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

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Deer Meadows Rehabilitation and Nursing | 600 Walden Road<br>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 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>21227<br><br>Based on staff interviews, clinical record review, and facility document review, the facility staff failed to ensure that residents and/or resident representatives had the opportunity to develop an advanced directive for two (2) of 27 sampled residents (Resident #36 and Resident #46).<br><br>The findings include:<br><br>1. The facility staff failed to ensure Resident #36 and/or the resident's representative had the opportunity to develop an advanced directive.<br><br>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.<br><br>Review of Resident #36's clinical documentation failed to provide evidence of the facility staff addressing whether the resident and/or the resident's representative desired to formulate an advanced directive. On 8/5/24 at 12:56 p.m., the facility's Director of Social Services reported no documented evidence could be found to indicate information related to the development of an advanced directive was provided to the resident and/or the resident's responsible party.<br><br>The following information was found in a facility policy titled Advanced Directive (with a reviewed/revised date of 10/1/21):<br><br>- It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive.<br><br>- On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive.<br><br>- The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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|---|---|
| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | 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 absence of documentation to provide evidence that information related to advanced directives were provided to Resident #36 and/or the resident's representative.<br><br>2. The facility staff failed to ensure Resident #46 and/or the resident's representative had the opportunity to develop an advanced directive.<br><br>Resident #46's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/16/24, was signed as completed on 5/29/24. Resident #46 was assessed as able to make self understood and as able to understand others. Resident #46's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition.<br><br>Review of Resident #46's clinical documentation failed to provide evidence of the facility staff addressing whether the resident and/or the resident's representative desired to formulate an advanced directive. On 8/5/24 at 1:00 p.m., the Director of Social Services reported they thought developing an advanced directive was discussed, but not documented, during the admission care planning process. The Director of Social Services stated they would have provided assistance if the resident and/or the resident's responsible party had wished to develop an advanced directive.<br><br>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 absence of documentation to provide evidence that information related to advanced directives were provided to Resident #46 and/or the resident's representative. |

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|---|---|
| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Not transfer or discharge a resident without an adequate reason; and must provide documentation and convey specific information when a resident is transferred or discharged.<br><br>47299<br><br>Based on staff interview, medical record review and facility document review, the facility staff failed to ensure appropriate information is documented and/or communicated to the receiving healthcare institution for 2 of 27 residents in the survey sample, resident # 13 and # 68.<br><br>The findings included:<br><br>1. For Resident #13 the facility staff failed to complete a transfer form or document any information was compiled and sent to the hospital with the resident.<br><br>Resident # 13's minimum data set (MDS) assessment with an assessment reference date of 6/6/24 assigned the resident a brief interview for mental status (BIMS) score of 3 indicating severe cognitive impairment. Resident was not interviewable.<br><br>The electronic medical record was reviewed and a progress note dated 6/6/24 at 11:18 AM read, Mobile images in for Venous/Arterial Doppler, blood clot to left lower extremity noted. Family informed, family raised concern that respiratory issues may be caused from blood clot that has traveled, (name omitted) FNP contacted and received order to send resident out for further evaluation. Resident out via (name omitted) Ambulance at this time. Resident was admitted to the hospital.<br><br>This surveyor was unable to locate documentation in the record to indicate that transfer documentation, such as contact information for the physician, resident representative contact information, advanced directive information, comprehensive care plan goals, or other information necessary to ensure a safe and effective transfer of care was sent to the hospital.<br><br>On 8/2/24 this surveyor met with the Director of Nursing (DON), Assistant Director of Nursing (ADON and Regional Director of Clinical Services (RDCS) to discuss this concern. When asked what paperwork is sent with residents when they have to go to the hospital they stated, I would have to ask, I haven't had to do that. The RDCS stated a transfer form and a facesheet should be sent at least. They were not able to produce a transfer form for this hospitalization . There was no follow up note in the record to explain what documents were sent with resident to the hospital.<br><br>On 8/6/24 at 12:15 PM this concern was reviewed with the Administrator, DON, ADON, RDCS, Regional Director of Operations and Regional Director of Culinary Services.<br><br>No further information was provided to the survey team prior to the exit conference.<br><br>2. For resident # 68, the facility staff failed to provide a transfer form or any documentation of information such as physician/responsible party contact information, advanced directives, care plan goals, or other information necessary to ensure a safe and effective transfer of care was sent to the hospital with resident.<br><br>Resident # 68's MDS with an ARD of 6/25/24 assigned the resident a BIMS score of 12, indicating mild cognitive impairment.<br><br>(continued on next page) |

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| F 0622<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The electronic medical record was reviewed and a progress note dated 6/14/24 at 11:44 PM read, Went to Res. room to check vital signs, Res. noted to be unresponsive to verbal and physical stimuli. Res. noted to be clammy,<br><br>checked blood sugar 194. Res. noted to be clammy. During checking pupils noted to have bloody white of right eye. VS 97.8-131/77-70-16-92% sat pm RA. Notified on call (name omitted) NP with new order May send to JMH ER for evaluation and treatment. Res. transported by stretcher by (name omitted) Ambulance. Notified by phone Father RP and on call supervisor. Report called to JMH ER nurse.<br><br>There was no transfer form located in the electronic medical record.<br><br>On 8/2/24 this surveyor met with the Director of Nursing (DON), Assistant Director of Nursing (ADON and Regional Director of Clinical Services (RDCS) to discuss this concern. When asked what paperwork is sent with residents when they have to go to the hospital they stated, I would have to ask, I haven't had to do that. The RDCS stated a transfer form and a facesheet should be sent at least. They were not able to produce a transfer form for this hospitalization . There was no follow up note in the record to explain what documents were sent with resident to the hospital.<br><br>On 8/6/24 at 12:15 PM this concern was reviewed with the Administrator, DON, ADON, RDCS, Regional Director of Operations and Regional Director of Culinary Services.<br><br>No further information was provided to the survey team prior to the exit conference. |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.<br><br>21227<br><br>Based on staff interviews, facility document review, and clinical record review, the facility staff failed to ensure that written transfer notices were provided for three (3) of 27 sampled residents and/or residents' representatives (Resident #107, Resident #98, and Resident #56).<br><br>The findings include:<br><br>1. The facility staff failed to provide Resident #107 or the resident's representative written transfer notice for the 6/7/24 transfer.<br><br>Resident #107's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/12/24, was signed as completed on 3/18/24. Resident #107 was assessed as being able to usually make self understood and as being able to usually understand others. Resident #107's Brief Interview for Mental Status (BIMS) summary score was documented as a 11 out of 15; this indicated moderate cognitive impairment.<br><br>Resident #107's clinical documentation indicated the resident was transferred to a local hospital on 6/7/24. No evidence of written notice of this transfer being provided to the resident or the resident's representative was found by or provided to the surveyor.<br><br>The following information was found in a facility policy titled Transfer and Discharge (including AMA) (with a reviewed/revised date of 12/1/22): Provide transfer notice as soon as practicable to resident and representative.<br><br>On 8/6/24 at 9:34 a.m., the facility's Assistant Director of Nursing (ADON) reported no evidence of written notice of transfer being provided was found.<br><br>On 8/6/24 at 12:16 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), ADON, Regional Director of Clinical Services, and Regional Director of Operations. During this meeting, the surveyor discussed the lack of evidence to indicate written transfer notification had been provided to Resident #107 and/or the resident's representative.<br><br>2. The facility staff failed to provide Resident #98 or the resident's representative written transfer notice for the 5/29/24 transfer.<br><br>Resident #98's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 6/28/24, was signed as completed on 7/5/24. Resident #98 was assessed as able to make self understood and as able to understand others. Resident #98's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition.<br><br>Resident #98's clinical documentation indicated the resident was transferred to a local hospital on 5/29/24. No evidence of written notice of this transfer being provided to the resident or the resident's representative was found by or provided to the surveyor.<br><br>(continued on next page) |

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| F 0623<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 8/6/24 at 11:32 a.m., the facility's Assistant Director of Nursing (ADON) reported no evidence of written notice of transfer being provided was found.<br><br>On 8/6/24 at 12:16 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), ADON, Regional Director of Clinical Services, and Regional Director of Operations. During this meeting, the surveyor discussed the absence of evidence of written transfer notification being provided to Resident #98 and/or the resident's representative.<br><br>3. The facility staff failed to provide Resident #56 or the resident's representative written transfer notice for the 2/27/24 transfer.<br><br>Resident #56's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/20/24, was signed as completed on 7/29/24. Resident #56 was assessed as able to make self understood and as able to understand others. Resident #56's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact and/or borderline cognition.<br><br>Resident #56's clinical documentation indicated the resident was transferred to a local hospital on 2/27/24. No evidence of written notice of this transfer being provided to the resident or the resident's representative was found by or provided to the surveyor.<br><br>On 8/6/24 at 11:32 a.m., the facility's Assistant Director of Nursing (ADON) reported no evidence of written notice of transfer being provided was found.<br><br>On 8/6/24 at 12:16 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), ADON, Regional Director of Clinical Services, and Regional Director of Operations. During this meeting, the surveyor discussed the lack of evidence to indicate written transfer notification had been provided to Resident #56 and/or the resident's representative. |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave.<br><br>47299<br><br>Based on resident and staff interview, clinical record review, and facility document review, the facility staff failed to provide evidence of a bed hold policy being given to 5 of 27 residents in the survey sample, residents #13, 68, 36, 98, and 56.<br><br>The findings included:<br><br>For resident # 13 the facility staff failed to provide evidence that the resident or their responsible party was notified of a bed hold policy when the resident was hospitalized in June 2024.<br><br>Resident # 13's minimum data set (MDS) assessment with an assessment reference date of 6/6/24 assigned the resident a brief interview for mental status (BIMS) score of 3 indicating severe cognitive impairment. Resident was not interviewable.<br><br>The electronic medical record was reviewed and a progress note dated 6/6/24 at 11:18 AM read, Mobile images in for Venous/Arterial Doppler, blood clot to left lower extremity noted. Family informed, family raised concern that respiratory issues may be caused from blood clot that has traveled, (name omitted) FNP contacted and received order to send resident out for further evaluation. Resident out via (name omitted) Ambulance at this time. Resident was admitted to the hospital.<br><br>On 8/2/24 this surveyor met with the Director of Nursing (DON), Assistant Director of Nursing (ADON and Regional Director of Clinical Services (RDCS) to discuss this concern. Surveyor asked for evidence of a bed hold notice being provided to the resident or the resident representative.<br><br>Surveyor requested and received a copy of the policy entitled, Bed Hold Notice Upon Transfer with a revised date of 12/1/22. The policy read in part, At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. The last paragraph of the document read, The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file.<br><br>On 8/6/24 at 12:15 PM this concern was reviewed with the Administrator, DON, ADON, RDCS, Regional Director of Operations and Regional Director of Culinary Services.<br><br>No further information was provided to the survey team prior to the exit conference.<br><br>2. For resident # 68, the facility staff failed to provide evidence that bed hold information was given to the resident or their representative for a hospitalization in June 2024.<br><br>Resident # 68's MDS with an ARD of 6/25/24 assigned the resident a BIMS score of 12, indicating mild cognitive impairment.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | The electronic medical record was reviewed and a progress note dated 6/14/24 at 11:44 PM read, Went to Res. room to check vital signs, Res. noted to be unresponsive to verbal and physical stimuli. Res. noted to be clammy,<br><br>checked blood sugar 194. Res. noted to be clammy. During checking pupils noted to have bloody white of right eye. VS 97.8-131/77-70-16-92% sat pm RA. Notified on call (name omitted) NP with new order May send to JMH ER for evaluation and treatment. Res. transported by stretcher by (name omitted) Ambulance. Notified by phone Father RP and on call supervisor. Report called to JMH ER nurse.<br><br>Surveyor requested and received a copy of the policy entitled, Bed Hold Notice Upon Transfer with a revised date of 12/1/22. The policy read in part, At the time of transfer for hospitalization or therapeutic leave, the facility will provide to the resident and/or the resident representative written notice which specifies the duration of the bed-hold policy and addresses information explaining the return of the resident to the next available bed. The last paragraph of the document read, The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file.<br><br>On 8/6/24 at 12:15 PM this concern was reviewed with the Administrator, DON, ADON, RDCS, Regional Director of Operations and Regional Director of Culinary Services.<br><br>No further information was provided to the survey team prior to the exit conference.<br><br>21227<br><br>3. The facility staff failed to provide Resident #56 and/or the resident's representative with the facility's bed-hold policy for the 2/27/24 transfer.<br><br>Resident #56's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/20/24, was signed as completed on 7/29/24. Resident #56 was assessed as able to make self understood and as able to understand others. Resident #56's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact and/or borderline cognition.<br><br>Resident #56's clinical documentation indicated the resident was transferred to a local hospital on 2/27/24. No evidence of the facility's bed-hold policy being provided to the resident and/or the resident's representative was found by or provided to the surveyor.<br><br>The following information was found in a facility policy titled Transfer and Discharge (including AMA) (with a reviewed/revised date of 12/1/22): Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, but no later than 24 hours of the transfer.<br><br>The following information was found in a facility policy titled Bed Hold Notice Upon Transfer (with a reviewed/revised date of 12/1/22): The facility will keep a signed and dated copy of the bed-hold notice information given to the resident and/or resident representative in the resident's file.<br><br>On 8/6/24 at 11:32 a.m., the facility's Assistant Director of Nursing (ADON) reported no evidence of the bed-hold policy being provided was found.<br><br>(continued on next page) |

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| F 0625<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 8/6/24 at 12:16 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Clinical Services, and Regional Director of Operations. During this meeting, the surveyor discussed the absence of evidence of the facility providing its bed-hold policy to Resident #56 and/or the resident's representative.<br><br>4. The facility staff failed to provide Resident #98 and/or the resident's representative with the facility's bed-hold policy for the 5/29/24 transfer.<br><br>Resident #98's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 6/28/24, was signed as completed on 7/5/24. Resident #98 was assessed as able to make self understood and as able to understand others. Resident #98's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition.<br><br>Resident #98's clinical documentation indicated the resident was transferred to a local hospital on 5/29/24. No evidence of the facility's bed-hold policy being provided to the resident and/or the resident's representative was found by or provided to the surveyor.<br><br>On 8/6/24 at 11:32 a.m., the facility's Assistant Director of Nursing (ADON) reported no evidence of the bed-hold policy being provided to Resident #98 and/or the resident representative was found.<br><br>On 8/6/24 at 12:16 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), ADON, Regional Director of Clinical Services, and Regional Director of Operations. During this meeting, the surveyor discussed the absence of evidence of written transfer notification being provided to Resident #98 and/or the resident's representative.<br><br>5. The facility staff failed to provide Resident #36 and/or the resident's representative with the facility's bed-hold policy for the 5/16/24 transfer.<br><br>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.<br><br>Resident #36's clinical documentation indicated the resident was transferred to a local hospital on 5/16/24. No evidence of the facility's bed-hold policy being provided to the resident and/or the resident's representative was found by or provided to the surveyor.<br><br>On 8/1/24 at 4:02 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Clinical Services (RDCS), and Regional Food Services Director. During this meeting, the surveyor discussed the absence of evidence that the facility's bed-hold policy was provided at the time of Resident #36's 5/16/24 hospital transfer. The RDCS acknowledged no evidence of the facility staff providing the bed-hold information was found. |

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| F 0645<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | PASARR screening for Mental disorders or Intellectual Disabilities<br><br>47299<br><br>Based on staff interview, clinical record review and facility document review, the facility staff failed to screen for a mental disorder or intellectual disability for 1 of 27 current residents in the survey sample, resident # 95.<br><br>The findings included:<br><br>Resident # 95's PASRR included a document dated 11/7/23 and entitled, Notice of PASRR Level I Screen Outcome that read in part, Your Level I screen shows you have evidence of a serious mental illness or intellectual disability (IDD). Further PASRR review is not needed because you meet criteria for a short-term convalescence stay. This means you are approved for up to 60 days in a nursing home that takes Medicaid without additional PASRR review. Your level I screen lists any mental health and/or IDD services needed for you during your stay at the nursing home and they must give you the services listed. If you or your care provider thinks you need to stay longer than 60 days, then a nursing home staff member must submit a new level I screen to Maximus. This must be done by or before the 60 th day from the admitted to the nursing home.<br><br>Resident #95's admitted was 12/26/23.<br><br>Resident # 95's diagnoses included but were not limited to, schizoaffective disorder and depression.<br><br>The most recent minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/7/24 assigned the resident a brief interview for mental status score of 13 out of 15 indicating a mild cognitive impairment. There were no behaviors captured in the lookback period.<br><br>On 7/30/24 at 3:28 PM this surveyor interviewed the social worker. They stated, I didn't do it. They stated they were not employed at the facility at that time and was not aware of the issue. They stated they would have to call Maximus and see what to do about it.<br><br>Resident was observed daily by the survey team sitting at a table on the outdoor patio. Resident could be heard hitting his fists on the table and cursing loudly. There was no obvious target to the behaviors as there was rarely anyone else around.<br><br>The comprehensive person centered care plan was reviewed and included a focus that read, The resident has potential to be verbally aggressive r/t Schizoaffective disorder. He has frequent verbal outburst but they are not normally directed towards staff. He sits in the commons area and front porch and curses loudly to himself.<br><br>This concern was discussed with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Director of Operations, and Regional Director of Clinical Services on 8/5/24 at 4:31 PM.<br><br>No further information was presented to the survey team prior to the exit conference. |

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| | 495338 | A. Building<br>B. Wing | 08/06/2024 |

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| Deer Meadows Rehabilitation and Nursing | 600 Walden Road<br>Abingdon, VA 24210 |

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| F 0655<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted<br><br>47299<br><br>Based on staff interview, record review and facility document review, the facility staff failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care for one of 27 residents in the survey sample, resident # 95.<br><br>The findings included:<br><br>Resident # 95's PASRR included a document dated 11/7/23 and entitled, Notice of PASRR Level I Screen Outcome that read in part, Your Level I screen shows you have evidence of a serious mental illness or intellectual disability (IDD). Further PASRR review is not needed because you meet criteria for a short-term convalescence stay. This means you are approved for up to 60 days in a nursing home that takes Medicaid without additional PASRR review. Your level I screen lists any mental health and/or IDD services needed for you during your stay at the nursing home and they must give you the services listed. If you or your care provider thinks you need to stay longer than 60 days, then a nursing home staff member must submit a new level I screen to Maximus. This must be done by or before the 60th day from the admitted to the nursing home.<br><br>The baseline care plan was reviewed. It was dated 11/7/24. On page 3 of 11, there was a section labeled PASRR. The section was blank, it had not been filled in to address the above concern.<br><br>On 8/1/24 at 3:59 PM the survey team met with the Regional Director of Clinical Services (RDCS), Director of Nursing (DON), Assistant Director of Nursing (ADON) and the Regional Director of Operations. This surveyor asked the RDCS if they would expect that section of the baseline care plan to be filled out. They stated that they would.<br><br>This surveyor was provided a policy entitled, Baseline Care Plan with a reviewed/revised date of 12/1/22. The document read in part, The facility will develop and implement a baseline care plan for each resident that includes the instruction needed to provide effective and person-centered care of the resident that meet professional standards of quality care. And under the heading Policy Explanation and Compliance Guidelines: 1. The base line care plan will: b. Include the minimum healthcare information necessary to properly care for a resident including, but not limited to: vi. PASRR recommendation, if applicable.<br><br>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 15:15 PM.<br><br>No further information was provided to the survey team prior to the exit conference. |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>47299<br><br>Based on staff interview, clinical record review and facility document review, the facility staff failed to develop and/or implement a comprehensive care plan for 2 of 27 residents in the survey sample, resident # 88 and resident # 258.<br><br>The findings included:<br><br>1. For resident # 258, the facility staff failed to implement a care plan intervention to notify the physician of hematuria (blood in the urine).<br><br>Resident # 258's diagnoses included but were not limited to displaced intertrochanteric fracture of the right femur, paroxysmal atrial fibrillation, and urinary retention.<br><br>Review of the electronic medical record revealed that resident was on an anticoagulant medication (medications that prevent or treat blood clots in the heart or blood vessels) related to atrial fibrillation. The comprehensive person centered care plan included a focus that read, at risk for abnormal bleeding R/T use of anticoagulant for AFIB with an intervention that read, Observe for S/S bleeding and report to MD (bleeding gums, hematuria, joint pain, swelling, epistaxis, increased bruising, abdominal pain.<br><br>The progress notes were reviewed. A note dated 5/26/24 at 5:34 AM read in part, .scant blood observed in the catheter tubing. A note dated 5/26/24 at 3:56 PM read in part, .has been pulling at Foley catheter which now has scant amount of blood visible in tubing d/to resident pulling on Foley and detaching the two pieces on their own. A note dated 5/27/1:22 AM read in part, .when trying to get resident back in bed and relieve tension off the Foley cath, resident became verbally upset. Explained to resident that he is placing tension on his Foley and causing it to bleed.<br><br>There was no evidence in the clinical record that the physician was notified of blood in the catheter tubing.<br><br>On 8/6/24 at 12:15 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, Regional Director of Operations, and the Regional Director of Culinary Services. This concerned was discussed at that time.<br><br>No further information was provided to the survey team prior to the exit conference.<br><br>49622<br><br>2. For Resident #88 (R88) the facility staff failed to implement a comprehensive, person-centered, activity care plan to provide two to three activities a week for ninety days.<br><br>R88's diagnosis list indicated diagnoses that included, but were not limited to, Bipolar Disorder, Personal History of Transient Ischemic Attack (TIA) and Cerebral Infarction, Depression, Peripheral Vascular Disease, Congestive Heart Failure, Chronic Kidney Disease-Stage 5, and Polyosteorarthritis.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | The most recent minimum data set (MDS) with an assessment reference date (ARD) of 06/22/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating Resident #88 was severely impaired in cognition.<br><br>A review of the current care plan revealed a Focus of, . [name omitted] (R88) attends activities of interest/choice and engages in self-initiated leisure activities . with a Goal of, .will initiate leisure activities 1-2 x/day (one to two times per day) such as watching tv and people watching . A second goal read, .will participate in 2-3 (two to three) in or out of room activities a week x 90 days (for ninety days) such as music, sensory and special snacks . The interventions read in part, .Invite, encourage and assist as needed to activities of choice/interest {sic} as tolerated by the resident . The interventions were assigned to activity assistant and activity director. The care plan revealed an initiated date of 11/13/2023 with a revision date of the first goal of 04/03/2024 and the second goal with a revision date of 04/09/2024, no changes were identified for this Focus, Goal or Interventions during this revision.<br><br>Further review of the clinical record revealed an, Activities Interview for Daily and Activity Preferences dated, 06/19/2024, that read in part, .B. Interview for Activity Preferences . and that it was Very Important to the resident to, .have books, newspapers, and magazines to read, .listen to music, .be around animals, .keep up with the news, .do things with groups of people, .do her favorite activities, .go outside to get fresh air when the weather is good, .and participate in religious services or practices .<br><br>A Multidisciplinary Care Conference progress note dated 07/09/2024 read in part, .Recreation Summary: Problems/Needs: Attends one to one activities, current events, special snacks, sensory .Evaluation/Goals: Will continue weekly in room activities 3 x (three times) weekly .Activities Director .<br><br>A review of the activity participation records for R88 for the month of May 2024, revealed R88 was provided with one-to-one activities on 5/1/24, 5/18/24, 5/22/24, and 5/24/24. A review of June 2024 activity participation records revealed that R88 was provided one-to-one activities on 6/1/24 and 6/27/24. July activity participation records revealed R88 was provided one-to-one activity programming on 7/1/24, 7/4/24, 7/18/24, and 7/26/24. No documentation for attendance to activity group programming or self-directed activity programming was located on the activity participation records for May/June/July 2024 for R88.<br><br>Surveyor could not locate any Activity Progress notes on the clinical record for R88.<br><br>On 07/31/24 at 1:14 PM, surveyor interviewed activity director-other staff #10 (OS#10) about R88's activities. OS#10 stated R88 rarely gets out of bed. She stated she does sensory, current events, special snacks/milkshakes for resident and she plays TV/music for her when going around the rooms and plays music over the intercom. Surveyor reviewed the activity participation records with OS#10 and she stated she does not have time to document. She stated she does social visits each day-just saying hi and that she tries to do structured activity one time a week and she plays lots of music.<br><br>This concern was discussed at the end of day meeting on 7/30/24 at 4:15 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 meetings on 7/31/24 at 4:47 PM, 8/1/24 at 4:00 PM, 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>(continued on next page) |

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| F 0656<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Surveyor requested and received a facility policy titled, Resident Self Determination and Participation (Activities), that read in part, .2. The Activity Director shall assist the resident to maintain as normal a lifestyle as possible while in the facility through the provision of activities consistent with the resident's interests .3. Information about the resident's former lifestyle and activity preferences shall be gathered during the initial activity program assessment, and subsequent assessments. When the resident is unable to communicate preferences, the resident's family members shall be asked for input .4. The Activity Director shall develop a plan of care for the resident based on the resident's assessment, goals and preferences .5. Resident's preferences and interests shall be accommodated .<br><br>Surveyor requested and received the facility policy titled Comprehensive Care Plans, which read in part, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's .psychosocial needs .The care planning process will include an assessment of the resident's strengths and needs, and will incorporate the resident's personal and cultural preferences in developing goals of care .Other factors identified by the interdisciplinary team, or in accordance with the resident's preferences, will also be addressed in the plan of care .The comprehensive care plan will describe, at a minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being .4. The comprehensive care plan will be prepared by an interdisciplinary team, that includes, but is not limited to .f. Other appropriate staff or professionals in disciplines as determined by the resident's needs . Examples include but are not limited to .ii. Activities Director/Staff .The comprehensive care plan will include measurable objectives and timeframes to meet the resident's needs .Alternate interventions will be documented as needed .Qualified staff for carrying out interventions specified in the care plan will be notified of their roles and responsibilities for carrying out interventions .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24. |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.<br><br>49622<br><br>Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure the comprehensive care plan was reviewed and revised by the interdisciplinary team, and/or failed to involve the resident or resident representative in planning care, for 5 of 27 sampled residents, Resident #88, #23, #73, #28, and #82.<br><br>The findings included:<br><br>1. For Resident #88 (R88), the facility staff failed to reassess the effectiveness of the interventions and review and revise the resident's activity care plan to meet the resident's needs.<br><br>R88's diagnosis list indicated diagnoses that included, but were not limited to, Bipolar Disorder, Personal History of Transient Ischemic Attack (TIA) and Cerebral Infarction, Depression, Peripheral Vascular Disease, Congestive Heart Failure, Chronic Kidney Disease-Stage 5, and Polyosteorarthritis.<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 06/22/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating Resident #88 was severely impaired in cognition.<br><br>A review of the current care plan revealed a Focus of, . [name omitted] (R88) attends activities of interest/choice and engages in self-initiated leisure activities . with a Goal of, .will initiate leisure activities 1-2 x/day (one to two times per day) such as watching tv and people watching . A second goal read, .will participate in 2-3 (two to three) in or out of room activities a week x 90 days (for ninety days) such as music, sensory and special snacks . The interventions read in part, .Invite, encourage and assist as needed to activities of choice/interest {sic} as tolerated by the resident . The interventions were assigned to activity assistant and activity director. The care plan revealed an initiated date of 11/13/2023 with a revision date of the first goal of 04/03/2024 and the second goal with a revision date of 04/09/2024, no changes were identified for the Focus, Goal or Interventions during this revision.<br><br>Surveyor could not locate any Activity Progress notes on the clinical record for R88.<br><br>On 7/30/24 at 3:20 PM, surveyor interviewed activity director-other staff #10 (OS#10) about activity assessments and activity progress notes. OS#10 stated she only completes activity assessments on admission, annually and for a significant change and does them with the ARD date of the MDS. She stated she does not do an activity progress note every ninety days or a quarterly assessment and she is behind on assessments.<br><br>On 7/31/24 at 3:12 PM, regional director of clinical services #4 (RDCS#4) informed surveyor she had spoken to OS#10, and she had informed her that she had not done any ninety-day progress notes for residents.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | This concern was discussed at the end of day meeting on 7/30/24 at 4:15 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 meetings on 7/31/24 at 4:47 PM, 8/1/24 at 4:00 PM, 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received the facility policy titled Comprehensive Care Plans, which read in part, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's .psychosocial needs .The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment .The objectives will be utilized to monitor the resident's progress .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24.<br><br>2. For Resident #23 (R23), the facility staff failed to reassess the effectiveness of the interventions and review and revise the resident's activity care plan to meet the resident's needs and the facility staff failed to ensure the resident was provided the opportunity to participate in planning care in the facility.<br><br>R23's diagnosis list indicated diagnoses that included, but were not limited to, Diabetes Mellitus Type 2, Atrial Fibrillation, Peripheral Vascular Disease, Chronic Kidney Disease Stage 4, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Morbid Obesity, and Major Depressive Disorder.<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 06/29/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating R23 was cognitively intact.<br><br>On 7/29/24 at 2:50 PM, surveyor interviewed R23, and he stated he did not attend activity programs and he used to get one-to-one activities, but that has decreased. R23 also stated that he has never attended a care plan meeting.<br><br>A review of the current care plan revealed an activity Focus of, . [name omitted] (R23) attends activities of interest/choice and engages in self-initiated leisure activities . with a Goal of, .will participate in 2-3 in or out of room activities a week x 90 days (for ninety days) such as online shopping via iPad, Art Cart, current events, music, sensory and accepting healthy snacks. A second goal read, .will initiate leisure activities 1-2 x/day (one to two times per day) such as talking on the phone, bird watching watching tv {sic} and DVDs. The interventions read in part, .Invite, encourage and assist as needed to activities of choice interest {sic} as tolerated by the resident . The interventions were assigned to activity assistant and activity director. The care plan revealed an initiated date of 12/14/2020 with a revision date of the first goal of 04/12/2024 and the second goal with a revision date of 07/10/2024, no changes were identified for the Focus, Goal or Interventions during this revision.<br><br>Surveyor could not locate any Activity Progress notes on the clinical record for R23.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 7/30/24 at 3:20 PM, surveyor interviewed activity director-other staff #10 (OS#10) about activity assessments and activity progress notes. OS#10 stated she only completes activity assessments on admission, annually and for a significant change and does them with the ARD date of the MDS. She stated she does not do an activity progress note every ninety days or a quarterly assessment and she is behind on assessments.<br><br>On 7/31/24 at 3:12 PM, regional director of clinical services #4 (RDCS#4) informed surveyor she had spoken to OS#10, and she had informed her that she had not done any ninety-day progress notes for residents.<br><br>In addition to the above stated findings, surveyor could not locate any evidence R23 was invited to or had attended any care plan meetings since his baseline care plan meeting on 11/24/2020.<br><br>On 8/1/24 at 10:17 AM, surveyor interviewed MDS nurses, registered nurse #1 (RN#1) and licensed practical nurse #6 (LPN#6) about R23 and care plan meeting attendance. Both nurses stated they did not have invitation letters but did keep logs of care plan attendance and they write if residents attended or not. At 10:40 AM LPN#6 informed surveyor she scanned through progress notes and could not locate any notes where residents declined or attended care plan meetings. She also informed surveyor the MDS office had taken over sending out care plan invitations since the former social worker was not doing them and RDCS#4 concurred with this statement and informed surveyor the facility had a different social worker who was not doing/sending out care plan meeting invitations and the MDS office has now taken over.<br><br>Surveyor requested and received copies of the care plan sign-in sheets for R23, and they revealed resident had not attended any care plan meetings since 12/2/2020. Surveyor also received a care plan meeting invitation dated 7/15/24 for a care plan meeting scheduled 7/23/24 at 2:30 PM for R23 and the care plan sign in sheet revealed R23 did not attend the care plan meeting on 7/23/24.<br><br>These concerns were discussed at the end of day meeting on 7/30/24 at 4:15 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 meetings on 7/31/24 at 4:47 PM, 8/1/24 at 4:00 PM, 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received the facility policy titled Comprehensive Care Plans, which read in part, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's .psychosocial needs .The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment .The objectives will be utilized to monitor the resident's progress .<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Surveyor requested and received a facility policy titled, Care Planning-Resident and/or Resident Representative participation that read in part, .This facility supports the residents and/or resident's representative right to be informed of, and participate in, his or her care planning and treatment .4. The facility will encourage and assist the resident and/or resident representative to participate in choosing care and treatment .7. The facility will honor the resident's choice in individuals to be included in the care planning process .9. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24.<br><br>3. For Resident #73 (R73), the facility staff failed to reassess the effectiveness of the interventions and review and revise the resident's activity care plan to meet the resident's needs and the facility staff failed to ensure the resident was provided the opportunity to participate in planning care in the facility.<br><br>R73's diagnosis list indicated diagnoses that included, but were not limited to, Morbid (severe) obesity, Anemia, Tachycardia, Constipation, Edema, and Hypothyroidism.<br><br>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.<br><br>On 7/29/24 at 4:10 PM, surveyor interviewed R73, and he stated activities come to see him once in a while and he gets his in-room supplies from his family and he rarely gets out of bed. R73 also stated that he attended his first, initial care plan meeting and they came to his room, but he has not been invited or heard of any other care plan meetings since then.<br><br>A review of the current care plan revealed an activity Focus of, .The resident has little or no activity involvement r/t resident wishes not to participate . with a Goal of, .resident will express satisfaction with type of activities and level of activity involvement when asked through the review date A second goal read, .The resident will participate in activities of choice 2-3 times per week by review date . The interventions read in part, .Establish and record the resident's prior level of activity involvement and interests . The interventions were assigned to activity assistant and activity director. The care plan revealed an initiated date of 08/01/2023 with a revision date of both goals of 07/16/2024, no changes were identified for the Focus, Goal or Interventions during this revision.<br><br>Surveyor could not locate any Activity Progress notes on the clinical record for R73.<br><br>On 7/30/24 at 3:20 PM, surveyor interviewed activity director-other staff #10 (OS#10) about activity assessments and activity progress notes. OS#10 stated she only completes activity assessments on admission, annually and for a significant change and does them with the ARD date of the MDS. She stated she does not do an activity progress note every ninety days or a quarterly assessment and she is behind on assessments.<br><br>(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<br>B. Wing | 08/06/2024 |

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

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|---|---|
| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 7/31/24 at 3:12 PM, regional director of clinical services #4 (RDCS#4) informed surveyor she had spoken to OS#10, and she had informed her that she had not done any ninety-day progress notes for residents.<br><br>In addition to the above stated findings, surveyor could not locate any evidence R73 was invited to or had attended any care plan meetings since his baseline care plan meeting on 08/01/2023.<br><br>On 8/1/24 at 10:17 AM, surveyor interviewed MDS nurses, registered nurse #1 (RN#1) and licensed practical nurse #6 (LPN#6) about R73 and care plan meeting attendance. Both nurses stated they did not have invitation letters but did keep logs of care plan attendance and they write if residents attended or not. At 10:40 AM LPN#6 informed surveyor she scanned through progress notes and could not locate any notes where residents declined or attended care plan meetings. She also informed surveyor the MDS office had taken over sending out care plan invitations since the former social worker was not doing them and RDCS#4 concurred with this statement and informed surveyor the facility had a different social worker who was not doing/sending out care plan meeting invitations and the MDS office has now taken over.<br><br>Surveyor requested and received copies of the care plan sign-in sheets for R73, and they revealed resident had not attended any care plan meetings since 08/01/2023. Surveyor also received a care plan meeting invitation dated 7/26/24 for a care plan meeting scheduled 8/6/24 at 1:15 PM for R73.<br><br>These concerns were discussed at the end of day meeting on 07/30/24 at 4:15 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 meetings on 7/31/24 at 4:47 PM, 8/1/24 at 4:00 PM, 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received the facility policy titled Comprehensive Care Plans, which read in part, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's .psychosocial needs .The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment .The objectives will be utilized to monitor the resident's progress .<br><br>Surveyor requested and received a facility policy titled, Care Planning-Resident and/or Resident Representative participation that read in part, .This facility supports the residents and/or resident's representative right to be informed of, and participate in, his or her care planning and treatment .4. The facility will encourage and assist the resident and/or resident representative to participate in choosing care and treatment .7. The facility will honor the resident's choice in individuals to be included in the care planning process .9. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. For Resident #28 (R28), the facility staff failed to reassess the effectiveness of the interventions and review and revise the resident's activity care plan to meet the resident's needs and the facility staff failed to ensure the resident was provided the opportunity to participate in planning care in the facility.<br><br>R28's diagnosis list indicated diagnoses that included, but were not limited to, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Congestive Heart Failure, Peripheral Vascular Disease, Major Depressive Disorder, and Anxiety Disorder.<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 06/27/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating R28 was cognitively intact.<br><br>On 7/29/24 at 2:26 PM, surveyor interviewed R28, and resident stated she did not attend activities at the facility. R28 also stated that she has never attended a care plan meeting.<br><br>A review of the current care plan revealed an activity Focus of, .(R28) attends activities of interest/choice and engages in self-initiated leisure activities. with a Goal of, .will participate in 2-3 (two to three) in or out of room activities a week x 90 days (for ninety days) such as accepting special snacks and exercise. A second goal read, .will initiate leisure activities 1-2 x/day such as using her smart phone, reading magazines and watching tv. The interventions read in part, .Invite, encourage and assist as needed to activities of choice/interest {sic} as tolerated by the resident . The interventions were assigned to activity assistant and activity director. The care plan revealed an initiated date of 12/20/2023 with a revision date of the first goal of 04/12/2024 and the second goal with a revision date of 07/04/2024, no changes were identified for the Focus, Goal or Interventions during this revision.<br><br>Surveyor could not locate any Activity Progress notes on the clinical record for R28.<br><br>On 7/30/24 at 3:20 PM, surveyor interviewed activity director-other staff #10 (OS#10) about activity assessments and activity progress notes. OS#10 stated she only completes activity assessments on admission, annually and for a significant change and does them with the ARD date of the MDS. She stated she does not do an activity progress note every ninety days or a quarterly assessment and she is behind on assessments.<br><br>On 7/31/24 at 3:12 PM, regional director of clinical services #4 (RDCS#4) informed surveyor she had spoken to OS#10, and she had informed her that she had not done any ninety-day progress notes for residents.<br><br>In addition to the above stated findings, surveyor could not locate any evidence R28 was invited to or had attended any care plan meetings since her baseline care plan meeting on 12/05/2023.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 8/1/24 at 10:17 AM, surveyor interviewed MDS nurses, registered nurse #1 (RN#1) and licensed practical nurse #6 (LPN#6) about R28 and care plan meeting attendance. Both nurses stated they did not have invitation letters but did keep logs of care plan attendance and they write if residents attended or not. At 10:40 AM LPN#6 informed surveyor she scanned through progress notes and could not locate any notes where residents declined or attended care plan meetings. She also informed surveyor the MDS office had taken over sending out care plan invitations since the former social worker was not doing them and RDCS#4 concurred with this statement and informed surveyor the facility had a different social worker who was not doing/sending out care plan meeting invitations and the MDS office has now taken over.<br><br>Surveyor requested and received copies of the care plan sign-in sheets for R28, and they revealed resident had not attended any care plan meetings since 12/05/2023. Surveyor also received a care plan meeting invitation dated 7/08/24 for a care plan meeting scheduled 7/16/24 at 2:30 PM for R28 and the care plan sign in sheet revealed R28 did not attend the care plan meeting on 7/16/24.<br><br>These concerns were discussed at the end of day meeting on 07/30/24 at 4:15 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 meetings on 7/31/24 at 4:47 PM, 8/1/24 at 4:00 PM, 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received the facility policy titled Comprehensive Care Plans, which read in part, .It is the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident .that includes measurable objectives and timeframes to meet a resident's .psychosocial needs .The comprehensive care plan will be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment .The objectives will be utilized to monitor the resident's progress .<br><br>Surveyor requested and received a facility policy titled, Care Planning-Resident and/or Resident Representative participation that read in part, .This facility supports the residents and/or resident's representative right to be informed of, and participate in, his or her care planning and treatment .4. The facility will encourage and assist the resident and/or resident representative to participate in choosing care and treatment .7. The facility will honor the resident's choice in individuals to be included in the care planning process .9. The facility will discuss the plan of care with the resident and/or representative at regularly scheduled care plan conferences, and allow them to see the care plan, initially, at routine intervals, and after significant changes .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24.<br><br>21227<br><br>5. The staff failed to ensure Resident #82's comprehensive care plan addressed the resident's use of medications to prevent blood clot formation. The facility staff failed to ensure Resident #82 was included in the care plan meeting.<br><br>(continued on next page) |

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| F 0657<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>On 7/29/24 at 2:30 p.m., Resident #82 reported they did not remember being invited to a care plan meeting in the past.<br><br>On 8/5/24 at 3:57 p.m., the Director of Nursing (DON) reported no evidence was available to indicate Resident #82 was involved in care plan meetings. The DON reported a letter for Resident #82's March 2024 meeting was found but it was not signed by the resident; the letter was addressed To whom it may concern: and provided the date and time for the March 2024 care plan meeting.<br><br>Review of Resident #82's clinical record included medical provider orders for the following medications for blood clot prevention: clopidogrel and enoxaparin. (Clopidogrel is an antiplatelet medication. Enoxaparin is an anticoagulant medication.) Resident #82's enoxaparin order had a start date of 7/17/24 to be administered for 17 days. Resident #82's clopidogrel order had a start date of 6/29/24. Resident #82's comprehensive care plan did not address bleeding risk related to the administration of antiplatelet and anticoagulant medications.<br><br>The following information was found in a facility policy titled Care Planning-Resident and/or Resident Representative participation [sic] (with the reviewed/revised date of 12/1/22): The facility will make an effort make every effort [sic] possible to schedule the conference at the best time of the day for the resident/resident's representative. The facility will obtain a signature from the resident and/or resident representative after discussion or viewing of the care plan.<br><br>The following information was found in a facility policy titled Comprehensive Care Plan (with a revised/reviewed date of 12/1/22):<br><br>- The comprehensive care plan will be prepared by an interdisciplinary team, that include, but is not limited to: . The resident and the resident's representative, to the extent practicable.<br><br>- The comprehensive care plan will describe, at the minimum, the following: a. The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.<br><br>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 Resident #82's care plan to address the resident's anticoagulant use. The DON confirmed that the care plan did not address the use of anticoagulants. |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide activities to meet all resident's needs.<br><br>49622<br><br>Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to provide an ongoing, person-centered activity program to support resident choice, interests and physical, mental, and psychosocial well-being for 2 of 27 residents in the current survey sample, Resident #88 and Resident #28.<br><br>The findings included:<br><br>1. For Resident #88 (R88) the facility staff failed to provide an ongoing, person-centered, activity program two to three times a week for ninety days to support resident choice, interests, and physical, mental, and psychosocial well-being as indicated in the plan of care.<br><br>R88's diagnosis list indicated diagnoses that included, but were not limited to, Bipolar Disorder, Personal History of Transient Ischemic Attack (TIA) and Cerebral Infarction, Depression, Peripheral Vascular Disease, Congestive Heart Failure, Chronic Kidney Disease-Stage 5, and Polyosteorarthritis.<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 06/22/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 for cognitive abilities, indicating Resident #88 was severely impaired in cognition.<br><br>A review of the current care plan revealed a Focus of, .attends activities of interest/choice and engages in self-initiated leisure activities .A Goal of, .will initiate leisure activities 1-2 x/day (one to two times per day) such as watching tv and people watching . A second goal read, .will participate in 2-3 (two to three) in or out of room activities a week x 90 days (for ninety days) such as music, sensory and special snacks . One of the interventions assigned to the goals read in part, .Invite, encourage and assist as needed to activities of choice/interest {sic} as tolerated by the resident . The care plan revealed an initiated date of 11/13/2023 with a revision date of the first goal of 04/03/2024 and the second goal with a revision date of 04/09/2024, no changes were identified for this Focus, Goal or Interventions during this revision.<br><br>Further review of the clinical record revealed an, Activities Interview for Daily and Activity Preferences dated, 06/19/2024, that read in part, .B. Interview for Activity Preferences . and that it was Very Important to the resident to, .have books, newspapers, and magazines to read, .listen to music, .be around animals, .keep up with the news, .do things with groups of people, .do her favorite activities, .go outside to get fresh air when the weather is good, .and participate in religious services or practices .<br><br>A Multidisciplinary Care Conference progress note dated 07/09/2024 read in part, .Recreation Summary: Problems/Needs: Attends one to one activities, current events, special snacks, sensory .Evaluation/Goals: Will continue weekly in room activities 3 x (three times) weekly .Activities Director .<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A review of the activity participation records for R88 for the month of May 2024, revealed R88 was provided with one-to-one activities on 5/1/24, 5/18/24, 5/22/24, and 5/24/24. A review of June 2024 activity participation records revealed that R88 was provided one-to-one activities on 6/1/24 and 6/27/24. July activity participation records revealed R88 was provided one-to-one activity programming on 7/1/24, 7/4/24, 7/18/24, and 7/26/24. No documentation for attendance to activity group programming or self-directed activity programming was located on the activity participation records for May/June/July 2024 for R88.<br><br>Surveyor could not locate any Activity Progress notes on the clinical record for R88.<br><br>On 07/31/24 at 1:14 PM, surveyor interviewed activity director-other staff #10 (OS#10) about R88's activities. OS#10 stated R88 rarely gets out of bed. She stated she does sensory, current events, special snacks/milkshakes for resident and she plays TV/music for her when going around the rooms and plays music over the intercom. Surveyor reviewed the activity participation records with OS#10 and she stated she does not have time to document. She stated she does social visits each day-just saying hi and that she tries to do structured activity one time a week and she plays lots of music.<br><br>This concern was discussed at the end of day meeting on 07/30/24 at 4:15 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 meetings on 7/31/24 at 4:47 PM, 8/1/24 at 4:00 PM, 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received the facility policy titled Activities, that read in part, .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident .1. Each resident's interests and needs will be assessed on a routine basis. The assessment shall include but is not limited to: a. RAI Process: MDS/CAA/Care Plan. b. Activity Assessment to include resident's interest, preferences and needed adaptations .2. Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging, and usefulness .c. Promote or enhance cognition. d. Promote or enhance emotional health .f. Reflect resident's interests .h. Reflect choices of the residents .4. Activities may be conducted in different ways: a. One-to-One Programs. b. Person Appropriate-activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for. c. Program of Activities-to include a combination of .one-to-one, and self-directed as the resident desires to attend .8. Activities will include individual .g. In-Room Activities. h. Individualized Activities .Special considerations will be made for developing meaningful activities for residents with .special needs .10. All staff will assist residents to and from activities when necessary .<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Surveyor requested and received a facility policy titled, Resident Self Determination and Participation (Activities), that read in part, .2. The Activity Director shall assist the resident to maintain as normal a lifestyle as possible while in the facility through the provision of activities consistent with the resident's interests .3. Information about the resident's former lifestyle and activity preferences shall be gathered during the initial activity program assessment, and subsequent assessments. When the resident is unable to communicate preferences, the resident's family members shall be asked for input .4. The Activity Director shall develop a plan of care for the resident based on the resident's assessment, goals and preferences .5. Resident's preferences and interests shall be accommodated .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24.<br><br>2. For Resident #28 (R28) the facility staff failed to provide an ongoing, person-centered, activity program two to three times a week for ninety days to support resident choice, interests, and physical, mental, and psychosocial well-being as indicated in the plan of care.<br><br>R28's diagnosis list indicated diagnoses that included, but were not limited to, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Congestive Heart Failure, Peripheral Vascular Disease, Major Depressive Disorder, and Anxiety Disorder.<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 06/27/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating R28 was cognitively intact.<br><br>On 7/29/24 at 2:26 PM, surveyor interviewed R28, and resident stated she did not attend activities at the facility.<br><br>A review of the current care plan revealed an activity Focus of, .(R28) attends activities of interest/choice and engages in self-initiated leisure activities. with a Goal of, .will participate in 2-3 (two to three) in or out of room activities a week x 90 days (for ninety days) such as accepting special snacks and exercise. A second goal read, .will initiate leisure activities 1-2 x/day such as using her smart phone, reading magazines and watching tv. The interventions read in part, .Invite, encourage and assist as needed to activities of choice/interest {sic} as tolerated by the resident . The interventions were assigned to activity assistant and activity director. The care plan revealed an initiated date of 12/20/2023 with a revision date of the first goal of 04/12/2024 and the second goal with a revision date of 07/04/2024, no changes were identified for the Focus, Goal or Interventions during this revision.<br><br>Further review of the clinical record revealed an, Activities Interview for Daily and Activity Preferences dated, 12/08/2023, that read in part, .B. Interview for Activity Preferences . and that it was Very Important to the resident to, .have books, newspapers, and magazines to read, .listen to music, .keep up with the news, .do her favorite activities, .go outside to get fresh air when the weather is good, .and participate in religious services or practices . It also revealed that it was Somewhat Important for resident to, do things with groups of people.<br><br>(continued on next page) |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | A Multidisciplinary Care Conference progress note dated 07/15/2024 read in part, .Recreation Summary: Problems/Needs: Self isolates at times, does not get up .Evaluation/Goals: Will participate in out of room activities per preferences .Activities Director .<br><br>A review of the activity participation records for R28 for the month of May 2024, revealed resident was provided with one-to-one activities on 5/1/24, 5/03/24, 5/12/24, and 5/24/24. A review of June 2024 activity participation records revealed that resident was provided one-to-one activities on 6/1/24, 6/07/24, 6/15/24, 6/27/24, and 6/28/24. July activity participation records revealed resident was provided one-to-one activity programming on 7/1/24, 7/4/24, 7/12/24, 7/18/24 and 7/26/24. No documentation for attendance to activity group programming or self-directed activity programming was located on the activity participation records for May/June/July 2024 for R28.<br><br>Surveyor could not locate any Activity Progress notes on the clinical record for R28.<br><br>These concerns were discussed at the end of day meeting on 07/30/24 at 4:15 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 meetings on 7/31/24 at 4:47 PM, 8/1/24 at 4:00 PM, 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received the facility policy titled Activities, that read in part, .It is the policy of this facility to provide an ongoing program to support residents in their choice of activities based on their comprehensive assessment, care plan, and preferences of each resident. Facility sponsored group and individual activities and independent activities will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident .1. Each resident's interests and needs will be assessed on a routine basis. The assessment shall include but is not limited to: a. RAI Process: MDS/CAA/Care Plan. b. Activity Assessment to include resident's interest, preferences and needed adaptations .2. Activities will be designed with the intent to: a. Enhance the resident's sense of well-being, belonging, and usefulness .c. Promote or enhance cognition. d. Promote or enhance emotional health .f. Reflect resident's interests .h. Reflect choices of the residents .4. Activities may be conducted in different ways: a. One-to-One Programs. b. Person Appropriate-activities relevant to the specific needs, interests, culture, background, etc. for the resident they are developed for. c. Program of Activities-to include a combination of .one-to-one, and self-directed as the resident desires to attend .8. Activities will include individual .g. In-Room Activities. h. Individualized Activities .Special considerations will be made for developing meaningful activities for residents with .special needs .10. All staff will assist residents to and from activities when necessary .<br><br>Surveyor requested and received a facility policy titled, Resident Self Determination and Participation (Activities), that read in part, .2. The Activity Director shall assist the resident to maintain as normal a lifestyle as possible while in the facility through the provision of activities consistent with the resident's interests .3. Information about the resident's former lifestyle and activity preferences shall be gathered during the initial activity program assessment, and subsequent assessments. When the resident is unable to communicate preferences, the resident's family members shall be asked for input .4. The Activity Director shall develop a plan of care for the resident based on the resident's assessment, goals and preferences .5. Resident's preferences and interests shall be accommodated .<br><br>(continued on next page) |

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|---|---|---|---|
| | 495338 | A. Building<br>B. Wing | 08/06/2024 |

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| Deer Meadows Rehabilitation and Nursing | 600 Walden Road<br>Abingdon, VA 24210 |

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| F 0679<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24. |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide appropriate treatment and care according to orders, resident's preferences and goals.<br><br>21227<br><br>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).<br><br>The findings include:<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>2. The facility staff failed have evidence of Resident #36 being assessed by a licensed nurse when the resident experienced a change in condition.<br><br>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.<br><br>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.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>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.<br><br>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.<br><br>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.<br><br>3. The facility staff failed to follow Resident #15's medical provider's bowel protocol standing orders.<br><br>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.<br><br>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 .<br><br>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.<br><br>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.<br><br>47299<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. For resident # 258, the facility staff failed to follow a physician's order to remove staples from a surgical incision.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>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.<br><br>No further information was provided to the survey team prior to the exit conference.<br><br>49622<br><br>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.<br><br>R73's diagnosis list indicated diagnoses that included, but were not limited to, Morbid (severe) obesity, Anemia, Tachycardia, Constipation, Edema, and Hypothyroidism.<br><br>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.<br><br>On 7/29/24 at 4:10 PM, surveyor interviewed R73, and he stated he has problems with constipation.<br><br>(continued on next page) |

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| F 0684<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 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.<br><br>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.<br><br>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 .<br><br>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.<br><br>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 .<br><br>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.<br><br>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.<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24. |

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| F 0755<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.<br><br>21227<br><br>Based on observations, staff interviews, clinical record review, and facility document review, the facility staff failed to ensure a medication was available for administration for one (1) of four (4) residents included in medication administration observations (Resident #14).<br><br>The findings include:<br><br>The facility staff had to contact Resident #14's medical provider because the ordered Lidocaine Pain Relief patch was not available. The medical provider changed the order to a patch that was available.<br><br>Resident #14's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/17/24, was signed as completed on 7/26/24. Resident #14 was assessed as able to make self understood and as able to understand others. Resident #14's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact and/or borderline cognition.<br><br>On 8/1/24 at 8:27 a.m., Licensed Practical Nurse (LPN) #9 was observed to administer medications to Resident #14. Resident #14 had orders for a Lidocaine Pain Relief patch. LPN #9 reported they would have to go get the patch for the resident. LPN #9 obtained and applied Menthol Pain patch for Resident #14.<br><br>On 8/1/24 at 12:40 p.m., the surveyor discussed Resident #14's Lidocaine Pain Relief patch not being available when LPN #9 was completing the aforementioned medication administration with the facility's Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services (RDCS). The ADON reported the ordered patch was not in the medication cart, so a medical provider order was obtained to provide a different patch. (This order was obtained prior to the application of the patch.)<br><br>The following information was found in a facility document titled Medication Administration (with a reviewed/revised date of 12/1/22):<br><br>- 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.<br><br>- Keep medication cart clean, organized, and stocked with adequate supplies.<br><br>On 8/1/24 at 4:02 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Clinical Services, Regional Director of Operations, and Regional Food Services Director. During this meeting, the surveyor discussed the facility staff having to obtain medical provider orders for Resident #14 to obtain a different medication because the medication that was initially ordered was not available. |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures.<br><br>47299<br><br>Based on staff interview, clinical record review and facility document review the facility staff failed to act on pharmacy recommendations for 4 of 27 residents in the survey sample residents # 83, 8, 56, 28.<br><br>The findings included:<br><br>1. For resident # 83 the facility staff failed to provided evidence of completed pharmacy recommendations for the months of September 2023 and May 2024.<br><br>Resident # 83's diagnoses included but were not limited to, unspecified dementia with unspecified severity and anxiety, epilepsy, generalized anxiety disorder, and psychotic disorder with delusions due to unknown physiological condition.<br><br>Resident # 83's minimum data set (MDS) assessment with an assessment reference date of 6/22/24 assigned the resident a brief interview for mental status (BIMS) score of 3 out of 15 indicating severe cognitive impairment.<br><br>During a review of the electronic medical record a pharmacist note dated 9/13/23 at 11:00 AM read, MRR complete-see report. A note dated 5/28/24 at 2:29 PM read, MRR complete-see report.<br><br>On 08/05/24 10:21 AM this surveyor asked the Assistant Director of Nursing (ADON) for resident # 83's pharmacist recommendations for 5/28/24 and 9/13/23. The ADON stated they were not able to locate either one.<br><br>This surveyor requested and received the policy entitled, Medication Regimen Review with a revised date of 12/1/22. The policy read in part, 5. The pharmacist shall communicate any irregularities to the facility in the following ways: a. Verbal communication to the attending physician, Director of Nursing, and/or staff of any urgent needs. b. Written communication to the attending physician, the facility's Medical Director, and the Director of Nursing. 6. Written communications from the pharmacist shall become a permanent part of the resident's medical record.<br><br>This concern was reviewed with the Administrator, Director of Nursing, ADON, Regional Director of Clinical Services, Regional Director of Operations and Regional Director of Culinary Services on 8/6/24 at 12:15 PM.<br><br>No further information was provided to the survey team prior to the exit conference.<br><br>49622<br><br>2. For Resident #8 (R8), the facility staff failed to provide evidence of the 5/28/24 drug regimen review being reported to and acted upon by the medical provider.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | R8's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Anxiety Disorder, Depression, Mood Affective Disorder, and Hypertensive Heart Disease.<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/8/24 assigned the resident a brief interview for mental status (BIMS) summary score of 5 out of 15 indicating the resident was severely cognitively impaired.<br><br>Progress notes within R8's clinical record indicated a drug regimen review was completed on 5/28/24 with recommendations. Surveyor was unable to locate the recommendation reports in the resident's clinical record.<br><br>Surveyor requested and received the drug regimen review recommendation reports completed by the pharmacist for R8 from the assistant director of nursing (ADON) on 8/2/24 at 10:26 AM and she stated some were missing and she was not sure what happened. The 5/28/24 Consultant Pharmacist Recommendation to Physician report had not been signed by the medical provider indicating review.<br><br>The 5/28/24 Consultant Pharmacist Recommendations to Physician read in part .This resident has been taking Divalproex 250 mg (milligrams) Q8 (every eight hours) since 5/17/2023 without a GDR (gradual dose reduction). Could we attempt a dose reduction at this time to perhaps Divalproex 125 mg Q8 to verify this resident is on the lowest possible dose . A review of the active provider orders indicated the recommendation was not addressed, as the medication was active on the order with a start date of 5/17/23.<br><br>This concern was discussed at the end of day meeting on 8/5/24 4:30 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 pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received the facility policy titled Medication Regimen Review which read in part The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart .f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24.<br><br>3. For Resident #28 (R28), the facility staff failed to provide evidence of the 12/28/23, 2/23/24, 3/27/24, and 4/28/24 drug regimen reviews being reported to and acted upon by the medical provider.<br><br>R28's diagnosis list indicated diagnoses that included, but were not limited to, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Congestive Heart Failure, Peripheral Vascular Disease, Major Depressive Disorder, and Anxiety Disorder.<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 06/27/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating R28 was cognitively intact.<br><br>(continued on next page) |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Progress notes within R28's clinical record indicated drug regimen reviews were completed on 12/28/23, 2/23/24, 3/27/24, and 4/28/24 with recommendations. Surveyor was unable to locate the recommendation reports in the resident's clinical record.<br><br>Surveyor requested and received the drug regimen review recommendation reports completed by the pharmacist for R28 from the regional director of clinical services on 7/31/24 at 4:24 PM and she stated the drug regimen reviews were not signed. A review of the reports indicated the 2/23/24, 3/27/24, and 4/28/24 Consultant Pharmacist Recommendation to Physician reports had not been signed by the medical provider indicating review.<br><br>The 12/28/23 Consultant Pharmacist Recommendations to Nursing Staff read in part .The resident is receiving the corticosteroid inhaler Symbicort. Reminder that the resident's mouth should be rinsed out after use to avoid oral thrush from developing . A review of the active provider orders, medication administration record and treatment administration records, indicated the recommendation was not addressed. On 7/31/24 at 4:24 PM, the regional director of clinical services informed surveyor the rinse had not been added after use.<br><br>The 2/23/24 and 3/27/24 Consultant Pharmacist Recommendations to Physician read in part .The resident is receiving two drugs with very similar therapeutic activity: 1. Advair 2. Budesonide-Formoterol .PLEASE VERIFY THIS DRUG REGIMEN IS REQUIRED, if not, adjust therapy as needed . The reports had not been signed by the medical provider indicating review. The Budesonide-Formoterol was discontinued indicating the February recommendation was not addressed until 4/17/24.<br><br>The 4/28/24 Consultant Pharmacist Recommendations to Physician read in part, .This resident has been taking Duloxetine 40 mg (milligrams) since 3/18/2024 without a GDR (gradual dose reduction). Could we attempt a dose reduction at this time to verify this resident is on the lowest possible dose? If not, please indicate response below . The report had not been signed by the medical provider indicating review. The dose of Duloxetine was reduced to 20 mg indicating the April recommendation was not addressed until 6/26/24.<br><br>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 at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received the facility policy titled Medication Regimen Review which read in part The drug regimen of each resident is reviewed at least once a month by a licensed pharmacist and includes a review of the resident's medical chart .f. Facility staff shall act upon all recommendations according to procedures for addressing medication regimen review irregularities .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24.<br><br>21227<br><br>4. The facility staff failed ensure Resident #56's medication regimen review recommendation was addressed by a medical provider.<br><br>(continued on next page) |

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| | 495338 | A. Building<br>B. Wing | 08/06/2024 |

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| Deer Meadows Rehabilitation and Nursing | 600 Walden Road<br>Abingdon, VA 24210 |

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| F 0756<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Resident #56's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/20/24, was signed as completed on 7/29/24. Resident #56 was assessed as able to make self understood and as able to understand others. Resident #56's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact and/or borderline cognition.<br><br>Resident #56 had a consultant pharmacist recommendation dated 5/28/24. This document included the following recommendation: This resident is on an antipsychotic medication and a current AIMS could not be located in the chart (in (electronic medical record company's name omitted)). AIMS should be done within the first 30 days of either admission or initiating therapy, then at least every 6 months after that. Please evaluate if applicable. Thank you. (Abnormal Involuntary Movement Scale (AIMS) is used to identify certain adverse reactions to antipsychotic medications.) The section of this pharmacist recommendation document where the medical provider addresses the recommendation was blank.<br><br>Review of Resident #56's clinical record indicated the resident continued to receive an antipsychotic medication. No evidence that an AIMS assessment had been completed was found by or provided to the surveyor.<br><br>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 a medical provider to address the 5/28/24 pharmacy recommendation for Resident #56 to have an AIMS completed. |

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| F 0758<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>21227<br><br>Based on staff interviews, clinical record review, and facility document review, the facility staff failed to ensure a correct diagnosis for the use of a psychotropic medication for one (1) of 27 sampled residents (Resident #56).<br><br>The findings include:<br><br>The facility staff failed to ensure the correct diagnosis for a psychotropic medication ordered for Resident #56.<br><br>Resident #56's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/20/24, was signed as completed on 7/29/24. Resident #56 was assessed as able to make self understood and as able to understand others. Resident #56's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact and/or borderline cognition.<br><br>Resident #56's clinical documentation included a consultant pharmacist recommendation dated 3/27/24 which stated, This resident is receiving the antipsychotic agent Aripiprazole (currently listed for mood), but lacks an allowable diagnosis to support its use. This pharmacist recommendation provided a list of diagnoses/conditions for the medical provider to consider. From this list the diagnoses/condition of Medical illness/delirium with manic/psychotic symptoms/treatment was circled with what appeared to be Ok written beside it. The medical provider dated addressing this pharmacist recommendation on 4/22/24. (Further review by the facility's Administrative Nursing staff indicated the note written beside the circled diagnosis/condition could be D/C (discontinue) not Ok.)<br><br>Resident #56's clinical record included an order for aripiprazole with a start date of 4/24/24; this order included the following information: .for delirium with manic/psychotic symptoms.<br><br>Documentation indicating Resident #56 was experiencing delirium with manic/psychotic symptoms was neither found by nor provide to the surveyor.<br><br>On 8/5/24 at 10:50 a.m., the Director of Nursing (DON) reported they spoke with the provider that signed the aforementioned pharmacy recommendation. The DON stated the medical provider was unable to provide clarification on what their response to the aforementioned pharmacy recommendation was intended to be when it was signed on 4/22/24. The DON provided the surveyor documentation of a progress note dated 8/2/24 which documented diagnosis for the aripiprazole as depression with mood disorder.<br><br>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 issue with Resident #56's documented reason for the aripiprazole being delirium with manic/psychotic symptoms. |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure medication error rates are not 5 percent or greater.<br><br>21227<br><br>Based on observations, staff interviews, clinical record review, and facility document review, the facility staff failed to ensure a medication error rate of less than 5%. There were two (2) medication errors in 30 opportunities for a medication error rate of 6.67%. These medication errors affected Resident #14.<br><br>The findings include:<br><br>The facility staff failed to ensure a medication error rate of less than 5% as evidenced by two (2) medication administration errors occurring during 30 opportunities witnessed during medication pass observations. Resident #14 was administered the incorrect dose of (a) fluticasone nasal spray and (b) furosemide tablets.<br><br>Resident #14's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 7/17/24, was signed as completed on 7/26/24. Resident #14 was assessed as able to make self understood and as able to understand others. Resident #14's Brief Interview for Mental Status (BIMS) summary score was documented as a 13 out of 15; this indicated intact and/or borderline cognition.<br><br>On 8/1/24 at 8:27 a.m., Licensed Practical Nurse (LPN) #9 was observed to administer medications to Resident #14. LPN #9 administered one (1) 40 mg tablet of furosemide; the medical provider order was for two (2) 40 mg tablets of furosemide. LPN #9 administered one (1) spray of fluticasone nasal spray in each of the resident's nostrils; the medical provider order was for two (2) sprays of fluticasone in each of the resident's nostrils. (Furosemide was ordered to treat excess fluid in the resident's body. Fluticasone nasal spray was ordered to treat the resident's allergies.)<br><br>The following information was found in a facility document titled Medication Administration (with a reviewed/revised date of 12/1/22):<br><br>- 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.<br><br>- Keep medication cart clean, organized, and stocked with adequate supplies.<br><br>- Review MAR to identify medication to be administered. (MAR - medication administration record)<br><br>- Compare medication source (bubble pack, vial, etc.) with MAR to verify resident name, medication name, form, dose, route, and time.<br><br>On 8/1/24 at 4:02 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Clinical Services, Regional Director of Operations, and Regional Food Services Director. During this meeting, the survey team discussed the aforementioned medication errors which resulted in a medication error rate of 6.67%. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47299<br><br>Based on observation, staff interview, and facility document review, the facility staff failed to store all medications and biologicals in a locked storage compartment on 1 of 2 nursing units, unit 1 hall C.<br><br>The findings included:<br><br>On 8/5/24 at 9:18 AM, this surveyor observed a medication cart in the hallway. The cart was unattended and unlocked. There was a staff member observed in room [ROOM NUMBER] interacting with a resident in the bed by the window. The staff member was not in the line of sight to the medication cart.<br><br>At 9:24 AM Licensed Practical Nurse (LPN) # 2 exited room [ROOM NUMBER]. When asked if they were assigned to that medication cart they stated, Yes, that's me today. When surveyor pointed out that the cart was unlocked they stated, I never do that. Surveyor asked if the cart should have been locked while unattended and unobserved and they stated, Yes, I should have locked it before I went in there.<br><br>This surveyor met with the Assistant Director of Nursing at 9:30 AM and discussed the concern.<br><br>A copy of the policy entitled, Medication Storage with a revised date of 12/1/22 was received. The policy, under the heading 1. General Guidelines, read in part a. All drugs and biologicals will be stored in locked compartments (i.e., medication carts, cabinets, drawers, refrigerators, medication rooms) under the proper temperature controls, and c. During a medication pass, medications must be under the direct observation of the person administering medications or locked in the medication storage area/cart.<br><br>The survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, Regional Director of Operations and Regional Director of Culinary Services on 8/6/24 at 12:15 PM and this concern was discussed.<br><br>No further information was provided to the survey team prior to the exit conference. |

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| F 0800<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs.<br><br>21227<br><br>Based on observations, staff interviews, and facility document review, the facility staff failed to use the correct size of serving utensils when plating residents' food.<br><br>The findings include:<br><br>The evening meal menu for 7/29/24 included: (a) a 4 oz. serving of corn and (b) a 6 oz. serving of mechanical soft pizza. On 7/29/24 at 5:54 p.m., Dietary Staff Member (DSM) #1 was observed to be plating resident food. DSM #1 stated a 3 oz. serving utensil was being used for the corn and a 4 oz. serving utensil was being used for the mechanical soft pizza. After reviewing the menu, the Dietary Manager confirmed the serving size for the corn was to be 4 oz. and the serving size for the mechanical pizza was to be 6 oz. DSM #1 was observed to change the serving utensils to allow for the correct serving size of the corn and the mechanical soft pizza.<br><br>On 7/31/24 at 1:45 p.m., the surveyor interviewed DSM #3 related to the serving size of the buttered noodles served during the midday meal on 7/31/24. DSM #3 reported they used a 3.25 oz serving utensil. The Regional Food Services Director reported the correct size of the serving utensil that should have been used would have provided a 4 oz serving of the buttered noodles.<br><br>On 7/31/24 at 4:47 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 failing to use the correct size serving utensil when plating resident food. |

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| F 0802<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service.<br><br>21227<br><br>Based on staff interviews and facility document review, the facility staff failed to have documented evidence of dietary staff training related to safe food handling.<br><br>The findings include:<br><br>The surveyor and the Regional Food Service Director (RFSD) reviewed the training and education of 12 dietary staff members who were working independently. These 12 dietary staff members did not have documentation of orientation. Nine (9) of the 12 dietary staff members reviewed did not have documentation of training related to safe food handling.<br><br>On 8/1/2 at 10:00 a.m., the surveyor discussed the facility's dietary staff training with the RFSD. The RFSD reported the facility did not have written policies related to the orientation of its dietary staff. The RFSD reported the facility did not have written policies related to the training of its dietary staff.<br><br>The RFSD provided the surveyor with a blank copy of a form titled ORIENTATION. This form did not specifically address safe food handling. The RFSD stated the topics on this form related to the overview of state and federal regulations would address information related to safe food handling. As of Monday, 8/5/24, several staff members had been trained in safe food handling.<br><br>The surveyor reviewed the dietary schedule with the RFSD and Dietary Manager on 8/1/24. The following full days were identified to not have a dietary staff member scheduled who had evidence of safe food handling training: 7/17/24, 7/21/24, 7/27/24, and 7/28/24. The following days were identified to not have a dietary staff member scheduled who had evidence of safe food handling training for part of the day: 7/14/24, 7/15/24, 7/16/24, 7/18/24, 7/19/24, 7/20/24, 7/25/24, 7/26/24, 7/29/24, and 7/30/24. |

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| F 0803<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident.<br><br>21227<br><br>Based on observations, staff interviews, and facility document review, the facility staff failed to consistently follow menus for resident meals.<br><br>The findings include:<br><br>On the afternoon of 7/29/24, Dietary Staff Member (DSM) #1 was observed preparing the tossed salad for the evening meal. DSM #1 was observed to chop up the lettuce for the salad without first washing the lettuce. DSM #1 stated that they chopped up the salad prior to washing it. DSM #1 was observed to place onions and tomatoes into the lettuce. On 7/29/24 at 3:25 p.m., the surveyor and the Dietary Manager watched DSM #1 wash the mixture of the chopped lettuce, chopped tomatoes, and chopped onions. The recipe for the toss salad included carrots; the recipe did not include onions. The instructions for the tossed salad included: Wash and drain lettuce. Chop lettuce into bite size pieces. In a large mixing bowl, add lettuce, carrots and tomatoes.<br><br>The evening meal menu for 7/29/24 included a 2 x 2 inch square of cake with icing. Observations of meal service for the evening meal for 7/29/24 revealed that cake without icing was being provided to the residents. The Dietary Manager stated the ordered icing did not come on the truck that brought the facility's food.<br><br>On 7/30/24 at 4:20 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Clinical Services, Regional Director of Operations, and Regional Food Services Director. During this meeting, the surveyor discussed the failure of facility dietary staff to follow the menu and/or recipes for resident food.<br><br>On 7/31/24 at 1:35 p.m., dietary staff were noted to be serving mashed potatoes when the menu for the midday meal indicated that buttered noodles where to be served. DSM #3 stated they had run out of buttered noodles. DSM #3 reported they were plating food for the last cart of resident trays when they had to start using mashed potatoes. Interviews with DSM #3 revealed they had not prepared enough buttered noodles. DSM #3 stated they had prepared one (1) bag of the noodles. Review of the facility's dietary documents indicated that two (2) bags of the noodles should have been prepared.<br><br>On 7/31/24, the facility's dietary staff were noted to be serving strawberry cake without icing. On 7/31/24, the Dietary Manager confirmed that strawberry cake without icing was served as part of the residents' midday meal. The Dietary Manager stated the menu for the midday meal was for strawberry short cake. The Dietary Manager reported that strawberry short cake would have included strawberries and whipped cream. The Dietary Manager reported they did not have strawberries or whipped cream.<br><br>On 7/31/24 at 4:47 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 dietary staff not being able to provide the dessert listed on the menu for the 7/31/24 midday meal due to not having the ingredients. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>21227<br><br>Based on observations, resident interviews, facility staff interviews, and facility document review, the facility staff failed to provide food that is palatable and/or attractive. The facility staff failed to ensure cookies were provided to three (3) of 27 sampled resident in a manner that ensured the cookies were palatable when served to the residents (Resident #28, Resident #73, and Resident #96).<br><br>The findings include:<br><br>1. The facility staff failed to ensure food was maintained on the steam table at a temperature to facilitate it being palatable when served to residents.<br><br>On 7/29/24 at 5:35 p.m., the cook (Dietary Staff Member (DSM) #1) had completed checking temperatures of the food on the steam/holding table. DSM #1 reported that the temperatures were okay, and they were planning to start serving food to residents from the steam/holding table. The Dietary Manager was asked to review the documentation of the aforementioned temperatures; the Dietary Manager denied having concerns with the temperatures. The form the temperatures were documented on included the following statement: Hot Foods above > 135 F . Take Immediate action if Temperatures are not at standard. The mechanical soft pizza was documented 126 F. The pureed cream corn was documented as 121 F. The pureed pizza was documented as 101 F. The surveyor asked the Dietary Manager about the three (3) aforementioned food temperatures; the Dietary Manager rechecked the temperatures and reheated the items that were still found to be below 135 F.<br><br>49622<br><br>2. For Resident #73 (R73), the facility staff failed to provide food that is palatable and attractive to ensure the resident's satisfaction.<br><br>R73's diagnosis list indicated diagnoses that included, but were not limited to, Morbid (severe) obesity, Anemia, Tachycardia, Constipation, Edema, and Hypothyroidism.<br><br>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.<br><br>On 7/29/24 at 2:10 PM, surveyor interviewed R73, and he stated the food is kind of, whacked. Surveyor observed resident's lunch tray and a cookie was observed sitting on top of the potatoes and carrots on the plate. Surveyor asked resident if he took the cookie out of a baggie and he stated, No, they do that all the time. Surveyor asked resident to pick cookie up and the cookie appeared wet on the bottom and resident agreed the cookie was soggy.<br><br>On 7/29/24 at 3:50 PM, surveyor interviewed dietary manager, and informed her that cookies had been observed on resident trays laying on top of the vegetables, she stated the cookies should have been wrapped.<br><br>(continued on next page) |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | This concern was discussed at the end of day meeting on 7/30/24 at 4:15 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 meetings on 7/31/24 at 4:47 PM, 8/1/24 at 4:00 PM, 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received a facility policy titled, Food Preparation Guidelines, that read in part, .It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition .status .2. Foods should be prepared by methods that conserve .appearance .3. Food .shall be palatable, attractive . Strategies to ensure resident satisfaction include .c. Serving .cold foods .cold .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24.<br><br>3. For Resident #96 (R96), the facility staff failed to provide food that is palatable and attractive to ensure the resident's satisfaction.<br><br>R96's diagnosis list indicated diagnoses that included, but were not limited to, Hyperlipidemia, Type 2 Diabetes Mellitus, Depression, and Transient Ischemic Attack (TIA).<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 05/18/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 13 out of 15 for cognitive abilities, indicating R96 was cognitively intact.<br><br>On 7/29/24 at 3:09 PM, surveyor interviewed resident and she stated the food is good, but her cookie was placed on her potatoes and carrots today (7/29/24).<br><br>On 7/29/24 at 3:50 PM, surveyor interviewed dietary manager, and informed her that cookies had been observed on resident trays laying on top of the vegetables, she stated the cookies should have been wrapped.<br><br>This concern was discussed at the end of day meeting on 7/30/24 at 4:15 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 meetings on 7/31/24 at 4:47 PM, 8/1/24 at 4:00 PM, 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received a facility policy titled, Food Preparation Guidelines, that read in part, .It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition .status .2. Foods should be prepared by methods that conserve .appearance .3. Food .shall be palatable, attractive . Strategies to ensure resident satisfaction include .c. Serving .cold foods .cold .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24.<br><br>(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<br>B. Wing | 08/06/2024 |

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

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | 4. For Resident #28 (R28), the facility staff failed to provide food that is palatable and attractive to ensure the resident's satisfaction.<br><br>R28's diagnosis list indicated diagnoses that included, but were not limited to, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, Congestive Heart Failure, Peripheral Vascular Disease, Major Depressive Disorder, and Anxiety Disorder.<br><br>The most recent minimum data set (MDS) with an assessment reference date (ARD) of 06/27/2024 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 for cognitive abilities, indicating R28 was cognitively intact.<br><br>On 7/29/24 at 2:26 PM, surveyor interviewed R28. Surveyor observed resident's lunch tray with a cookie on top of her potatoes and carrots and resident stated, the cookie got soggy.<br><br>On 7/29/24 at 3:50 PM, surveyor interviewed dietary manager, and informed her that cookies had been observed on resident trays laying on top of the vegetables, she stated the cookies should have been wrapped.<br><br>This concern was discussed at the end of day meeting on 7/30/24 at 4:15 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 meetings on 7/31/24 at 4:47 PM, 8/1/24 at 4:00 PM, 8/5/24 at 4:30 PM and again at the pre-exit meeting on 8/6/24 at 12:16 PM.<br><br>Surveyor requested and received a facility policy titled, Food Preparation Guidelines, that read in part, .It is the policy of this facility to prepare foods in a manner to preserve or enhance a resident's nutrition .status .2. Foods should be prepared by methods that conserve .appearance .3. Food .shall be palatable, attractive . Strategies to ensure resident satisfaction include .c. Serving .cold foods .cold .<br><br>No further information regarding this concern was presented to the survey team prior to the exit conference on 08/06/24. |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.<br><br>49622<br><br>21227<br><br>Based on observations, staff interviews, and facility document review, the facility staff failed to appropriately prepare, store, and/or serve resident food items.<br><br>The findings include:<br><br>On 7/29/24 at approximately 1:30 p.m., a surveyor (with the Dietary Manager present) observed Dietary Staff Member (DSM) #1 and DSM #2 working in the kitchen food preparation area without wearing beard covers. The Dietary Manager confirmed that DSM #1 and DSM #2 should have been wearing beard covers.<br><br>The following information was found in a facility policy titled Dietary Employee Personal Hygiene (with a reviewed/revised date of 12/2/22): All dietary staff must wear hair restraints (e.g., hairnet, hat and/or beard restraint) to prevent hair from contacting food.<br><br>On 7/26/24 at 1:35 p.m., a surveyor (with the Dietary Manager present) made observations of the facility's food storage in the dietary department. The following was observed:<br><br>- A metal pan containing chicken noodle soup was observed in the facility's freezer. This pan had foil between the lid and the pan. The lid was labeled with a date that could not be read due to it being smeared. When the Dietary Manager lifted the foil, ice crystals were noted to be on the top of the frozen chicken noodle soup. The Dietary Manager reported the chicken noodle soup should not have been stored in this manner. The Dietary Manager reported they would discard this chicken noodle soup.<br><br>- A container of broccoli soup was stored in one of the kitchen's freezers. This broccoli soup was labeled to indicate it was good until 7/13/24. The Dietary Manager reported the broccoli soup should have already been discarded.<br><br>- A bag of leftover frozen French toast was dated 7/1/24. The Dietary Manager reported the French toast should not have been frozen. The Dietary Manager reported they would discard the French toast.<br><br>- A bag of leftover frozen breaded fish was dated 7/1/24. The Dietary Manager reported this fish could not be used. The Dietary Manager reported the fish would be discarded.<br><br>- A bag of biscuits was noted on a shelf in the kitchen. This bag of biscuits was labeled with the date 7/26/24. The Dietary Manager reported that the biscuits should not have been saved. The Dietary Manager reported they would discard the biscuits.<br><br>(continued on next page) |

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| F 0812<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | On 7/29/24 at 2:40 p.m., a surveyor observed a bowl of vanilla pudding on a resident's nightstand. This bowl of pudding had a plastic lid that was labeled with a sticker that identified the resident's name, the room number, and the contents of the bowl. This label was dated 7/13/24. Licensed Practical Nurse (LPN) #7 read the lid on the bowl and confirmed it was dated 7/13/24. LPN #7 opened the lid; the pudding appeared curdled. LPN #7 threw the bowl of pudding in the trash.<br><br>The following information was found in a facility policy titled Date Marking for Food Safety (with a reviewed/revised date of 12/1/22):<br><br>- The facility adheres to a date marking system to ensure the safety of ready-to-eat, time/temperature control for safety [sic] food.<br><br>- The food shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded.<br><br>- The Head Cook, or designee, shall be responsible for checking the refrigerators daily for food items that are expiring, and shall discard accordingly.<br><br>- Note: prepared, temperature sensitive, foods that are delivered to the nursing units shall be discarded within two hours, if not consumed. These items shall not be refrigerated as the time/temperature controls cannot be verified.<br><br>On 7/29/24 at approximately 2:45 p.m., the surveyor and the Dietary Manager observed the storage of serving bowls. The bowls were overflowing from the container in which they were stored. Six (6) bowls were noted to be resting on a window ledge; this window ledge was noted to also have debris which included two (2) dead winged insects. Two (2) pink water pitchers were noted in the sink in the dishwashing room. The Dietary Manager confirmed this sink was a hand washing sink. The Dietary Manager reported the two (2) pink water pitchers would be discarded.<br><br>On 7/29/24 at 5:25 p.m., DSM #1 was observed to be checking the temperatures of food on the steam/holding table. DSM #1 was observed to clean the thermometer with a wet towel obtained from a green bucket; DSM #1 was observed to check the temperature of another food item after cleaning the thermometer with the wet towel obtained from the green bucket. The Dietary Manager was asked if it was okay to clean the thermometer with the towel from the green bucket; the Dietary Manager instructed DSM #1 to clean the thermometer with an alcohol wipe. The Dietary Manager determined the green bucket contained water with a soap/cleaning solution. |

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| F 0814<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Many | Dispose of garbage and refuse properly.<br><br>21227<br><br>Based on observations, staff interviews, and facility document review, the facility staff failed to ensure proper disposal and/or containment of the facility's garbage/waste.<br><br>The findings include:<br><br>On 7/31/24 at 1:15 p.m., the surveyor and the Dietary Manager made observations of the garbage disposal area outside of the facility but located on the facility's campus. The following observations were noted:<br><br>- One (1) of the two (2) facility dumpsters was noted to have its two (2) doors partially open. The right door was open approximately four (4) inches; the left door was open approximately eight (8) inches. The left door was observed to have a bag, containing garbage, hanging partially out of the door.<br><br>- Ten (10) medical gloves were noted to be on the ground to the right of and/or behind the facility's dumpsters.<br><br>- Six (6) foam bowls were noted to be on the ground to the right of the facility's dumpsters.<br><br>- One (1) meal size foam clam shell container was noted to be on the ground to the right of the facility's dumpsters.<br><br>- One (1) bag of garbage containing disposable adult briefs and disposable blue pads was noted in a dumpster that did not have a lid/door to prevent/limit animal access to the bag of garbage.<br><br>- A barrel where the facility staff disposes of used cooking grease was noted outside the facility. The lid to this barrel was not completely closed. A piece of aluminum foil was noted to be hanging out of the opening of the barrel and the unclosed lid.<br><br>The following information was found in a facility policy titled Disposal of Garbage and Refuse (with a reviewed/revised date of 12/1/22):<br><br>- Refuse containers and dumpsters kept outside the facility shall be designed and constructed to have tightly fitting lids, doors, or covers. Containers and dumpsters shall be kept covered when not being loaded. Surrounding area shall be kept clean so that accumulation of debris and insect/rodent attractions are minimized.<br><br>- Dumpsters shall be emptied according to the facility contract. Garbage should not accumulate or be left outside the dumpster.<br><br>On 7/31/24 at 4:47 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 survey team discussed the aforementioned observations of the improper disposal of facility garbage/waste. |

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| F 0842<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.<br><br>21227<br><br>Based on staff interviews, clinical record reviews, and facility document review, the facility staff failed to maintain complete and/or accurate clinical documentation for one (1) of 27 sampled residents (Resident #15).<br><br>The findings include:<br><br>Resident #15's Durable Do Not Resuscitate (DDNR) form, dated 5/1/24, was incomplete.<br><br>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.<br><br>The DDNR form has a section where the individual completing the form certifies that the resident is either capable or incapable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment. This section was not answered by the individual completing Resident #15's DDNR Order form.<br><br>The DDNR form has a section that is to be completed when the resident is determined to be incapable of making an informed decision about providing, withholding, or withdrawing a specific medical treatment or course of medical treatment . This section identifies by whom and/or under what authority the DDNR was issued for a resident who had been determined incapable in the aforementioned section. This section was not answered for Resident #15.<br><br>The following information was found in a facility document titled Documentation in Medical Record (with a reviewed/revised date of 12/1/22):<br><br>- 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.<br><br>- Documentation shall be accurate, relevant, and complete, containing sufficient details about the resident's care and/or responses to care.<br><br>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 Resident #15's DDNR being incomplete. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>47299<br><br>Based on observation, staff interview and facility document review, the facility staff failed to perform hand hygiene between residents during a medication pass and pour observation.<br><br>The findings included:<br><br>On 8/1/24 at 8:39 AM Licensed Practical Nurse (LPN) # 1 failed to perform hand hygiene appropriately between residents during a medication pass and pour observation.<br><br>LPN # 1 administered medications to included an inhaler to a resident in the first bed. They handled items on the residents bedside table as well. They then went back to the medication cart and pulled all the medications for the window bed resident. They did not perform hand hygiene until after all medications were administered. When surveyor asked what the policy was for performing hand hygiene during a medication pass, they stated, I should have done it before I started the next ones medications.<br><br>On 8/1/24 surveyor requested and received the policy entitled, Medication Administration with a revised date of 12/1/22, that confirmed hand hygiene is expected to be done before and after administering medications to a resident.<br><br>A document entitled, Handwashing Competency Skills: Infection Control with LPN # 1's name and date of 7/22/24 was provided by the Regional Director of Clinical Services (RDCS). They stated that the facility had a skills fair and hand hygiene had been covered.<br><br>On 8/1/24 at 3:59 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing and the RDCS. This concern was discussed at that time.<br><br>No further information was provided to the survey team prior to the exit conference. |