STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495126	A. Building B. Wing	11/19/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Waddell Nursing and Rehab Center	202 Painter St Galax, VA 24333

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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 - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview and clinical record review, the facility staff failed to review and revise the comprehensive care plan (CCP) for 1of 24 residents, Resident #9.The findings included. The findings included.The facility staff failed to review and revise Resident #9's CCP when the resident elected to sign a Do Not Resuscitate (DNR) order. The CCP included the focus area of full code. Resident #9's diagnoses included gastro-esophageal reflux disease, anemia, dysphagia, and weakness. Section C (cognitive patterns) of Resident #9's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/17/25 included a brief interview for mental status (BIMS) score of 10 out of a possible 15 points. Per the MDS manual a 10=moderately impaired in cognitive skills for daily decision making. Resident #9's clinical record included the following orders. 1. Full code order dated 08/08/25 and a discontinued order date of 09/03/25.2. DNR order dated 09/03/25. Resident #9's current CCP included the problem area Advanced Directives/Code Status resident has chosen to be a full code. Interventions included if resident/responsible party chooses to change code status, necessary items will be completed, new order, update documentation/care plan, face sheet. The face sheet in the clinical record included the information DNR. On 10/01/2025 at 10:10 a.m., the surveyor notified the Social Worker that Resident #9's CCP included the problem area of full code when they had a DNR order in place. The facility staff provided the surveyor with a copy of a signed Durable Do Not Resuscitate Order from the Virginia Department of Health dated 09/13/25. During an end of the day meeting on 11/18/25 at 5:10 p.m., with the Administrator, Director of Nursing, Assistant Director of Nursing, and Regional Nurse the issue with Resident #9's CCP not being reviewed and revised to reflect their current DNR status was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference on 11/19/25.

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on staff interview, clinical record review, and facility document review the facility staff failed to administer a medication per the providers orders for 1 of 24 residents Resident #59 and failed to follow a medical provider order for notification of elevated Blood Sugars for 1 of 24 residents, Resident #21. The findings included: 1. For Resident #59, the facility staff failed to ensure they had a prescription for the medication Gabapentin. Resulting in Resident #59 missing 7 doses of this medication. Gabapentin is a controlled medication and requires an updated prescription to be dispensed. Resident #59's diagnoses included low back pain, muscle weakness, migraine, and dementia. Section C (cognitive patterns) of Resident #59's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/06/25 was coded 1/1/3 to indicate Resident #59 had problems with long-and short-term memory and was severely impaired in cognitive skills for daily decision making. Resident #59's comprehensive care plan (CCP) included the problem area of pain. Approaches included Medications as ordered. Resident #59's clinical record included a provider order for Gabapentin 100 mg twice a day. Date of order 10/16/24. The clinical record included a progress note documented on 10/20/25 that read in part. Resident out of prescription gabapentin 100mg. On-call provider.notified; however, unable to refill prescription at this time as the medication requires MD setup due to an alert in the system. On-call provider gave new order to hold HS [bedtime] dose of gabapentin tonight. Pharmacy notified; representative stated they will continue to search for a script but confirmed they did not receive a new script from today. A review of Resident #59's electronic medication administration record (eMAR) revealed that the nursing staff had documented the following. 10/17/25 9:00 p.m. Not administered, unavailable, Pharmacy and MD notified awaiting script. 10/18/25 5:00 p.m. Not administered, waiting for script from MD. 10/18/25 9:00 p.m., Not administered drug/item unavailable waiting on script. 10/19/25 5:00 p.m., Not administered drug/item unavailable waiting on new script. 10/19/25 9:00 pm., Not administered drug/item unavailable waiting script MD aware. 10/20/25 5:00 p.m., Not administered drug/item unavailable. Provider to send script to pharmacy-delayed due to internet connection issues today. 10/20/25 9:00 p.m., Not administered: On hold. A review of the Omnicell list (backup supply of medication) revealed this medication was available for administration. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/18/25 at 5:10 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON) and Regional Nurse the issue with Resident #59 not receiving their medication per the providers orders was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #21, the facility staff failed to follow a medical provider orders for notification of blood sugar levels greater than 400 (four hundred). Resident #21's diagnosis list indicated diagnoses, which included, but not limited to, Type 2 Diabetes Mellitus, Vascular Dementia, Atrial Fibrillation, and Atherosclerotic Heart Disease. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 10/16/25, coded the resident in Section C (Cognitive Patterns) as rarely/never understood with short and long-term memory problems and severe impairment in cognitive skills for daily decision making. A review of a medical provider orders with a start date of 8/20/25 read in part, .insulin lispro.special instructions.blood sugar.Call provider if over 400. This order had a discontinued date of 9/7/25. A review of a medical provider orders with a start date of 9/11/25 read in part, .insulin lispro.special instructions.Call MD (medical doctor) if <400 (greater than 400). This order had a discontinued date of 10/16/25. This surveyor reviewed Resident #21's August 2025 and October 2025 MARs (medication administration records) and observed documentation of the resident's BS (blood sugar) being elevated over 400 on (2) two occasions. No evidence could be located in the clinical record that a medical provider was notified as indicated in the medical provider orders on the following dates: 8/29/25-BS 402 10/1/25-BS 532 A review of the comprehensive person-centered care plan disclosed a focus and intervention which read in part, .The resident has Diabetes Mellitus with CKD (chronic kidney disease).Assess/document/report to MD.for.hyperglycemia (high blood sugar-a condition where there is an abnormally high level of glucose in the bloodstream). This surveyor requested evidence that the medical provider was notified of Resident #21's elevated blood sugars on 8/29/25 and 10/1/25. On 11/18/25 at 11:00 AM, the director of nursing (DON) provided this surveyor with a copy of a page from a medical provider communication book which read in part, .8-29-25.(Resident #21).FBS (fasting blood sugar)-402 this AM (morning). The NP (nurse practitioner) had initialed the concern as acknowledged. On 11/18/25 at 1:20 PM, the DON agreed her expectation would be for the nurse to call the provider as ordered at the time the blood sugar was taken. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This concern was discussed on 11/18/25 at 5:10 PM at the end of day meeting with the administrator, director of nursing, assistant director of nursing, and regional nurse consultant. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/19/25.

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide necessary respiratory services in accordance with professional standards of practice for 1 of 4 closed record reviews, Resident #133. For Resident #133, the facility staff failed to ensure supplemental oxygen was available continuously via nasal cannula to the resident as ordered by a medical provider during transportation to a medical appointment on 12/20/23. Resident #133's diagnosis list indicated diagnoses that included, but were not limited to, COPD (chronic obstructive pulmonary disease), Chronic Respiratory Failure with Hypoxia, Anxiety, and Cerebral Infarction affecting Left Nondominant Side. The most recent complete quarterly minimum data set (MDS) with an assessment reference date (ARD) of 7/22/23, assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the clinical record disclosed the following documentation: A medical provider orders with a start date of 4/15/23 which read in part, .OXYGEN: O2 @ (at) 3 LPM (three liters per minute) via n/c (nasal cannula- a medical device that delivers supplemental oxygen through a lightweight tube with two prongs that are placed in the nostrils) every shift for COPD w/Chronic hypoxic resp (with/respiratory) failure. A progress note dated 12/20/2023 at 11:51(11:51 AM) read in part, .Note.Reason for Departure: Appointment.LOA (leave of absence) with outside transportation. A progress note dated 12/20/2023 at 18:30 (6:30 PM) read in part, .Note.Time of return: 12/20/2023 6:30 PM. A review of the comprehensive person-centered care plan disclosed a focus, goal, and intervention which read in part, .At risk for altered.resp (respiratory) status r/t (related to).copd, chronic resp. failure.Resident will have no preventable crisis thru {sic} next review.O2 as ordered.Date Initiated: 03/29/2023. On 11/17/25, the administrator provided this surveyor with (3) three witness statements regarding Resident #133's transportation to a medical appointment on 12/20/23. A review of the witness statements disclosed a statement from the interim administrator dated 12/27/23, which read in part, .was notified by our van transport scheduler.that the.transport company came to pick up (Resident #133) to take her to the Neurology clinic.I was told this was a longer than normal trip, so our Charge nurse offered for the driver to take an extra O2 tank. The driver called in to his supervisor of which stated for him not to. The charge nurse made sure the resident had a full tank upon leaving which should have been enough to get to the appointment and return. We received a call from an OBGYN (obstetrics and gynecology) clinic and found out the driver actually took the resident to the wrong location and dropped her off.We asked the OBGYN office if we could use one of their O2 tanks being the time was getting more critical. They were fine with it. The transport company was finally notified and they sent someone else to transport the resident to the right office and bring her back. We were later notified the new driver had to contact EMS (emergency medical services) before making it back to our facility due to the second tank running out of 02. A second witness statement dated 12/27/23 written by licensed practical nurse #3 (LPN#3) read in part, .Transportation arrived.for an appointment.in Roanoke, VA.Making sure resident had enough O2 for her departure and return trip to appt (appointment), her portable O2 tank was changed. This nurse asked if another tank could be sent with her in case she needed it, transportation aide stated it was only his 3rd day on the job and he didn't know how to change it, that he would call his supervisor to see if he could take it in the van, after talking with his supervisor, we were notified that the van had nowhere to store a O2 cylinder. Resident left with a full tank O2 cylinder to her appt. Notified by Neurology Clinic that resident was late for her appointment, that the transportation aide dropped her off a the OB dept. (department) and left.In route back to the facility, resident had been picked up by another transportation aide who had stated that resident ran out of O2 on her way back to facility, so she had to pull over on the side of the highway and call EMS for O2, stated that [name of clinic omitted] did not supply her with a full tank as they said they would do. A third witness statement dated 12/27/23 written by licensed practical nurse #4 (LPN#4)-unit manager, read in part, (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	.Resident.was scheduled with transport to neurology, pick up set for 11:40 AM.driver arrived.driver noted that she (Resident #133) had O2 and was afraid she would run out & was uncomfortable taking her. The Charge Nurse.offered to send another E-cylinder with him, he stated that is was his 3rd day on the job and he didn't know how to change it out.called his supervisor who also said he could not take an extra tank. Staff got a new tank and hooked resident up at that time. Resident should have enough O2 for appointment and return to facility.Later in the day, the neurology office called & notified the facility.(Resident #133) had been taken to the wrong office (OB/GYN) and was so late arriving that she missed her appointment and was now running low on O2 and would not have enough to make the return trip. They also stated the driver had not left a call back # (number) for him to be reached.Staff contacted the office to try to secure a e-cylinder for.return trip.contacted her (Resident #133) insurance.to reach out to transport agency.I was on the phone for over 1 1/2 hours while they were trying to reach the driver to establish an ETA (estimated time of arrival). On 11/17/25 at 12:41 PM, this surveyor interviewed other staff #5 (OS#5) and she remembered that transport took Resident #133 to the wrong appointment and then took her to correct appointment. The family called the facility and informed them the resident had run out of oxygen. On 11/17/25 at 3:45 PM, this surveyor interviewed other staff #6 (OS#6) and she stated she set-up transport for the appointment and the resident was scheduled to go to the neurologist in Roanoke. She recalled neurology called the facility and informed them Resident #133 needed to be picked up from the appointment. OS#6 stated it took the transport driver a while to get there and the resident ran out of oxygen, so the driver called 911. OS#6 denied Resident #133 was accidentally taken to the ob-gyn office that day by mistake. OS#6 provided this surveyor with a copy of the appointment page depicting Resident #133's appointments. Resident #133's neurology appointment on 12/20/23 was scheduled for 1:45 PM. On 11/17/25 at 3:52 PM, this surveyor interviewed other staff #10 (OS#10) and she informed surveyor she took the call from neurology on 12/20/23 and stated neurology called to let the facility know Resident #133 was ready to be picked up. OS#10 denied Resident #133 was accidentally taken to the ob-gyn clinic by mistake on that day. On 11/17/25 at 3:56 PM, this surveyor interviewed LPN#4 and she informed surveyor Resident #133 was on oxygen and had a full tank when she left the facility for the appointment. The transport driver stated he was not allowed to take extra tanks of oxygen on the van. LPN#4 recalled neurology switched the tank to her understanding so the resident could get back to the facility. She recalled there was a delay in transport picking the resident up from neurology and the resident was later coming back. LPN#4 stated she was not working by the time the resident returned to the facility, but it had been discussed that the resident ran out of oxygen on the way back and the driver pulled over and called 911 and they (EMS) gave Resident #133 enough oxygen to get back to the facility. On 11/18/25 at 3:04 PM, this surveyor interviewed LPN#3 and she informed surveyor that she was Resident #133's nurse on 12/20/23. She stated she was going to send another oxygen cylinder with the resident and transport told her they could not take an extra oxygen tank on the van and the driver did not know how to change the oxygen tank. This surveyor inquired the process for ensuring there is an adequate supply of oxygen for appointments that are a greater distance away from the facility and LPN#3 stated she believes in times past that the oxygen tank should have lasted, but she believed the transport driver took Resident #133 to the wrong appointment first or was late getting her to the neurology appointment and that's why the resident ran out of oxygen. LPN#3 did not recall speaking with the ob-gyn office or the neurology office. On 11/18/25 at 3:17 PM, this surveyor and LPN#3 observed the oxygen cylinders at the facility. LPN#4 assisted LPN#3 and this surveyor and found information on the internet and the information stated a fully charged e-tank (tanks the facility utilizes) contains 680 (six-hundred eighty) liters of oxygen. The survey team reviewed an internet site at https://pipingtechs.com/oxygen-tank-size-chart-calculating-oxygen-tank-duration/ that calculated a fully charged e-tank at 680 liters divided by the flow rate of 3 liters per minute x 60 = 3.78 hours of supplemental oxygen. Resident #133 departed the facility at approximately 11:40 AM and the (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	neurology appointment was scheduled at 1:45 PM at an approximate distance of 97.48 miles with an uninterrupted drive duration of one hour and thirty-nine minutes one-way. Total time for the appointment trip with an uninterrupted drive was calculated at two hours and eighty minutes, excluding the duration of time Resident #133 would have been at the appointment facility. This concern was discussed on 11/18/25 at 5:10 PM, at the end of day meeting with the administrator, director of nursing, assistant director of nursing, and regional director of clinical services. The director of nursing informed this surveyor her expectation would have been to send a CNA (certified nursing assistant) with Resident #133 to the appointment on 12/20/23. Surveyor requested and received a facility policy titled, Oxygen Administration (all routes) Policy with a revision date of 6/23/25 that read in part, .licensed clinicians with demonstrated competence will administer oxygen.as ordered by the provider. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/19/25.