STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495432	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Vierra Falls Church	2100 Powhatan Street Falls Church, VA 22043

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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and policy review, the facility failed to ensure a contracted wound Nurse Practitioner (NP) 2 recognized a change in wound status for one of one resident (R162) whose wound had exposed spinal hardware and possible infection in the sample of 31 residents. NP2 failed to ensure timely identification and escalation of a change in a resident's surgical wound. NP2 did not recognize or act upon a documented change in the wound, which contributed to a delay in further assessments and treatment. As a result, the resident experienced a delay in care, required transfer to the hospital for further evaluation, and was initiated on antibiotic therapy. Findings include:Review of R162's electronic medical record (EMR) titled admission Record located under the Profile tab indicated that the facility admitted the resident on 04/02/25 with a diagnosis of an unstable burst fracture of the first lumbar vertebra. Review of R162's EMR admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/25 located under the MDS tab indicated a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed the resident was cognitively intact. The MDS indicated that the resident had an impairment on one side of her upper body but no impairment of her lower bilateral extremities. R162 was dependent on staff for all activities of daily living (ADLs), which included hygiene and toileting. The assessment indicated the resident had a surgical wound. Review of R162's EMR hospital Discharge summary dated [DATE] located under the Misc (Miscellaneous) tab indicated that the resident was in the hospital for trauma related injuries and was to be discharged to the facility. The principal problem was to treat the resident's closed burst fracture of lumbar vertebra. The document revealed that the resident was to be seen for a follow-up with the wound care clinic promptly for the wound on the resident's back. Review of R162's EMR Care Plan located under the Care Plan tab dated 04/02/25 indicated that the resident had a surgical status post T (thoracic) 10-L (lumbar) 4 laminectomy. The goal was for the resident to have clean and intact skin. The care plan interventions included monitor/document location, size, and treatment of skin injury. To reportabnormalities, failure to heal, signs and symptoms of infection to the physician dated 04/13/26. Review of R162's EMR Wound Assessment Report dated 04/03/25 located under the Misc tab indicated that the resident's back wound was full thickness surgical dehiscence (which was present upon admission) and measured 0.50 centimeters (cm) length by 11.50 cm width. The length and width of 5.75 square centimeters/unit of area (cm2) and a depth of 0.00 cm.NP1 described the back wound with 100 percent epithelial, with no granulation, slough (devitalized dead tissue and used as a barrier to heal), or eschar (dead tissue that can be black or brown). The treatment ordered was to cleanse with wound cleanser and apply steri-strips per shift. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of R162's EMR Treatment Administration Record (EMR) located under the Orders tab for the month of 04/25 indicated clinical staff completed the wound care orders, however, there was a lack of progress notes associated with the wound care which would show the progression of deterioration of the wound. Review of R162's EMR Wound Assessment Report dated 04/08/25 located under the Misc tab indicated that the resident's back wound was stable, per NP1, and measured 8.50 cm in length by 0.50 cm width by length and width of 4.25 cm2 by 1.20 cm. NP1 described the back wound with no epithelial, 20 percent slough, and no eschar. The exudate description mentioned moderate serosanguineous. The wound treatment changed to change the dressing three times per week. To clean the wound with Vashe, Hydrofera Blue and cover with an ABD dressing. Review of R162's EMR Wound Assessment Report dated 04/18/25, located under the Misc tab indicated that NP2 noted that the resident's back wound was stable and measured 7.00 cm in length by 1.50 cm width by length and width of 10.50 cm2 by 1.00 cm. NP2 described the back wound with no epithelial, 80 percent granulation, 20 percent slough, and no eschar. The exudate description mentioned moderate serosanguineous. NP2 noted that the wound was stable. The wound treatment changed to change the dressing three times per week. To clean the wound with Vashe, Hydrofera Blue and cover with an ABD dressing. NP2 mentioned that there was exposed tissue which included the spinal surgical hardware. Review of R162's EMR Skin and Wound Note located under the Prog (Progress) Note tab dated 04/18/25 indicated NP2 mentioned again that the resident had exposed tissue that included surgical hardware. There was no indication that NP2 alerted the resident's physician of the significant change in the resident's wound. The facility failed to ensure the physician (DR2) and neurosurgeon (DR1) were notified when the resident's wound deteriorated and exposed spinal surgical hardware as directed by the resident's care plan. Review of R162's EMR Communication located under the Prog Note tab dated 04/21/25 indicated the resident had a follow-up appointment scheduled with DR1 on 04/23/25. Review of R162's EMR Skin and Wound Note located under the Prog Note tab dated 04/22/25 indicated NP2 did not see the resident since the resident had a scheduled appointment with DR1 and would follow up with the resident the following week after her post-surgical appointment. Review of R162's EMR Administration Note located under the Prog Note dated 04/23/25 that the resident was transferred to the emergency room from DR1's appointment due to a wound infection. Review of a document provided by the facility titled Quality Improvement Organizations (QIO) dated 07/29/25 indicated that R162 filed a formal complaint to the QIO (a group of clinicians and to improve healthcare for Medicare beneficiaries). The QIO determined .On April 8, 2025, a week after admission, the back wound was debrided, and the size improvedslightly to 8.5 x 0.5 cm. The same plan was recommended. However, by April 18, 2025, thewound had widened (7 x 1.5 cm), and wound care noted concerning findings. The record statedthe 'surgical hardware' is visible towards the 6 o'clock position of the wound. Wound stable onexam today. Consistent with current treatment recommendations as outlined above. Ifcomplications arise; staff understands to contact the operating surgeon. Monitor closely for signsand symptoms of infection. The patient had been scheduled since admission to see her surgeonon April 23, 2025; however, it did not appear the surgeon was contacted sooner about theexposed hardware. Wounds, including spinal wounds, with findings of new exposedof underlying (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	hardware is a major concern that should prompt immediate contact with thepatient's surgeon (or other physician if unavailable) and consideration for possiblehospitalization. During an interview conducted on 04/22/26 at 9:33 AM, R162 stated when she went to DR1's appointment from the facility. R162 stated the wound on her back was open upon her admission to the facility. R162 confirmed that she was sent to DR1 for a follow-up appointment and then was sent to the hospital and readmitted to treat a wound infection on her back with antibiotics. During an interview conducted on 04/22/26 at 1:52 PM, the Administrator stated that they no longer had access to the hospital records since R162 never returned back to the facility. During an interview conducted on 04/23/26 at 8:45 PM, NP1 confirmed her visits with R162 on 04/03/25 and again on 04/08/25. During this interview, NP1 presented photographs of R162's back. NP1 described the resident's back wound and stated that the resident's back wound was dehisced at the time of her admission. NP1 described the wound on 04/02/25 as no angry red (sign of infection) and the wound looked good. NP1 confirmed the same information from her assessment completed on 04/08/25. NP1 stated she did not see R162 on 04/18/25 and identified that NP2 did complete the visit. NP1 showed the photograph taken on this date and stated the wound was worse. NP1 stated there was red around the opening and the wound's width was bigger and she could see slough and identified the spinal surgical hardware. NP1 stated she did not know the reasons for NP2 to document that the wound had no signs and symptoms of infection. NP1 stated that the surgeon should have been notified immediately after observing the condition of the wound. NP1 stated that typically the facility's wound nurse (not the wound nurse practitioners) would notify the surgeon of a change in the resident's wound. NP1 stated that if she completed the assessment on 04/18/25 she would have directed the facility's wound nurse to contact the surgeon and get the resident to her follow-up appointment sooner than five days later. On 04/23/26 at 9:07 AM, a call was placed to DR1 and was informed that information could not be shared regarding R162. During an interview conducted on 04/23/26 at 9:49 AM, NP3, who was the Medical Director's NP, stated that if R162's wound was coming apart, she would have called DR1 immediately. During an interview conducted on 04/23/26 at 11:30 AM, the Director of Nursing (DON) was asked for contact information for NP2. The DON stated the exposure of R162's spinal surgical hardware should have been escalated and DR1 alerted. The DON stated that the former wound nurse was Licensed Practical Nurse (LPN) 4 and was not available for an interview. The DON stated LPN4 should have questioned NP2 on the exposed surgical hardware and did not. The DON stated the floor nurses, who conducted the wound care treatments should have documented what the back wound looked like after each dressing change. During an interview conducted on 04/23/26 at 2:42 PM, R162's DR2 stated that if a wound was worsening the surgeon should have been notified immediately. Review of a facility policy titled Wound Treatment Management dated 07/01/24 indicated . To promote wound healing of various types of wounds, it is the policy of this facility to provideevidence-based treatments in accordance with current standards of practice and physician orders. The effectiveness of treatments will be monitored through ongoing assessment of the wound.Considerations for needed modifications include. Lack of progression towards healing.

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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 - Few	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 interviews, record reviews, document review and policy review, the facility failed to ensure showers were provided for two (Resident (R)22 and (R)161 of two residents reviewed in the sample of 31 residents. Specifically, R22 and R161's records lacked documentation of showers being provided according to the facility's shower schedule.Findings included1. During an interview on 04/20/26 11:24 AM, family member (FM) 1stated that resident is supposed to get two showers a week but last week the second week of his stay he did not get one shower. She said his shower days are on Monday and Thursdays in the morning. She said now it is Monday again and she will see if he gets one today. During an interview on 04/21/26 at 10:30 AM, R22 and FM1 stated that yesterday (Monday) no one came and asked him about a shower or if he wanted to have a shower. So, he missed his third shower in a row. FM1 stated that R22 may be going home on Thursday and maybe he could have a shower before he went home. During an interview on 04/22/26 at 2:05 PM, R22 stated that he still had not had a shower. Review of R22's admission Record in the EMR under the Profile tab indicated the resident was admitted on [DATE] with diagnoses of arthritis of left knee and hip, muscle weakness, and lack of coordination. Review of R22's admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/04/26 and located in the MDS tab of the EMR revealed a Brief Interview for Mental Status (BIMS) score of 10 out of 15 indicating moderate cognitive impairment. The MDS revealed under preferences for customary routine and activities that it was very important to the resident to choose between a shower or a sponge bath and that R22 was dependent on staff for shower and bathing. Review of R22's Care Plan revised 04/07/26, located in the EMR under the Care Plan tab revealed R22 needs assistance for Activities of Daily Living (ADLs) due to impaired mobility/cognition/communication. Interventions included: Date initiated 04/7/26 honor R22's ADL preference. Date initiated 03/30/26 Bathing/Showering R22 requires dependent assistance by (1) staff with bathing/showering twice/week and as necessary. Review of facility's Shower Assignment Certified Nurse Aide (CNA) located in the CNA binder on the nursing unit station, indicated that R22's bed number was to get a shower on Mondays and Thursdays on the day shift. During an interview on 4/21/26 at 1:45 PM, CNA2 stated that she gives showers according to the listing schedule in the CNA book at the nurse's station. CNA2 said after she completes the shower she documents it in the EMR under the Task tab, so it is recorded in the record. During an interview on 4/21/26 at 1:55 PM, Licensed Practical Nurse (LPN)1 stated that showers are assigned to each resident according to the bed assignment. The assignment grid or chart is in the CNA book. LPN1 stated if the resident refuses a shower the CNA will let her know. LPN1 stated after the shower is completed the CNA charts in the EMR that the shower was completed and how much assistance the resident needed. Review of the Plan of Care (POC) response history indicated that R22 should have received a shower (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	on 04/13/26, 04/16/26 and 04/20/26. Review of R22'sPOC document revealed CNA3 gave R22 a shower on 04/16/26 on the evening shift about 9:17 PM. Further review showed that on 04/13/26 and 04/20/26, CNAs documented that the shower was non-applicable (N/A). Review of CNA tasks for showering and bathing show revealed that CNA4 documented that she gave R22 a bed bath on 04/16/26 at 10:06 AM. During an interview on 04/23/26 at 11:52 AM, CNA4 stated that she had not given R22 a shower or a bed bath on 04/16/26 as documented at 10:06 AM. CNA4 stated she must have charted on the wrong resident. Review of R22's EMR Task tab for Shower and bathing shows the following: On 4/13/26 CNA5 documented at 10:06 AM that she gave R22 a bed bath. On 4/14/26 CNA5 documented at 5:18 PM R22 was given a shower. On 4/16/26 CNA4 documented at 10:06 AM that R22 was given a bed bath. On 4/17/26 CNA7 documented at 2:59 PM that R22 was given a shower. On 4/18/26 CNA7 documented at 8:14 PM that R22 was given a tub bath. On 4/20/26 CNA8 documented at 1:28 AM that R22 was given a shower. O 4/20/26 CNA9 documented at 2:14 PM that R22 was given a bed bath. During an interview on 04/22/26 at 11:30 AM, Assistant Director of Nursing (ADON) stated she would investigate each of the CNAs' documentation and acknowledge that the facility does not have a tub bath. 2. Review of R161's EMR admission Record located under the Profile tab indicated that the facility admitted the resident on 09/19/24 with a diagnosis of muscle weakness. Review of R161's EMR admission MDS with an ARD of 09/25/24 indicated the resident had a BIMS score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated that the resident required partial to moderate assistance with bathing, such as showers/baths. Review of R161's EMR Care Plan located under the Care Plan tab to provide the resident with a sponge bath if a full shower/bath could not be tolerated by the resident. Review of a document provided by the facility for R161 titled Documentation Survey Report for the month of 10/24 indicated that the resident received either a shower/bath or sponge bath on 10/01/24. A request was made to the Administrator for all bathing/shower records during R161's stay which would have included 09/24. No additional shower/bath records were provided by the end of the (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	survey. During an interview on 04/22/26 at 12:20 PM, Director of Nursing (DON) stated that all residents were to be given two showers per week according to the schedule in the CNA book. DON stated it would be his expectation that the CNA would do the showers as directed by the schedule and document correctly. Review of the facility's policy titled Resident Shower dated 01/29/24 indicated, . It is the practice of this facility to assist residents with bathing to maintain proper hygiene, stimulate circulation and help prevent skin issues as per current standards of practice. Residents will be provided with showers as per request or as per facility schedule protocols and based upon resident safety.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on record review, interview and policy review, the facility failed to ensure accurate clinical documentation was entered into the resident's medical records for one of one resident (Resident (R)162) in the sample of 31 residents. Specifically, pictures of R162's wound were not posted in the resident's record (EMR). This failure had the potential to affect the quality of care for R162 and to assist with the resident's treatment plan.Findings include: Review of 162's electronic medical record (EMR) titled admission Record located under the Profile tab indicated that the facility admitted the resident on 04/02/25 with a diagnosis of an unstable burst fracture of the first lumbar vertebra. Review of R162's EMR titled admission Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 04/08/25, located under the MDS tab indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which revealed the resident was cognitively intact. The assessment indicated that the resident had an impairment on one side of her upper body but no impairment of her lower bilateral extremities. The MDS indicated the resident had a surgical wound. Review of R162's EMR titled Wound Assessment Report dated 04/03/25, located under the Misc tab indicated that the resident's back wound was full thickness surgical dehiscence. Review of R162's EMR titled Wound Assessment Report dated 04/08/25, located under the Misc tab indicated that the resident's back wound was stable. Review of R162's EMR titled Wound Assessment Report dated 04/18/25, located under the Misc tab indicated that NP2 noted that the resident's back wound was stable and indicated the surgical hardware was exposed. During an interview on 04/23/26 at 8:45 PM, NP1, who worked for a contracted wound management company, confirmed her visits with R162 on 04/03/25 and again on 04/08/25. During this interview, NP1 presented photographs of R162's back. The photographs clearly showed the improvement of R162's wound from the wound notes dated 04/03/25 and 04/08/25. The image from 04/18/25 showed a decline in the wound. NP1 described the wound from 04/03/25 and 04/08/25 with no signs of infection. NP1 stated the 04/18/25 image of the resident's back wound was worse than 04/08/25. NP1 stated that the area around the wound was red and the width of the wound had increased. NP1 stated she did not know why the images (pictures) were not incorporated into the resident's clinical records. During an interview on 04/23/26 at 1:06 PM, the Director of Nursing (DON) stated it was important to have a complete clinical records for a resident. The DON confirmed that R162's photographs of her wound were not uploaded to the clinical records. The DON stated by having the images this would provide critical information on the status of a resident and identify whether or not wound was healing. Review of a facility's policy titled Documentation in Medical Record dated 01/30/24 indicated .Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation.Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy.Documentation may be performed manually or as per the facility's specific electronic medical record software program.