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	11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide basic life support, including CPR, prior to the arrival of emergency medical personnel , subject to physician orders and the resident's advance directives. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review the facility staff failed provide basic life support, including cardiopulmonary resuscitation (CPR) to 1 of 13 residents, Resident #2, which constututed a determination of Immediate Jeopardy (IJ). The scope and severity was originally cited at Immediate Jeopardy, Level IV isolated and was reduced to a Level II isolated after the facility was cleared of Immediate Jeopardy. The Administrator, DON (director of nursing) regional vice-president of operations and regional clinical director were notified on [DATE] that the extended survey process had begun at 1:30 pm, as the survey team had identified Immediate Jeopardy in the area of Quality of Life. The finding included: For Resident #2 the facility staff withheld cardiopulmonary resuscitation based on verbal directions from the resident's boyfriend. Resident #2's face sheet listed the resident as their own authorized representative. Resident #2's face sheet listed diagnoses which included but not limited to unspecified protein calorie malnutrition, dysphagia, gastrostomy status, abnormal weight loss, and adult failure to thrive. Resident #2's most recent minimum data set with an assessment reference date of [DATE] coded the resident as 99 in section C, cognitive patterns. This indicated that the resident was unable to complete the interview. Section B, Hearing, Speech, and Vision indicated the resident had adequate hearing, unclear speech, is sometimes understood, and usually understands others. Resident #2's comprehensive care plan was reviewed and contained a care plan for Patient has an advance directive as evidenced by: Goals for this care plan were Patient's wishes will be honored -FULL CODE. Interventions for this care plan included CPR will be performed as ordered, and Follow facility protocol for identification of code status. Resident #2's physician's order summary was reviewed and contained a signed physician's order dated [DATE] which read in part, Full resuscitation. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Resident #2's clinical record was reviewed and contained nurse's progress notes which read in part, [DATE] 11:08 Hospice nurse in to evaluate Resident. Increase in air hunger and pain noted. MD made aware. Discussion of DNR (do not resuscitate) status, no changes at this time ., [DATE] 13:19 .hospice nurse in to assess resident, resident appears to be in active stage of passing, BP (blood pressure) 103/62, HR (heart rate) 128, RR (respiratory rate) 33, T (temperature) 99.1, mottling noted to feet and lower legs, . (name omitted) SW (social worker) for hospice contacted .(resident boyfriend) to sign DNR. (resident's boyfriend) came to facility and signed DNR for resident, [DATE] 08:04 Dr . (name omitted) seen resident on rounds; resident declining. very shallow, rapid breathing; c/o (complaints of) air hunger. Dr . (name omitted) requested resident be given morphine for comfort measures. significant other/life partner in w/resident at this time; agreed to comfort care; he stated to Dr . (name omitted) and this nurse that he doesn't want resident to receive CPR; social worker notified d/t (due to) current code status, and [DATE] 17:15 Called to room by staff, Resident without respirations, no pulse noted, apical heart rate absent. Time of death at 1706 (5:06 pm). Family present in room and aware . Surveyor requested a copy of Resident #2's DNR form and was informed by the administrator on [DATE] at 1:30 pm that they could not locate a DNR form for the resident. Administrator provided surveyor with a nurse's progress note dated [DATE] which read in part, 08:04 Dr . (name omitted) seen resident on rounds; resident declining. very shallow, rapid breathing; c/o (complaints of) air hunger. Dr . (name omitted) requested resident be given morphine for comfort measures. significant other/life partner in w/resident at this time; agreed to comfort care; he stated to Dr . (name omitted) and this nurse that he doesn't want resident to receive CPR; social worker notified d/t (due to) current code status. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor requested and was provided with hospice notes on [DATE] at 8:45 am. Hospice notes read in part, RN Initial Assessment: [DATE] Was the patient/responsible party asked about preference regarding the use of cardiopulmonary resuscitation: 1. Yes, and discussion occurred. Was the patient/responsible party asked about preferences regarding life-sustaining treatment other than CPR? 1. Yes, and discussion occurred . Psychological Status: Overall Mental Status: Alert. Alerted To: Person Place. Responsiveness: Semi-responsive. Responds To: Verbal Stimuli. Neurological Status: Overall Neurological Status: Non-verbal. Overall Emotional Status: Flat affect, Withdrawn, Difficulty coping, Inability to recognize problems, Unrealistic expectations, Denial of problems .Spiritual/Religious: Primary Religion: Catholic. Level of Religious Affiliation: Fairly religious. Is the patient part of a religious or spiritual community? yes. Are the patient's beliefs disrupted by the disease process? No. Summary/Comments: . (Resident #2) is a . at . (facility name omitted). A patient of Dr. (name omitted). She was born in the . and came to the US between 1981 and 1990. She has been with their SO (significant other) since 1990. She is able to understand more English compared to him, however there is a friend that does a lot of translation for him. She has no children. She has enjoyed taking care of her chickens. She is a FULL CODE at this moment , [DATE] Skilled Nursing Visit: .Staff expressed some concern about her medication ordered and her full code status. I am receiving differing answers from the patient when asked about CPR. Will talk with Dr . (name omitted) regarding code status. No other needs voiced ., [DATE] RN Comprehensive Assessment: Pt is alert and oriented . Discussion had with the patient about her wishes for CPR and attempted to educate with her what all would happen. She chooses to remain a full code , [DATE] RN Skilled Nursing Visit: Pt lying in bed watching TV. She continues to be very soft spoken. However is able to voice her needs .Staff expressed some concern about her medication ordered and her full code status. Code status addressed again with the patient and she continues to stress that she wants CPR ., [DATE] RN Skilled Nursing Visit: .Code status discussed again. DON (director of nursing) updated , and [DATE] RN Skilled Nursing Visit: .Code status discussed again. DON updated . All notes were signed by registered nurse (RN) #1, the resident's hospice case manager. The hospice notes also contained a note dated [DATE] which read in part, Received call from nurse on call stating that facility staff had called and reported that patient was declining and they were concerned because patient is still a full code. This author made phone call to patients significant other explaining that patient was declining and educated on death and dying process. Understanding was expressed. This author made signing any other (sic) aware of patients code status and provided education. Significant other was encouraged to go to facility and sign DNR order if this was their and patients wishes. Understanding expressed and significant other states that they would be going to facility. No other needs at this time. Significant other realistic and grieving appropriately at this time. This note was signed by hospice social worker/clinical manager. Surveyor spoke with certified nurse's aide (CNA) #1 and #2 on [DATE] at 2:45 pm regarding Resident #2. CNA #1 stated resident didn't speak English, but she could communicate by pointing at what she wanted, nods, and gestures. Both CNA's stated resident was a full code and was receiving hospice services. CNA #2 stated, Her husband wanted her to be DNR, but she wanted to stay full code. She stayed full code unless they changed it at the end. Surveyor spoke with licensed practical nurse (LPN) #1 on [DATE] at 3:30 pm regarding Resident #2. LPN #1 stated, Resident was a hospice patient. She was a full code, it never changed. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Surveyor spoke with LPN #6 on [DATE] at 3:35 pm regarding Resident #2. LPN #6 stated, Resident did not speak good English. She was a full code. Her significant other voiced he wanted her to be DNR. I don't know if he was authorized to say that. Surveyor spoke with physician #8 via telephone on [DATE] at 3:40 pm regarding Resident #2. Physician stated they do not recall resident, but in reviewing notes, stated they wrote the full resuscitation order at the request of the hospice nurse and that nurse's assessment of the resident. Physician stated There are numerous hospice notes saying she wished to remain a full code. It looks like they discussed it with her several times. Surveyor spoke with registered nurse (RN) #1, who was the hospice case manager, via telephone on [DATE] at 4:00 pm. RN #1 stated. Resident was limited English speaking. She was a full code on admission to hospice. I had multiple conversations with her regarding code status. She had a significant other that I believed was her husband, I later found out he was not. He was ready to sign a DNR, but she was not ready. MD said it was not legal for significant other to sign for her. In my opinion, she wanted to stay a full code. Surveyor spoke with the social worker/clinical manager for hospice on [DATE] at 8:30 am via telephone. Clinical manager stated they completed the hospice admissions consent forms with Resident #2 and her boyfriend, and they did not want a DNR at that time. Clinical manager stated hospice staff continued to provide education regarding end of life and DNR. Clinical manager stated they received a call from the facility on a weekend regarding resident's code status, and then called resident's boyfriend let him know resident was declining. Clinical manager stated that resident's boyfriend said he would go to facility and sign a DNR. Clinical manager stated they later found out that resident and boyfriend were not legally married, so resident was never technically a DNR. Clinical manager stated they don't know if resident's boyfriend ever completed DNR form for resident. Clinical manager stated that resident was cognitively aware to make her own decisions. Surveyor spoke with RN #2 on [DATE] at 8:40 am regarding Resident #2. Surveyor asked RN #2 if they were the staff that completed section C of the resident's minimum data set, and RN #2 stated that the social worker usually does that section, but they had spoken with the resident, and the resident was unable to complete the brief interview for mental status due to being in a lot of pain, and limited English skills. RN #2 stated, Her boyfriend talked a lot for her, but I think she would be able to make her own decisions. Surveyor spoke with the social worker (SW) on [DATE] at 8:45 am. SW stated they were not the SW at the time Resident #2 was in the facility but was the receptionist. SW stated, She had a husband, but he could not speak English, well, he wasn't technically her husband. Surveyor spoke with RN #1 on [DATE] at 10:00 am. Surveyor asked RN #1 if they had discussed code status with Resident #2, and RN #1 stated they had discussed it with resident multiple times. RN #1 stated resident was not willing to sign DNR form. Surveyor spoke with LPN #6 on [DATE] at 10:50 am. Surveyor asked LPN #6 why they made the decision not to perform CPR on Resident #2, and LPN #6 stated, The DON said they had spoken with . (physician #9) and they had a signed DNR form on file from hospice that had not been put in . (electronic health record). It all happened the day she was actively dying. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	During a meeting with the administrator, director of nursing (DON), assistant director of nursing (ADON), regional clinical director, and regional director of operations on [DATE] at 2:10 pm, the concern of failing to perform CPR for Resident #2 was discussed, and surveyor informed administrative team that a Level IV Immediate Jeopardy had been cited as of [DATE] at 1:30 pm. On [DATE] at 2:15 pm, the regional clinical director and regional vice-president of operations provided surveyor with a Virginia Department of Health Durable Do Not Resuscitate Order which read in part, The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternatives to that decision and The patient has not executed a written advanced directive (living will or durable power of attorney for healthcare). (Signature of 'Person Authorized to Consent on the Patient's Behalf is required.) This form was signed by physician #9 and two other persons. Surveyor spoke with the administrator on [DATE] at 2:20 pm and asked administrator who had signed the DNR form for Resident #2, and administrator stated that her boyfriend had signed it. Surveyor pointed out to administrator that the signatures on the form were not that of the resident's boyfriend, and administrator stated they had obtained verbal consent and the DON and ADON had co-signed the form. Surveyor spoke with the DON on [DATE] at 2:25 pm. DON stated they had called resident's boyfriend to obtain verbal consent for the DNR order, and they had co-signed the form, along with the ADON. DON stated that the resident's boyfriend stated to them that he did not want staff doing compressions on Resident #2. Surveyor asked DON if they were aware that Resident #2 wanted to remain a full code, and DON stated, Not at the time I took the verbal consent from her boyfriend. Surveyor spoke with the ADON on [DATE] at 2:30 pm. ADON stated resident's boyfriend was very adamant that he wanted Resident #2 to be a DNR. Surveyor asked ADON if they were aware that Resident #2 wanted to remain a full code, and ADON stated, I was aware that it went back and forth, but thought she was in agreement. Surveyor requested and was provided with a facility policy entitled Cardiopulmonary Resuscitation (CPR) which read in part, Cardiopulmonary Resuscitation (CPR) is initiated to support the ventilation and circulation function until: aid arrives and the resident is placed on advanced life support systems; he/she is stimulated to function on his/her own; and/or he/she is pronounced dead. 1. Cardiopulmonary resuscitation is initiated on all resident except those with a no code order and appropriate documentation . On [DATE] at 4:45 pm, the administrator presented the surveyor with the facility's removal plan, which read as follows: The following served as the plan of correction for F-678. 1. The facility was placed into Immediate Jeopardy on [DATE] at 1410 (2:10 pm) for not performing full resuscitation, facility withheld CPR based on verbal direction form the resident's boyfriend. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	2. All residents have the potential to be affected by the deficient practice. The following actions were completed: a. Code status was verified with all current residents, to be completed by [DATE] b. All staff will be educated on code status policies and procedures, to be completed by [DATE] c. Orders were audited on all current residents, to be completed by [DATE]. d. All residents with BIMS (brief interview for mental status)>12 without a health care proxy will be interviewed and asked to designee a proxy, to be completed by [DATE]. e. DON or designee will review 5 resident charts per week for 4 weeks to verify code status and orders match in PCC (electronic health record), to be completed by [DATE] 3. To ensure the deficient practice does not occur, all newly admitted residents' code status will be discussed in the clinical IDT (interdisciplinary team) meeting and verified in the meeting. Any code status changes will also be discussed and verified in the clinical/IDT meeting. 4. The plan was presented to the QAA (quality assessment and assurance) committee, including the medical director and center IDT. On [DATE] at 9:15 am, the administrator provided the surveyor with a code status and order audit form for all current residents of the facility. On [DATE] at 2:30 pm, the administrator provided the surveyor with staff education sign-in sheets related to education on resident code status, and cardiopulmonary resuscitation. On [DATE] at 3:15 pm, after validation of the implementation of the removal plan, including staff interviews (LPN #6, CNA#10, Housekeeper #6, CNA #3, Receptionist #10), reviews of audits, and education, the administrator and DON were made aware that the Level IV isolated Immediate Jeopardy citation had been reduced to a Level II isolated deficiency. (continued on next page)

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F 0678 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The concern of the facility staff failing to perform CPR for Resident #2 was discussed during a meeting with the administrator, director of nursing, regional clinical director, and regional vice-president of operations during a meeting on [DATE] at 4:15 pm. No further information was provided prior to exit.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, resident interview, staff interview, and facility document review, the facility staff failed to ensure a hazard free environment on 1 of 2 units, Unit B. The findings included: There were numerous missing floor tiles in the shower room on Unit B, underneath the shower fixture where the residents of the facility would shower. On 11/20/24 at 12:15 p.m., the surveyor entered the shower room on Unit B. This shower room was observed to have numerous missing floor tiles, underneath the shower fixture where the residents of the facility would shower. On 11/20/24 at 12:20 p.m., during an interview with Certified Nursing Assistant (C.N.A.) #1 regarding the missing tiles this staff stated the tiles had been that way for at least 4 months and it was getting worse. When asked if any resident had ever been injured due to the missing tiles this staff stated no, but the shower chair wheels did catch on the area where the floor tiles were missing. C.N.A. #1 was observed to bend over and pick up a few of the loose tiles from the floor. On 11/20/24 at 1:30 p.m., the surveyor and the Maintenance Director observed the area of the missing tiles in the shower room. The Maintenance Director stated the wrong type of tile had been used on the floor and they had to install some of the tiles again. On 11/20/24 at 1:40 p.m., the Administrator stated they were actively obtaining quotes for the shower room and shared an email with the surveyor dated 11/11/24 that included a quote to tile the floor and .fix anything underneath . On 11/21/24 at 8:15 a.m., during an interview with Resident #12 this resident stated during a resident council meeting the Administrator had told them they were going to work on the missing floor tiles in the shower room. On 11/21/24 at 8:20 a.m., during an interview with Resident #13, this resident stated the tiles had been missing in the shower room for a while. On 11/21/24 at 9:30 a.m., during a meeting with the Administrator, Director of Nursing, Regional [NAME] President of Operations, and Regional Nurse Consultant the Administrator stated the current floor had been put down the beginning of the year and they were trying to locate the receipts. No further information regarding this issue was provided to the survey team prior to the exit conference.