STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495274	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Davis and McDaniel Veterans Care Center	4550 Shenandoah Ave N W Roanoke, VA 24017

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **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 to notify the Office of the Long-term Care Ombudsman of resident transfers and/or discharges to higher levels of care and the facility staff failed to ensure the appropriate information was provided to the receiving healthcare institution(s) and/or resident(s) and resident representative(s) for 2 of 35 residents, Residents #6 and #125. The findings included:1.For the facility, the facility staff failed to notify the Office of the State Long-Term Care Ombudsman of resident transfers/discharges to higher levels of care. This surveyor requested evidence that the Office of the State Long-Term Care Ombudsman received notification of resident transfers/discharges to higher levels of care. On 1/8/26 at 8:38 AM, other staff #7 (OS#7) informed this surveyor that she agreed the notifications of resident transfers/discharges were not sent to the ombudsman and that she was never educated or informed to send notifications to the ombudsman when a resident is transferred/discharged to the hospital/higher level of care. She informed this surveyor that she does send notifications to the ombudsman if a resident expires at the facility, expires at the hospital, or is discharged home and provided this surveyor with evidence of those ombudsman notifications. This concern was discussed at the pre-exit meeting on 1/8/26 at 11:33 AM with the administrator, director of nursing, assistant director of nursing, administrator-in-training, and assistant administrator. Surveyor requested a facility policy on emergency discharges/transfers and/or a change in condition policy and was informed by registered nurse #2 (RN#2) the facility did not have either of these policies. No other information was provided to the survey team prior to exit on 1/8/26. 2. For Resident #6, the facility staff failed to ensure the appropriate information was provided to the receiving healthcare institution for a transfer/discharge on [DATE] and 11/26/25, and the facility staff failed to provide written notification of the reason(s) for a transfer/discharge to the resident and resident representative for a transfer/discharge on [DATE]. Resident #6's diagnosis list indicated diagnoses that included, but were not limited to, end stage renal disease, ulcerative proctitis, type 2 diabetes mellitus, and dependence on renal dialysis. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	12/2/25, assigned the resident a brief interview for mental status (BIMS) summary score of 8 out of 15 for cognitive abilities, indicating the resident was moderately impaired in cognition. A review of the clinical record indicated Resident #6 was transferred to the hospital on [DATE] and on 11/25/25. No evidence that appropriate information was provided to the receiving healthcare institution for the transfer/discharge on [DATE] and 11/25/25 could be located and no evidence of a written notice of the reason(s) for the transfer/discharge being provided to the resident and the resident's representative could be located for the discharge on [DATE]. This surveyor requested evidence that appropriate information was provided to the receiving healthcare institution for the transfer/discharge on [DATE] and 11/25/25. This surveyor also requested evidence that written notification was provided to the resident and resident representative for the reason(s) of transfer/discharge for 11/25/25. On 1/7/26 at 3:12 PM, the assistant director of nursing (ADON) provided this surveyor evidence of written notification for the reason(s) of transfer/discharge provided to the resident and the resident's representative for the transfer/discharges on 10/02/25 and 11/16/25. Evidence of written notification of the reason(s) for the transfer/discharge for 11/25/25 was not provided to this surveyor. The ADON agreed a Resident Transfer Form could not be located for the 10/2/25 transfer/discharge and the ADON informed this surveyor a Resident Transfer Form was not needed for the transfer/discharge on [DATE] because the resident returned to the facility on [DATE]. This concern was discussed at the end of day meeting on 1/7/26 at 4:15 PM with the administrator, director of nursing, assistant director of nursing, administrator-in-training, and assistant administrator. Surveyor requested a facility policy on emergency discharges/transfers and/or a change in condition policy and was informed by registered nurse #2 (RN#2) the facility did not have either of these policies. No other information was provided to the survey team prior to exit on 1/8/26. 3. For Resident #125, the facility staff failed to provide evidence to the survey team that the appropriate information was communicated to the receiving health care institution when the resident was transferred to a higher level of care on 11/26/25 and failed to provide written notice of transfer and a bed hold to the resident and/or resident representative until 12/01/25. Resident #125's diagnoses included adult failure to thrive, malignant neoplasm of colon, hypertension, diabetes, and heart failure. Section C (cognitive patterns) of Resident #125's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 12/08/25 included a brief interview for mental status (BIMS) score of 15 indicating Resident #125 was cognitively intact. Resident #125's clinical record included a nursing progress note that indicated this resident was transferred and admitted to a higher level of care on 11/26/25 for hypoxia and hypotension. On 12/01/25 at 9:09 a.m., Social Worker #1 documented that a temporary transfer notice was mailed to the responsible party/daughter of Resident #125. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 01/08/26 at 9:00 a.m., during an interview with Registered Nurse (RN) #2 this staff stated the date the resident was transferred (11/26/25) was a state holiday and 12/01/25 would have been the next business day. On 01/08/26 at 11:30 a.m., during a meeting with the Administrator, Assistant Administrator, Administrator in Training, Director of Nursing, and Assistant Director of Nursing the above issues were reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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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 residents comprehensive care plan (CCP) to include the residents current code status for 1 of 35 current residents, Resident #9.The findings included:The facility staff failed to include Resident #9's code status on their CCP when the care plan was reviewed and revised on 12/05/25. Resident #9's diagnoses included myocardial infarction, peripheral vascular disease, and post-traumatic stress disorder.Section C (cognitive patterns) of Resident #9's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/24/25 included a brief interview for mental status (BIMS) score of 14 out of a possible 15 points indicating Resident #9 was cognitively intact.Resident #9s clinical record included provider orders dated 02/26/24 indicating this resident was a full code.During a review of Resident #9's CCP the surveyor was unable to locate any information related to this resident's code status.On 01/06/26 at 4:40 p.m., during an end of the day meeting with the Administrator, Assistant Administrator, Director of Nursing, Administrator in Training, and Assistant Director of Nursing the issue with Resident #9's code status not being included on the CCP was reviewed.On 01/07/26 at 11:41 a.m., during an interview with Registered Nurse (RN) #4 this nurse stated the Social Worker had revised/updated the CCP on 12/05/25 and failed to put Resident #9's code status back on the CCP.No further information regarding this issue was provided to the survey team prior to the exit conference.

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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, resident interview, clinical record review and facility document review, the facility staff failed to follow physician orders for 1 of 35 current residents, Resident #1. The findings included:For Resident #1 the facility staff failed to follow physician's orders for sliding scale insulin protocol.Resident #1's clinical record listed diagnoses which included but not limited to type 2 diabetes mellitus and chronic kidney disease.Resident #1's most recent minimum data set with an assessment reference date of 10/15/25 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Section N, medications, coded the resident as receiving insulin injections for 7 out of 7 days in the look back period. Resident #1's comprehensive care plan contained a plan for . has Diabetes Mellitus with neuropathy, episodes of hyper/hypoglycemia; refuses insulin at times . Interventions for this care plan included diabetes medication as ordered by doctor ., Monitor blood sugar as indicated by MD orders for s/s (signs/symptoms) of hypo/hyperglycemia. Administer insulin and S/S (sliding scale) insulin as indicated by MD orders, and Monitor/document/report to MD PRN (as needed) for s/sx (signs/symptoms) of hyperglycemia: increased thirst and appetite, frequent urination, weight loss, fatigue, dry skin, poor wound healing, muscle cramps, .Resident #1's clinical record was reviewed and contained a physician's order summary which read in part, Accuchecks prn notify MD if above 400. If below 60 follow standing order for Hypoglycemia and notify MD ** as needed for b/s (blood sugar) checks. Notify MD if below 60 or above 400, and Novolin R Solution 100 unit/m; (Insulin Regular Human). Inject as per sliding scale: if 300-350 = 6; 351-400 = 8; 401 + = 10, subcutaneously before meals and at bedtime for Diabetes Mellitus. If reading is 60 or below refer to hypoglycemia standing orders.Resident #1's electronic medication administration record (eMAR) for the month of December 2025 was reviewed and contained entries which read in part, Accuchecks prn notify MD if above 400. If below 60 follow standing order for Hypoglycemia and notify MD ** as needed for b/s (blood sugar) checks. Notify MD if below 60 or above 400, and Novolin R Solution 100 unit/m; (Insulin Regular Human). Inject as per sliding scale: if 300-350 = 6; 351-400 = 8; 401 + = 10, subcutaneously before meals and at bedtime for Diabetes Mellitus. If reading is 60 or below refer to hypoglycemia standing orders. Resident #1's blood sugar was recorded as 410 on 12/06/25 at 9 pm, 493 on 12/12/25 at 4:30 pm, and 497 on 12/12/25 at 9 pm. These entries were also coded 2 on the eMAR. eMAR code 2 is equivalent to drug refused. Surveyor spoke with Resident #1 on 01/07/26 at 2:45 pm. Surveyor asked resident if they every refused their insulin, and resident stated, Sometimes I refuse it at night. Even if my sugar is high, if I take the insulin, my sugar will drop way down. I don't like for it to drop like that.Surveyor spoke with registered nurse (RN) #8 on 01/07/26 at 2:30 pm. Surveyor asked RN #8 what the protocol is when a resident refuses to take their medication, and RN #8 stated, I would find out why they were refusing, document the refusal in an eMAR note and health status note. Surveyor asked RN #8 specifically about residents who refuse insulin, and RN #8 stated, depends on their blood sugar, but I would notify the physician. RN #8 went on to say, without being asked, that Resident #1 will refuse his insulin, even if his blood sugar is within parameters to get it. Surveyor asked RN #8 what the protocol is if a resident's blood sugar is greater than 400, and RN #8 stated, Make a note and contact the physician.Surveyor reviewed Resident #1's nursing progress notes and could not locate any evidence that the physician had been notified on the days that Resident #1 had refused his insulin, and his blood sugar was greater than 400.Surveyor requested and was provided with a facility policy entitled Recommended Order for Sliding Scale Insulin/ Applies to all Nursing Home Residents which read in part, For blood sugar greater than 400, give 10 units of Regular insulin subcutaneously and notify the MD.The concern of not notifying the physician of resident's blood sugars being greater than 400 was discussed with the administrator, assistant administrator, administrator-in-training, director of nursing and assistant director of nursing on 01/07/26 at 4:15 pmNo further information was provided prior to exit.