STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495338	A. Building B. Wing	08/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Deer Meadows Rehabilitation and Nursing	600 Walden Road Abingdon, VA 24210

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 21227 Based on staff interviews, clinical record review, and facility document review, the facility staff failed to provide care and/or services for five (5) of 27 sampled residents (Resident #15, Resident #36, Resident #73, Resident #82, and Resident #258). The findings include: 1. The facility staff failed to have documented evidence of Resident #82 being assessed by a licensed nurse prior to facility staff assisting the resident back to their wheelchair after the resident experienced a fall on 7/11/24. Resident #82's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 6/29/24, was signed as completed on 7/8/24. Resident #82 was assessed as able to make self understood and as able to understand others. Resident #82's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. On the afternoon of 8/5/24, the surveyor interviewed the facility's Assistant Director of Nursing (ADON), Licensed Practical Nurse (LPN) #8, Certified Nurse Aide (CNA) #6, and CNA #7. These three (3) staff members were involved in the care of Resident #82 after the fall on 7/11/24. It was reported that a licensed nurse was notified of the fall and involved in the resident's post-fall care. On 8/5/24 at 4:00 p.m., the Director of Nursing (DON) confirmed that no immediate post-fall assessment of the resident was documented. The DON confirmed that an assessment by a licensed nurse should have been completed after the fall and prior to the resident being assisted from the floor back to the wheelchair. On 8/5/24 at 4:31 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Clinical Services, and Regional Food Services Director. During this meeting, the surveyor discussed the failure of the facility staff to have documented evidence of a licensed nurse completing an assessment of Resident #82 after the resident experienced a fall on 7/11/24. 2. The facility staff failed have evidence of Resident #36 being assessed by a licensed nurse when the resident experienced a change in condition. (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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #36's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/3/24, was signed as completed on 5/14/24. Resident #36 was assessed as able to make self understood and as able to understand others. Resident #36's Brief Interview for Mental Status (BIMS) summary score was documented as an eight (8) out of 15; this indicated moderate cognitive impairment. Resident #36's clinical record indicated the resident experienced a change in condition which resulted in a transfer to a local hospital on the evening of 5/16/24. The following information was found on a medical provider note dated 5/16/24: Send to ED (emergency department) to evaluate and treat; (oxygen saturation levels) in low 80's when I entered the room, increased (oxygen) to 4 (liters per minute) . Continues to be (short of breath) at rest. She is dependent on hemodialysis and states she does not feel she can attend her session tomorrow (due to) her current condition. Hopefully she will be admitted and can receive dialysis inpatient as she needs it, concerned about (pneumonia) and volume overload. Review of Resident #36's clinical record failed to reveal an assessment by a licensed nurse. No vital signs to include an oxygen saturation level was documented by nursing staff for 5/16/24. On 8/1/24 at 3:41 p.m., the surveyor discussed the absence of an assessment by a licensed nurse, when Resident #36 experienced a change in condition on 5/16/24, with the facility's Regional Director of Clinical Services (RDCS). The RDCS confirmed a nurse assessment, to include a full set of vital signs, should have been completed. On 8/1/24 at 4:02 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, RDCS, and Regional Food Services Director. During this meeting, the surveyor discussed the absence of a nursing assessment when Resident #35 experienced a change in condition on 5/16/24 which resulted in a transfer to the local hospital. 3. The facility staff failed to follow Resident #15's medical provider's bowel protocol standing orders. Resident #15's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/16/24, was signed as completed on 5/30/24. Resident #15 was assessed as being able to sometimes make self understood and as being able to sometimes understand others. Resident #15 was assessed as having moderate impairment with making decisions regarding tasks of daily life. On 8/2/24 at 1:05 p.m., the Assistant Director of Nursing (ADON) provided the surveyor a copy of Resident #15's standing orders including the following bowel protocol instructions: . if no (bowel movement) in 3 days; give Milk of magnesia 30 ml by mouth/peg . If no BM (bowel movement) in 24 hours after Milk of magnesia, give Dulcolax 10 mg suppository rectally . Resident #15's medical record included documentation to indicate the resident did not have a bowel movement for the following five (5) days: 7/22/24, 7/23/24, 7/24/24, 7/25/24, and 7/26/24. No evidence of the implementation of the resident's bowel protocol was found until a Dulcolax suppository was administered on 7/26/24 at 6:49 p.m. No evidence was found by or provided to the surveyor to indicate Resident #15 had been provided/administered oral milk of magnesia after three (3) days without a BM. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/5/24 at 4:31 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Clinical Services, and Regional Food Services Director. During this meeting, the surveyor discussed the facility staff not following the medical provider's bowel protocol for Resident #15. 47299 4. For resident # 258, the facility staff failed to follow a physician's order to remove staples from a surgical incision. Resident # 258's pertinent diagnoses included displaced intertrochanteric fracture of the right femur post surgical repair for which resident was admitted to the facility for rehabilitation. Review of the clinical record revealed a nurse progress note dated 5/16/24 that read, refused to go to f/up Ortho appointment scheduled this day x 4 attempts. MD notified. A physician's note dated 5/21/24 read under the heading Plan/Orders: Remove staples today. There was no note that discussed staples being removed. There was no order entered into the electronic medical record to remove staples. According to the electronic medical record, resident # 258 was rehosptialized on 5/27/24 and a document entitled ED Notes dated 5/27/24 was reviewed. The document read in part, Staples removed by this RN. Chart shows that staples should have been removed two weeks from the date of his surgery on 4/27/24. On 8/5/24 this nurse interviewed the Assistant Director of Nursing (ADON). They stated they did not remember if resident # 258's staples had been removed but I feel like if we had an order we did it. They called the wound nurse, Licensed Practical Nurse (LPN) # 4 and stated She would have been the one to take them out. LPN # 4 was interviewed. When asked if she recalled removing staples from resident # 258, she stated, No, I didn't take his staples out. When asked if she was aware that an order was written to do so she stated, No, I didn't know. On 8/5/24 at 12:13 PM this surveyor met with the Director of Nursing (DON), ADON, and Regional Director of Clinical Services (RDCS). When asked how the order to remove staples didn't get carried out the RDCS stated, It was just missed. This concern was reviewed with the Administrator, DON, ADON, RDCS, Regional Director of Operations and Regional Director of Culinary Services on 8/6/24 at 12:15 PM. No further information was provided to the survey team prior to the exit conference. 49622 5. For Resident #73 (R73), the facility staff failed to follow provider orders for bowel protocol for the administration of Milk of Magnesia and Dulcolax used to treat constipation. R73's diagnosis list indicated diagnoses that included, but were not limited to, Morbid (severe) obesity, Anemia, Tachycardia, Constipation, Edema, and Hypothyroidism. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The most recent minimum data set (MDS) with an assessment reference date (ARD) of 07/13/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating R73 was cognitively intact. On 7/29/24 at 4:10 PM, surveyor interviewed R73, and he stated he has problems with constipation. R73's provider orders included an order dated 06/28/24 for Milk of Magnesia 30 ml (milliliters) by mouth on day three (3) without a bowel movement; then initiate Bowel Protocol: Step 3. The resident's orders also included an order dated 06/28/24 for Dulcolax 10 mg (milligrams) Suppository per rectum on day four (4) without a bowel movement and no result from Milk of Magnesia; then initiate Bowel Protocol: Step 4 and a provider's order dated 06/28/24 for Administer Fleet enema per rectum on day five (5) without a bowel movement and no result from Milk of Magnesia or Dulcolax suppository; then initiate Bowel Protocol: Step 4. Surveyor reviewed R73's July 2024 MAR (medication administration record) and was unable to locate evidence of staff administering Milk of Magnesia or Dulcolax prior to administering Fleet enemas on 07/01/24, 07/09/24, and 07/26/24. A review of R73's current care plan with a focus that read in part, .has potential for fluid deficit r/t (related to) recent constipation . and interventions that read in part, .Administer medications as ordered. Observe for side effects and effectiveness .Observe bowel sounds and frequency of BM (bowel movement): provide medication per order and notify MD (medical doctor) as necessary . A review of R73's Bowel Movement flow sheet revealed documentation of resident having bowel movements only on the following dates: 07/01/24, 07/09/24, 07/14/24, 07/15/24, 07/26/24, 07/27/24, and 07/31/24. Surveyor requested and received the facility document titled, Bowel Protocol which read in part, .if no bm in 3 days; give Milk of magnesia 30 ml by mouth .If no BM 24 (twenty-four) hours after Milk of magnesia, give Dulcolax 10 mg suppository rectally .If no BM in 24 hours after Dulcolax suppository, administer fleet enema rectally .If no BM 4 hours after Fleet enema, notify MD . On 08/02/24 at 11:20 AM, surveyor spoke with regional director of clinical services (RDCS#4), and she informed surveyor they could not locate any evidence where Milk of Magnesia or Dulcolax were given to resident in July 2024 per bowel protocol. She agreed there were no notes indicating anything was given prior to the enemas and there was no proof. These concerns were discussed at the end of day meeting on 8/1/24 at 4:00 PM with the administrator, director of nursing, assistant director of nursing, regional director of clinical services, regional director of operations, and regional director of dietary services and again during the end of day meeting on 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM. No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24.