STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495250	A. Building B. Wing	11/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Galax Health and Rehab	836 Glendale Rd Galax, VA 24333

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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to receive visitors of his or her choosing, at the time of his or her choosing. 28169 28567 Based on staff interview, clinical record review, and facility document review, the facility staff failed to allow family visitation for 1 of 4 closed record reviews, Resident #92. The findings included: The facility staff failed to allow the family to stay with the Resident at the facility after the resident had a change in condition. Resident #92's diagnoses included but were not limited to, Alzheimer's, dementia, and muscle weakness. Section C (cognitive patterns) of Resident #92's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/16/23 included a brief interview for mental status (BIMS) summary score of 3 out of a possible 15 points. Resident #92's comprehensive care plan included the focus areas sometimes shows behavior symptoms, at risk for pressure ulcers, requires assistance with one or more staff for activity of daily living, and difficulty with independent feeding. Resident #92's clinical record included an order for Hospice effective 10/13/23. The facility staff provided the survey team with a copy of the Hospice documentation. On 10/19/23, the Hospice nurse documented the patients immediate needs were comfort and support for patient and family and the facility staff had told the family they could not stay with this resident as it was against the facility's policy. The facility staff provided the surveyor with a copy of their document titled, Nursing Home Resident Rights. This document read in part, .You have the following rights .To have visitors at any time, as long as you wish to see them, as long as the visit does not interfere with the provision of care and privacy rights of other residents . (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2023
NAME OF PROVIDER OR SUPPLIER: Galax Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE: 836 Glendale Rd 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 0563 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/23 at 1:40 p.m., during an interview with the current interim Director of Nursing (DON) this staff stated they had received a call from Licensed Practical Nurse (LPN) #1 (no longer employed) and stated the family wanted to stay overnight at the facility. The DON stated they could not remember who they called but someone had told them their policy was no overnight stays. The DON stated before they had a chance to move this resident the resident had been discharged . On 11/15/23 at 1:27 p.m., during an interview with Certified Nursing Assistant (C.N.A.) #8 this staff stated the family wanted to spend the night, but they don't allow visitors to stay. On 11/15/23 at 3:30 p.m., during an end of the day meeting with the Administrator, Regional [NAME] President of Operations, and Chief Nursing Officer. The surveyor asked about family members spending the night with Resident #92. The Administrator stated if you are admitted on Hospice, you would be in a room by yourself (private) so the family could stay. If you become Hospice, we ask the roommate to move we would not want to move the Hospice patient. The Administrator stated by not being here I can't really say I don't know all the in's and out's, but I would think it would be done as quickly as possible. No further information regarding this issue was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2023
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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47299 Based on staff interview, clinical record review, and facility document review the facility staff failed to ensure injuries of unknown origin were reported for 1 of 22 current residents sampled and one of 4 closed records sampled. Resident #19 and Resident #26. The findings included: 1. For resident # 19, the facility staff failed to report a right hip fracture that was identified on 10/13/23. This was a closed record review. Resident # 19's diagnoses included but were not limited to, unspecified dementia, cognitive communication deficit, generalized anxiety, Alzheimer's with late onset, insomnia, weakness, history of falling. Resident # 19's Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 10/20/23 assigned the resident a Brief Interview for Mental Status (BIMS) score of 3, indicating they were severely cognitively impaired. The resident was also coded as dependent for Activities of Daily Living (ADL's) and mobility. The clinical record was reviewed. A progress note dated 10/13/23 at 8:06 AM read, Situation : xray results back show fracture of femoral neck fracture of right hip Background : found in floor on 10/06/2023 Assessment : pain to right hip Response : called md on call new order send to er. A progress note was located for 10/6/23 at 2:34 AM that read, Situation : Staff alerted me to residents room at 02:25am (they) was found with (their) trunk lying beside bed and legs tucked underneath the bed. (They) is awake and alert, states (they) is unsure what happened. Background : Resident is a 90 y.o. with dementia and mild cases of confusion, h/x of falls and generalized weakness. Assessment : Resident appears baseline status prior to any incident, is able to answer most questions with occasional confusion pre existing prior to possible incident. is verbal and able to follow commands, neurological checks remain at baseline, denies any pain or injury at this time, Vital signs remain within normal limits BP 148/86, Temp. 98.4 tympanic, Pulse 83, 18 RR no visual injuries noted. Skin appears intact without breaks or bruising at this time. Resident states does not know what happened. Response : Two CNA's and myself sat patient upright and assisted back in bed, appears as normal baseline prior to incident. Fall protocol initiated, resident is back in his bed lying supine with no complaints at this time. There were no notes in between these two notes to indicate resident was having pain or had another fall. There was no explanation in the notes as to why or when the x-ray was ordered. There was an order entered on 10/11/23 that read, X-ray rt hip two views and pelvis one time only for Rt. hip pain from previous fall. Resident # 19 was readmitted to the facility on [DATE] after it was determined they were not a surgical candidate. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/16/23 at 8:41 AM this surveyor interviewed LPN # 10 who was caring for resident #19 the morning 10/6/23 when resident # 19 fell . They stated that they assessed resident and there was no indication of any injuries so they and 2 other staff members assisted resident back to bed. This surveyor requested and received a copy of the policy entitled, Resident Abuse- Injuries of Unknown Origin with a revision date of 4/2020. The policy read in part, Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc. which have no know cause. 4. The Administrator or the Director of Nursing must begin a documented investigation for the cause of the injury. 7. All injuries of unknown origin must be reported to the appropriate agencies per state specific protocols. This surveyor met with the Administrator on 11/16/23 at approximately 11:00 AM and asked for the Facility Reported Incident (FRI) for resident # 19's right hip fracture October 13, 2023. They stated they could not locate an FRI for this resident in October. Surveyor asked if they would have expected one to be done for a hip fracture identified a week after the last fall, and they stated, I would, but I wasn't here at the time and can't say what the previous Administrator did or didn't do. The survey team met with the Administrator, Regional [NAME] President of Operations, and the Chief Nursing Officer on 11/16/23 at 5:20 PM and this concern was discussed. No further information was provided to the survey team prior to the exit conference. 2. For resident # 26 the facility staff failed to report a fracture of the right humerus that was identified 9/8/23. Resident # 26's diagnoses included but were not limited to, hypertension, Alzheimer's Disease, anxiety, depression, unspecified mood disorder, diabetes and chronic obstructive pulmonary disease. Resident # 26's most recent MDS assigned them a BIMS score of 4 indicating severe cognitive impairment. During a review of the clinical record, a note dated 9/8/23 at 1:01 PM read in part, Resident continues to complain of right shoulder and arm pain. New order given to sent to ED (emergency department) for x-ray of arm and shoulder. On 9/8/23 at 2200 a note was entered that read in part, Returned following x-ray of right elbow and shoulder due to complaints of pain. No previous injury reported. Imaging shows possible fracture of right humerus. This surveyor was not able to locate an explanation in the progress notes as to how the injury occurred. On 11/15/23 at 3:30 PM the survey team met with the Administrator, Chief Nursing Officer and Regional [NAME] President. This concern was discussed at that time. The Administrator is newly employed and states they were not aware of this incident. This surveyor requested and received a copy of the policy entitled, Resident Abuse- Injuries of Unknown Origin with a revision date of 4/2020. The policy read in part, Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc. which have no know cause. 4. The Administrator or the Director of Nursing must begin a documented investigation for the cause of the injury. 7. All injuries of unknown origin must be reported to the appropriate agencies per state specific protocols. (continued on next page)

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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 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/16/23 The Administrator presented a packet to the surveyor with what information they could locate in the record as well as staff statements and stated that they were investigating the injury and would be submitting an FRI. No further information was provided to the survey team prior to the exit conference.

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47299 Based on staff interview, clinical record review, facility document review, facility staff failed to initiate a thorough investigation of an injury of unknown origin for 1 of 22 active residents sampled and 1 of 4 closed records. Resident # 19 and Resident # 26. The findings included: 1. For resident # 19 the facility staff failed to investigate a right hip fracture that was identified October 13, 2023. This was a closed record review. Resident # 19's diagnoses included but were not limited to, unspecified dementia, cognitive communication deficit, generalized anxiety, Alzheimer's with late onset, insomnia, weakness, history of falling. Resident # 19's Minimum Data Set (MDS) Assessment with an Assessment Reference Date (ARD) of 10/20/23 assigned the resident a Brief Interview for Mental Status (BIMS) score of 3, indicating they were severely cognitively impaired. The resident was also coded as dependent for Activities of Daily Living (ADL's) and mobility. The clinical record was reviewed. A progress note dated 10/13/23 at 8:06 AM read, Situation : xray results back show fracture of femoral neck fracture of right hip Background : found in floor on 10/06/2023 Assessment : pain to right hip Response : called md on call new order send to er. A progress note was located for 10/6/23 at 2:34 AM that read, Situation : Staff alerted me to residents room at 02:25am (they) was found with (their) trunk lying beside bed and legs tucked underneath the bed. (They) is awake and alert, states (they) is unsure what happened. Background : Resident is a 90 y.o. with dementia and mild cases of confusion, h/x of falls and generalized weakness. Assessment : Resident appears baseline status prior to any incident, is able to answer most questions with occasional confusion pre existing prior to possible incident. is verbal and able to follow commands, neurological checks remain at baseline, denies any pain or injury at this time, Vital signs remain within normal limits BP 148/86, Temp. 98.4 tympanic, Pulse 83, 18 RR no visual injuries noted. Skin appears intact without breaks or bruising at this time. Resident states does not know what happened. Response : Two CNA's and myself sat patient upright and assisted back in bed, appears as normal baseline prior to incident. Fall protocol initiated, resident is back in his bed lying supine with no complaints at this time. There were no notes in between these two notes to indicate resident was having pain or had another fall. There was no explanation in the notes as to why or when the x-ray was ordered. There was an order entered on 10/11/23 that read, X-ray rt hip two views and pelvis one time only for Rt. hip pain from previous fall. Resident # 19 was readmitted to the facility on [DATE] after it was determined they were not a surgical candidate. On 11/16/23 at 8:41 AM this surveyor interviewed LPN # 10 who was caring for resident #19 the morning 10/6/23 when resident # 19 fell . They stated that they assessed resident and there was no indication of any injuries so they and 2 other staff members assisted resident back to bed. (continued on next page)

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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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	This surveyor requested and received a copy of the policy entitled, Resident Abuse- Injuries of Unknown Origin with a revision date of 4/2020. The policy read in part, Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc. which have no know cause. 4. The Administrator or the Director of Nursing must begin a documented investigation for the cause of the injury. 5. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors, or volunteers which may have had contact with the resident and may help with the investigation. Obtain written statements as deemed necessary. This surveyor met with the Administrator on 11/16/23 at approximately 11:00 AM and asked for the Facility Reported Incident (FRI)/investigation for resident # 19's right hip fracture October 13, 2023. They stated they could not locate an FRI for this resident in October. Surveyor asked if they would have expected one to be done for a hip fracture identified a week after the last fall, and they stated, I would, but I wasn't here at the time and can't say what the previous Administrator did or didn't do. The survey team met with the Administrator, Regional [NAME] President of Operations, and the Chief Nursing Officer on 11/16/23 at 5:20 PM and this concern was discussed. No further information was provided to the survey team prior to the exit conference. 2. For resident # 26 the facility staff failed to report a fracture of the right humerus that was identified 9/8/23. Resident # 26's diagnoses included but were not limited to, hypertension, Alzheimer's Disease, anxiety, depression, unspecified mood disorder, diabetes and chronic obstructive pulmonary disease. Resident # 26's most recent MDS assigned them a BIMS score of 4 indicating severe cognitive impairment. During a review of the clinical record, a note dated 9/8/23 at 1:01 PM read in part, Resident continues to complain of right shoulder and arm pain. New order given to sent to ED (emergency department) for x-ray of arm and shoulder. On 9/8/23 at 2200 a note was entered that read in part, Returned following x-ray of right elbow and shoulder due to complaints of pain. No previous injury reported. Imaging shows possible fracture of right humerus. This surveyor was not able to locate an explanation in the progress notes as to how the injury occurred. On 11/15/23 at 3:30 PM the survey team met with the Administrator, Chief Nursing Officer and Regional [NAME] President. This concern was discussed at that time. The Administrator is newly employed and states they were not aware of this incident. Surveyor requested a copy of the FRI/investigation. This surveyor requested and received a copy of the policy entitled, Resident Abuse- Injuries of Unknown Origin with a revision date of 4/2020. The policy read in part, Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc. which have no know cause. 4. The Administrator or the Director of Nursing must begin a documented investigation for the cause of the injury. 5. The investigation will include interviews with the resident, all staff involved (directly or indirectly), any family, visitors, or volunteers which may have had contact with the resident and may help with the investigation. Obtain written statements as deemed necessary. (continued on next page)

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Galax Health and Rehab	836 Glendale Rd 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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	11/16/23 The Administrator presented a packet to the surveyor with what information they could locate in the record as well as staff statements and stated that they were investigating the injury and would be submitting an FRI as there was no evidence that one had been done. No further information was provided to the survey team prior to the exit conference.

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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prepare residents for a safe transfer or discharge from the nursing home. 42353 Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility for 1 of 22 residents in the survey sample, Resident #86. The findings included: For Resident #86, the facility staff failed to provide the resident with discharge instructions or medication prescriptions prior to a planned discharge home. Resident #86's diagnosis list indicated diagnoses, which included, but not limited to Pressure Ulcer of Right Buttocks, Open Wound of Abdominal Wall, Ventral Hernia with Obstruction, Type 2 Diabetes Mellitus, and Muscle Weakness. The quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/23/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating Resident #86 was cognitively intact. The resident was coded as being dependent with personal hygiene and toileting hygiene. Resident #86 was coded as having one stage 4 pressure ulcer and a surgical wound. Resident #86's comprehensive person-centered care plan included a focus area stating, I would like assistance in planning my next steps to be able to go home safely when my care/rehab goals are met with an intervention stating, Help me with developing transition strategies that will make my leaving go smoothly. According to Resident #86's clinical record, the resident was discharged home on 11/01/23. A nursing progress note dated 11/01/23 11:29 AM stated 10:30 am Resident left with all [his/her] belongings with [spouse] by [his/her] side, staff assisted this pt [patient] into [his/her] car. Pt has to return to get [his/her] prescriptions for [his/her] medications. Surveyor reviewed Resident #86's clinical record and was unable to locate evidence of discharge instructions provided to the resident prior to discharge home on 11/01/23. On 11/13/23 at 5:30 PM, surveyor spoke with Resident #86 who stated when they were discharged from the facility on 11/01/23, they did not speak to anyone about discharge, did not receive any discharge papers, instructions, medications, or medication prescriptions, only a prescription for a walker. Resident #86 stated facility staff were aware of their discharge and wheeled them out to their car when leaving. The resident stated after leaving the facility, they went to their community pharmacy and the pharmacy had to contact the facility to obtain prescriptions. The resident stated they missed all their medications on the day of discharge. (continued on next page)

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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 0624 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/14/23 at 11:00 AM, surveyor spoke with the Social Services Director (SSD) regarding Resident #86's planned discharge. SSD stated they were recently employed by the facility and Resident #86's discharge was their first planned discharge. SSD stated they were unaware they were supposed to assemble the discharge packet, and this was the reason the resident did not receive discharge instructions or medication prescriptions. SSD provided copies of physician signed medication prescriptions dated 10/30/23 for Furosemide, Atorvastatin Calcium, Montelukast Sodium, Amlodipine, Gabapentin, and Potassium Chloride which were not provided to the resident. On 11/14/23 at 12:01 PM, surveyor spoke with licensed practical nurse (LPN) #7, the nurse present at the time of Resident #86's discharge. LPN #7 stated they were aware Resident #86 was discharging but did not have the discharge packet and thought the SSD went over the discharge instructions and packet with the resident. LPN #7 stated the SSD had the resident's orders. Surveyor requested and received the facility policy titled Discharge Planning Documentation which read in part: .4. At the time of discharge, a discharge summary and home-going instructions are provided to the resident or the resident's caregiver which will include the following: A. Current diagnosis B. Rehabilitation potential C. Summary of prior treatment D. Physician's orders for immediate care E. Pertinent social information F. Community referrals as needed (e.g., home health, mental health, adult day care, etc.) . On 11/14/23 at 4:32 PM, the survey team met with the administrator, regional vice president of operations, and the chief nursing officer and discussed the concern of staff failing to provide discharge instructions and medication prescriptions to Resident #86 at discharge home. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.

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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 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. 28567 Based on observation, staff interview, clinical record review, and facility document review the facility staff failed to follow standards of professional practice for 2 of 22 residents, Resident's #242 and #24. The findings included: 1. For Resident #242, the facility nursing staff documented they had administered the medication Isosorbide when this medication had never been delivered to the facility from the pharmacy. This medication was not available in the facility STAT box. Resident #242's diagnoses included hypertension, congestive heart failure, and chronic kidney disease. There was no completed minimum data set (MDS) assessment for this Resident. Resident #242 was alert and orientated to self. Resident #242's clinical record included an order for the medication Isosorbide Mononitrate 10 mg 1 tablet three times a day for hypertension. The order date was documented as 11/08/23. A review of Resident #242's medication administration record (MAR) revealed that the nursing staff had documented they had administered this medication on 11/09/23 at 8:00 a.m. and 2:00 p.m., 11/10/23 at 8:00 a.m. and 2:00 p.m., 11/11/23 at 8:00 a.m., 2:00 p.m. and 8:00 p.m., 11/12/23 at 8:00 a.m. and 2:00 p.m., and again on 11/13/23 at 8:00 a.m. 2:00 p.m. and 8:00 p.m. The facility nursing staff had documented a 7 for 11/08/23 at 2:00 p.m. and 8:00 p.m., a 3 on 11/09/23 and 11/10/23 at 8:00 p.m., and a 7 on 11/12/23 at 8:00 p.m. Per the preprinted code on the MAR a 7=other/see nurses note and a 3=hold/see nurses note. A review of the progress notes indicated the nursing staff had documented the medication was on hold/awaiting delivery and/or on order from the pharmacy. The clinical record included a note from the pharmacy dated 11/08/23 that read Isosorbide Mononitrate oral tablet 10 mg give 1 tablet by mouth three times a day for hypertension. The frequency of 3 times per day exceeds the usual frequency of 2 times per day. On 11/14/23 at 8:45 a.m., Licensed Practical Nurse (LPN) #7 and the surveyor checked the medication cart for this medication. This medication was not located on the medication cart. LPN #7 stated they would have to order the medication. On 11/14/23 at 9:50 a.m., during an interview with Pharmacy Technician #1 this staff stated this medication had not been sent to the facility and the medication order needed to be clarified. On 11/14/23 at 10:00 a.m., during an interview with Resident #242 this resident stated they were unaware if they got their medication, they got a cup full. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/15/23 at 10:50 a.m., LPN #7 stated they had not clarified the medication order and they needed to do that. When asked how they administered this medication if it was not available, they stated you can't administer it if you ain't got it. On 11/15/23 at 3:30 p.m., during an end of the day meeting with the Administrator, Regional [NAME] President of Operations, and Chief Nursing Officer the issue with the medication was reviewed. On 11/16/23 at 12:25 p.m., the Administrator provided the survey team with a copy of a policy titled, Medication Administration General Guidelines. This policy was dated 01/23 and read in part, .If two consecutive doses of a vital medication are withheld or refused, the physician is notified . No further information regarding this issue was provided to the survey team prior to the exit conference. 42353 2. For Resident #24, the facility staff failed to complete neurological assessments following a fall on 11/03/23 in which the resident hit their head. Resident #24's diagnosis list indicated diagnoses, which included, but not limited to Iliotibial Band Syndrome of the Right Leg, Dementia, Major Depressive Disorder, Mood Disorder, Generalized Anxiety Disorder, Nightmare Disorder, Parkinson's Disease, Unsteadiness on Feet, and Muscle Weakness. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 9/15/23 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #24 was coded as requiring limited assistance with transfers, dressing, and personal hygiene. The resident was coded as having one fall with no injury since the prior MDS assessment. On 11/14/23 at 10:20 AM, surveyor spoke with Resident #24 who stated they have falls because they reach in the floor for things. The resident stated a week or two ago they fell and landed on their head. Resident #24's clinical record included a nursing progress note dated 11/03/23 3:32 PM which read in part resident fell from wheelchair .some redness on the forehead . Surveyor reviewed the Resident's Neurological Assessment Flowsheet initiated on 11/03/23 at 1:25 PM. The flowsheet was blank for level of consciousness, pupil response, hand grasps, motor function extremities, pain response, and staff signature for the following times: 11/03/23 1:25 PM, 1:40 PM, 1:55 PM, 2:10 PM, 3:10 PM, 4:10 PM, 5:10 PM, and 6:10 PM with only vital signs documented. Surveyor requested and received the facility policy titled Neurological Assessment which read in part Resident with a suspected head injury will have neurological signs monitored and recorded. Neurological observations are the responsibility of licensed nurses .Document neurological checks on the Neurologic Assessment Sheet .Level of Consciousness .Pupil Response .Motor Function .Pain Response .Vital Signs . Observations . (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495250	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/16/2023
NAME OF PROVIDER OR SUPPLIER Galax Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 836 Glendale Rd Galax, VA 24333	

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 - Few	On 11/15/23 at 9:45 AM, surveyor spoke with the Interim Director of Nursing (DON) regarding Resident #24's neurological checks. The DON stated they did not know why the neuro checks were not completed. On 11/15/23 at 3:35 PM, the survey team met with the Administrator, Chief Nursing Officer, and the Regional [NAME] President of Operations and discussed the concern of the incomplete neurological checks following Resident #24's fall on 11/03/23. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23.