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	03/14/2025

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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on staff interviews and facility document review, the facility staff failed to have evidence of attempting to resolve four (4) grievances. The findings include: A grievance dated 9/9/24 referenced Resident #6. This grievance was documented as being made by a member of the resident's family. This grievance included concerns related to urine appearance, wound care, and housekeeping. No evidence was found by or provided to the surveyor to indicate this grievance had been investigated. The form this grievance was documented on included areas for Investigation/Analysis of Concern and Actions Taken to Correct Concern; both of these areas were blank. The form had an area for facility staff to document the response to the individual lodging the grievance; this area was blank. On 3/11/25 at 3:10 p.m., the surveyor discussed the aforementioned grievance with the facility's Social Worker. The Social Worker reported that no additional information related to this grievance was available. On 3/11/25 at 3:48 p.m., the Regional Director of Clinical Services confirmed that no evidence was found to indicate a response was provided to the individual who lodged the aforementioned complaint. Review of the facility's grievance documentation revealed three (3) additional grievances which had the Investigation/Analysis of Concern and Actions Taken to Correct Concern sections not completed; two (2) of these grievances were dated 1/8/25 and one (1) grievance was dated 1/9/25. These three (3) additional grievances did not include evidence of the facility providing a response to the individuals lodging the grievances. These incomplete grievances were reviewed with the facility's Administrator on 3/14/25 at 3:55 p. m. The following information was found in a facility policy titled Resident and Family Grievances (with a reviewed/revised date of 12/1/22): - The resident has the right to, and the facility must make prompt efforts by the facility [sic] to resolve grievances the residents may have . (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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The resident will be provided a written summary of the resolution (excluding any information protected by HIPAA or labor laws). Every attempt will be made to provide this summary within 48 hours of receiving the grievance. An acknowledgement signed by the resident validating he or she has received a written response will be maintained with the grievance. - Grievances from any non-resident will receive a verbal, and if requested, written response within 5 (five) working days or will be notified if the investigation requires more time. - Investigation documents must include the following (as applicable): . Witness Statements and contact information . Grievance disposition . A Signed Communication of Grievance Resolution validating the resident (and/or responsible party) has received a written response. The survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services on 3/14/25 at 4:12 p.m. During this meeting, the failure of the facility staff to follow their grievance process to address the aforementioned four (4) grievances was discussed.

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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 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on staff interviews and clinical record review, the facility staff failed to ensure a baseline/admission care plan addressed indwelling urinary catheter care for one (1) of 11 sampled residents (Resident #8). The findings include: Resident #8's baseline/admission care plan did not address personal hygiene related to indwelling urinary catheter care. Resident #8's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/24/25, was signed as completed on 2/5/25. Resident #8 was assessed as able to make self understood and as able to understand others. Resident #8's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #8 was admitted to the facility with orders for an indwelling urinary catheter due to a diagnosis of neurogenic bladder. Resident #8's baseline/admission care plan included the presence of an indwelling urinary catheter but did not include interventions for personal hygiene related to indwelling urinary catheter care. The following information was found in a facility policy titled Baseline Care Plan (with a reviewed/revised date of 12/1/22): - The facility will develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. - The baseline care plan will: . Include the minimum healthcare information necessary to properly care for a resident . On 3/14/25 at 9:15 a.m., the Director of Nursing (DON) reported Resident #8's baseline/admission care plan discussed personal hygiene but did not specifically address personal hygiene related to urinary catheter care. On 3/13/25 at 3:33 p.m., the Regional Director of Clinical Services (RDCS) reported the facility did not have a policy to address indwelling urinary catheter care. The RDCS reported they use a professional reference to guide indwelling urinary catheter care. The following information was found in a professional referenced provided to the survey team by the facility administrative staff: Clean around the area where the catheter enters urethral meatus (meatal-catheter junction) with soap and water during the daily bath to remove debris (Lippincott Manual of Nursing Practice, 11th edition, 2019). The survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services on 3/14/25 at 4:12 p.m. During this meeting, the failure of the facility staff to ensure Resident #8's baseline/admission care plan addressed urinary catheter care was discussed.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interviews and clinical record review, the facility staff failed to ensure a comprehensive care plan addressed indwelling urinary catheter care for one (1) of 11 sampled residents (Resident #8). The findings include: Resident #8's comprehensive care plan did not address personal hygiene related to indwelling urinary catheter care. Resident #8's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/24/25, was signed as completed on 2/5/25. Resident #8 was assessed as able to make self understood and as able to understand others. Resident #8's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #8 was admitted to the facility with orders for an indwelling urinary catheter due to a diagnosis of neurogenic bladder. Resident #8's admission MDS assessment had the resident documented as having an indwelling urinary catheter. Resident #8's comprehensive care plan included the presence of an indwelling urinary catheter but did not include interventions for personal hygiene related to indwelling urinary catheter care. The following information was found in a facility policy titled Comprehensive Care Plan (with a reviewed/revised date of 12/1/22): - It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. - The comprehensive care plan will describe, at a minimum, the following: . The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. On 3/14/25 at 9:15 a.m., the Director of Nursing (DON) confirmed that Resident #8's comprehensive care plan identified an indwelling urinary catheter but did not address personal hygiene related to urinary catheter care. The DON stated expectations for indwelling urinary catheter care was at least daily but reported the facility's order was for catheter care every shift. (The facility divides the workday into two (2) shifts.) On 3/13/25 at 3:33 p.m., the Regional Director of Clinical Services (RDCS) reported the facility did not have a policy to address indwelling urinary catheter care. The RDCS reported they use a professional reference to guide indwelling urinary catheter care. (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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following information was found in a professional referenced provided to the survey team by the facility administrative staff: Clean around the area where the catheter enters urethral meatus (meatal-catheter junction) with soap and water during the daily bath to remove debris (Lippincott Manual of Nursing Practice, 11th edition, 2019). The survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services on 3/14/25 at 4:12 p.m. During this meeting, the failure of the facility staff to ensure Resident #8's comprehensive care plan addressed urinary catheter care was discussed.

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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 interviews, clinical record review, and facility document review, the facility staff failed to provide treatment and/or care to address the needs of one (1) of 11 sampled residents (Resident #6). The findings include: The facility staff failed to: (a) follow-up on Resident #6's 9/3/24 emergency department visit and (b) consistently document Resident #6's urine output as ordered by the medical provider. Resident #6's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/27/24, was signed as completed on 9/2/24. Resident #6 was assessed as able to make self understood and as able to understand others. Resident #6's Brief Interview for Mental Status (BIMS) summary score was documented as a 10 out of 15; this indicated moderate cognitive impairment. On the afternoon of 3/11/25, the surveyor was unable to find information in Resident #6's clinical record to detail the outcome of the resident's 9/3/24 emergency department visit. On 3/11/25 at 2:15 p.m., the Director of Nursing (DON) reported she was only able to find the EKG from Resident #6's 9/3/24 emergency department visit. The facility staff obtained Resident #6's 9/3/24 emergency department visit documentation on 3/11/25 at 1:10 p.m. This documentation indicated the resident was seen for fatigue and included instructions for the resident to see a nurse practitioner by 9/6/24 to follow-up on the resident's urine cultures. On 3/12/25 at 2:35 p.m., the DON reported there was no documentation to indicate the time Resident #6 returned to the facility after a 9/3/24 emergency department visit. (Resident #6 was sent to the emergency department from a post-op visit at a local surgical provider's office.) The DON reported a nursing note should have indicated when the resident returned to the facility. The DON reported facility staff should have attempted to obtain information from the local emergency department related to Resident #6's emergency department visit. The DON reported there was no evidence of the facility staff following up on Resident #6's urine cultures as directed in the emergency department discharge information. Resident #6's clinical record included orders for an indwelling urinary catheter with documentation of urine output every shift. Review of Resident #6's urine output documentation showed the facility staff failed to document the resident's urine output for at least nine (9) shifts between the dates of 8/28/24 through 9/13/24. (The following day shifts did not have the resident's urine output documented: 8/30/24, 8/31/24, 9/5/24, 9/7/24, 9/9/24, 9/10/24, and 9/11/24. The following night shifts did not have the resident's urine output documented: 9/1/24 and 9/7/24.) On 3/12/25 at 9:00 a.m., the surveyor reviewed the absence of documentation of urine output for multiple shifts with the facility's Administrator, Director of Nursing (DON), and Assistant Director of Nursing (ADON). The survey team met with the facility's Administrator, DON, ADON, and Regional Director of Clinical Services on 3/14/25 at 4:12 p.m. During this meeting, the following was discussed: (a) the failure of the facility staff to follow-up on Resident #6's emergency department visit and (b) the failure of facility staff to monitor Resident #6's urinary output as ordered by the medical provider.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interviews, clinical record review, and facility document review, the facility staff failed to consistently provide treatment and/or services to address pressure areas for one (1) of 11 sampled residents (Resident #6). The findings include: The facility staff failed to assess and/or provide treatment for Resident #6's sacral wound which was identified as part of a skin assessment dated [DATE] at 9:07 p.m. The facility staff failed to consistently provide treatment to Resident #6's left heel deep tissue injury. Resident #6's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/27/24, was signed as completed on 9/2/24. Resident #6 was assessed as able to make self understood and as able to understand others. Resident #6's Brief Interview for Mental Status (BIMS) summary score was documented as a 10 out of 15; this indicated moderate cognitive impairment. Resident #6's clinical record included skin assessments dated 8/20/24 at 9:07 p.m. and 8/24/24 at 3:41 a.m. Both skin assessments stated Sacrum- wound covered (with) dressing. These skin assessments did not detail the condition of the skin and/or describe the appearance of the wound. The following information was found in a facility policy titled Skin Assessment (with a reviewed/revised date of 12/1/22): - It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management. This policy includes the following procedural guidelines in performing the full body skin assessment. - A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. - Procedure: . Remove any dressings, using clean technique, and note findings. - Documentation of skin assessment: Weekly Skin Review in (electronic medical record name omitted) a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain) (Pressure and Non-pressure Wound Log). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate. The following information was found in a facility policy titled Pressure Injury Prevention and Management (with a reviewed/revised date of 12/1/22): Licensed nurses will conduct a full body skin assessment on all residents upon admission/re-admission, weekly, and after any newly identified pressure injury. Findings will be documented in the medical record. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 3/14/25 at 10:33 a.m., the surveyor reviewed Resident #6's skin assessments and wound orders with the facility's Infection Preventionist (IP) and Regional Director of Clinical Services (RDCS). The facility's Infection Preventionist (IP) confirmed there was not a description of Resident #6's sacral wound documented as a part of the aforementioned 8/20/24 and 8/24/24 skin assessments. The IP reported there was no evidence to indicate the sacral dressing was removed and the skin under the dressing assessed. The RDCS reported that facility staff should have removed the dressing to assess the wound and obtain orders if the skin was open. Resident #6's clinical documentation indicated the resident had a sacrum wound and a coccyx wound; the IP and the RDCS reported they believed the sacrum wound and the coccyx wound was the same wound based on the clinical documentation. Resident #6's clinical record failed to include orders for care of a sacral skin area at the time of the resident's admission on [DATE]. Resident #6's clinical record included nursing documentation, dated 9/6/24 at 2:10 a.m., which indicated the resident experienced a change in condition. The resident was assessed as having an open skin area identified as a Skin wound or ulcer described as a white, open area to the coccyx. Resident #6 had an order to Apply Zinc to Coccyx (every) shift and (as needed) every day and night shift for Coccyx dated 9/6/24 at 11:44 a.m. The next documentation of the sacral wound was on a medical provider note dated 9/11/24. On 9/11/24, Resident #6's sacral wound was described as a Stage II wound measuring 4.0 cm x 1.5 cm with a clean, moist wound bed. The facility staff failed to promptly obtain orders to address Resident #6's left heel deep tissue injury that was present on admission. On 3/12/25 at 2:40 p.m., the Director of Nursing (DON) provided a copy of a spreadsheet that contained the skin assessment information of three (3) different residents. This spreadsheet was dated 8/21/24. This spreadsheet included assessment information for Resident #6's left heel DTI (deep tissue injury). This spreadsheet included the following treatment information for the left heel DTI: Apply betadine and cover with abd pad, secure with rolled gauze and tape. This order was entered into Resident #6's clinical record on 8/22/24 at 1:59 p.m. by a member of the facility's nursing staff for the order to be started on 8/23/24 at 7:00 a.m. Review of Resident #6's August 2024 Treatment Administration Record (TAR) indicated the facility staff failed to provide evidence that Resident #6 received care to the left heel area on 8/29/24. Review of Resident #6's September 2024 Treatment Administration Record (TAR) indicated the facility staff failed to provide evidence that Resident #6 received care to the left heel area and to the coccyx wound on 9/7/24. The survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services on 3/14/25 at 4:12 p.m. During this meeting, the failure of the facility staff to promptly and/or consistently provide treatment to Resident #6's pressure areas was discussed.

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. Based on staff interviews, clinical record review, and facility document review, the facility staff failed to consistently provide treatment and/or services to address a surgical foot wound for one (1) of 11 sampled residents (Resident #6). The findings include: The facility staff failed to ensure Resident #6's left foot surgical wound care included orders and/or documentation to address the use of a wound vac dressing. (Wound Vacuum-Assisted Closure (VAC) is a wound treatment that uses pressure to remove fluid and/or bacteria.) Resident #6's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/27/24, was signed as completed on 9/2/24. Resident #6 was assessed as able to make self understood and as able to understand others. Resident #6's Brief Interview for Mental Status (BIMS) summary score was documented as a 10 out of 15; this indicated moderate cognitive impairment. Resident #6's admission CHECKLIST form, dated 8/20/24, indicated the resident had a wound with a wound vac. Resident #6's nursing documentation indicated the resident had a wound vac in use on 8/20/24 at 10:08 p.m. Resident #6's nursing note, dated 8/21/24 at 3:16 p.m., included the following statement: Wound vac applied by wound care to residents [sic] foot. Resident #6's nursing note, dated 8/22/24 at 1:33 a.m., included the following statement: Resident continues to have wound vac on left foot. The following statement was found in discharge paperwork (printed on 8/20/24 at 12:46 p.m.) provided to the facility by the local hospital: Plan: OK to discharge from surgical standpoint. Continue wound vac per orders. WOUND VAC IS TO BE ON AT ALL TIMES UNLESS DURING PACKING/DRESSING CHANGES. IF VAC IS TO BE OFF MORE THAN 2 HOURS, DRESSING IS TO BE REMOVED AND WET TO DRY DRESSING IS TO BE ADMINISTERED UNTIL VAC IS ABLE TO BE REAPPLIED. VAC DRESSING CHANGES EVERY 48-72 HOURS PER ORDERS. Follow up with (medical provider name omitted) in surgical office in 2 weeks. Resident #6's clinical record failed to include medical provider orders addressing the aforementioned use of a wound vac at the facility. No orders were found by or provided to the surveyor to address the removal of the wound vac that was documented as being used between the dates of 8/20/24 - 8/22/24. No provider documentation was found by or provided to the surveyor to evidence the facility's medical provider consulting with the surgeon related to Resident #6's wound vac decisions. On 3/12/25 at 9:00 a.m., the Director of Nursing (DON) confirmed no medical provider information was found to address Resident #6's wound vac. The following information was found in a facility policy titled Wound Treatment Management (with a reviewed/revised date of 12/1/22): - To promote wound healing of various types of wounds, it is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and physician orders. - Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- In the absence of treatment orders, the licensed nurse will notify physician [sic] to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. - Treatments will be documented on the Treatment Administration Record. Resident #6's clinical record included a medical provider order for clean with wound cleaner, pat dry, apply calcium alginate, cover with abd pad and secure with rolled gauze to be started on 8/22/24. Clinical documentation failed to indicate this wound care was provided on 8/22/24. Resident #6's clinical record included a medical provider order for Clean surgical wound to left foot with (normal saline), apply skin prep to periwound, apply collagen to wound bed, cover with ABD pads and secure with kerlix . This order was documented as being ordered to be started on 8/29/24. Clinical documentation failed to indicate this wound care was provided on 8/29/24. Review of Resident #6's September 2024 Treatment Administration Record (TAR) failed to provide evidence that Resident #6 received wound care to the left foot surgical wound on 9/7/24. The survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services on 3/14/25 at 4:12 p.m. During this meeting, the failure of the facility staff to address Resident #6's wound vac for the resident's left foot surgical wound was discussed.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. Based on staff interviews, facility document review, and clinical record review, the facility staff failed to provide indwelling urinary catheter care for one (1) of 11 sampled residents (Resident #8). The findings include: Resident #8's clinical documentation indicated a delay in the facility providing personal hygiene care for an indwelling urinary catheter. Resident #8's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/24/25, was signed as completed on 2/5/25. Resident #8 was assessed as able to make self understood and as able to understand others. Resident #8's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact or borderline cognition. Resident #8 was admitted to the facility with orders for an indwelling urinary catheter due to a diagnosis of neurogenic bladder. Resident #8's admission MDS assessment had the resident documented as having an indwelling urinary catheter. Resident #8's care plan included the presence of an indwelling urinary catheter but did not include interventions for personal hygiene related to indwelling urinary catheter care. On 3/14/25 at 9:15 a.m., the Director of Nursing (DON) confirmed that Resident #8's care plan identified an indwelling urinary catheter but did not address personal hygiene related to urinary catheter care. The DON stated expectations for indwelling urinary catheter care was at least daily but reported the facility's order was for catheter care every shift. (The facility divides the workday into two (2) shifts.) On 3/13/25 at 3:33 p.m., the Regional Director of Clinical Services (RDCS) reported the facility did not have a policy to address indwelling urinary catheter care. The RDCS reported they use a professional reference to guide indwelling urinary catheter care. The following information was found in a professional referenced provided to the survey team by the facility's administrative staff: Clean around the area where the catheter enters urethral meatus (meatal-catheter junction) with soap and water during the daily bath to remove debris (Lippincott Manual of Nursing Practice, 11th edition, 2019). Resident #8's first order for an indwelling urinary catheter was dated 10/18/24. Resident #8's clinical record did not include an order for Foley care (every) shift every day and night shift until 1/16/25. Review of Resident #8's Treatment Administration Records (TARs) indicated indwelling urinary catheter care started on 1/16/25. The survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services on 3/14/25 at 4:12 p.m. During this meeting, the failure of the facility staff to ensure indwelling urinary catheter care was being provided to Resident #8 from the time of admission was discussed.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interviews, clinical record review, and facility document review, the facility staff failed to ensure medical provider orders were signed by the ordering provider when the orders were entered into residents' clinical records by non-prescribing facility staff members for two (2) of 11 sampled residents (Resident #4 and Resident #6). The findings include: 1. Review of Resident #6's clinical record revealed multiple orders that had not been signed by the prescribing medical provider. Resident #6's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/27/24, was signed as completed on 9/2/24. Resident #6 was assessed as able to make self understood and as able to understand others. Resident #6's Brief Interview for Mental Status (BIMS) summary score was documented as a 10 out of 15; this indicated moderate cognitive impairment. The following orders were not signed by the ordering medical provider: - Resident #6's laboratory order for multiple blood tests dated 8/20/24. - Resident #6's medication order for Ferrous Sulfate Tablet 325 mg dated 8/21/24. - Resident #6's medication order for Eliquis 5mg dated 8/21/24. - Resident #6's order for Zinc to be applied to the coccyx dated 9/6/24. - Resident #6's wound care order dated 8/22/24 at 1:57 p.m. - Resident #6's left heel Deep Tissue Injury (DTI) care order dated 8/22/24 at 1:59 p.m. - Resident #6's wound care order dated 8/23/24 at 11:42 a.m. On 3/12/25 at 2:35 p.m., the Director of Nursing (DON) confirmed that some of Resident #6's wound orders had not been signed by the ordering medical provider. The following information was found in a facility document titled Verbal Orders (with a reviewed/revised date of 12/1/22): - Verbal Orders are those given to the nurse by the physician in person or by telephone, however, are not written by the physician in the medical record. - The physician should sign the order on his/her next visit to the facility or within the time frame required by the facility. On 3/12/25 at 3:08 p.m., the Director of Nursing (DON) reported that verbal orders should be signed by the medical provider at the next visit. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services on 3/14/25 at 4:12 p.m. During this meeting, the failure of the facility staff to ensure verbal orders were signed by the ordering medical provider was discussed. 2. For Resident #4, facility staff failed to ensure multiple orders for Invega (a medication that can treat schizophrenia and schizoaffective disorder) were signed by the prescribing provider. On 03/14/25, Resident #4's clinical record was reviewed. The following orders for Invega were not signed by the prescribing provider, a nurse practitioner (NP): 1. On 11/03/22, Invega Sustenna Suspension Prefilled Syringe 234 MG/1.5ML. Inject 1.5 ml intramuscularly one time only related to SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE . The start and end date were 11/07/22. 2. On 11/03/22, Invega Sustenna Suspension Prefilled Syringe 234 MG/1.5ML. Inject 1.5 ml intramuscularly one time a day every 30 day(s) related to SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE . The start date: 12/07/22 with no end date. 3. On 11/03/22, Invega Sustenna Suspension Prefilled Syringe 156 MG/ML. Inject 1 ml intramuscularly one time only related to SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE. The start and end date were: 11/15/22. 4. On 11/23/22, Invega Sustenna Suspension Prefilled Syringe 156 MG/ML. Inject 156 mg intramuscularly one time a day every 30 day(s) for schizoaffective disorder. The start date: 11/24/22 with no end date. During an interview with the regional director of clinical services (RDCS) and director of nursing (DON) on 03/14/25 at 10:10 a.m., the RDCS acknowledged Resident #4's four (4) Invega orders were not signed by the NP who wrote the order. The DON provided printed copies of each of the Invega orders and pointed out where the provider signature should have been and acknowledged none of the four (4) orders were signed. The NP who wrote the order and the medical director at the time were no longer employed at the facility therefore neither were interviewed. During a summary meeting with the administrator, RDCS, DON, and assistant director of nursing on 03/14/25 at 4:12 p.m., the concern regarding Resident #4's unsigned medication orders was discussed. No further information was provided prior to the exit conference.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. Based on staff interviews, clinical record review, and facility document review, the facility staff failed to ensure a correct diagnosis prior to the use of an antipsychotic medication and failed to monitor for behaviors for one (1) of 11 sampled residents (Resident #4). The findings were: For Resident #4, facility staff failed to ensure a new diagnosis of schizoaffective disorder was appropriate prior to a new medication order for Invega (an atypical antipsychotic medication that can treat schizoaffective disorder) and failed to implement behavior monitoring for Resident #4. Resident #4's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/25/22 was signed as completed on 11/07/22. The resident's Brief Interview for Mental Status (BIMS) summary score was documented as a 09 out of 15 which indicated moderately impaired cognition. Section I (Active Diagnoses) coded the resident's primary medical condition category a 13. Medically Complex Conditions. The active diagnoses in the last 7 days included but were not limited to Anemia, Hyperlipidemia, Non-Alzheimer's Dementia, Anxiety Disorder, Depression, Psychotic Disorder (other than schizophrenia), and Asthma, Chronic Obstructive Pulmonary Disease or Chronic Lung Disease. The diagnosis of Schizophrenia (e.g. schizoaffective and schizophreniform disorders) was not marked. The resident's care plan included but was not limited to a focus area which read the resident had a potential for side effects related to use of psychotropic medication for schizoaffective disorder, anxiety, mood disorder and depression. In an interview with an MDS coordinator, a licensed practical nurse (Employee #8) on 3/14/25 at 10:40 a.m., the MDS coordinator reported schizoaffective disorder was added to Resident #4's care plan during a care plan revision on 11/03/22. Resident #4's clinical record contained a list of diagnoses that included (but was not limited to) schizoaffective disorder, depressive type with an onset date of 11/02/22, over three (3) months following Resident #4's admission to the facility. The nurse practitioner (NP) hand-written Medical Evaluation Form/Progress Note listed Schizoaffective D/O as a diagnosis for the first time on 11/02/22. That progress note showed hand-marked checks and X's next to items in the physical exam. For the psych area, there were X's beside psych, attention and affect with a check beside agitation/aggression. The legend for the physical exam indicated a check equaled normal, and X equaled abnormal with a blank box equaled not assessed. The clinical record failed to contain evidence of a psychologist, or a psychiatrist evaluation related to the diagnosis of schizoaffective disorder. The NP wrote orders for Invega as follows: 1. On 11/03/22, Invega Sustenna Suspension Prefilled Syringe 234 MG/1.5ML. Inject 1.5 ml intramuscularly one time only related to SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE . The start and end date were 11/07/22. 2. On 11/03/22, Invega Sustenna Suspension Prefilled Syringe 234 MG/1.5ML. Inject 1.5 ml (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	intramuscularly one time a day every 30 day(s) related to SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE . The start date: 12/07/22 with no end date. 3. On 11/03/22, Invega Sustenna Suspension Prefilled Syringe 156 MG/ML. Inject 1 ml intramuscularly one time only related to SCHIZOAFFECTIVE DISORDER, DEPRESSIVE TYPE. The start and end date were: 11/15/22. 4. On 11/23/22, Invega Sustenna Suspension Prefilled Syringe 156 MG/ML. Inject 156 mg intramuscularly one time a day every 30 day(s) for schizoaffective disorder. The start date: 11/24/22 with no end date. A review of Resident #4's Medication Administration Record for November 2022 noted Invega Sustenna 234 mg/1.5 ml was administered on 11/07/22. Resident #4 received Invega Sustenna 156 mg/ml on 11/24/22. Resident #4 was admitted to an acute care hospital for sepsis on 11/15/22 and therefore did not receive that scheduled dose. Resident #4's Order Summary Report included an order that read, PLEASE DOCUMENT APPROPRIATE NUMBER THAT BEST MATCHES BEHAVIOR OBSERVED 1= No Behaviors noted 2= Kicking/Hitting 3= Grabbing/Pushing 4= Sexually Inappropriate 5=Yelling/Screaming/Cursing 6= Refusing Care (ADL, Meds etc) 7= Wandering/Pacing 8= Exit Seeking 9= OTHER (** Document in Notes **) every shift if you Code **OTHER** please make an entry in Progress notes to describe. The order date and start date was 11/23/22 with no end date documented. The MARs for November and December 2022 failed to contain evidence facility staff documented Resident #4's behaviors. When the surveyor requested a policy regarding anti-psychotic medication orders, the regional director of clinical services (RDCS) provided a policy titled, Medication Orders with an implementation order dated 11/01/2020 with a reviewed/revised date of 12/01/2022 which read in part, . 3. Elements of the Medication Order: .i. Diagnosis or indication for use . The RDCS reported there was no policy found which addressed antipsychotic medication orders specifically. During an interview with the RDCS and director of nursing (DON) on 03/14/25 at 10:20 a.m., the RDCS acknowledged there were no documented behaviors as ordered for Resident #4 and no evidence of a psychological evaluation, note, or referral. On 03/12/25 at 4:20 p.m., when asked about the NP's documentation on the hand-written progress note dated 11/02/22, specifically the checks versus the Xs for the physical exam under psych compared to the legend, the RDCS stated we don't know for sure what [NP's name omitted] meant with checks and Xs on the written progress notes. The NP who wrote the orders and the medical director at the time were no longer employed at the facility therefore neither were interviewed. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a summary meeting with the administrator, RDCS, DON, and assistant director of nursing on 03/14/25 at 4:12 p.m., the concerns regarding Resident #4's new schizoaffective disorder diagnosis with Invega medication ordered and administered, and behaviors not documented were discussed. No further information was provided prior to the exit conference.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on staff interviews, facility document review, and clinical record review, the facility staff failed to ensure antibiotics were administered as order by the medical provider for one (1) of 11 sampled residents (Resident #6). The findings include: The facility staff failed to ensure that Resident #6's intravenous (IV) Ertapenem was administered as ordered by the medical provider. Resident #6's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/27/24, was signed as completed on 9/2/24. Resident #6 was assessed as able to make self understood and as able to understand others. Resident #6's Brief Interview for Mental Status (BIMS) summary score was documented as a 10 out of 15; this indicated moderate cognitive impairment. Resident #6's medical record included the following antibiotic orders: - Ertapenem 1 gram intravenously (IV) for the morning of 8/21/24. - Ertapenem 1 gram intravenously (IV) in the morning for six (6) weeks to start on 8/22/24. - Cubicin 700 mg intravenously (IV) at bedtime for six (6) weeks to start on 8/21/24. The following information was found in a facility policy titled Medication Administration (with a reviewed/revised date of 12/1/22): Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. Resident #6's clinical record failed to indicate the 8/21/24 dose of Ertapenem had been administered as ordered by the provider. On 3/13/25 at 10:22 a.m., the surveyor met with the facility's Director of Nursing (DON) and Assistant Director of Nursing (ADON); the surveyor discussed the absence of documentation indicating this medication had been administered. The following information was documented in a nursing note dated 8/22/24 at 2:57 p.m.: (PICC) line dressing intact without signs of infection however only flushes with firm but gentle pressure and scheduled antibiotics do not run through line, pending replacement at this time. Alternate order for IM (intramuscular) Ertapenem administered per (Nurse Practitioner) . No documentation was found to address the IV Cubicin order. (A PICC (peripherally inserted central catheter) is a thin tube inserted through a vein then advanced into larger veins near the heart. A PICC line allows for intravenous administration of fluids and/or medications.) A nursing note dated 8/22/24 at 2:18 p.m., indicated the nurse practitioner ordered the PICC line to be replaced. A nursing note dated 8/22/24 at 8:51 p.m., indicated the previous PICC line had been removed and a new PICC line had been inserted with an x-ray scheduled to verify correct placement. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility staff documented the evening dose of IV Cubicin was held awaiting confirmation of correct PICC line placement. A nursing note documented 8/23/24 at 1:02 a.m. included the following statement: IV tech informed this nurse that chest x-ray to confirm placement must be completed before use. A nursing note dated 8/23/24 at 3:11 p.m. included the following statement: Xray resulted . states The [sic] needs to be pulled back about 3 cm. (Nurse practitioner name omitted) aware. (Vascular access provider name omitted) contacted and order placed for someone to come to this facility to adjust the picc line . Antibiotic currently on hold until picc line is adjusted. Documentation indicated the vascular access provider repositioned the PICC line on 8/23/24 at 5:40 p.m. A nursing note dated 8/23/24 at 10:12 p.m. indicated the chest x-ray confirmed placement of the PICC line and that (antibiotics) resumed as per protocol. The evening dose of IV Cubicin was documented as being administered on 8/23/24. Resident #6's medication administration records (MARS) indicated the IV Ertapenem was held on 8/22/24, 8/23/24, and 8/24/24. Nursing documentation indicated the medical provider provided orders for IM Ertapenem on 8/22/24. The 8/24/24 morning dose of IV Ertapenem was documented as being held although the PICC line had been documented as being okay to use with an IV antibiotic being documented as administered on the evening of 8/23/24. The survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services on 3/14/25 at 4:12 p.m. During this meeting, the failure of the facility staff to appropriately administer Resident #6's antibiotic medications was discussed.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on staff interviews, facility document review, and clinical record review, the facility staff failed to obtain laboratory tests as ordered by the medical provider for two (2) of 11 sampled residents (Resident #2 and Resident #7). The findings include: 1. The facility staff failed to obtain Resident #7's urinalysis laboratory test as ordered by a medical provider on 2/10/25. Resident #7's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 12/20/24, was signed as completed on 12/26/24. Resident #7 was assessed as able to make self understood and as able to understand others. Resident #7's Brief Interview for Mental Status (BIMS) summary score was documented as a 12 out of 15; this indicated moderate cognitive impairment. Review of Resident #7's clinical records failed to reveal results for a urinalysis (a laboratory test) ordered for 2/10/25. On 3/13/25 at 1:45 p.m., the surveyor asked the Director of Nursing (DON) and Assistant Director of Nursing (ADON) about the missing urinalysis results. The following information was found as part of a facility policy titled Laboratory Services and Reporting (with a reviewed/revised date of 12/1/22): - The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. - The facility must provide or obtain laboratory services to meet the needs of its residents. - The facility is responsible for the timeliness of the services. A document from the laboratory, dated as being reported on 2/15/25, indicated the 2/10/25 urinalysis was not completed due to a specimen issue. The issue with the specimen was documented as either (a) the age of this specimen or (b) required specimen for the test ordered was not received. Resident #7's medical provider signed this laboratory report on 2/18/25. On 3/14/25 at 10:27 a.m., the ADON confirmed that no results were found for the aforementioned urinalysis laboratory test; the ADON reported the medical provider signed the laboratory report and chose not to reorder the test. The survey team met with the facility's Administrator, DON, ADON, and Regional Director of Clinical services on 3/14/25 at 4:12 p.m. During this meeting, the failure of the facility staff to obtain Resident #7's 2/10/25 urinalysis laboratory test was discussed. 2. For Resident #2 the facility staff failed to obtain laboratory tests per the physician's order. Resident #2's face sheet listed diagnoses which included but not limited to schizoaffective disorder and type 2 diabetes mellitus. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #2's most recent minimum data set with an assessment reference date of 05/31/24 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. Resident #2's clinical record was reviewed and contained a physician's order summary which read in part, CBC (complete blood count), CMP (comprehensive metabolic panel), TSH (thyroid stimulating hormone), A1C (hemoglobin A1C), FLP (full lipid panel) on admission or next lab day every night shift for Z79.899 (long term drug therapy). Make lab sheet please. This order was written on 05/24/24 with a start date of 05/26/24. The order was discontinued on 06/12/24. Resident #2's electronic medication administration record (MAR) for the months of May 2024 and June 2024 were reviewed and contained an entry as above. The MAR for May indicated that the lab tests were obtained on 05/27/24, 05/29/24, 05/30/24, and 05/31/24. The MAR for June indicated that the lab tests were obtained on 06/01/24, 06/02/24, 06/04/24, 06/05/24, 06/06/24, 06/07/24, and 06/08/24. Resident #2's clinical record contained laboratory reports for the laboratory tests dated 05/30/24, 05/31/24, 06/05/24, 06/06/24, and 06/10/24. Surveyor spoke with the regional director of clinical services on 03/11/25 at 5:15 pm regarding Resident #2's lab tests. Regional director of clinical services stated that the lab orders should be entered for 3 days upon admission, and once obtained one time should be discontinued. Surveyor asked if the lab tests for Resident #2 should have been obtained multiple times and regional director of clinical services stated they should not. Surveyor requested and was provided with a facility policy entitled, Laboratory Services and Reporting which read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. The concern of not following the physician's order for lab tests was discussed with the administrator, director of nursing, and regional director of clinical services on 03/14/25 at 12:25 pm. No further information provided prior to exit.

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on staff interview, clinical record review and facility document review the facility staff failed to obtain a physician's order prior to obtaining a laboratory test for 1 of 11 residents, Resident #2. The findings included: For Resident #2 the facility staff failed to obtain a physician's order for a urinalysis. Resident #2's face sheet listed diagnoses which included but not limited to schizoaffective disorder and type 2 diabetes mellitus. Resident #2's most recent minimum data set with an assessment reference date of 93/31/24 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. Resident #2's clinical record was reviewed and contained a laboratory report dated 05/31/24 which read in part, Clinical Laboratory Results: Urinalysis: Urinalysis with Microscopic (Reflex Culture if indicated) . Comments: CULTURE TO FOLLOW. Surveyor reviewed Resident #2's physician's orders and could not locate an order to obtain a urinalysis. Surveyor spoke with the regional director of clinical services on 03/13/25 regarding Resident #2's urinalysis. Regional director of clinical stated that the expectation would be that a there would be a physician's order prior to obtaining a urinalysis. Surveyor requested and was provided with a facility policy entitled, Laboratory Services and Reporting which read in part, The facility must provide or obtain laboratory services when ordered by a physician, physician assistant, nurse practitioner, or clinical nurse specialist in accordance with state law. The concern obtaining a urinalysis without an order was discussed with administrator, director of nursing, and regional director of clinical services on 03/14/25 at 12:25 pm. No further information provided prior to exit.

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	03/14/2025

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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interviews, facility document review, and clinical record review, the facility staff failed to maintain complete and/or accurate clinical records for one (1) of 11 sampled residents (Resident #6). The findings include: Resident #6's clinical record failed to include: (a) wound assessment details/documentation and (b) complete wound orders. Resident #6's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/27/24, was signed as completed on 9/2/24. Resident #6 was assessed as able to make self understood and as able to understand others. Resident #6's Brief Interview for Mental Status (BIMS) summary score was documented as a 10 out of 15; this indicated moderate cognitive impairment. Review of Resident #6's clinical documentation failed to provide evidence of an assessment of the resident's wounds which included wound measurements and a description of the wounds on admission. On 3/12/25 at 2:40 p.m., the Director of Nursing (DON) provided a copy of a spreadsheet that contained the wound assessments of three (3) different residents. This spreadsheet was dated 8/21/24. This spreadsheet included assessment information for Resident #6's left foot surgical wound and left heel DTI (deep tissue injury). The DON confirmed this documentation was not part of Resident #6's clinical record. The DON reported this spreadsheet was found in the MDS (minimum data set) staff's documents. Resident #6's clinical record contained two (2) orders for wound care which did not identify which wound the order was intended to address. An ordered dated 8/22/24 at 1:57 p.m. stating clean with wound cleaner, pat dry, apply calcium alginate, cover with abd pad and secure with rolled gauze every day shift AND as needed did not identify which wound was to be treated by this order. An ordered dated 8/23/24 at 11:42 a.m. stating clean with wound cleaner, pat dry, cover with abd pad and secure with rolled gauze every day shift AND as needed did not identify which wound was to be treated by this order. The following information was found in a facility policy titled Documentation in Medical Record (with a reviewed/revised date of 12/1/22): - Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. - Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. - Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care. (continued on next page)

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	03/14/2025

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The survey team met with the facility's Administrator, DON, Assistant DON, and Regional Director of Clinical Services on 3/14/25 at 4:12 p.m. During this meeting, the failure of the facility staff to ensure Resident #6's wound orders addressed the specific wound for which the order was being given was discussed.