 2025.A review of R3's clinical record revealed the following physician order dated 6/18/25: Blood glucose checks ac and hs before meals and at bedtime for DM (diabetes mellitus). Notify MD if blood glucose >200 (is greater than 200).A review of R3's clinical record revealed the facility staff failed to notify the physician on the following dates for the corresponding blood sugars: 6/19/25 at 8:00 a.m./250; 6/19/25 at 12:00 p.m./267; 6/19/25 at 5:00 p.m./462; 6/21/25 at 8:00 a.m./370; 6/22/25 at 8:00 a.m./391; 6/22/25 at 12:00 p.m./325; 6/22/25 at 5:00 p.m./338; 6/24/25 at 12:00 p.m./318; 6/24/25 at 5:00 p.m./336; 6/25/25 at 8:00 a.m./336.On 10/8/25 at 8:10 a.m., LPN (licensed practical nurse) #2, a unit manager, was interviewed. After reviewing R3's orders, she stated that, according to the order, R3's physician should have been notified each time the resident's blood sugar was over 200. LPN #2 reviewed R3's June MAR and progress notes. She stated that the nurse did not follow the physician's order for physician notification for the dates and times outlined above. She stated if a resident's blood sugar is too high, the resident may need additional insulin to prevent an adverse event. She agreed that it is a professional standard of practice to notify a physician if a resident's blood sugar exceeds the parameter set by the physician in the order.On 10/8/25 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were informed of these concerns.A review of the facility policy Change in a Resident's Condition revealed, in part: The facility will promptly notify the .physician .of a significant change in the resident's condition.No additional information was provided prior to exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement physicians' orders for three of 11 residents in the survey sample, Residents #6, #3, and #8.The findings include:1. For Resident #6 (R6), the facility staff failed to administer Lantus (long acting insulin) according to the physician's order during a medication administration observation on 10/7/25. On 10/7/25 at 8:03 a.m., RN (registered nurse) #2 was observed preparing insulin for administration to R6. RN #2 prepared the injector pen of Lantus (long acting insulin) by turning the dial to 10. RN #2 confirmed that R6 was to receive 10 units of Lantus to R6. At 8:12 a.m., RN #2 was observed administering 10 units of Lantus to R6. A review of R6's physician orders revealed the following order dated 9/6/25: Lantus SoloStar Subcutaneous Solution Pen-injector 100 UNIT/ML (units per milliliter) (Insulin Glargine) Inject 9 unit subcutaneously one time a day for DM (diabetes mellitus). On 10/8/25 at 9:24 a.m., RN #2 was interviewed. RN #2 stated she remembered administering Lantus to R6 the previous morning. She stated that R6 receives 10 units of Lantus each morning before breakfast. She explained she always checks the order two or three times before administering insulin because it is a high risk medication. She admitted too little insulin can result in a resident's blood sugar climbing too high, and too much insulin can cause a resident's blood sugar to reach a dangerously low level. On 10/8/25 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were informed of these concerns. A review of the facility policy Injectable Medication Administration revealed, in part: Check the order on the Medication Administration Record to see that an injection is currently ordered.Check the 5 Rights (at a minimum) against the order as the medication is selected.Check 5 rights again as dose is prepared.Check 5 rights again after dose is prepared.before injection [is] administered. No additional information was provided prior to exit. 2. For Resident #3 (R3), the facility staff failed to administer Midodrine (1) according to the physician's order multiple times in June 2025. A review of R3's physician orders revealed the following order dated 6/19/25: Midodrine Oral Tablet 5 MG (milligrams) Give 1 tablet by mouth two times a day for hypotension. Hold for SBP (systolic blood pressure) > (greater than) 120. A review of R3's June 2025 MAR (medication administration record) revealed that R3 received Midodrine on the following dates with the following blood pressures: 6/19/25 at 5:00 p.m. – no blood current blood pressure recorded; 6/20/25 at 9:00 a.m. – 132/69; 6/21/25 at 9:00 a.m. – 121/71; 6/23/25 at 5:00 p.m. – 122/78; 6/28/25 at 9:00 a.m. – 122/76. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/8/25 at 8:10 a.m., LPN (licensed practical nurse) #2, a unit manager, was interviewed. After reviewing R3's orders, she stated that R3 should not have received Midodrine if his blood pressure was over 120 systolic (upper number). After reviewing R3's June 2025 MAR, LPN #2 agreed that R3 should not have received Midodrine on the dates and times outlined above. She explained that Midodrine is used to raise a resident's blood pressure and should not be given if the upper blood pressure number is over 120 due to the risk of causing an opposite effect of high blood pressure. On 10/8/25 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were informed of these concerns. No additional information was provided prior to exit. (1) Midodrine is used to treat orthostatic hypotension (sudden fall in blood pressure that occurs when a person assumes a standing position). Midodrine is in a class of medications called alpha-adrenergic agonists. It works by causing blood vessels to tighten, which increases blood pressure. This information is taken from the website https://medlineplus.gov/druginfo/meds/a616030.html. 3. The facility failed to administer insulin as ordered for Resident #8 (R8). R8 was admitted to the facility on [DATE] with diagnosis that included ESRD (end stage renal disease), diabetes and osteoarthritis. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 8/21/25, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 3/27/25 revealed, FOCUS: The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus with insulin use. INTERVENTIONS: administer insulin as ordered A review of the physician order dated 4/21/25 revealed Admelog SoloStar 100 UNIT/ML Solution pen-injector Inject as per sliding scale: if 70 - 200 = 2 units INJECT AS PER SLIDING SCALE: IF 151 - 200 = 1 UNIT NOTIFY MD OF BLOOD SUGAR <70. BLOOD SUGAR 70-150; 201 - 250 = 4 units; 251 - 300 = 6 units; 301 - 350 = 8 units; 351 - 400 = 10 units INJECT AS PER SLIDING SCALE: IF 151 - 200 = 1 UNIT NOTIFY MD OF BLOOD SUGAR <70. BLOOD SUGAR 70-150, subcutaneously before meals and at bedtime for DM. A review of the September and October 2025 MAR (medication administration record) reveals insulin not provided and coded as a 15 indicating no insulin required: on the following times and dates: 7:30 AM: 9/9-BS92, 9/18-BS118, 9/13 BS 113, 10/7 BS 93; 11:30 AM: 9/9-BS 100, 9/18-BS 125, 9/23-BS 132; 4:30 PM: 10/3-BS 105 and 9:00 PM: 10/3-BS 115. On 10/8/25 at 8:45 AM, an interview was conducted with LPN (licensed practical nurse) 1, the second-floor unit manager. When asked to review the insulin order of R8, LPN 1 was asked why insulin was not administered, LPN1 stated this order should have been clarified. If the order is not clarified, the insulin could be administered improperly. When asked about the potential outcomes if insulin is not administered properly, LPN 1 stated, the resident could have hyperglycemia or hypoglycemia. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 10/8/25 at 11:40 AM, ASM (administrative staff member) 1, the administrator, ASM #2, director of nursing and ASM #3, the regional director of clinical operations, was made aware of the findings. A review of the facility's Injectable Medication policy reveals, Medications will be administered in a safe and effective manner. Check the order on the Medication Administration Record (MAR) to see that an injection is currently ordered and due. No further information was provided prior to exit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, and facility document review, the facility staff failed to store medications safely on one of three medication carts on the second floor, the cart serving room [ROOM NUMBER].The findings include:The facility staff failed to secure the key to the medication cart for room [ROOM NUMBER] when the nurse went to another floor.On 10/7/25 at 8:28 a.m., RN (registered nurse) #1 was observed standing at a medication cart. He explained that he only works a few shifts a month at the facility and was not familiar with the residents or where things were kept on this medication cart. After spending several minutes searching for a resident's medication in the cart, he stated that he needed to go to the emergency medication supply machine on another floor of the facility. He locked the medication cart and placed the keys to the medication cart under a towel on top of the cart. He left the cart in the hallway and went to the first floor to obtain a medication from the emergency supply. He returned to the cart at 8:35 a.m., took the keys from under the towel, unlocked the cart, and continued searching for additional medications. At 8:38 a.m., he stated he needed to go to the emergency medication supply machine again because he could not locate another medication. He locked the medication cart and placed the keys to the medication cart under a towel on top of the cart. He left the cart in the hallway and went to the first floor to obtain a medication from the emergency supply. At 8:40 a.m., two residents walked by the medication cart as they returned their breakfast trays to the meal cart. RN #1 returned to the cart at 8:46 a.m., took the keys from under the towel, unlocked the cart, and continued searching for additional medications. At 8:51 a.m., RN #1 stated he had secured the medication cart by locking it. He acknowledged that the cart was not totally secure because he had left the keys on top of the cart.On 10/8/25 at 8:10 a.m., LPN (licensed practical nurse) #2, a unit manager, was interviewed. She stated if a nurse needs to leave a medication cart for any reason, the keys to the medication cart should be stored in the nurse's pocket once the cart is locked. She explained that keeping the medications locked is for safety reasons, and added that the cart is full of medications, including narcotics. On 10/8/25 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were informed of these concerns.A review of the facility policy Medication Storage revealed, in part: The facility shall store all drugs and biologicals in a safe, secure, and orderly manner .The nursing staff shall be responsible for maintaining medication storage and preparation areas in a clean, safe, and sanitary manner .Compartments .containing drugs and biologicals shall be locked when not in use, and trays or carts used to transport such items shall not be left unattended if open or otherwise potentially available to others.No additional information was provided prior to exit.

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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 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, facility document review, and clinical record review, the facility staff failed to follow infection control procedures for one of 11 residents in the survey sample, Resident #7.The findings include:For Resident #7 (R7), the facility staff failed to follow enhanced barrier precautions and to sanitize vital sign equipment before and after use.On 10/7/21 at 8:20 a.m., RN (registered nurse) #1 was observed standing beside R7's bed preparing to take R7's vital signs using a machine. R7 was lying on his back in bed, and RN #1 was not wearing any PPE (personal protective equipment), including gown or gloves. RN #1 did not sanitize the blood pressure cuff or the pulse oximeter prior to applying them to R7's arm and finger. Once the readings were obtained, RN #1 did not sanitize the blood pressure cuff or the pulse oximeter. He turned the machine over to another staff member for use on the next resident.A review of R7's clinical record revealed the following physician's order dated 9/4/25: Enhanced Barrier Precautions r/t (related to) wounds.On 10/7/25 at 3:55 p.m., CNA (certified nursing assistant) #2 was interviewed. She stated enhanced barrier precautions require anyone providing care to a resident should wear a gown and gloves. She stated vital sign equipment should always be sanitized immediately before and immediately after a resident's use. She stated these procedures help to prevent the spread of infection between residents.On 10/8/25 at 8:10 a.m., LPN (licensed practical nurse) #2, a unit manager, was interviewed. She stated vital sign equipment should be sanitized before and after each resident's use. She added that any staff member who is obtaining a resident's vital signs should wear gown and gloves if the resident has an order for enhanced barrier precautions. She stated that these residents have a higher risk of infection because they have some sort of break in the skin or a device which increases the resident's infection risk.On 10/8/25 at 10:55 a.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, and ASM #3, the regional director of clinical operations were informed of these concerns.A review of the policy Cleaning and Disinfecting Environmental Surfaces revealed, in part: Environmental surfaces will be cleaned and disinfected according to current CDC (Centers for Disease Control) recommendations for disinfection of healthcare facilities .non-critical items are those that come in contact with intact skin but not mucous membranes .most non-critical items can be decontaminated where they are used.No additional information was provided prior to exit.