STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495409	A. Building B. Wing	08/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Abingdon Health Care LLC	15051 Harmony Hills Lane Abingdon, VA 24211

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 28169 Based on staff interviews, clinical record review, and document review, facility staff failed to ensure provider ordered medications were administered for 1 of 23 current residents sampled. (Resident #31) The findings were: For Resident #31, facility staff failed to administer the resident four (4) doses of provider ordered Gabapentin in May 2024. Resident #31's diagnoses included but were not limited to Coalworker's Pneumoconiosis. Section C (cognitive patterns) of the minimum data set with an assessment reference date of 06/20/24 coded the resident's brief interview for mental status as 14 out of 15 points. Resident #31's clinical record contained an order for Gabapentin 600 mg, give 1 tablet by mouth four times a day for neuropathy began on 11/07/23 and was scheduled to be administered at midnight, 6:00 a.m., noon, and 6:00 p.m. daily. The medication administration record (MAR) for May 2024 indicated four doses of Gabapentin were not administered between 05/19/24 and 05/21/24: 1. 05/19/24 noon dose, 2. 05/19/24 6:00 p.m. dose, 3. 05/20/24 6:00 p.m. dose, and 4. 05/21/24 midnight dose. A registered nurse (RN) supervisor's progress note dated 05/19/24 at 12:23 p.m. read, called pharmacy to try to get a code to pull Gabapentin for resident- was told by pharmacist that resident did not have any more pills on his prescription to be able to get a code to pull one and that he needed a new prescription, messaged [Physician Assistant name omitted] to try to get a prescription faxed in and then tried to call a little while ago with no answer. The same RN supervisor wrote a progress note the same day at 7:05 p.m. which read, pharmacy stated that they had the e script for medicine but that it was not ready for me to get a code to pull it. (continued on next page)

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

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

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The RN supervisor was unavailable for interview. The director of nursing (DON) was interviewed on 08/07/24 at 11:05 a.m. and acknowledged Resident #31 did not receive four doses of their scheduled Gabapentin doses in May 2024. The DON reported it took two days for the medication refill to arrive at the facility and their Cubex (backup medication system) ran out of Gabapentin. No further information was provided prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 42353 Based on observation, staff interview, and facility document review, the facility staff failed to prepare, distribute, and serve food in accordance with professional standards for food service safety in the facility kitchen. The findings included: The facility staff stacked (nested) wet chafing pans together after washing. On 8/05/24 at 7:00 PM, the surveyor observed a shelving unit with multiple stacks of stacked (nested) small chafing pans. At the surveyor's request, Dietary Staff Member (DSM) #1 separated individual pans from three separate stacks and found water droplets between pans in each stack. DSM #1 stated staff would wash the pans again. On 8/06/24 at 4:48 PM, the survey team met with the Administrator, Director of Nursing, and the Clinical Services Specialist and discussed the concern of dietary staff nesting wet pans. On 8/07/24 at 9:54 AM, surveyor received a Staff In-service Education form dated 8/06/24 which read in part Reviewed Policy #FN.501 .air drying pot/pans/dishes after washing cycle - no wet nesting . which was signed by nine staff members. Surveyor received the facility policy titled Dishwasher Use and Temperature Monitoring with a reviewed/revised date of 1/15/24 and Reference Number of FN.501 which read in part .12. Dishes are left in racks until dry. Dietary staff should check all dishes, trays, bowls, and cups to ensure they are dry before stacking or placing in the proper storage area . No further information regarding this concern was presented to the survey team prior to the exit conference on 8/07/24.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 28567 Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 6 of 23 residents, Residents #100, 101, 115, 263, 36, and 57. The findings include: 1. For Resident #100, the facility staff failed to complete a preliminary consent to treat form in the residents clinical record. Resident #100's diagnoses included muscle wasting/atrophy and diabetes. Section C (cognitive patterns) of Resident #100's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 05/06/24 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. The clinical record included the following documents. Provider order dated 01/30/24 for a full code. A signed preliminary consent to treat and assignment of benefits form dated 01/30/24. The area that referenced the residents Do Not Resuscitate (DNR) and advance directive status had not been completed. On 08/06/24 at 2:40 p.m., during an interview with the Director of Admissions this staff confirmed part of this form was incomplete. The Administrator stated they would be providing education. On 08/06/24 at 4:45 p.m., during an end of the day meeting with the Administrator, Director of Nursing, and Clinical Service Specialist the issue with the incomplete document was reviewed. On 08/07/24, the Administrator provided the survey team with a copy of an in-service dated 08/06/24 indicating they had begun staff education regarding this issue. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #101, the facility staff failed to complete a preliminary consent to treat form in the residents clinical record. Resident #101's diagnoses included chronic kidney disease and hypertension. Section C (cognitive patterns) of Resident #101's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 07/30/24 included a brief interview for mental status (BIMS) score of 12 out of a possible 15 points. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	The clinical record included the following documents. Provider order dated 04/24/24 for a full code. A signed preliminary consent to treat and assignment of benefits form dated 02/28/24. The area that referenced the residents Do Not Resuscitate (DNR) and advance directive status had not been completed. On 08/06/24 at 2:40 p.m., during an interview with the Director of Admissions this staff confirmed part of this form was incomplete. The Administrator stated they would be providing education. On 08/07/24 the Administrator provided the survey team with a copy of an in-service dated 08/06/24 indicating they had begun staff education regarding this issue. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident #115, the facility staff failed to complete a preliminary consent to treat form in the residents clinical record. Resident #115's diagnoses included acute on chronic systolic congestive heart failure and diabetes. There was no completed minimum data set (MDS) assessment for this resident, The clinical record included the following documents. Provider order dated 08/01/24 for a full code. Signed preliminary consent to treat and assignment of benefits form dated 08/01/24. The area that referenced the residents Do Not Resuscitate (DNR) and advance directive status had not been completed. On 08/06/24 at 2:40 p.m., during an interview with the Director of Admissions this staff confirmed part of this form was incomplete. The Administrator stated they would be providing education. On 08/07/24 the Administrator provided the survey team with a copy of an in-service dated 08/06/24 indicating they had begun staff education regarding this issue. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #263, the facility staff failed to complete a preliminary consent to treat form in the residents clinical record. Resident #263's diagnoses included age related osteoporosis with current pathological fracture. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Section C (cognitive patterns) of Resident #263's minimum data set (MDS) assessment included a brief interview for mental status (BIMS) score of 12. The clinical record included the following documents. Provider order dated 07/29/24 indicating this resident had a Do Not Resuscitate (DNR) order in place. Signed preliminary consent to treat and assignment of benefits form dated 07/26/24. The area that referenced the residents Do Not Resuscitate (DNR) and advance directive status had not been completed. On 08/06/24 at 2:40 p.m., during an interview with the Director of Admissions this staff confirmed part of this form was incomplete. The Administrator stated they would be providing education. On 08/07/24, the Administrator provided the survey team with a copy of an in-service dated 08/06/24 indicating they had begun staff education regarding this issue. No further information regarding this issue was provided to the survey team prior to the exit conference. 28169 5. For Resident #36, facility staff failed to complete the advance directive portion of a preliminary consent to treat and assignment of benefits document found in the resident's clinical record. Resident #36's diagnoses included but were not limited to hemiplegia and hemiparesis following cerebral infarction affecting left non-dominant side. Section C (cognitive patterns) of the minimum data set with an assessment reference date of 05/30/24 coded the resident's brief interview for mental status as 00 (zero) out of 15 points. Resident #36's clinical record contained a document titled Preliminary Consent to Treat and Assignment of Benefits, dated 01-09-23 and signed by Resident #36's agent. The document's section titled, DNA Status and Advance Directive had blank spaces which had not been filled out. On 08/07/24 at approximately 10:30 a.m., the administrator acknowledged the form was not filled out completely and stated the concern was an opportunity for staff education. No further information was provided prior to the exit conference. 6. For Resident #57, facility staff failed to complete a preliminary consent to treat document found in the resident's clinical record. Resident #57's diagnoses included but were not limited to osteomyelitis of vertebra, lumbar region. Section C (cognitive patterns) of the minimum data set with an assessment reference date of 07/15/24 coded the resident's brief interview for mental status as 02 (two) out of 15 points. (continued on next page)

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F 0842 Level of Harm - Potential for minimal harm Residents Affected - Some	Resident #57's clinical record contained a document titled Preliminary Consent to Treat and Assignment of Benefits, dated 04-23-24. There is a signature at the Resident's Signature line however no signature at the Resident Agent's Signature line. The document's section titled, DNA Status and Advance Directive had blank spaces which had not been filled out. On 08/07/24 at approximately 10:30 a.m., the administrator acknowledged the form was not filled out completely and stated the concern was an opportunity for staff education. No further information was provided prior to the exit conference.