		ND HUMAN SERVICES			FORM APPROVED
STATEMENT (S FOR MEDICARE & OF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED
	\mathbf{D}	495250	B. WING		C 11/16/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE 6 GLENDALE RD	
GALAX H	EALTH AND REHAB			ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 000	Initial Comments		E 000		
E 004 SS=D	survey was conducte Corrections are requ CFR Part 483.73, Re Care Facilities. No e complaints were inve Develop EP Plan, Re CFR(s): 483.73(a) §403.748(a), §416.54		E 004		12/27/23
	§441.184(a), §460.8 §483.475(a), §484.10 §485.542(a), §485.63 §485.920(a), §486.30 §494.62(a).	25(a), §485.727(a),			
	Federal, State and lo preparedness require develop establish an emergency prepared requirements of this	ements. The [facility] must d maintain a comprehensive ness program that meets the section. The emergency m must include, but not be			
	and maintain an eme that must be [reviewe	The [facility] must develop gency preparedness plan ed], and updated at least plan must do all of the			
	CAH] must comply w State, and local eme	ency Plan. The [hospital or ith all applicable Federal, rgency preparedness nospital or CAH] must			
		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

Electronically Signed

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.

PRINTED: 12/19/2023

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HI	EALTH AND REHAB		-	GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
E 004	requirements of this all-hazards approach * [For LTC Facilities a Plan. The LTC facility an emergency preparent reviewed, and update * [For ESRD Facilitie Plan. The ESRD facility maintain an emerger must be [evaluated], years. This REQUIREMENT by: Based on staff interview, the facility sta Emergency Prepared reviewed and update The findings included The facility EP Plan we updated on 2/25/22. On 11/16/23 at 9:30 EP Plan was conduct and Maintenance Dir page of the facility E statement "Reviewed Administrator verified on 2/25/22 and state reviewed, updated, a (Quality Assurance a	Iness program that meets the section, utilizing an h. at §483.73(a):] Emergency y must develop and maintain redness plan that must be ed at least annually. Is at §494.62(a):] Emergency lity must develop and here and here and here and here and updated at least every 2 T is not met as evidenced view and facility document aff failed to ensure the dness (EP) Plan was ed annually. d: was last reviewed and AM, a review of the facility ted with the Administrator rector. The table of contents P Plan included the difference of the plan was last reviewed di typically the EP Plan was and brought through the QAPI and Performance	E 004	 The center reviewed and updated t Emergency Preparedness Plan (EPP) 12/15/2023. The center identified that the EPF had not been reviewed in 2023. The NHA/designee will ensure that the plan reviewed annually in January of each calendar year to remain in compliance The VP of Operations will re-educ the Administrator on the need to updat the EPP annually. The NHA/designee will ensure th plan is reviewed by the QA committee January of 2024 to ensure the plan is reviewed in January of each calendar year. 	on b n is cate e e
	On 11/16/23 at 9:30 EP Plan was conduct and Maintenance Dir page of the facility El statement "Reviewed Administrator verified on 2/25/22 and state reviewed, updated, a (Quality Assurance a Improvement) Comm	ted with the Administrator rector. The table of contents P Plan included the d February 25, 2022." The d the plan was last reviewed d typically the EP Plan was and brought through the QAPI		the Administrator on the need to updat the EPP annually. 4) The NHA/designee will ensure th plan is reviewed by the QA committee January of 2024 to ensure the plan is reviewed in January of each calendar	e e

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CENTER	S FOR MEDICAR	E & MEDICAID SERVICES		(DMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	DNSTRUCTION	(X3) DATE SURVEY COMPLETED
				с	
	495250		B. WING		11/16/202 <u>3</u>
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HEALTH AND REHAB			GLENDALE RD .AX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIO DATE
E 004	Continued From	page 2	E 004		
	this had not been	done in 2023 but was unable to			
	employed by the	as they were only recently facility.			
		59 PM, the survey team met			
		rator, Regional Vice President of the Chief Nursing Officer and			
		ncern of the facility EP Plan not			
	being reviewed a	nd updated annually.			
	No further inform	ation regarding this concern was			
	presented to the	survey team prior to the exit			
F 000	conference on 11		F 000		40/07/00
E 006 SS=D	CFR(s): 483.73(a	l Hazards Risk Assessment)(1)-(2)	E 006		12/27/23
		2), §416.54(a)(1)-(2), 2), §441.184(a)(1)-(2),			
	§460.84(a)(1)-(2)	, §482.15(a)(1)-(2), §483.73(a)			
		$(a)(1)-(2), \ $ §484.102 $(a)(1)-(2), \ $			
		, §485.542(a)(1)-(2), 2), §485.727(a)(1)-(2),			
		2), §486.360(a)(1)-(2),			
	§491.12(a)(1)-(2)	, §494.62(a)(1)-(2)			
	[(a) Emergency F	Plan. The [facility] must develop			
		emergency preparedness plan			
		ewed, and updated at least every n must do the following:]			
		and include a documented,			
	-	l community-based risk zing an all-hazards approach.*			
		gies for addressing emergency by the risk assessment.			
	* [For Hospices a	t §418.113(a):] Emergency Plan.			

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>
GALAX HI	EALTH AND REHAB		-	ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
E 006	emergency prepared reviewed, and updat plan must do the foll (1) Be based on and facility-based and co assessment, utilizing (2) Include strategies events identified by including the manag of power failures, na emergencies that wo ability to provide car *[For LTC facilities a Plan. The LTC facilities a Plan. The LTC facilities a Plan. The LTC facilities a reviewed, and updat must do the following (1) Be based on and facility-based and co assessment, utilizing including missing res (2) Include strategies events identified by *[For ICF/IIDs at §48 The ICF/IID must de emergency prepared reviewed, and updat plan must do the foll (1) Be based on and facility-based and co assessment, utilizing including missing clii (2) Include strategies	evelop and maintain an dness plan that must be ted at least every 2 years. The owing: I include a documented, ommunity-based risk g an all-hazards approach. s for addressing emergency the risk assessment, ement of the consequences tural disasters, and other build affect the hospice's e. t §483.73(a):] Emergency y must develop and maintain aredness plan that must be ted at least annually. The plan g: I include a documented, ommunity-based risk g an all-hazards approach, sidents. s for addressing emergency the risk assessment. 33.475(a):] Emergency Plan. evelop and maintain an dness plan that must be ted at least every 2 years. The owing: I include a documented, ommunity-based risk g an all-hazards approach,	E 006		

Facility ID: VA0037

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		E & MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
495250		B. WING		C 11/16/2023	
NAME OF PR	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333	
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETIO
E 006	Continued From p	bage 4	E 006		
	This REQUIREM	ENT is not met as evidenced			
	Based on staff interview and facility document			1) The center reviewed and updated t	
		v staff failed to ensure the		Emergency Preparedness Plan (EPP)	
	Emergency Preparedness (EP) Plan included a documented, facility-based, and			12/15/2023, including the All-Hazard R	lisk
		l risk assessment utilizing an		Assessment. 2) The center identified that the	
	· ·	ach that was reviewed and		All-Hazard Risk Assessment had not b	een
	updated annually.			reviewed in 2023. The NHA/designee ensure that the plan is reviewed annual	will
	The findings inclu	ded:		in January of each calendar year to remain in compliance.	
	The facility's EP F	Plan was last reviewed and		3) The VP of Operations will re-edu	cate
		22 and the all-hazard risk		the Administrator on the need to updat	
		last reviewed and updated on		the EPP annually, including the All-Ha	zard
	9/16/22.			Risk Assessment. 4) The NHA/designee will ensure the	e
	On 11/16/23 at 9:	30 AM, a review of the facility		plan is reviewed by the QA committee	
		ducted with the Administrator		January of 2024 to ensure the plan is	
		Director. The table of contents		reviewed in January of each calendar	
		y EP Plan included the		year.	
		wed February 25, 2022." The fied the plan was last reviewed			
		ated typically the EP Plan was			
		d, and brought through the QAPI			
		e and Performance			
	Improvement) Co	mmittee during January or			
	February of each	year.			
		d and Vulnerability Analysis			
		cility EP Plan was dated 9/16/22			
		Long Term Care communities			
		nduct and annually review their			
		lity Analysis (HVA)" The fied the all-hazard risk			
		last reviewed on 9/16/22.			
	The Administrator assessment and t	verified the all-hazard risk			

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	-	I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
TATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING		(X3) DATE SURVEY COMPLETED
495250		B. WING	ETN/	C 11/16/202 <u>3</u>	
NAME OF P	ROVIDER OR SUPPLIER		STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			GLENDALE RD LAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
E 006	Continued From	page 5	E 006		
		updated in 2023 but was unable on as they were only recently facility.			
	with the Administ Operations, and t discussed the cor	59 PM, the survey team met rator, Regional Vice President of he Chief Nursing Officer and ncern of the facility EP Plan not nd updated annually.			
		ation regarding this concern was survey team prior to the exit /16/23.			
E 013 SS=D	Development of E CFR(s): 483.73(b	EP Policies and Procedures)	E 013		12/27/23
	§441.184(b), §46 §483.475(b), §48 §485.542(b), §48	6.54(b), §418.113(b), 0.84(b), §482.15(b), §483.73(b), 4.102(b), §485.68(b), 5.625(b), §485.727(b), 6.360(b), §491.12(b),			
	develop and imple policies and proce plan set forth in p assessment at pa and the communi this section. The	rocedures. [Facilities] must ement emergency preparedness edures, based on the emergency aragraph (a) of this section, risk aragraph (a)(1) of this section, cation plan at paragraph (c) of policies and procedures must updated at least every 2 years.			
	procedures. The implement emerg procedures, base forth in paragraph	s at §483.73(b):] Policies and LTC facility must develop and ency preparedness policies and ed on the emergency plan set n (a) of this section, risk aragraph (a)(1) of this section,			

Facility ID: VA0037

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	-	ND HUMAN SERVICES					APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING			L	LETED
		495250	B. WING	_			C 16/2023
NAME OF P	ROVIDER OR SUPPLIER			STRI	EET ADDRESS, CITY, STATE, ZIP CODE		
	EALTH AND REHAB			836	GLENDALE RD		
GALAA H	EALTH AND REHAD			GAI	LAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 013	this section. The pole be reviewed and up *Additional Requirer Facilities: *[For PACE at §460 procedures. The P/ develop and implem policies and procedu plan set forth in para assessment at para and the communica this section. The pole address manageme emergencies, include equipment, power, of emergencies; and n threaten the health staff, or the public. must be reviewed a years. *[For ESRD Facilities procedures. The dia and implement emergencies set forth in paragrap assessment at para and the communica this section. The pole set forth in paragrap assessment at para and the communica this section. The pole be reviewed and up These emergencies to, fire, equipment of emergencies, water	ge 6 tion plan at paragraph (c) of olicies and procedures must dated at least annually. ments for PACE and ESRD .84(b):] Policies and ACE organization must nent emergency preparedness ures, based on the emergency agraph (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of olicies and procedures must ent of medical and nonmedical ling, but not limited to: Fire; or water failure; care-related atural disasters likely to or safety of the participants, The policies and procedures and updated at least every 2 es at §494.62(b):] Policies and alysis facility must develop rgency preparedness policies sed on the emergency plan ob (a) of this section, risk graph (a)(1) of this section, tion plan at paragraph (c) of olicies and procedures must dated at least every 2 years. include, but are not limited or power failures, care-related supply interruption, and ely to occur in the facility's	EO	13			

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PRINTED: 12/19/2023

		AND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
	/ 1	495250	B. WING		11/16/202 <u>3</u>	
GALAX HEALTH AND REHAB			TREET ADDRESS, CITY, STATE, ZIP CODE			
		836 GLENDALE RD GALAX, VA 24333				
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA	DATE	
IAG	REGOLATORI		IAG	DEFICIENCY)		
E 013	Continued From	bade 7	E 013			
	This REQUIREM	ENT is not met as evidenced	2013			
		terview and facility document		1) The center reviewed and updated the		
		/ staff failed to ensure the		Emergency Preparedness Plan (EPP)	on	
		aredness (EP) Policy and		12/15/2023, including Procedures.		
		reviewed and updated annually.		 The center identified that the EPP Procedures had not been reviewed in 		
	The findings inclu	ded:		2023. The NHA/designee will ensure the plan is reviewed annually in Januar		
	The facility's EP F	Policy and Procedures were last		each calendar year to remain in	,	
	reviewed and upo	lated on 2/25/22.		compliance. 3) The VP of Operations will re-educ	ate	
	On 11/16/23 at 9:	30 AM, a review of the facility		the Administrator on the need to update		
		ducted with the Administrator		the EPP annually, including Procedures		
	and Maintenance	Director. The table of contents		4) The NHA/designee will ensure the	;	
	page of the facility	y EP Plan included the		plan is reviewed by the QA committee i	n	
	statement "Revie	wed February 25, 2022." The		January of 2024 to ensure the plan is		
	Administrator veri	fied the plan including the policy		reviewed in January of each calendar		
		vere last reviewed on 2/25/22		year.		
		lly the EP Plan was reviewed,				
		ught through the QAPI (Quality				
		erformance Improvement)				
		January or February of each				
		istrator was unable to provide a				
	•	ere only recently employed by				
	the facility.					
	On 11/16/23 at 4 [.]	59 PM, the survey team met				
		rator, Regional Vice President of				
		he Chief Nursing Officer and				
		ncern of the facility's EP Policy				
	and Procedures r	not being reviewed and updated				
	annually.					
		ation regarding this concern was				
		survey team prior to the exit				
F 000	conference on 11				10/07/00	
E 029 SS=D	Development of C	Communication Plan	E 029		12/27/23	

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD	
GALAX HI	EALTH AND REHAB			GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
E 029	Continued From page CFR(s): 483.73(c)	e 8	E 029		
	§403.748(c), §416.54 §441.184(c), §460.84 §483.475(c), §484.10 §485.542(c), §485.62 §485.920(c), §486.30 §494.62(c).	4(c), §482.15(c), §483.73(c), 02(c), §485.68(c), 25(c), §485.727(c),			
	emergency prepared that complies with Fe and must be reviewe 2 years [annually for This REQUIREMENT by:	develop and maintain an ness communication plan ederal, State and local laws d and updated at least every LTC facilities]. T is not met as evidenced view and facility document		1) The center reviewed and updated t	the
	Emergency Prepared Plan was reviewed a			Emergency Preparedness Plan (EPP) 12/15/2023, including the Communica Plan. 2) The center identified that the EPF	tion
	The findings included The facility's EP Com reviewed and update	nmunication Plan was last		Communication Plan had not been reviewed in 2023. The NHA/designee ensure that the plan is reviewed annua in January of each calendar year to	
	EP Plan was conduct and Maintenance Dir page of the facility Ef Communication Plan "Reviewed February Administrator verified on 2/25/22 and state was reviewed, update QAPI (Quality Assura	I the plan was last reviewed d typically the entire EP Plan ed, and brought through the ance and Performance ittee during January or		remain in compliance. 3) The VP of Operations will re-edu the Administrator on the need to updat the EPP annually, including the Communication Plan. 4) The NHA/designee will ensure th plan is reviewed by the QA committee January of 2024 to ensure the plan is reviewed in January of each calendar year.	e

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
	ROVIDER OR SUPPLIER	495250	B. WING	TREET ADDRESS, CITY, STATE, ZIP CODE	C 11/16/202 <u>3</u>
	EALTH AND REHAB		8	36 GLENDALE RD GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
E 029 E 030 SS=D	Plan had not been re 2/25/22 but was unal they were only recent On 11/16/23 at 4:59 with the Administrate Operations, and the discussed the conce being reviewed and of No further informatio presented to the surve conference on 11/16 Names and Contact CFR(s): 483.73(c)(1) §403.748(c)(1), §416 §441.184(c)(1), §460 §483.73(c)(1), §483. §485.68(c)(1), §485. §485.727(c)(1), §485. §485.727(c)(1), §485. §491.12(c)(1), §494. [(c) The [facility must emergency prepared that complies with Fe and must be reviewe 2 years [annually for communication plan following:] (1) Names and conta following: (i) Staff.	rified the EP Communication eviewed and/or updated since ble to provide a reason as thy employed by the facility. PM, the survey team met rr, Regional Vice President of Chief Nursing Officer and rn of the facility EP Plan not updated annually. n regarding this concern was vey team prior to the exit /23. Information 6.54(c)(1), §418.113(c)(1), 0.84(c)(1), §482.15(c)(1), 1475(c)(1), §482.15(c)(1), 542(c)(1), §485.625(c)(1), 542(c)(1), §486.360(c)(1), 62(c)(1). a develop and maintain an lness communication plan ederal, State and local laws ad and updated at least every LTC facilities]. The must include all of the act information for the services under arrangement.	E 029		12/27/23

Facility ID: VA0037

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED
- E	495250		B. WING		C 11/16/2023
NAME OF PI	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HI	EALTH AND REHAB			LAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 030	Continued From pag (v) Volunteers.	<u>e</u> 10	E 030		
	§485.625(c)] The col include all of the follo (1) Names and conta following: (i) Staff.	act information for the services under arrangement. ans and CAHs].			
	communication plan following: (1) Names and conta following: (i) Staff.	must include all of the act information for the services under arrangement.			
	plan must include all (1) Names and conta following: (i) Staff. (ii) Entities providing (iii) Patients' physicia (iv) Volunteers.	act information for the services under arrangement. ans.			
	following:	18.113(c):] The must include all of the act information for the			

Event ID: N6VL11

Facility ID: VA0037

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
	495250		B. WING		C
NAME OF P	ROVIDER OR SUPPLIER	400200		IREET ADDRESS, CITY, STATE, ZIP CODE	11/16/202 <u>3</u>
			83	36 GLENDALE RD	
GALAX R	EALTH AND REHAB		G	ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
E 030	Continued From pag	ge 11	E 030		
	(i) Hospice employe	es. I services under arrangement.			
	plan must include al (1) Names and conta following: (i) Staff.	act information for the services under arrangement.			
	plan must include al (2) Names and contr following: (i) Staff. (ii) Entities providing (iii) Volunteers. (iv) Other OPOs. (v) Transplant and d Donation Service Ar This REQUIREMEN	act information for the services under arrangement. onor hospitals in the OPO's			
	by: Based on staff inter review, the facility st Emergency Prepare Plan including staff r information was revi The findings include The facility's staff na	view and facility document taff failed to ensure the dness (EP) Communication names and contact ewed and updated annually. d: the sand contact information n was last reviewed and		 The center reviewed and updated t Emergency Preparedness Plan (EPP) 12/15/2023, including Staff Names and Contact Information. The center identified that the EPF had not been reviewed in 2023. The NHA/designee will ensure that the plan reviewed annually in January of each calendar year to remain in compliance 3) The VP of Operations will re-educ the Administrator on the need to update the EPP annually, including the Staff 	on d n is cate
	On 11/16/23 at 9:30	AM, a review of the facility		Names and Contact Information.	

Facility ID: VA0037

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	MENT OF HEALTH S FOR MEDICAR	E & MEDICAID SERVICES			FORM APPRO OMB NO. 0938-0
TATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
	/ []]	495250	B. WING		11/16/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 36 GLENDALE RD	
GALAX HI	EALTH AND REHAB			ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLET
E 030	Continued From p	hade 12	E 030		
	EP Plan was contant Maintenance page of the facility Communication F "Reviewed Febru Communication F contact informatic was no longer em Administrator veri on 2/25/22 and st was reviewed, up QAPI (Quality Ass Improvement) Co February of each The Administrator Plan had not been 2/25/22 but was u they were only re On 11/16/23 at 4:	ducted with the Administrator Director. The table of contents y EP Plan which included the Plan included the statement ary 25, 2022." The Plan included the name and on for a Director of Nursing that apployed by the facility. The fied the plan was last reviewed cated typically the entire EP Plan dated, and brought through the surance and Performance mmittee during January or		 4) The NHA/designee will ensure the plan is reviewed by the QA committee January of 2024 to ensure the plan is reviewed in January of each calendar year. 5) Allegation of Compliance: 12/27/2 	in
E 024	Operations, and t discussed the cor being reviewed at No further informa presented to the s conference on 11	he Chief Nursing Officer and neern of the facility EP Plan not nd updated annually. ation regarding this concern was survey team prior to the exit /16/23.	E 024		10/07/0
	CFR(s): 483.73(c §403.748(c)(2), § §441.184(c)(2), § §483.73(c)(2), §4 §485.68(c)(2), §4	416.54(c)(2), §418.113(c)(2), 460.84(c)(2), §482.15(c)(2), 83.475(c)(2), §484.102(c)(2), 85.542(c)(2), §485.625(c)(2), 485.920(c)(2), §486.360(c)(2),	E 031		12/27/2

Facility ID: VA0037

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/19/2023 APPROVED . 0938-0391
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE S COMPL	
		495250	B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER		S	IREET ADDRESS, CITY, STATE, ZIP CODE		6/202 <u>3</u>
GALAXH	EALTH AND REHAB		8	36 GLENDALE RD		
			G	ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 031	Continued From pag	e 13	E 031			
	emergency prepared that complies with Fe and must be reviewe 2 years [annually for communication plan following: (2) Contact informatii (i) Federal, State, trik emergency prepared (ii) Other sources of *[For LTC Facilities a information for the fo (i) Federal, State, trik emergency prepared (ii) The State Licensi (iii) The Office of the Ombudsman. (iv) Other sources of	must include all of the on for the following: oal, regional, and local iness staff. assistance. It §483.73(c):] (2) Contact ilowing: oal, regional, and local iness staff. ng and Certification Agency. State Long-Term Care				
	information for the fo (i) Federal, State, trik emergency prepared (ii) Other sources of (iii) The State Licens (iv) The State Protect This REQUIREMENT by: Based on staff interv review, the facility state Emergency Prepared	Ilowing: bal, regional, and local Iness staff. assistance. ing and Certification Agency. tion and Advocacy Agency. T is not met as evidenced view and facility document aff failed to ensure the dness (EP) Communication ed contact information was ed annually.		 The center reviewed and updated the Emergency Preparedness Plan (EPP) 12/15/2023, including Required Contact Information. The center identified that the EPF had not been reviewed in 2023. The NHA/designee will ensure that the plan 	on ct	

Facility ID: VA0037

If continuation sheet Page 14 of 136

		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/19/2023 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE	
		495250	B. WING			C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			36 GLENDALE RD		
			I	GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 031	Continued From pag	e 14	E 031			
	information for the fe local emergency pre- licensing and certific Long Term Care Om reviewed and update On 11/16/23 at 9:30 EP Plan was conduc and Maintenance Dir page of the facility E Communication Plan "Reviewed February Administrator verified on 2/25/22 and state was reviewed, updat QAPI (Quality Assura Improvement) Comm February of each yea The Administrator ver Plan including requir not been reviewed a	AM, a review of the facility sted with the Administrator rector. The table of contents P Plan which included the included the statement 25, 2022." The d the plan was last reviewed d typically the entire EP Plan ted, and brought through the ance and Performance nittee during January or ar. Prified the EP Communication red contact information had nd/or updated since 2/25/22 ovide a reason as they were		reviewed annually in January of each calendar year to remain in compliance 3) The VP of Operations will re-educ the Administrator on the need to updat the EPP annually, including Required Contact Information. 4) The NHA/designee will ensure the plan is reviewed by the QA committee January of 2024 to ensure the plan is reviewed in January of each calendar year. 5) Allegation of Compliance: 12/27/2	cate e e in	
	with the Administrato Operations, and the discussed the conce being reviewed and No further informatio	n regarding this concern was				
E 036 SS=D	conference on 11/16		E 036			12/27/23

Facility ID: VA0037

If continuation sheet Page 15 of 136

CENTERS FOR MEDICARE & MEDICARD SERVICES ONB NO. 0938-0331 MORTANNO FORMECTION (x) providemensupplication, identification Number: (x) providemensupplication, identification Number: (x) providemensupplication, identification Number: (x) providemensupplication, identification AND FLAN OF CONFECTION (x) providemensupplication, identification (x) providemensupplication, identification (x) providemensupplication, identification AND FLAN OF CONFECTION (x) providemensupplication, identification (x) providemensupplication, identification (x) providemensupplication, identification Galaxy NA FLAN DREAD (x) providemensupplication, identification (x) providemensupplication, identification (x) providemensupplication, identification (x) providemensupplication, identification (x) providemensupplication, identification (x) providemensupplication (x) providemensupplication (x) providemensupplication (x) providemensupplication		-				FORM APPROVED
Construction Construction NAME OF PROVIDER OR SUMPLIER STREET ADDRESS, CITY, STATE JP CODE CALAX HEALTH AND REHAB STREET ADDRESS, CITY, STATE JP CODE CALAX HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCES (CAU) CONFIGURATION CITY OF CONFECTION CITY OF CONFECTION (EXC) CONFECTION CITY OF CONFECTION (EXC) CONFECTION CITY OF CONFECTION (EXC) CONFECTION CITY OF CONFECTION (EXC) CONFECTION CITY OF CONFECTION CITY OF CONFECTION (EXC) CONFECTION CITY OF CONFECTION (EXC) CONFECTION CITY OF CONFECTION (EXC) CONFECTION CITY OF CONFECTION (EXC) CONFECTION CITY OF C	STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· · /		
State Alexandro Section 2012 GALAX HEALTH AND REHAB CALAX, VX 2333 PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY PLL), TAG PROVIDERS FLAN OF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY PLL), REQUIRTERY OR LSC IDENTIFYING INFORMATION) DEFICIENCY E 036 Continued From page 15 E 036 \$403,748(d), \$416,54(d), \$418,113(d), \$444,1184(d), \$460,84(d), \$422,15(d), \$483,73(d), \$445,522(d), \$445,522(d), \$485,727(d), \$445,522(d), \$445,522(d), \$485,727(d), \$445,522(d), \$445,522(d), \$485,727(d), \$445,522(d), \$466,522(d), \$485,727(d), \$444,52(d), "FOR NCHIS at \$403,748, ASCs at \$416,54, Hospice at \$418,113, PRTFs at \$441,184, PACE at \$460,44, Hospitals at \$420,748, ASCs at \$416,54, Hospice at \$418,113, PRTFs at \$441,184, PACE at \$460,25, "Organizations" under 485,727, CMHCs at \$485,522(d), \$485,522(d), at \$486,320, and RHC/FHQs at \$491,121(d) Training and testing, The [facilit] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a)(1) of this section, nick assessment at paragraph (b) of this section, and the communication plan at paragraph (c) of this section, The training and testing program must be reviewed and updated at least every 2 years. "IFor LIC facilities at \$438,73(d); (d) Training and testing program that is based on the emergency plan set forth in paragraph (a)(1) of this section, nick assessment at paragraph (b) of this section, and the colore and proceed and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragrap			495250	B. WING		
GALAX HEALTH AND REHAB GALAX, VA 24333 PAGENC TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH EDFICIENCY MIST BERECEDED BY FULL RECULATORY OR LSC IDENTIFYING INFORMATION) PROVINCE TAG PEERX TAG Continued From page 15 E 036 Continued From page 15 §403.748(d), §416.54(d), §418.113(d), §445.12(d), §485.62(d), §485.727(d), §485.542(d), §486.522(d), §486.527(d), §485.542(d), §486.522(d), §486.527(d), §485.542(d), §486.525(d), §485.727(d), §484.102, CORFs at §486.30(d), §491.12(d), §484.62(d). E 036 "[For RNCHIs at §403.748, ASCs at §416.54, Hospice at §418.113, PRTFs at §485.542, CAHs at \$486.65; Organizations" under 485.727, CMHCs at §485.920, OPOs at §486.300, and RHC/FHQs at §491.12(d) Training and testing. The facility must develop and maintain an emergency preparedness training and testing. The facility must develop and maintain an emergency preparedness training and testing program this is based on the emergency planest forth in paragraph (b) of this section, nolicies and procedures at paragraph (b) of this section, nolicies and procedures at paragraph (b) of this section, nolicies and procedures at paragraph (c) of this section, nolicies and procedures at paragraph (b) of this section, nolicies and procedures at paragraph (c) of this section, nolicies and procedures at paragraph (b) of this section, nolicies and procedures at paragraph (c) of t	NAME OF PI	ROVIDER OR SUPPLIER				
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION) PREFIX TAG (EACH DECRETIFY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) E 036 Continued From page 15 E 036 \$403.748(d), \$416.54(d), \$418.113(d), \$441.184(d), \$460.84(d), \$482.15(d), \$433.73(d), \$485.542(d), \$486.52(d), \$486.5727(d), \$485.542(d), \$486.52(d), \$486.5727(d), \$485.542(d), \$486.52(d), \$486.5727(d), \$485.542(d), \$486.52(d), \$486.5727(d), \$486.542(d), \$486.62(d), \$491.12(d), \$486.542(d), \$486.62(d), \$491.12(d), \$486.360, and HR/CFHOs at \$485.920, OPDs at \$486.360, and HR/CFHOs at \$491.12; (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing, The [facility] must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, policies and procedures at paragraph (b) of this section. The training and testing program must be reviewed and updated at least every 2 years. "[For LTC facilities at \$483.73(d); (d) Training and testing The LTC facility must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a) (1) of this section, risk assessment at paragraph (a) (1) of this section, risk assessment at paragraph (b) of this section, risk assessment at paragraph (a) (1) of this section, risk assessment at paragraph (b) of this section, risk assessment at paragraph (b) of this section, risk assessment at paragraph (b) (c) this section, risk assessment at pa	GALAX HI	EALTH AND REHAB				
 \$403.748(d), \$416.54(d), \$418.113(d), \$441.184(d), \$460.84(d), \$482.15(d), \$483.73(d), \$443.475(d), \$484.102(d), \$485.68(d), \$485.542(d), \$484.525(d), \$485.727(d), \$485.542(d), \$486.360(d), \$491.12(d), \$494.62(d). "[For RNCHIs at \$403.748, ASCs at \$416.54, Hospice at \$418.113, PRTFs at \$441.184, PACE at \$460.84, Hospitals at \$482.15, HHAs at \$484.102, COFFs at \$485.68, REHs at \$485.542, CAHs at \$486.625, "Organizations" under 485.727, CMHCs at \$485.920, OPCs at \$486.360, and RHC/FHOs \$4 \$491.12] (d) Training and testing. The [facility] must develop and maintain an emergency preparedness training and testing. The [facility] must develop and maintain an emergency preparedness training and testing. The Ifacility] for this section, risk assessment at paragraph (a) of this section, risk assessment at paragraph (a) of this section, risk assessment at paragraph (b) of this section, notice and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least every 2 years. "[For LTC facilities at \$483.73(d):] (d) Training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing. The LTC facility must develop and maintain and mergency preparedness training and testing. The LTC facility must develop and maintain an emergency preparedness training and testing. The LTC facility must develop and maintain and the testing training and testing program that is based on the emergency plan set forth in	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA	E COMPLETION
paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.	E 036	§403.748(d), §416.5 §441.184(d), §460.6 §483.475(d), §484.7 §485.542(d), §485.6 §485.920(d), §486.3 §494.62(d). *[For RNCHIs at §44 Hospice at §418.113 at §460.84, Hospita §484.102, CORFs at CAHs at §486.625, 485.727, CMHCs at §486.360, and RHC Training and testing and maintain an em training and testing emergency plan set section, risk assess this section, policies (b) of this section, a paragraph (c) of this testing program emergency plan set section, risk assess this section, rhe LT maintain an emerge and testing. The LT maintain an emerge and testing program emergency plan set section, risk assess this section, policies (b) of this section, a paragraph (c) of this testing program	54(d), §418.113(d), 64(d), §482.15(d), §483.73(d), 102(d), §485.68(d), 525(d), §485.727(d), 360(d), §491.12(d), 03.748, ASCs at §416.54, 3, PRTFs at §441.184, PACE Is at §482.15, HHAs at t §485.68, REHs at §485.542, "Organizations" under §485.920, OPOs at /FHQs at §491.12:] (d) . The [facility] must develop ergency preparedness program that is based on the forth in paragraph (a) of this ment at paragraph (a)(1) of and procedures at paragraph nd the communication plan at a section. The training and st be reviewed and updated at At §483.73(d):] (d) Training C facility must develop and ncy preparedness training that is based on the forth in paragraph (a) of this ment at paragraph (a) (1) of and procedures at paragraph nd the communication plan at is based on the forth in paragraph (a) of this ment at paragraph (a) (1) of and procedures at paragraph nd the communication plan at a section. The training and	E 036		

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PRINTED: 12/19/2023

	-	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/19/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIEF	R	s	STREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HI	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
E 036	testing. The ICF/ an emergency pr program that is b forth in paragraph assessment at pa policies and proc section, and the op paragraph (c) of testing program r least every 2 year requirements for §483.470(i). *[For ESRD Facilitesting, and orient develop and main preparedness tra- orientation progra- emergency plan section, risk asset this section, polic (b) of this section paragraph (c) of and orientation p updated at every This REQUIREM by: Based on staff in review, the facility Emergency Prep	§483.475(d):] Training and IID must develop and maintain eparedness training and testing ased on the emergency plan set h (a) of this section, risk aragraph (a)(1) of this section, edures at paragraph (b) of this communication plan at this section. The training and must be reviewed and updated at rs. The ICF/IID must meet the evacuation drills and training at lities at §494.62(d):] Training, nation. The dialysis facility must nain an emergency ining, testing and patient am that is based on the set forth in paragraph (a) of this essment at paragraph (a) of this essment at paragraph (a)(1) of the set forth in paragraph (b) and the communication plan at this section. The training, testing rogram must be evaluated and 2 years. ENT is not met as evidenced atterview and facility document y staff failed to ensure the aredness (EP) Training and was reviewed and updated	E 036	 The center reviewed and updated t Emergency Preparedness Plan (EPP) 12/15/2023, including the Training and Testing Program. The center identified that the EPF had not been reviewed in 2023. The NHA/designee will ensure that the plar reviewed annually in January of each 	on
	-	aining and Testing Program was d updated on 2/25/22.		calendar year to remain in compliance 3) The VP of Operations will re-educ the Administrator on the need to updat	cate

Event ID: N6VL11

Facility ID: VA0037

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<u>CENTER</u>		HAND HUMAN SERVICES			FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF PI	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HI	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
E 036	On 11/16/23 at 9: EP Plan was com- and Maintenance page of the facilit and Testing Progu "Reviewed Febru Administrator ver on 2/25/22 and st reviewed, update (Quality Assurand Improvement) Co February of each this had not been provide a reason employed by the On 11/16/23 at 4: with the Administ Operations, and t discussed the con- including the Trai- being reviewed a	30 AM, a review of the facility ducted with the Administrator Director. The table of contents y EP Plan including the Training ram included the statement ary 25, 2022." The ified the plan was last reviewed tated typically the EP Plan was d, and brought through the QAPI ce and Performance mmittee during January or year. The Administrator stated done in 2023 but was unable to as they were only recently facility. 59 PM, the survey team met rator, Regional Vice President of the Chief Nursing Officer and neern of the facility EP Plan ning and Testing Program not ind updated annually. ation regarding this concern was survey team prior to the exit /16/23.	E 036	the EPP annually, including the Trainin and Testing Program. 4) The NHA/designee will ensure the plan is reviewed by the QA committee January of 2024 to ensure the plan is reviewed in January of each calendar year. 5) Allegation of Compliance: 12/27/2	e in
	CFR(s): 483.73(d §403.748(d)(1), § §441.184(d)(1), § §483.73(d)(1), §4 §485.68(d)(1), §4				
		§403.748, ASCs at §416.54, .15, ICF/IIDs at §483.475, HHAs			

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		ND HUMAN SERVICES			FORM	: 12/19/2023 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE COMP	LETED
		495250	B. WING		(11/	C 16/2023
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			GLENDALE RD _AX, VA 24333		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
E 037	Continued From pag	ge 18	E 037			
	at §484.102, REHs a under §485.727, OF RHC/FQHCs at §49					
	(1) Training program the following:	n. The [facility] must do all of				
	policies and procedu	mergency preparedness ures to all new and existing				
	· · ·	viding services under olunteers, consistent with their				
		ncy preparedness training at				
	(iii) Maintain docume preparedness trainir					
	procedures.	aff knowledge of emergency				
	procedures are sign must conduct trainin	r preparedness policies and ificantly updated, the [facility] ig on the updated policies and				
	procedures.					
	hospice must do all	-				
	policies and procedu	emergency preparedness ures to all new and existing				
		and individuals providing ngement, consistent with their				
	(ii) Demonstrate stat procedures.	ff knowledge of emergency				
	least every 2 years.	ncy preparedness training at				
		ew and rehearse its dness plan with hospice g nonemployee staff), with				
		aced on carrying out the ary to protect patients and				
1						

Facility ID: VA0037

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		ND HUMAN SERVICES			FORM	D: 12/19/2023 MAPPROVED D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		<u> </u>	LETED
		495250	B. WING			C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
E 037	Continued From pag (v) Maintain docume preparedness trainin (vi) If the emergency procedures are signi must conduct training procedures. *[For PRTFs at §441 program. The PRTF (i) Initial training in en- policies and procedu staff, individuals prov- arrangement, and vo- expected roles. (ii) After initial trainin- preparedness trainin (iii) Demonstrate stat procedures. (iv) Maintain docume preparedness trainin (v) If the emergency procedures are signi must conduct training procedures. *[For PACE at §460.1 organization must do (i) Initial training in en- policies and procedu staff, individuals prov- arrangement, contra- volunteers, consister (ii) Provide emergence least every 2 years. (iii) Demonstrate stat procedures, including what to do, where to	<pre>le 19 ntation of all emergency g. preparedness policies and ficantly updated, the hospice g on the updated policies and 1.184(d):] (1) Training must do all of the following: mergency preparedness ures to all new and existing viding services under olunteers, consistent with their g, provide emergency g every 2 years. ff knowledge of emergency g, preparedness policies and ficantly updated, the PRTF g on the updated policies and 84(d):] (1) The PACE o all of the following: mergency preparedness ures to all new and existing viding on-site services under ctors, participants, and nt with their expected roles. cy preparedness training at ff knowledge of emergency g informing participants of go, and whom to contact in</pre>	E 037			
		go, and whom to contact in				

Facility ID: VA0037

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		ND HUMAN SERVICES			FORM): 12/19/2023 1 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	<u> </u>	LETED
		495250	B. WING		(11/ [,]	C 16/2023
NAME OF PF	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HE	ALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
	STIMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
E 037	Continued From pag	e 20	E 037			
	()	entation of all training.				
		preparedness policies and ficantly updated, the PACE				
		g on the updated policies and				
		t §483.73(d):] (1) Training cility must do all of the				
	following:	morranavaradaaaa				
		nergency preparedness res to all new and existing				
	staff, individuals prov	-				
	arrangement, and vo expected role.	lunteers, consistent with their				
	(ii) Provide emergen	cy preparedness training at				
	least annually. (iii) Maintain docume	ntation of all emergency				
	preparedness trainin	g.				
	(iv) Demonstrate stat procedures.	ff knowledge of emergency				
	*[For CORFs at §485 CORF must do all of	5.68(d):](1) Training. The the following:				
	(i) Provide initial train	ning in emergency				
		s and procedures to all new dividuals providing services				
	-	and volunteers, consistent				
	with their expected re	bles. cy preparedness training at				
	least every 2 years.	cy preparedness training at				
	()	ntation of the training.				
		ff knowledge of emergency personnel must be oriented				
	and assigned specifi	c responsibilities regarding				
	-	ncy plan within 2 weeks of he training program must				
	-	the location and use of				
	alarm systems and s	ignals and firefighting				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 36 GLENDALE RD	
GALAX H	EALTH AND REHAB			GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
E 037	procedures are signi must conduct training procedures. *[For CAHs at §485.1 The CAH must do al (i) Initial training in en- policies and procedur reporting and extingu- and where necessar personnel, and gues cooperation with firet authorities, to all new individuals providing and volunteers, cons- roles. (ii) Provide emergen least every 2 years. (iii) Maintain docume (iv) Demonstrate star procedures. (v) If the emergence procedures are signi must conduct training procedures. *[For CMHCs at §48 CMHC must provide preparedness policies and existing staff, ind under arrangement, with their expected re documentation of the demonstrate staff kn procedures. Thereat	y preparedness policies and ficantly updated, the CORF g on the updated policies and 625(d):] (1) Training program. I of the following: mergency preparedness res, including prompt uishing of fires, protection, y, evacuation of patients, ts, fire prevention, and fighting and disaster v and existing staff, services under arrangement, sistent with their expected cy preparedness training at entation of the training. ff knowledge of emergency y preparedness policies and ficantly updated, the CAH g on the updated policies and 5.920(d):] (1) Training. The initial training in emergency es and procedures to all new dividuals providing services and volunteers, consistent	E 037		

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	2: 12/19/2023 1 APPROVED 2: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	<u> </u>	LETED
		495250	B. WING		(11/	C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB			836 GLENDALE RD GALAX, VA 24333		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	COMPLETION DATE
E 037	Continued From page	ge 22	E 037	,		
	years.	IT is not met as evidenced				
	by:	I IS NOT THE AS EVIDENCED				
	Based on staff inter	rview and facility document		1) The center will provide Emergency		
	-	taff failed to ensure staff		Preparedness Plan (EPP) training to a current staff members and all new hire		
		gency Preparedness (EP) w employees (licensed		2) The center identified that the EPF		
		and annual EP training for 1 of		had not been consistently reviewed wi		
	5 employees (certifi	ed nursing assistant #11).		all current staff and newly hired staff		
	The findings include	ed:		members. The NHA/designee will ens that the plan is reviewed with all newly	,	
	Licensed Practical N	Nurse (LPN) #7 was hired by		hired staff members upon hire and all annually in January of each calendar y		
		/23 and had not received		3) The VP of Operations will re-edu		
	-	Certified Nursing Assistant #11		the Administrator on the need to educa	ate	
	had not received an	inual EP training.		staff members on the EPP. 4) The NHA/designee will ensure th	e	
	On 11/16/23, survey	/or spoke with the		training plan is reviewed by the QA	0	
		equested evidence of initial		committee in January of 2024 to ensur		
	÷	#7 who was hired on		the training plan is reviewed in Januar	y of	
	evidence of the trair	nistrator was unable to provide ning.		each calendar year. 5) Allegation of Compliance: 12/27/2	23	
	On 11/16/23, survey	or spoke with the				
	Administrator and re	equested evidence of annual				
		#11; the Administrator was				
	for CNA #11.	vidence of the annual training				
	The Administrator w	as unable to provide a reason				
		ngs as they were only recently				
		PM, the survey team met or, Regional Vice President of				
		Chief Nursing Officer and				
		ern of facility staff not				

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	S FOR MEDICARE O	X MEDICAID SERVICES	(X2) MULTIPLE C	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		495250	B. WING		C
NAME OF PI	ROVIDER OR SUPPLIER	-00200		REET ADDRESS, CITY, STATE, ZIP CODE	11/16/202 <u>3</u>
				GLENDALE RD	
GALAX HI	EALTH AND REHAB		GA	LAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO
E 037	Continued From page	ge 23	E 037		
	No further information	on regarding this concern was rvey team prior to the exit			
E 039 SS=D	EP Testing Requirer CFR(s): 483.73(d)(2		E 039		12/27/23
	§460.84(d)(2), §482 §483.475(d)(2), §48 §485.542(d)(2), §48	3.113(d)(2), §441.184(d)(2), 2.15(d)(2), §483.73(d)(2), 34.102(d)(2), §485.68(d)(2), 35.625(d)(2), §485.727(d)(2), 11.12(d)(2), §494.62(d)(2).			
	at §485.542, OPO, ' §485.727, CMHCs a	.54, CORFs at §485.68, REHs "Organizations" under at §485.920, RHCs/FQHCs at) Facilities at §494.62]:			
		ility] must conduct exercises cy plan annually. The [facility] llowing:			
	community-based e (A) When a commu accessible, conduct exercise every 2 yea (B) If the [facilit	inity-based exercise is not a facility-based functional ars; or y] experiences an actual			
	activation of the em- exempt from engagi community-based o functional exercise f actual event.	e emergency that requires ergency plan, the [facility] is ing in its next required r individual, facility-based following the onset of the			
	years, opposite the functional exercise i	tional exercise at least every 2 year the full-scale or under paragraph (d)(2)(i) of ucted, that may include, but is lowing:			

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PRINTED: 12/19/2023

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/19/2023 APPROVED . 0938-0391
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE S COMPL	LETED
		495250	B. WING		C 11/1	C 16/2023
NAME OF PR	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HE	ALTH AND REHAB			6 GLENDALE RD ALAX, VA 24333		_
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
E 039	Continued From pag	e 24	E 039			
	 (A) A second full-scal community-based or functional exercise; of (B) A mock disaster of (C) A tabletop exercise a facilitator and inclua a narrated, clinically-scenario, and a set of directed messages, of designed to challeng (iii) Analyze the [facil maintain documentate exercises, and emerge [facility's] emergency *[For Hospices at 411 (2) Testing for hospic patient's home. The exercises to test the annually. The hospic (i) Participate in a fur community based ev (A) When a commun accessible, conduct a functional exercise e (B) If the hospic expressible, conduct a facility-based function onset of the emergency plan, engaging in its next recommunity-based exercise under paragement of the emergency plan, engaging in the emergency plan, engaging the emergency pl	ale exercise that is individual, facility-based or drill; or se or workshop that is led by des a group discussion using relevant emergency of problem statements, or prepared questions je an emergency plan. lity's] response to and tion of all drills, tabletop gency events, and revise the <i>r</i> plan, as needed. 8.113(d):] ces that provide care in the hospice must conduct emergency plan at least ce must do the following: ill-scale exercise that is very 2 years; or periences a natural or cy that requires activation of the hospital is exempt from required full scale kercise or individual nal exercise every 2 years, a full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited	E 039			

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		ND HUMAN SERVICES			FORM	2: 12/19/2023 1 APPROVED 2: 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE S COMPL	LETED
		495250	B. WING		C 11/1	C 16/2023
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333		_
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 039	exercise; or (B) A mock disaster (C) A tabletop exerci- a facilitator and inclu- a narrated, clinically- scenario, and a set of directed messages, designed to challeng (3) Testing for hospid care directly. The ho- exercises to test the year. The hospice m (i) Participate in an a is community-based (A) When a communi- accessible, conduct facility-based function (B) If the hospice exer- man-made emergen- the emergency plan, engaging in its next of based or facility-based following the onset of (ii) Conduct an addir may include, but is next of (iii) Conduct an addir	r a facility based functional r drill; or cise or workshop that is led by udes a group discussion using -relevant emergency of problem statements, or prepared questions ge an emergency plan. ces that provide inpatient ospice must conduct r emergency plan twice per nust do the following: annual full-scale exercise that ; or nity-based exercise is not an annual individual onal exercise; or periences a natural or ney that requires activation of , the hospice is exempt from required full-scale community ed functional exercise that itional annual exercise that not limited to the following:	E 039	DEFICIENCY)		
	exercise; or (B) A mock disaster (C) A tabletop exerci- facilitator that include narrated, clinically-re and a set of problem messages, or prepar challenge an emerge	r a facility based functional ⁻ drill; or cise or workshop led by a es a group discussion using a elevant emergency scenario, n statements, directed red questions designed to				

Facility ID: VA0037

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		ND HUMAN SERVICES			FORM APPROVED
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	ECONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			336 GLENDALE RD	
GALAX, VA 24333					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
E 039	exercises, and emer hospice's emergence *[For PRFTs at §441 §482.15(d), CAHs at	tion of all drills, tabletop gency events and revise the y plan, as needed. .184(d), Hospitals at	E 039		
	conduct exercises to twice per year. The do the following: (i) Participate in an is community-based (A) When a commun accessible, conduct facility-based functio (B) If the [PRTF, Hos actual natural or man requires activation o [facility] is exempt fro required full-scale co	test the emergency plan [PRTF, Hospital, CAH] must annual full-scale exercise that ; or hity-based exercise is not an annual individual, nal exercise; or spital, CAH] experiences an n-made emergency that f the emergency plan, the om engaging in its next ommunity based or individual, nal exercise following the			
	 (ii) Conduct an and that may include following: (A) A second full-sc community-based or functional exercise; a (B) A mock (C) A tabletop e led by a facilitator ar discussion, using a remergency scenario statements, directed questions designed plan. 	[additional] annual exercise or e, but is not limited to the ale exercise that is individual, a facility-based or disaster drill; or xercise or workshop that is			

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PRINTED: 12/19/2023

		ND HUMAN SERVICES			FORM	12/19/2023 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE S COMPL	ETED
		495250	B. WING		C 11/1	6/2023
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			GLENDALE RD LAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From pag	je 27	E 039			
		tion of all drills, tabletop gency events and revise the y plan, as needed.				
	exercises to test the annually. The PACE following: (i) Participate in an a is community-based (A) When a commun accessible, conduct facility-based function (B) If the PACE expen- man-made emergen the emergency plan, engaging in its next based or individual, the exercise following the event. (ii) Conduct an a years opposite the ye exercise under parage is conducted that may the following: (A) A second full-sc community-based or functional exercise; of (B) A mock disaster (C) A tabletop exerci- a facilitator and inclu- using a narrated, clir scenario, and a set of directed messages, designed to challeng (iii) Analyze the PAC	CE organization must conduct emergency plan at least organization must do the annual full-scale exercise that ; or hity-based exercise is not an annual individual, onal exercise; or eriences an actual natural or toy that requires activation of , the PACE is exempt from required full-scale community facility-based functional te onset of the emergency additional exercise every 2 ear the full-scale or functional graph (d)(2)(i) of this section ay include, but is not limited to cale exercise that is r individual, a facility based or				

Facility ID: VA0037

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		ND HUMAN SERVICES			FORM	: 12/19/2023 APPROVED . 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE COMPL	LETED
		495250	B. WING		11/1	C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	- "	0/202 <u>5</u>
GALAX H	EALTH AND REHAB			GLENDALE RD		
			GA	LAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 039	Continued From pag	je 28	E 039			
		gency events and revise the				
	test the emergency p	at §483.73(d):] must conduct exercises to olan at least twice per year, ced staff drills using the				
	ICF/IID] must do the	res. The [LTC facility, following: annual full-scale exercise that				
	is community-based;	; or iity-based exercise is not				
	facility-based functio					
	actual natural or mar	n-made emergency that f the emergency plan, the				
	LTC facility is exemp required a full-scale	ot from engaging its next community-based or				
	following the onset o	sed functional exercise if the emergency event.				
	may include, but is n	tional annual exercise that not limited to the following:				
	-	an individual, facility based				
	functional exercise; c (B) A mock disaster					
	a facilitator includes	a group discussion, using a elevant emergency scenario,				
	and a set of problem	n statements, directed red questions designed to				
		C facility] facility's response to				
	exercises, and emer	entation of all drills, tabletop gency events, and revise the s emergency plan, as needed.				
		י הואסיקטווא אס וופכעבע.				

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	-	ND HUMAN SERVICES			FORM APPROVED
STATEMENT	S FOR MEDICARE & OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY
AND PLAN O	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			336 GLENDALE RD	
_				GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
E 039	to test the emergency The ICF/IID must do (i) Participate in an a is community-based (A) When a commun accessible, conduct facility-based function (B) If the ICF/IID exp man-made emergen the emergency plan, engaging in its next community-based or functional exercise for emergency event. (ii) Conduct an addit may include, but is n (A) A second full-sca community-based or functional exercise; (B) A mock disaster (C) A tabletop exerci a facilitator and inclu using a narrated, clir scenario, and a set of directed messages, designed to challeng (iii) Analyze the ICF/ maintain documenta exercises, and emer ICF/IID's emergency *[For HHAs at §484. (d)(2) Testing. The H to test the emergency	33.475(d)]: (IID must conduct exercises ey plan at least twice per year. the following: annual full-scale exercise that ; or nity-based exercise is not an annual individual, nal exercise; or. periences an actual natural or cy that requires activation of the ICF/IID is exempt from required full-scale individual, facility-based pollowing the onset of the ional annual exercise that not limited to the following: ale exercise that is an individual, facility-based or drill; or ise or workshop that is led by ides a group discussion, nically-relevant emergency of problem statements, or prepared questions ge an emergency plan. IID's response to and tion of all drills, tabletop gency events, and revise the r plan, as needed. 102] IHA must conduct exercises	E 039		

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PRINTED: 12/19/2023

		ND HUMAN SERVICES			FORM): 12/19/2023 1APPROVED): 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE S COMPL	LETED
		495250	B. WING		C 11/1	C 16/2023
NAME OF P	ROVIDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
GALAX H	EALTH AND REHAB			GLENDALE RD LAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
E 039	community-based; o (A) When a com accessible, conduct facility-based function or. (B) If the HHA e or man-made emerg of the emergency platengaging in its next of community-based or functional exercise for emergency event. (ii) Conduct an additt opposite the year the exercise under parage is conducted, that limited to the followin (A) A second full community-based or functional exercise; o (B) A mock disa (C) A tabletop e led by a facilitator and discussion, using a r emergency scenario statements, directed questions designed to plan. (iii) Analyze the HHA documentation of all emergency events, a emergency plan, as *[For OPOs at §486. (d)(2) Testing. The C to test the emergency following:	nr nmunity-based exercise is not an annual individual, anal exercise every 2 years; experiences an actual natural gency that requires activation an, the HHA is exempt from required full-scale individual, facility based ollowing the onset of the ional exercise every 2 years, e full-scale or functional graph (d)(2)(i) of this section at may include, but is not ng: Il-scale exercise that is r an individual, facility-based or ster drill; or xercise or workshop that is nd includes a group narrated, clinically-relevant o, and a set of problem messages, or prepared to challenge an emergency A's response to and maintain drills, tabletop exercises, and and revise the HHA's needed.	E 039			

Facility ID: VA0037

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OLIVILI	S FOR MEDICAR	E & MEDICAID SERVICES			OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
495250		B. WING		С	
				TREET ADDRESS, CITY, STATE, ZIP CODE	11/16/202 <u>3</u>
NAME OF PROVIDER OR SUPPLIER			36 GLENDALE RD		
GALAX HEALTH AND REHAB				GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIC
E 039	Continued From	page 31	E 039		
		t annually. A tabletop exercise is	2 000		
		r and includes a group			
		a narrated, clinically relevant			
		ario, and a set of problem			
		ted messages, or prepared			
		ed to challenge an emergency			
		experiences an actual natural or gency that requires activation of			
		lan, the OPO is exempt from			
		ext required testing exercise			
		et of the emergency event.			
	(ii) Analyze the O	PO's response to and maintain			
		f all tabletop exercises, and			
		ts, and revise the [RNHCI's and cy plan, as needed.			
	*[RNCHIs at §40	-			
		e RNHCI must conduct			
	must do the follow	the emergency plan. The RNHCI			
		per-based, tabletop exercise at			
		tabletop exercise is a group			
	· ·	a facilitator, using a narrated,			
		emergency scenario, and a set			
		nents, directed messages, or			
		ns designed to challenge an			
	emergency plan.				
		NHCI's response to and ntation of all tabletop exercises,			
		events, and revise the RNHCI's			
	emergency plan,	as needed.			
		ENT is not met as evidenced			
	by: Based on staff in	nterview and facility document		1) The center will organize a Full Sca	le
		y staff failed to participate in an		Exercise of the Emergency Preparedr	
		Emergency Preparedness (EP)		Plan (EPP).	
	exercise.			2) The center identified that the cen	nter
				had not participated in a Full Scale	
	The findings inclu	ıded:		Exercise annually. The NHA/designed	e will

Facility ID: VA0037

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 12/19/2023 APPROVED D: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		<u> </u>	LETED
		495250	B. WING			C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
E 039	Continued From pag	e 32	E 039			
F 000	full-scale EP exercise On 11/16/23 at 9:30 EP Plan was conduct and Maintenance Din full-scale exercise way The Administrator act most recent full-scale unable to provide ev coordinated with outs a full-scale exercise. The Administrator way for the lack of a full-sc only recently employ On 11/16/23 at 4:59 with the Administrator Operations, and the discussed the conce participate in an ann No further information presented to the sum conference on 11/16 INITIAL COMMENTS An unannounced Ma	AM, a review of the facility ted with the Administrator rector. The most recent as completed on 5/12/22. knowledged this was the e EP exercise and was idence that the facility had side EP agencies to schedule as unable to provide a reason acale exercise as they were ed by the facility. PM, the survey team met or, Regional Vice President of Chief Nursing Officer and rn of the facility failing to ual full-scale EP exercise. In regarding this concern was vey team prior to the exit /23.	F 000	ensure that the center participates in a Full Scale Exercise annually each yea remain in compliance. 3) The VP of Operations will re-edu the Administrator on the need to participate in a Full Scale Exercise wit the Healthcare Coalition annually by 12/27/2023. 4) The NHA/designee will coordinat and schedule a Full Scale Exercise of EPP. 5) Allegation of Compliance: 12/27/	r to cate h the	
	survey:	were investigated during the ompliant with regulations				

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	OMB NO. 0938-0391
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: A. BUILDI	IPLE CONSTRUCTION (X3) DATE SURVEY OMPLETED
495250 B. WING	C 11/16/2023
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GALAX HEALTH AND REHAB	GALAX, VA 24333
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFI TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
 2. VA00059998 - Non-compliant with regulations 3. VA00059988 - Non-compliant with regulations 4. VA00059957 - Non-compliant with regulations 5. VA00059953 - Non-compliant with regulations 6. VA00059918 - Compliant with regulations 7. VA00059911 - Non-compliant with regulations 8. VA00059296 - Compliant with regulations The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 89 at the time of the survey. The survey sample consisted of 22 current resident reviews and 4 (four) closed record reviews. 	

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	11/10/202 <u>5</u>
GALAX H	EALTH AND REHAB			36 GLENDALE RD	
				GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 550	Continued From pag	e 34	F 550		
		under the State plan for all			
		right to exercise his or her f the facility and as a citizen			
	resident can exercise	cility must ensure that the e his or her rights without n, discrimination, or reprisal			
	free of interference, reprisal from the faci rights and to be supp exercise of his or he subpart. This REQUIREMEN	esident has the right to be coercion, discrimination, and lity in exercising his or her ported by the facility in the r rights as required under this T is not met as evidenced			
	interview and facility staff failed to respec	on, staff interview, Resident document review the facility residents' rights to a or 1 of 22 residents, Resident d:		The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies herein. To remain in compliance with all federa and state regulations, the center has taken or is planning to take the actions	al
	For Resident #8 the incontinence pads. Resident #8's face s	facility staff failed to provide heet listed diagnoses which ed to multiple sclerosis,		forth in the following plan of correction The following plan of correction constitutes the center's allegation of compliance. All alleged deficiencies cit have been or are to be corrected by th date or dates indicated.	ted
		ne, and pressure ulcer to			
	-			F550	
		ecent minimum data set with ence date of 09/18/23		1) The center provided incontinence)

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CENTER	-	H AND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIEF	र	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HEALTH AND REHAB		836 GLENDALE RD GALAX, VA 24333			
			I		
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES DENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLÉTIC
F 550	Continued From	page 35	F 550		
	status score of 1	ident a brief interview for mental 5 out of 15 in section C, cognitive dicates that the resident is		supplies per resident #8 preference o 12/20/23. 2) The center identified current	n
	cognitively intact			incontinent residents and new admiss with incontinence to be at risk. The	sions
	reviewed and cor	mprehensive care plan was ntained a care plan for " has ination of bowel and bladder,		DON/Designee reviewed the current incontinent resident's incontinence management regimen on or before	
	diuretic use, inco	intinence." Interventions for this ed, "Use of briefs/pads for		12/27/23 and determined appropriate incontinence management.	
	incontinence prot	-		 The DON/Designee will re-educate the licensed nurses and CNAs on 	ated
	4:40 pm. Resider	with Resident #8 on 11/13/23 at nt #8 stated to surveyor that they		resident's rights and incontinence management on or before 12/27/23.	
	that the facility us	d still use the incontinent pads sed to provide. Resident #8		4) The DON/Designee will monitor residents incontinence management	
	anymore, "they ju	oesn't place a pad under them ust use a blanket or sheet folded s, I have to buy them myself, and		regimen weekly times 4 weeks. Findi will be reviewed during QAPI meeting Additional interventions to be initiated	
	resident if they us	h money." Surveyor asked se incontinent briefs and resident		needed. 5) AOC: 12/27/23	
	stated, "I do, but through."	I'm a heavy wetter, and it leaks			
	#13 on 11/16/23	with certified nurse's aide (CNA) at 10:20 pm. Surveyor asked acility has incontinence pads, and			
	CNA #13 stated t	they do not. Surveyor asked CNA			
	#13 what they us use a blanket if w	se, and CNA #13 stated, "We'll ve're in a bind."			
	10:30 am. Surve	with Resident #8 on 11/16/23 at yor asked Resident #8 if it			
	incontinence pad	have a blanket used as an l, and Resident #8 stated, "Yeah,			
	stay wet constan	on't like laying on a wet blanket. I tly because I leak all the time. I oney to keep buying pads."			
		ed a folded blanket underneath			

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	0: 12/19/2023 APPROVED 0: 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		16/202 <u>3</u>
GALAX H	EALTH AND REHAB			36 GLENDALE RD		
				ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 550	Continued From pag resident in the bed.	e 36	F 550			
F 563 SS=D	Surveyor requested facility policy entitled read in part, "The Re existence, self-deter with, and access to, and outside the Faci The concern of not p Resident #8 was dis administrator, chief r vice-president of ope No further informatic Right to Receive/De CFR(s): 483.10(f)(4) §483.10(f)(4) The re visitors of his or her her choosing, subject deny visitation when that does not impose resident. (ii) The facility must a resident by immed of the resident, subject deny or withdraw coo (iii) The facility must a resident by others consent of the reside clinical and safety re right to deny or witho (iv) The facility must to a resident by any provides health, soc	providing incontinence pad for cussed with the nursing officer and regional erations on 11/16/23 at 5 pm. In was provided prior to exit. Iny Visitors (ii)-(v) sident has a right to receive choosing at the time of his or et to the resident's right to applicable, and in a manner on the rights of another provide immediate access to iate family and other relatives ect to the resident's right to nsent at any time; provide immediate access to who are visiting with the ent, subject to reasonable strictions and the resident's draw consent at any time; provide reasonable access entity or individual that ial, legal, or other services to to the resident's right to deny	F 563			12/27/23

Facility ID: VA0037

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		ND HUMAN SERVICES				12/19/2023 APPROVED 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SU COMPLE	
- E		495250	B. WING		C 11/16	6/2023
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	GALAX HEALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
			I	PROVIDER'S PLAN OF CORRECTION		(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	- 1	(X5) COMPLETION DATE
F 563	procedures regardin residents, including clinically necessary limitation or safety re such limitations may requirements of this need to place on suc the clinical or safety This REQUIREMEN by: Based on staff inter and facility documer failed to allow family record reviews, Res The findings include The facility staff faile with the Resident at had a change in cor Resident #92's diag limited to, Alzheimer weakness. Section C (cognitive	have written policies and g the visitation rights of those setting forth any or reasonable restriction or estriction or limitation, when r apply consistent with the subpart, that the facility may ch rights and the reasons for restriction or limitation. T is not met as evidenced view, clinical record review, at review, the facility staff visitation for 1 of 4 closed ident #92. d: ed to allow the family to stay the facility after the resident	F 563	 F563 1) Resident #92 was discharged on 10/20/23 to a hospice house. 2) The center identified current residents. No other residents were identified at this time. 3) The Administrator/Designee re-educated the facility staff regarding center's visitation guidance on or befor 12/27/23. 4) DON/Designee will monitor adherence to the visitation policy week for 4 weeks. Findings will be review during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23 	re	
	with an assessment 08/16/23 included a status (BIMS) summ possible 15 points. Resident #92's com the focus areas som symptoms, at risk fo assistance with one	reference date (ARD) of brief interview for mental ary score of 3 out of a prehensive care plan included letimes shows behavior r pressure ulcers, requires or more staff for activity of culty with independent				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	GALAX HEALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 563	Continued From pag	e 38	F 563			
	Resident #92's clinication for Hospice effective	al record included an order 10/13/23.				
	copy of the Hospice of the Hospice nurse do immediate needs we patient and family an	ided the survey team with a documentation. On 10/19/23, ocumented the patients re comfort and support for d the facility staff had told not stay with this resident as cility's policy.				
	of their document title Rights." This docume the following rights as long as you wish t	ided the surveyor with a copy ed, "Nursing Home Resident ent read in part, "You have To have visitors at any time, to see them, as long as the re with the provision of care other residents"				
	the current interim Di staff stated they had Licensed Practical N employed) and state overnight at the facili could not remember someone had told the overnight stays. The	p.m., during an interview with irector of Nursing (DON) this received a call from urse (LPN) #1 (no longer d the family wanted to stay ty. The DON stated they who they called but em their policy was no DON stated before they had is resident the resident had				
	Certified Nursing Ass	p.m., during an interview with sistant (C.N.A.) #8 this staff nted to spend the night, but ors to stay.				
		p.m., during an end of the Administrator, Regional Vice				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/19/2023 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/1	; 6/2023
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
GALAX H	GALAX HEALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 563	Officer. The surveyor members spending for The Administrator st Hospice, you would (private) so the famil Hospice, we ask the not want to move the Administrator stated really say I don't know would think it would possible. No further information provided to the survey conference. Notify of Changes (H CFR(s): 483.10(g)(1 §483.10(g)(14) Notif (i) A facility must immediate consistent with the resist consistent injury and physician intervention (B) A significant chair mental, or psychoson deterioration in healt status in either life-th clinical complications (C) A need to alter the a need to discontinu treatment due to adv commence a new for	ons, and Chief Nursing r asked about family the night with Resident #92. ated if you are admitted on be in a room by yourself y could stay. If you become roommate to move we would a Hospice patient. The by not being here I can't w all the in's and out's, but I be done as quickly as on regarding this issue was ey team prior to the exit njury/Decline/Room, etc.) 4)(i)-(iv)(15) ication of Changes. nediately inform the resident; dent's physician; and notify, r her authority, the resident en there is- lving the resident which has the potential for requiring in; nge in the resident's physical, cial status (that is, a th, mental, or psychosocial areatening conditions or s); eatment significantly (that is, e an existing form of verse consequences, or to rm of treatment); or nsfer or discharge the	F 563			12/27/23

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/19/2023 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE S COMPL	ETED
		495250	B. WING		C 11/1	; 6/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		0/202
GALAX H	EALTH AND REHAB		-	36 GLENDALE RD		
	CLIMMA DV C		I	SALAX, VA 24333		()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 580	 (14)(i) of this section all pertinent informat is available and prov physician. (iii) The facility must resident and the resi when there is- (A) A change in room as specified in §483. (B) A change in resid State law or regulation (e)(10) of this section (iv) The facility must update the address (phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must discloss its physical configurat locations that compring part, and must specificon 	ification under paragraph (g) , the facility must ensure that ion specified in §483.15(c)(2) ided upon request to the also promptly notify the dent representative, if any, n or roommate assignment 10(e)(6); or dent rights under Federal or ons as specified in paragraph n. record and periodically mailing and email) and e resident posite distinct part. A facility distinct part (as defined in the in its admission agreement ation, including the various ise the composite distinct fy the policies that apply to even its different locations	F 580			
	by: Based on staff interv facility document rev notify the MD and/or the resident's physic	T is not met as evidenced view, clinical record review, iew, the facility staff failed to RP of significant changes in al, mental or psychosocial idents sampled. Resident #		 F580 1) Resident #19 expired 10/29/23 a #26 was discharged on 11/19/23. 2) Residents identified with change condition are being reviewed during th clinical meeting by the DON/Designee confirm notification of physician and resident representative has been 	in e	

Event ID: N6VL11

Facility ID: VA0037

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	S FOR MEDICARE	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	E CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY	
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED	
				С		
_		495250	B. WING		11/16/202 <u>3</u>	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB		836 GLENDALE RD GALAX, VA 24333			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO	
E 590	O antinua d Ename					
F 580		-	F 580			
		19, the facility staff failed to and responsible party of a fall		completed. 3) The DON/Designee re-educat	ted the	
	that occurred 10/6			licensed nurses regarding notificati		
				change in condition by 12/27/23.		
	This was a closed	l record review.		4) The DON/Designee will audit		
	Posidont #10's di	agnoses included but were not		in condition notification during the of meeting to verify physician, resider		
		ified dementia, angina, cognitive		and/or responsible representative v		
		eficit, moderate protein calorie		for 4 weeks. Findings will be revie		
	malnutrition, Alzhe	eimer's with late onset, adult		during QAPI meeting. Additional		
		uscle weakness (generalized),		interventions to be initiated as need	ded.	
	essential hyperter fibrillation.	nsion, and paroxysmal atrial		5) AOC: 12/27/23		
		ninimum data set (MDS) ned the resident a brief				
	interview for ment	al status score (BIMS) of 3, cognitive impairment.				
		ress note in the clinical record late of 10//6/23 at 2:34 AM that				
		fell at 2:25 AM. The resident				
		injury and assisted back to bed.				
	There was no indi	cation in the note that the				
		onsible party were notified of the				
		o follow up notes during the day				
	were notified later	e responsible party or physician				
	The surveyor was	unable to locate a progress				
		sician to indicate they were				
		on 10/6/23. The surveyor spoke				
		ator and requested copies of all the month of October 2023 on				
		AM. No notes were provided				
		uested and received the policy evention Program", there was no				

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			GLENDALE RD	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 580	Continued From pag	e 42	F 580		
	entitled, "Steps to Fo	Page 13 of the policy was Illow When a Fall Occurs", Notify Doctor and family."			
	LPN #10 who docum	AM the surveyor interviewed nented the fall. They stated all notifying the physician or /.			
	Regional Vice Presid	t with the Administrator, lent and Chief Nursing :20 PM and this concern was			
	No further informatio survey team prior to	n was presented to the the exit conference.			
		the facility staff failed to e party or the physician of an igin.			
	limited to, hypertensi anxiety, depression,	noses included but were not ion, Alzheimer's Disease, unspecified mood disorder, c obstructive pulmonary			
		t recent MDS assigned them dicating severe cognitive			
	dated 9/8/23 at 1:01 continues to complai pain. New order give department) for x-ray note also indicated the responsible party ha	e clinical record, a note PM read in part, "Resident in of right shoulder and arm en to sent to ED (emergency y of arm and shoulder." The hat the physician and the d been notified. On 9/8/23 at ered and read in part,			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/ FORM APPRC OMB NO. 0938-0	VED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			6 GLENDALE RD ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 580	shoulder due to com injury reported. Imag of right humerus. The physician or the resp the fracture. On 11/15/23 at appro- surveyor spoke with Assistant (PA) who s resident's primary ca the fracture until sev stated that they docu progress note. Surve the note and they sta they should be able to On 11/15/23 at appro- surveyor spoke with Attorney (POA). Whe of the fracture, they se I knew they were ser hospital to have it loo the end result was." Surveyor requested a entitled, "Resident A Origin", which read in origin are bruises, sk abrasions, etc. which Under the heading "F Notifications MUST to Resident's responsib On 11/15/23 at 3:30 the Administrator, Ch Regional Vice Presid discussed and a cop	k-ray of right elbow and plaints of pain. No previous ing shows possible fracture ere was no indication that the onsible party were notified of eximately 2:00 PM, this resident # 26's Physician's tated that they nor the re physician were notified of eral days after the fact. They umented this fact in a eyor asked where to locate ated, "I couldn't tell you but to get it for you." eximately 3:00 PM, this resident # 26's Power of en asked if they were notified stated, "No. Nobody told me. nding (resident) to the oked at, but never heard what and received the policy puse- Injuries of Unknown in part,"Injuries of unknown	F 580			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
- E		495250	B. WING		C 11/16/2023
NAME OF P	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	11/10/202
GALAX H	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 583 SS=D	"Patient seen on rou humerus fracture. My were not made awar and patient was not p evaluate the patient been in the building, and Dr. (omitted) on of us was made awa fracture." The survey team me Regional Vice Presic Officer on 11/16/23 5:20 PM and this cor further information w team prior to the exit Personal Privacy/Co CFR(s): 483.10(h)(1) §483.10(h) Privacy a The resident has a ri confidentiality of his o records. §483.10(h)(I) Person accommodations, mo telephone communic and meetings of fam this does not require private room for each §483.10(h)(2) The far residents right to per right to privacy in his written, and electron the right to send and	ed 9/14/23 and read in part, nds 9/14/23 for right yself or Dr. (name omitted) e of the ER visit or fracture blaced on rounds for us to until today. We have both myself on Monday 9/11/23 Tuesday 9/12/23 and neither re that the patient had a t with the Administrator, lent and Chief Nursing neern was discussed. No as provided to the survey conference. nfidentiality of Records 0-(3)(i)(ii) and Confidentiality. ght to personal privacy and or her personal and medical al privacy includes edical treatment, written and eations, personal care, visits, ily and resident groups, but the facility to provide a	F 580		12/27/23

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	IT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING				(X3) DATE SURVEY COMPLETED
- E		495250	B. WING		C 11/16/2023
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HEALTH AND REHAB		-	36 GLENDALE RD GALAX, VA 24333		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	STENDED OF DELIVITION OF DELIVITICO OF DELIVICO OF DELIVICO OF DELIVICO	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 583	Continued From pag	e 45	F 583		
		o the facility for the resident, ered through a means other			
	and confidential pers (i) The resident has t of personal and med provided at §483.70(federal or state laws. (ii) The facility must a Office of the State Lo to examine a residen administrative record law. This REQUIREMENT by: Based on document Licensure and Certifi failed to ensure the r confidential medical sampled (Resident # Resident #68 was ad diagnoses which incl hypertension, conges recurrent falls, and d neuropathy. On the assessment with Ass	ecords for 1 of 22 residents 68). Imitted to the facility with uded Alzheimer's dementia, stive heart failure, dysphagia, iabetes mellitus type 2 with		F583 1) Resident #68 responsible representative will be notified of the privacy/confidentiality records breach or before 12/27/2023 by the Administr 2) The center identified current residents to be at risk. The center interdisciplinary team (IDT) will intervise the current residents or responsible representatives regarding knowledge breaches in HIPPA on or before 12/27 3) The Administrator/Designee re-educated facility staff on HIPPA and	ator. ew of /23.
	interview for mental s in daily decision-mak as without signs of de behaviors affecting c On 11/15/2023, a cor which included a scre progress note in the	status, indicating impairment ing skills, and was assessed elirium, psychosis, or		Personal Privacy/Confidentiality of Records on 11/27/2023 and 11/28/202 4) The Administrator/Designee will interview 5 staff members per week regarding HIPPA/ Privacy and Confidentiality times 4 weeks. Finding will be reviewed during QAPI meeting Additional interventions to be initiated needed.	23. Js

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	-	I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039	
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	
- E		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			GLENDALE RD LAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	DATE	
F 583	Continued From p	page 46	F 583			
	progress note des address the comp complaint form in faxed to OLC on	ailure to report an incident (the scribed an incident, but did not plainant's allegation). The cluding the progress note was 11/15/2023. This was not an f the resident's record.		5) AOC: 12/27/23		
	confidentiality and records to the adu summary confere	orted the concern with d inappropriate use of clinical ministrator and RVPO during a nce on 11/16/2023. Neither f clinical records was				
F 604 SS=D		rom Physical Restraints)(1), 483.12(a)(2)	F 604		12/27/23	
	§483.10(e) Respe The resident has and dignity, inclue	a right to be treated with respect				
	physical or chemi purposes of disci	e right to be free from any cal restraints imposed for oline or convenience, and not he resident's medical symptoms, 483.12(a)(2).				
	neglect, misappro and exploitation a includes but is no corporal punishm any physical or ch	the right to be free from abuse, opriation of resident property, is defined in this subpart. This t limited to freedom from ent, involuntary seclusion and nemical restraint not required to s medical symptoms.				
	§483.12(a) The fa	acility must-				
	8483 12(a)(2) En	sure that the resident is free				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/202 <u>3</u>	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB		8	36 GLENDALE RD		
		G	GALAX, VA 24333			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 604	purposes of discipline	nical restraints imposed for e or convenience and that eat the resident's medical	F 604			
	alternative for the lead document ongoing re- restraints. This REQUIREMENT by: Based on staff interview the facility sta	must use the least restrictive ast amount of time and e-evaluation of the need for Γ is not met as evidenced riews and facility document ff failed to provide the n of the need for physical sampled residents.		F604 1) Resident #33 elopement assessment was updated on 11/15/20 indicating high risk for elopement by th licensed nurse. 2) The DON/Designee will review	e	
	reassess the risk for to applying a Wander The resident's Admis diagnoses to include multiple sclerosis, de Parkinson's disease diabetes mellitus. On the quarterly Mini assessment with an a of 10/11/23, the resid the brief interview for (Restraints and Alarm wander/elopement al	sion Record listed their d, but were not limited to mentia, Alzheimer's disease, with dyskinesia, and type 2 mum Data Set (MDS) assessment reference date lent scored a 10 out of 15 on r mental status. Section P ns) read the resident had a		current residents identified as at risk for elopement with orders for wanderguar use to ensure re-evaluation of risk completed per policy by 12/27/23. 3) The DON/Designee will re-educa licensed nurses and interdisciplinary to members (IDT) on residents at risk for elopement and Resident's Right to be from Physical Restraints, elopement ri management guidance and the wanderguard system on or before 12/27/23. 4) The DON/Designee will monitor 3 residents at risk for elopement per wea times 4 weeks to ensure compliance w elopement risk guidance and wanderguard use guidance. Findings be reviewed during QAPI meeting.	d te eam free sk sk	
	(1) Elopement Risk A found, dated 04/03/2	ssessment document was 3 and read the resident was ent. There were no other		Additional interventions to be initiated needed. 5) AOC: 12/27/23	as	

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			6 GLENDALE RD	
			I	ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 604	Continued From pag	ge 48	F 604		
F 604	Treatment Administr November 2023 was documented the Wa each shift. A provide to right ankle was da progress note dated Guard to right ankle (every) shift". The n note was interviewed 1:33 p.m. The nurse the facility occasiona unable to recall Resi Wander Guard. On 11/15/23 at 9:38 LPN #8, observed R a Wander Guard on was sitting up in a w closed. When asked Wander Guard, the r know." His eyes ren administrator and ch informed of this restr	a.m. this surveyor, along with theelchair with his eyes d how staff were testing the resident replied, "I don't named closed. The named closed. The named closed. The named closed. The named closed. The this surveyor and the	F 604		
	regarding Resident # elopement risk asser Coordinator provided resident had multiple over the past severa Coordinator and the was no evidence of a assessment after Ap completed yesterday about the assessme provided an Elopem 11/15/23, which read	facility's MDS Coordinator #33's Wander Guard and ssments. Although the MDS d documentation showing the e orders for a Wander Guard al years, both the MDS CNO acknowledged there an elopement risk oril 2023 until the one y, after the surveyor asked ents. The MDS Coordinator ent Risk Assessment, dated d Resident #33 was at risk for IO reported the resident has			

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		ND HUMAN SERVICES			FORM	12/19/2023 APPROVED 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SI COMPLE	
		495250	B. WING		C 11/16	6/2023
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB		_	36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 604	A certified nursing as statement dated 11/ CNA wrote that Resi to go home, needing things, and needing The resident voiced every other day." Th staff tried to redirect to leave, "it worsens This concern was di administrator, CNO, of operations during 11/16/23. No further prior to the exit confe Reporting of Alleged CFR(s): 483.12(b)(5 §483.12(c) In respon neglect, exploitation must: §483.12(c)(1) Ensur involving abuse, neg mistreatment, includ source and misappra are reported immedi hours after the allega that cause the allega serious bodily injury the events that caus abuse and do not re the administrator of officials (including to adult protective serv for jurisdiction in lon	t verbalizes wanting to leave. ssistant's hand-written 16/23 was provided. The ident #33 mentioned leaving g to go the store for various to leave to visit his brother. these statements "at least he CNA wrote that any time Resident #33 from wanting his behavior." scussed with the and regional vice president an end of day meeting on r information was provided erence. I Violations D(i)(A)(B)(c)(1)(4) hse to allegations of abuse, , or mistreatment, the facility e that all alleged violations	F 604		1	2/27/23

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	11/10/202 <u>5</u>
GALAX H	EALTH AND REHAB		8	36 GLENDALE RD	
			G	GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 609	Continued From pag procedures.	e 50	F 609		
	designated represen accordance with Stat Survey Agency, with incident, and if the al appropriate correctiv This REQUIREMENT by: Based on staff intervant and facility document to ensure injuries of reported for 1 of 22 of and one of 4 closed f #19 and Resident #22 The findings included 1. For resident # 19, report a right hip fract 10/13/23. This was a closed re Resident # 19's diag limited to, unspecifie communication defic Alzheimer's with late history of falling. Resident # 19's Minin Assessment with an (ARD) of 10/20/23 as Interview for Mental indicating they were The resident was als	administrator or his or her tative and to other officials in te law, including to the State in 5 working days of the leged violation is verified e action must be taken. Γ is not met as evidenced view, clinical record review, t review the facility staff failed unknown origin were current residents sampled records sampled. Resident 6. d: the facility staff failed to ture that was identified on		 F609 1) Resident #19 no longer resided in the facility at time of survey. Resident discharged from the facility on 11/19/2 Investigation and FRI completed on 11/15/23. 2) Current resident event reports for November were reviewed by the NHA/designee for potential reportable events. None noted. 3) The Administrator/Designee will re-educate facility staff on reporting Resident Abuse/Significant Events on before 12/27/23. 4) The Administrator/Designee will monitor 3 resident records weekly time weeks for potential reportable events. Findings will be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23 	#26 3. or •s 4

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	2: 12/19/2023 1 APPROVED 2: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		(11/-	C 16/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	- '''	10/202
GALAXH	EALTH AND REHAB		8	36 GLENDALE RD		
UALAX II			G	GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From pag	e 51	F 609			
	dated 10/13/23 at 8: results back show fra fracture of right hip E 10/06/2023 Assessin Response : called m er." A progress note 2:34 AM that read, " residents room at 02 (their) trunk lying bes underneath the bed. states (they) is unsu Background : Reside and mild cases of co generalized weaknes able to answer most confusion pre existin is verbal and able to neurological checks any pain or injury at within normal limits E tympanic, Pulse 83, noted. Skin appears bruising at this time. know what happenes and myself sat paties in bed, appears as r incident. Fall protoco his bed lying supine time." There were no notes to indicate res another fall. There w notes as to why or w There was an order read, " X-ray rt hip tw only for Rt. hip pain	ent is a 90 y.o. with dementia infusion, h/x of falls and ss. Assessment : Resident atus prior to any incident, is questions with occasional ig prior to possible incident.				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/19/2023 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		<u> </u>	LETED
		495250	B. WING			C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB		-	36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From pag after it was determine	e 52 ed they were not a surgical	F 609			
	candidate. On 11/16/23 at 8:41, LPN # 10 who was c morning 10/6/23 whe stated that they asse no indication of any i staff members assist This surveyor request the policy entitled, "F Unknown Origin" with The policy read in pa origin are bruises, sk abrasions, etc. which The Administrator or begin a documented the injury. 7. All injuri be reported to the ap specific protocols." This surveyor met wi 11/16/23 at approxim for the Facility Repor resident # 19's right I 2023. They stated th for this resident in Oo they would have exp hip fracture identified and they stated, "I we time and can't say wi Administrator did or of The survey team me Regional Vice Preside	AM this surveyor interviewed aring for resident #19 the in resident # 19 fell. They ssed resident and there was njuries so they and 2 other ed resident back to bed. ted and received a copy of Resident Abuse- Injuries of in a revision date of 4/2020. rt, "Injuries of unknown in tears, fractures, in have no know cause. 4. the Director of Nursing must investigation for the cause of es of unknown origin must propriate agencies per state th the Administrator on hately 11:00 AM and asked ted Incident (FRI) for hip fracture October 13, ey could not locate an FRI cober. Surveyor asked if ected one to be done for a a week after the last fall, puld, but I wasn't here at the hat the previous didn't do."				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	2: 12/19/2023 1 APPROVED 2: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE	
		495250	B. WING		(
NAME OF P	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	- "	16/202 <u>3</u>
GALAX HI	EALTH AND REHAB			36 GLENDALE RD		
				ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 609	Continued From pag	e 53	F 609			
		n was provided to the survey				
		the facility staff failed to ne right humerus that was				
	limited to, hypertensi anxiety, depression,	noses included but were not ion, Alzheimer's Disease, unspecified mood disorder, obstructive pulmonary				
		t recent MDS assigned them dicating severe cognitive				
	dated 9/8/23 at 1:01 continues to complai pain. New order give department) for x-ray 9/8/23 at 2200 a note part, "Returned follow shoulder due to com injury reported. Imag of right humerus." The locate an explanation how the injury occurr On 11/15/23 at 3:30	PM the survey team met with				
	Regional Vice Presic discussed at that tim employed and states incident.	hief Nursing Officer and lent. This concern was e. The Administrator is newly they were not aware of this				
		sted and received a copy of Resident Abuse- Injuries of				

Facility ID: VA0037

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/19/2023 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE	
		495250	B. WING		C 11/16/2023	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	- ''	10/202 <u>5</u>
GALAX H	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 609	Continued From pag		F 609			
		n a revision date of 4/2020. rt, "Injuries of unknown				
	origin are bruises, sk	-				
		have no know cause. 4. the Director of Nursing must				
		investigation for the cause of				
		es of unknown origin must				
	specific protocols."	propriate agencies per state				
		strator presented a packet to				
	-	at information they could is well as staff statements				
	and stated that they and would be submit	were investigating the injury ting an FRI.				
	team prior to the exit					
F 610 SS=D	Investigate/Prevent/0 CFR(s): 483.12(c)(2)	Correct Alleged Violation -(4)	F 610			12/27/23
		se to allegations of abuse, or mistreatment, the facility				
	§483.12(c)(2) Have e violations are thorou	evidence that all alleged ghly investigated.				
		nt further potential abuse, or mistreatment while the ogress.				
	designated represen accordance with Stat Survey Agency, withi	the results of all administrator or his or her tative and to other officials in te law, including to the State n 5 working days of the leged violation is verified				

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		ND HUMAN SERVICES			FORM	: 12/19/2023 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE : COMPL	LETED
		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	- "	10/202
GALAX H	EALTH AND REHAB			336 GLENDALE RD GALAX, VA 24333		
		TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(ME)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 610	Continued From pag	ge 55	F 610			
		ve action must be taken. IT is not met as evidenced				
	Based on staff inter facility document rev	view, clinical record review, view, facility staff failed to		F610		
	unknown origin for 1	nvestigation of an injury of l of 22 active residents closed records. Resident # 26.		1) Resident #19 no longer resided i the facility at time of survey. Resident discharged from the facility on 11/19/2 Investigation and FRI completed on	t #26	
	The findings include	d:		11/15/23.2) Current resident event reports foNovember were reviewed by the	r	
		the facility staff failed to p fracture that was identified		NHA/designee for potential reportable events with investigation completed. N issues noted. 3) The Administrator/Designee will		
	This was a closed re	ecord review.		re-educate facility staff on reporting Resident Abuse/Significant Events ar	ıd	
	limited to, unspecifie	gnoses included but were not ed dementia, cognitive		the investigation process on or before 12/27/23.		
	Alzheimer's with late	cit, generalized anxiety, e onset, insomnia, weakness,		 The Administrator/Designee will monitor 3 resident records weekly time weeks for potential reportable events. 		
	history of falling.			Findings will be reviewed during QAP		
	Assessment with an (ARD) of 10/20/23 a Interview for Mental indicating they were The resident was also	imum Data Set (MDS) Assessment Reference Date assigned the resident a Brief Status (BIMS) score of 3, severely cognitively impaired. so coded as dependent for ving (ADL's) and mobility.		meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23	>	
	dated 10/13/23 at 8: results back show fr fracture of right hip I 10/06/2023 Assess Response : called m	vas reviewed. A progress note 06 AM read, "Situation : xray racture of femoral neck Background : found in floor on nent : pain to right hip nd on call new order send to was located for 10/6/23 at				

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	-				PRINTED: 12/19/20 FORM APPROVI		
ATEMENT C	S FOR MEDICAR	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED		
		495250	B. WING		C 11/16/2023		
NAME OF PR	ROVIDER OR SUPPLIEF		STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
	ALTH AND REHAB		836 0	GLENDALE RD			
			GAL	GALAX, VA 24333			
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE		
F 610	Continued From	page 56	F 610				
	2:34 AM that read	d, "Situation : Staff alerted me to					
		t 02:25am (they) was found with					
		beside bed and legs tucked ed. (They) is awake and alert,					
		nsure what happened.					
	· · ·	sident is a 90 y.o. with dementia					
		f confusion, h/x of falls and					
	•	ness. Assessment : Resident					
		ost questions with occasional					
		sting prior to possible incident.					
		e to follow commands,					
	•	cks remain at baseline, denies					
		at this time, Vital signs remain its BP 148/86, Temp. 98.4					
		33, 18 RR no visual injuries					
		ars intact without breaks or					
	•	ne. Resident states does not					
		ened. Response : Two CNA's					
	•	atient upright and assisted back as normal baseline prior to					
		ocol initiated, resident is back in					
		ine with no complaints at this					
		e no notes in between these two					
		resident was having pain or had					
		e was no explanation in the or when the x-ray was ordered.					
	-	ler entered on 10/11/23 that					
		p two views and pelvis one time					
	• • • •	ain from previous fall." Resident					
		ted to the facility on 10/14/23 mined they were not a surgical					
	candidate.	ninea may word not a surgidar					
		41 AM this surveyor interviewed					
		as caring for resident #19 the					
	-	when resident # 19 fell. They					
	no indication of a	ssessed resident and there was					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION	
F 610	Continued From pag	e 57	F 610			
		ed resident back to bed.				
	the policy entitled, "F Unknown Origin" with The policy read in pa- origin are bruises, sk abrasions, etc. which The Administrator or begin a documented the injury. 5. The inve- interviews with the re- (directly or indirectly) volunteers which may resident and may hel Obtain written statem This surveyor met wi 11/16/23 at approxim for the Facility Repor (FRI)/investigation for fracture October 13, not locate an FRI for Surveyor asked if the to be done for a hip fa fiter the last fall, and wasn't here at the tim previous Administrato The survey team me Regional Vice Presid Chief Nursing Officer this concern was diso No further informatio team prior to the exit 2. For resident # 26 to	a have no know cause. 4. the Director of Nursing must investigation for the cause of estigation will include esident, all staff involved a, any family, visitors, or y have had contact with the lp with the investigation. hents as deemed necessary." th the Administrator on hately 11:00 AM and asked ted Incident r resident # 19's right hip 2023. They stated they could this resident in October. ey would have expected one racture identified a week d they stated, "I would, but I he and can't say what the or did or didn't do." t with the Administrator, lent of Operations, and the r on 11/16/23 at 5:20 PM and cussed. n was provided to the survey				

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	11110/202
GALAX H	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
F 610	Continued From pag	e 58	F 610		
	identified 9/8/23.				
	limited to, hypertensi anxiety, depression,	noses included but were not ion, Alzheimer's Disease, unspecified mood disorder, obstructive pulmonary			
		t recent MDS assigned them dicating severe cognitive			
	dated 9/8/23 at 1:01 continues to complai pain. New order give department) for x-ray 9/8/23 at 2200 a note part, "Returned follow shoulder due to com injury reported. Imag of right humerus." Th	e clinical record, a note PM read in part, "Resident in of right shoulder and arm en to sent to ED (emergency y of arm and shoulder." On e was entered that read in wing x-ray of right elbow and plaints of pain. No previous ging shows possible fracture his surveyor was not able to in in the progress notes as to red.			
	the Administrator, Ch Regional Vice Presic discussed at that tim employed and states	PM the survey team met with hief Nursing Officer and dent. This concern was e. The Administrator is newly they were not aware of this equested a copy of the			
	the policy entitled, "F Unknown Origin" wit The policy read in pa origin are bruises, sk	sted and received a copy of Resident Abuse- Injuries of h a revision date of 4/2020. art, "Injuries of unknown kin tears, fractures, n have no know cause. 4.			

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		ND HUMAN SERVICES			FORM): 12/19/2023 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING			C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 36 GLENDALE RD		
GALAX HI	EALTH AND REHAB			GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 610 F 624 SS=D	begin a documented the injury. 5. The invi interviews with the re- (directly or indirectly) volunteers which ma- resident and may he Obtain written statem 11/16/23 The Admini- the surveyor with wh locate in the record a and stated that they and would be submit- evidence that one ha No further information team prior to the exit Preparation for Safe, CFR(s): 483.15(c)(7) §483.15(c)(7) Orient discharge. A facility must provid preparation and oriensafe and orderly tran- facility. This orientation form and manner that understand. This REQUIREMEN by: Based on resident in clinical record review review, the facility st preparation and orien a safe and orderly di	 the Director of Nursing must the vestigation for the cause of vestigation will include esident, all staff involved), any family, visitors, or ay have had contact with the elp with the investigation. ments as deemed necessary." istrator presented a packet to nat information they could as well as staff statements were investigating the injury tting an FRI as there was no ad been done. on was provided to the survey t conference. /Orderly Transfer/Dschrg) tation for transfer or de and document sufficient entation to residents to ensure here or discharge from the ion must be provided in a at the resident can T is not met as evidenced nterview, staff interview, v, and facility document intation to residents to ensure ischarge from the facility for 1 	F 610	F624 1) Resident #86 currently resides at center. No discharge date set at this ti The interdisciplinary team (IDT) will rev	me. ⁄iew	12/27/23
	review, the facility st preparation and orie a safe and orderly di	aff failed to provide sufficient ntation to residents to ensure		center. No discharge date set at this ti	me. ⁄iew	

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		ND HUMAN SERVICES			FORM	12/19/2023 APPROVED 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/1	6/2023
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE		0,202 <u>5</u>
GALAX H	EALTH AND REHAB			36 GLENDALE RD		
	SLIMMADY S	TATEMENT OF DEFICIENCIES		GALAX, VA 24333 PROVIDER'S PLAN OF CORRECTION		(VE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 624	Continued From pag	je 60	F 624			
	The findings include	d:		plan. 2) The SSD reviewed current reside with plans to discharge to the commun		
		ne facility staff failed to		to determine safe discharge needs with	-	
	·	with discharge instructions or		the Interdisciplinary team (IDT).		
	discharge home.	ions prior to a planned		 The Administrator/Designee re-educated the SSD and IDT on the interdisciplinary discharge summary ar 	nd	
		nosis list indicated diagnoses,		Discharge/Transfer planning guidance		
		not limited to Pressure Ulcer		or before 12/27/23.		
		pen Wound of Abdominal with Obstruction, Type 2		4) The SSD/Designee will monitor resident discharges/transfers to ensure	a	
		nd Muscle Weakness.		safe interdisciplinary team (IDT) discha plan prior to the scheduled discharge		
		um data set (MDS) with an		weekly times 4 weeks. Findings to be		
		ce date (ARD) of 10/23/23 nt a brief interview for mental		reviewed during QAPI meeting. Addition interventions to be initiated as needed.		
		ary score of 15 out of 15		5) AOC: 12/27/23		
	u u u u u u u u u u u u u u u u u u u	#86 was cognitively intact.				
		ded as being dependent with d toileting hygiene. Resident				
		aving one stage 4 pressure				
	ulcer and a surgical	wound.				
	-	prehensive person-centered				
		focus area stating, "I would				
	-	anning my next steps to be ely when my care/rehab goals				
		ervention stating, "Help me				
	with developing tran make my leaving go	sition strategies that will smoothly."				
	•	nt #86's clinical record, the rged home on 11/01/23. A				
		te dated 11/01/23 11:29 AM				
	stated "10:30 am Re	esident left with all [his/her]				
		ouse] by [his/her] side, staff ent] into [his/her] car. Pt has				
		ner] prescriptions for [his/her]				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/19/2023 1 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING			C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	- "	10/202 <u>5</u>
	EALTH AND REHAB		8	36 GLENDALE RD		
			G	ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 624	Continued From pag medications."	e 61	F 624			
	Surveyor reviewed R and was unable to lo instructions provided discharge home on 1 On 11/13/23 at 5:30 I Resident #86 who sta discharged from the not speak to anyone receive any discharg medications, or medi prescription for a wal facility staff were awa wheeled them out to resident stated after to their community pl had to contact the far The resident stated after to their community pl had to contact the far The resident stated to medications on the d On 11/14/23 at 11:00 Social Services Direct Resident #86's plann they were recently er Resident #86's disch discharge. SSD stat were supposed to as packet, and this was not receive discharge prescriptions. SSD p signed medication pr for Furosemide, Ator Montelukast Sodium.	PM, surveyor spoke with ated when they were facility on 11/01/23, they did about discharge, did not e papers, instructions, cation prescriptions, only a ker. Resident #86 stated are of their discharge and their car when leaving. The leaving the facility, they went narmacy and the pharmacy cility to obtain prescriptions. hey missed all their ay of discharge. • AM, surveyor spoke with the ctor (SSD) regarding ted discharge. SSD stated mployed by the facility and arge was their first planned ed they were unaware they semble the discharge the reason the resident did e instructions or medication provided copies of physician escriptions dated 10/30/23 vastatin Calcium, , Amlodipine, Gabapentin,				
	to the resident.	ide which were not provided PM, surveyor spoke with				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 12/19/2023 APPROVED D: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING			C 16/2023
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HE	EALTH AND REHAB			836 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES XY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 624	Continued From pag		F 624	4		
		rse (LPN) #7, the nurse f Resident #86's discharge.				
	-	vere aware Resident #86				
		did not have the discharge he SSD went over the				
		s and packet with the				
	resident. LPN #7 sta	ted the SSD had the				
	resident's orders.					
	Surveyor requested a	and received the facility				
		ge Planning Documentation"				
	which read in part: "4. At the time of o	discharge, a discharge				
	summary and home-	going instructions are				
	provided to the reside					
	caregiver which will i A. Current diagnosis	-				
	B. Rehabilitation pot					
	C. Summary of prior					
	D. Physician's orderE. Pertinent social in					
		als as needed (e.g., home				
	-	, adult day care, etc.)"				
	On 11/14/23 at 4:32	PM, the survey team met				
		r, regional vice president of				
	•	chief nursing officer and rn of staff failing to provide				
	discharge instruction					
		dent #86 at discharge home.				
	No further informatio	n regarding this concern was				
	presented to the surv	vey team prior to the exit				
_	conference on 11/16	/23.		_		40/07/00
F 655 SS=E	Baseline Care Plan CFR(s): 483.21(a)(1)	-(3)	F 65			12/27/23
	§483.21 Comprehen	sive Person-Centered Care				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/19/2023 1 APPROVED). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/1	C 16/2023
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			6 GLENDALE RD ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	Planning §483.21(a) Baseline §483.21(a)(1) The fai implement a baseline that includes the inst effective and person that meet profession The baseline care pl (i) Be developed with admission. (ii) Include the minim necessary to properl including, but not lim (A) Initial goals base (B) Physician orders (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recomm §483.21(a)(2) The fai comprehensive care care plan if the comp (i) Is developed with admission. (ii) Meets the require (b) of this section (ex) this section). §483.21(a)(3) The fai resident and their rep of the baseline care limited to: (i) The initial goals co (ii) A summary of the dietary instructions. (iii) Any services and	Care Plans cility must develop and e care plan for each resident tructions needed to provide -centered care of the resident al standards of quality care. an must- nin 48 hours of a resident's hum healthcare information y care for a resident tited to- d on admission orders.	F 655			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/10/202 <u>5</u>
GALAX H	EALTH AND REHAB		8	36 GLENDALE RD	
			G	GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	D 475
F 655	Continued From pag	le 64	F 655		
	on behalf of the facil	ity.			
		ormation based on the details			
	-	e care plan, as necessary. T is not met as evidenced			
	by:				
		view, clinical record, facility a facility staff failed to develop		F655	
		within 48 hours of admission		1) Resident #64 baseline care plans	
	for 4 of 22 residents	sampled. Resident #64,		were completed and reviewed with	
	#77, 294, and #86.			resident representative. Resident #77 listed on survey resident sample identi	
	The findings include:	:		list. Resident #294 baseline care plan	
				completed on 11/22/23 with copy provi	
		the facility staff failed to are plan when the resident		to resident. Resident #86 baseline car plan completed on 11/22/23 with copy	e
	was admitted to the			provided to resident. 2) The DON/Designee reviewed the	
	-	noses included, but were not		November and December new admiss	
		d dementia, chronic atrial ed osteoporosis, essential		resident records to validate resident centered baseline care plans will be	
	-	c pain syndrome, and		completed with a copy provided to the	
	presence of a cardia			resident or responsible representative 12/27/23.	by
		patterns) of Resident # 64's		3) The DON/Designee re-educated	
		n data (MDS) assessment reference date (ARD) of		IDT and licensed nurses on the resider centered baseline care plan guidance	
	10/20/23 included a	brief interview for mental		by 12/27/23.	
		ary score of 4 out of a		4) The DON/Designee will monitor n	iew
	impairment.	ndicating severe cognitive		admissions weekly times 4 weeks to validate resident centered baseline car	re
				plans are completed with a copy provid	
		e clinical record the surveyor a baseline care plan.		to the resident or responsible	(od
		a vasellite care pidit.		representative. Findings will be review during QAPI meeting. Additional	
	On 11/15/23 during a	-		interventions to be initiated as needed.	
		Nursing Officer and Regional		5) AOC: 12/27/23	
	-	erations, the surveyor the baseline care plan for			
		dministrator stated, "We've			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF PR	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HE	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 655	Continued From pag determined that it wa	is not done."	F 655			
		n regarding this issue was ey team prior to the exit				
		the facility staff failed to are plan when the resident acility.				
	limited to, unspecifie loss of concsiousnes pulmonary disorder,	noses included, but were not d intracranial injury without s, chronic obstructive restelessness and agitation, sorder, unspecified dementia,				
	most recent minimum with an assessment 8/23/23 included a bi status (BIMS) summ	patterns) of Resident # 77's n data (MDS) assessment reference date (ARD) of rief interview for mental ary score of 6 out of a ndicating severe cognitive				
		e clinical record the surveyor a baseline care plan.				
	Vice President of oper requested to review to	Nursing Officer and Regional erations, the surveyor the baseline care plan for dministrator stated, "We				
		n regarding this issue was ay team prior to the exit				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	12/19/2023 APPROVED 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/1	6/2023
NAME OF PI	ROVIDER OR SUPPLIER		STRI	EET ADDRESS, CITY, STATE, ZIP CODE		0/202 <u>0</u>
GALAX H	EALTH AND REHAB			GLENDALE RD LAX, VA 24333		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 655	Continued From pag	e 66	F 655			
		the facility staff failed to are plan for intravenous nt usage.				
		e sheet listed diagnoses ot limited to sepsis and of pancreatic duct.				
	not yet completed; h	imum data set (MDS) was owever, Resident # 294 was person, place, time, and				
	contained a physicia read in part, "Merren Reconstituted 500 m mg intravenously ev days." Resident #29	ical record was reviewed and n's order summary which n Intravenous Solution Ig (Meropenem). Use 2000 ery 8 hours for sepsis for 5 4's clinical record also ted Consent for the use of form.				
	Surveyor could not lo Resident #294's clin	ocate a baseline care plan in ical record.				
	11/15/23 at 8:30 am baseline care plan. N	MDS coordinator on regarding Resident #294's MDS coordinator stated that are completed on paper and chart.				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			GLENDALE RD LAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 655	Surveyor reviewed R but could not locate a manager stated to su plans are located in the chart. During a meeting with nursing officer, and r operations on 11/15/ about baseline care stated, "I don't think is that's what they told Surveyor requested a facility policy entitled part, "Procedure: 2. be developed within insure that the reside appropriately until the is completed." The concern of not d plan was discussed of nursing officer, and r operations on 11/16/ No further information 4. For Resident #86 develop and implement within 48 hours of ad Resident #86's diagr which included, but r of Right Buttocks, Of Wall, Ventral Hernia	Resident #294's paper chart a baseline care plan. Unit urveyor that baseline care the MDS office, not in the the MDS office, not in the the administrator, chief regional vice president of '23 at 3:30 pm, when asked plans, the chief nursing office they've been doing them, me." and was provided with a I "Care Plan" which read in A Baseline Care plan must 48 hours of admission to ent's needs are met e Comprehensive Care Plan leveloping a baseline care with the administrator, chief regional vice president of '23 at 5 pm. on was provided.	F 655	DEFICIENCY)		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19 FORM APPR OMB NO. 0938	OVED
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/202	3
NAME OF PI	ROVIDER OR SUPPLIER		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	11/10/202	-
GALAX HI	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333		
	SUMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X	5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPL	ETION
F 655	Continued From pag	e 68	F 655			
	sheet, the resident w 11/02/23. An "Admis dated 11/02/23 docu alert and independer tasks of daily living. On 11/15/23, survey clinical record and w completed baseline of on 11/02/23 or a curr person-centered care On 11/15/23 at 8:39. minimum data set (M reviewed Resident # also unable to locate MDS Coordinator stat have a baseline care admitting nurse and by the IDT (interdisci Coordinator stated th records to try and loc On 11/15/23 at 3:35 with the Administrato Operations (RVPO), (CNO) and discussed #86 not having a bas admission. The CNO staff were doing base Surveyor requested a policy titled "Care Pla Baseline Care plan m hours of admission to	care plan following admission rent comprehensive e plan. AM, surveyor spoke with the IDS) coordinator who 86's clinical record and was the baseline care plan. Atted Resident #86 should plan initiated by the completed the following day plinary team). MDS rey would check with medical cate the document. PM, the survey team met rr, Regional Vice President of and Chief Nursing Officer d the concern of Resident celine care plan initiated with D stated they did not think eline care plans at the time. and received the facility an" which read in part "2. A nust be developed within 48 p insure [sic] that the				
		met appropriately until the Plan is completed"				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	12/19/2023 APPROVED 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE S COMPL	
		495250	B. WING		C	6/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		0/202 <u>5</u>
GALAX HI	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333		_
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 655	Continued From pag	e 69	F 655			
F 657 SS=D	presented to the surv conference on 11/16, Care Plan Timing and CFR(s): 483.21(b)(2) §483.21(b) Compreh §483.21(b)(2) A com- be- (i) Developed within a the comprehensive a (ii) Prepared by an in- includes but is not lim (A) The attending ph (B) A registered nurs- resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent pra- the resident and the An explanation must medical record if the and their resident rep not practicable for the resident's care plan. (F) Other appropriate	d Revision)(i)-(iii) eensive Care Plans prehensive care plan must 7 days after completion of assessment. Atterdisciplinary team, that nited to ysician. e with responsibility for the a responsibility for the d and nutrition services staff. cticable, the participation of resident's representative(s). be included in a resident's participation of the resident oresentative is determined e development of the e staff or professionals in nined by the resident's needs	F 657			12/27/23
	(iii)Reviewed and reviewed and reviewed and reviewed assessments. This REQUIREMENT by: Based on staff interviewed	vised by the interdisciplinary essment, including both the		F657		

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		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/19/20 FORM APPROVE OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/202 <u>3</u>
NAME OF P	ROVIDER OR SUPPLIER			IREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLÉTIO
F 657	Continued From p	bage 70	F 657		
	failed to review and care plan for 3 of Resident # 26, # 0	nd revise the comprehensive 22 residents sampled. 64, and # 33.		1) Resident #26 discharged on 11/19/2023. Resident #64 and #33 comprehensive care plans reviewed updated and validated as complete MDS Coordinator on 10/16/23 and	d, by the
	1. For resident # 2			ew	
	Resident # 26's d	ter an injury of unknown origin. iagnoses included but were not ension, Alzheimer's Disease,		plans during their quarterly assessn reference to validate that the care p are updated and appropriate for the residents.	lans
		on, unspecified mood disorder, onic obstructive pulmonary		3) The DON/Designee will re-edu the center's interdisciplinary team (I and licensed nurses on the comprehensive care plan by 12/27/2	DT)
		nost recent MDS assigned them 4 indicating severe cognitive		4) The MDS Coordinator will revier resident comprehensive care plans weekly x 4 weeks. Finding will be reviewed during QAPI meeting. Add	ew 2
	note dated 9/8/23 "Resident continu and arm pain. Ne (emergency depa shoulder." The no	of the clinical record, a progress at 1:01 PM read in part, lies to complain of right shoulder w order given to sent to ED ortment) for x-ray of arm and ote also indicated that the		interventions to be initiated as need 5) AOC: 12/27/23	
	notified. On 9/8/2 and read in part, elbow and should previous injury re fracture of right h	e responsible party had been 3 at 2200 a note was entered "Returned following x-ray of right ler due to complaints of pain. No ported. Imaging shows possible umerus. There was no care plan cture in the clinical record.			
	read in part, "four for injury. quarter pack applied to a	lated 10/01/2023 at 09:41 AM nd on floor in hallway. assessed sized knot to back of head. ice rea. pearl. MAE. assisted up x2 ks initiated. MD and RP made			

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CENTERS FOR MEDICARE & MI	HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES (> AND PLAN OF CORRECTION	(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
DOC	495250	B. WING		C 11/16/2023
NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HEALTH AND REHAB		-	36 GLENDALE RD GALAX, VA 24333	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
fall with injury located inOn 11/16/2023 at 10:36with the Administrator atdocumentation that resistbeen reviewed and revistincidents. No documentAdministrator confirmedupdate for either issue.The surveyor requestedthe policy entitled, "Fall13 of the packet entitleda Fall Occurs" read in pinterventions and placeImplement interventionsOn 11/16/23 at 5:25 PMthe Administrator, RegioOperations, and the Chthis issue was discussedNo further information wteam prior to the exit co2. For resident # 64 theupdate the comprehenswith injury.Resident # 64's diagnoslimited to, dementia, chrelated osteoporosis, esmuscle weakness.During a review of the ornote dated 10/14/2023"Called to resident's root	care plan update for this in the medical record. AM this surveyor met and asked for ident # 26's care plan had ised after each of these tation was provided, the d there was no care plan d and received a copy of ing Stars Program". Page d, "Steps to Follow When wart, "7. Establish new them on the care plan. 8. s on care plan." A the survey team met with onal Vice President of tief Nursing Officer and ed. was provided to the survey onference. e facility staff failed to sive care plan after a fall ses included but were not ronic atrial fibrillation, age ssential hypertension, and clinical record, a progress at 1:00 PM read in part,	F 657		

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
0(0)5	CLIMMA DV C			PROVIDER'S PLAN OF CORRECTION	()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 657	Continued From pag	je 72	F 657			
		de, stated (they) rolled out of				
		urse performed assessment ny abnormalities to hips,				
	resident complained	of pain all over and then that				
	· · ·	into, Dr. Bonsu was called o send to ER, ambulance				
		ved at 1:25pm. Resident				
	loaded on stretcher	itale were obtained and				
		itals were obtained and to (nurse) at (name omitted)				
	hospital."					
		eadmitted to the facility				
		PM according to a progress				
		art, "Resident returned via Resident pleasantly confused.				
	VSS, messaged MD	for orders for pain meds.				
		pelvic fx and left femoral ed 3 units of blood at hospital				
	and eliquis on hold.	Large purple/blue hematoma				
		a. Resident assisted with all d to back of heel to right				
		care plan update in the				
	clinical record for the	e fall or the fractures.				
	On 11/16/2023 at 10	:36 AM this surveyor met				
	with the Administrate					
		esident # 64's care plan had evised after each of these				
	incidents. No docum	entation was provided, the				
		ned there was no care plan fractures on 11/16/23 at 1:20				
	PM.					
	The surveyor reques	sted and received a copy of				
	the policy entitled, "F	alling Stars Program". Page				
		tled, "Steps to Follow When n part, "7. Establish new				
		ace them on the care plan. 8.				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB		-	36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 657	the Administrator, Re Operations, and the this issue was discus No further informatio team prior to the exit 3. For Resident #33	ons on care plan." PM the survey team met with egional Vice President of Chief Nursing Officer and ssed. n was provided to the survey	F 657			
	applied. The resident's Admis diagnoses to include multiple sclerosis, de Parkinson's disease diabetes mellitus. O Data Set (MDS) asse reference date of 10, 10 out of 15 on the b status. Section P (R the resident had a way On 11/15/23 at 9:38	ssion Record listed their d, but were not limited to ementia, Alzheimer's disease, with dyskinesia, and type 2 n the quarterly Minimum essment with an assessment (11/23, the resident scored a rief interview for mental estraints and Alarms) read ander/elopement alarm daily. a.m. this surveyor, along with esident #33 who was wearing				

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	11/10/202	
GALAX H	EALTH AND REHAB			6 GLENDALE RD ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 657	was unable to locate elopement risk or Wa On 11/16/23 at 8:48 a chief nursing officer (facility's MDS Coordi #33's elopement risk found on the compre care plan. The MDS of provider orders for	ed Resident #33's on-centered care plan and documentation of an ander Guard device. a.m., this surveyor and the (CNO) spoke with the inator regarding Resident and Wander Guard not hensive person-centered Coordinator provided a list r the resident to have a	F 657			
	and 2023. The MDS indicated the elopem resolved and acknow elopement risk had n as a current focus an On 11/16/23, Reside person-centered care the resident had a fo	evious years; 2021, 2022, coordinator and CNO eent risk focus area had been vledged the focus area for not been revised to include it ea. nt #33's comprehensive e plan was revised to indicate cus area of risk of elopement initiated on 11/16/23.				
F 658 SS=D	of operations during a 11/16/23. No further prior to the exit confe Services Provided M CFR(s): 483.21(b)(3) §483.21(b)(3) Compt The services provide as outlined by the co must- (i) Meet professional	and regional vice president an end of day meeting on information was provided erence. eet Professional Standards)(i) rehensive Care Plans ed or arranged by the facility, mprehensive care plan,	F 658		12/27/23	

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/19/2023 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING			C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	- "	10/202 <u>5</u>
GALAX H	EALTH AND REHAB			36 GLENDALE RD		
				GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	Continued From pag	e 75	F 658			
	by: Based on observation record review, and fa facility staff failed to fa professional practice Resident's #242 and The findings included 1. For Resident #242 documented they have medication Isosorbid never been delivered pharmacy. This medi- the facility STAT box. Resident #242's diag hypertension, congest chronic kidney diseas There was no complet (MDS) assessment for #242 was alert and of Resident #242's clinit for the medication Iso 1 tablet three times a order date was docum A review of Resident administration record nursing staff had doc administered this me a.m. and 2:00 p.m., 12 2:00 p.m., 11/12/23 a	 an, staff interview, clinical cility document review the follow standards of for 2 of 22 residents, #24. b. the facility nursing staff d administered the e when this medication had to the facility from the cation was not available in anoses included stive heart failure, and se. beted minimum data set for this Resident. Resident rientated to self. cal record included an order psorbide Mononitrate 10 mg day for hypertension. The mented as 11/08/23. #242's medication (MAR) revealed that the 		 F658 1) Resident #242 Isosorbide medication order clarified on 11/15/202 by licensed nurse and received by pharmacy on 11/15/2023. Resident discharged to community on 11/29/202 Resident #24 assessed by Geripsych on 11/07/2023 with no change in neuro assessment noted. DON/Designee will complete a MAR to Cart audit on current residents with Isosorbide by 12/27/23 to validate medication available as documented. DON/Designee reviewed subsequent neurocheck completion as indicated of 11/4/23 with no negative findings. 2) DON/Designee will re-educate licensed nurses on Professional Standards and accuracy of documentation for accuracy and meet professional standards weekly times 4 weeks. Findings will be reviewed duri QAPI meeting. Additional intervention be initiated as needed. 4) AOC: 12/27/23 	23. MD o o n ation 5 ing	

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	2: 12/19/2023 1 APPROVED 2: 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		(11/ [,]	C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GALAX HI	EALTH AND REHAB		-	36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 658	11/08/23 at 2:00 p.m 11/09/23 and 11/10/2 11/12/23 at 8:00 p.m the MAR a 7=other/s 3=hold/see nurses no A review of the progr nursing staff had doc on hold/awaiting deliv pharmacy. The clinical record in pharmacy dated 11/0 Mononitrate oral tabl mouth three times a frequency of 3 times frequency of 2 times On 11/14/23 at 8:45 a Nurse (LPN) #7 and medication cart for th medication was not be cart. LPN #7 stated t medication. On 11/14/23 at 9:50 a Pharmacy Technician medication had not be the medication order On 11/14/23 at 10:00 with Resident #242 t unaware if they got the cup full. On 11/15/23 at 10:50	taff had documented a 7 for . and 8:00 p.m., a 3 on 23 at 8:00 p.m., and a 7 on . Per the preprinted code on ee nurses note and a ote. ess notes indicated the sumented the medication was very and/or on order from the 08/23 that read Isosorbide et 10 mg give 1 tablet by day for hypertension. The per day exceeds the usual per day. a.m., Licensed Practical the surveyor checked the	F 658			
		medication order and they				

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			836 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION	
F 658	 available, they state ain't got it. On 11/15/23 at 3:30 day meeting with the President of Operati Officer the issue with reviewed. On 11/16/23 at 12:2 provided the survey titled, "Medication A Guidelines." This por read in part, "If two medication are with is notified" No further informatic provided to the surv conference. 2. For Resident #24 complete neurologic fall on 11/03/23 in w head. 	ge 77 edication if it was not d you can't administer it if you p.m., during an end of the e Administrator, Regional Vice ons, and Chief Nursing h the medication was 5 p.m., the Administrator team with a copy of a policy dministration General licy was dated 01/23 and o consecutive doses of a vital held or refused, the physician on regarding this issue was ey team prior to the exit	F 658	Β		

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/19/2023 APPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING			C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	- "	10/202 <u>5</u>
GALAX H	EALTH AND REHAB			36 GLENDALE RD		
				GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	Syndrome of the Rig Depressive Disorder Generalized Anxiety Disorder, Parkinson's Feet, and Muscle We The most recent qua (MDS) with an asses of 9/15/23 assigned if for mental status (BII out of 15 indicating th intact. Resident #24 limited assistance wi personal hygiene. T having one fall with r assessment. On 11/14/23 at 10:20 Resident #24 who st they reach in the floo stated "a week or two on their head. Resident #24's clinic progress note dated in part "resident fell f redness on the foreh the Resident's "Neur	not limited to Iliotibial Band ht Leg, Dementia, Major , Mood Disorder, Disorder, Nightmare s Disease, Unsteadiness on	F 658			
	flowsheet was blank pupil response, hand extremities, pain resp the following times: 1:55 PM, 2:10 PM, 3 and 6:10 PM with on Surveyor requested	for level of consciousness, I grasps, motor function ponse, and staff signature for 11/03/23 1:25 PM, 1:40 PM, :10 PM, 4:10 PM, 5:10 PM, Iy vital signs documented. and received the facility gical Assessment" which				

STATEMENT OF DEFICIENCIES (M) PROVIDERSIGNELIANDER: (Q2) MULTIPLE CONSTRUCTION (Q3) DATE SURVEY ADD FLAN OF ORDERTION (PS) DATE SURVEY C (C) CMPLETED MARE OF PROVIDER OR SUPPLIER 495250 B. WING C C OALAX HEALTH AND REHAB STREET ADDRESS, CITY, STATE, ZAP CODE C 111/62/023 OWING BUILWARY STATEMENT OF DEFICIENCIES B. WING STREET ADDRESS, CITY, STATE, ZAP CODE C FRANK BECH DEPICIONNUMSTE ERRECEDED BY FULL 0.0 PROVIDER PLAN OF CORPECTIVE ATION STOLENCE DE STRUCTION COMPLETE FRANK BECH DEPICIONNUMSTE ERRECEDED BY FULL 0.0 PROVIDER PLAN OF CORPECTIVE ATION STOLED BY FULL COMPLETE CONTINUE OF CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUE OF CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CORPECTIVE ATION STOLED BY FULL TO CONTINUES (PLAN OF CONTINUES (PLAN OF CORPECTIVE ATION STOLED			ND HUMAN SERVICES MEDICAID SERVICES			FORM	0: 12/19/2023 APPROVED 0: 0938-0391
MAGE OF PROVIDER ON SUPPLIER TITIE/2023 IMME OF PROVIDER ON SUPPLIER STREET ADDRESS .CTY, STATE, ZIP CODE SALAX HEALTH AND REHAB CALAX HEALTH AND REHAB SUMMARY STATEMENT OF DEFICIENCIES Colspan="2">CALAX, VA 24333 MILE SUMMARY STATEMENT OF DEFICIENCIES Colspan="2">Colspan="2">CODE MILE SUMMARY STATEMENT OF DEFICIENCIES Colspan="2">Colspan="2">COLSPANE" COLSPANE OPTIMING TO FORMOUND IN THE PRECIDEND YILL PREGULTORY OF USE DEFICIENCIES IF 658 Continued From page 79 F 658 F 658 Continued From page 79 F 658 OPTIMENT OF DEFICIENCES - Pupil Response Notor FunctionPain Response Notor FunctionPain Response Notor FunctionPain Resident #24's neurolo						COMPLETED	
SB GLENDALE RD GALAX, VA. 2433 OWID PHEFIX TG SUMMARY STATIMENT OF DEFICIENCIES (EACH CARGENDA Y MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PD PRECENT TG PROVIDER'S PLAV OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F658 F 664 On 11/16/23 at 3:35 PM. The nurvey team prior to the exit conference on 11/16/23. F 664 12/27/23 F 664 SP 0 CRRS; 433.25 OLINING RESIDENT			495250	B. WING	I/		
CMUD HYERX TVG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST REPROCEED BY FULL RECULTORY OR LSCIDENTFYING INFORMATION) DEFINIT PROVIDENS FLAN OF COMPLETION (EACH CONPECTIVE ACTION SHOLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) COMPLETION (EACH CONPECTIVE ACTION SHOLD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) F 658 Continued From page 79 read in part "Resident with a suspected head injury will have neurological observations are the responsibility of license number objects Pupil ResponseMotor FunctionPain ResponseVital SignsObservations* F 658 On 111/15/23 at 9.45 AM, surveyor spoke with the Interim Director of Nursing (DON) regarding Resident #2/4s neurological checks. The DON stated they did not know why the neuro checks were not completed. F 664 On 111/15/23 at 3.35 PM, the survey team met with the Administrator. Chief Nursing Officer, and the Regional Vice President of Operations and discussed the concern of the incomplete neurological checks following Resident #2/4's fail on 11/03/23. F 684 No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23. F 684 SS=0 CPR(s): 483.25 F 684 Quality of care Quality residents. Based on the comprehensive assessment of a resident, the facility must tensure that residents. The administer and care provided to facility residents. The teatherent and care in accercare. F 684							
Principal TAG IEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG IEACH CORSERTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY COMMELTION BATE F 658 Continued From page 79 read in part "Resident with a suspected head injury will have neurological signs monitored and recorded. Neurological observations are the responsibility of licensed nursesDocument neurological checks on the Neurologic Assessment SheetLevel of Consciousness Pupil ResponseMotor FunctionPain ResponseMata SignsObservations" F 658 On 11/15/23 at 9-45 AM, surveyor spoke with the Interim Director of Nursing (DON) regarding Resident #24's neurological checks. The DON stated they did not know why the neuro checks were not completed. F 684 On 11/15/23 at 3-35 PM, the survey team met with the Administrator. Chief Nursing Officer, and the Regional Vice President of Operations and discussed the concern of the incomplete neurological checks following Resident #24's fall on 11/03/23. F 684 Sero CFR(s): 483.25 Quality of Care Sully of Care Sully of Care Sully of Care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of F 684	GALAX HI	EALTH AND REHAB		G	GALAX, VA 24333		
read in part "Resident with a suspected head injury will have neurological signs monitored and recorded. Neurological observations are the responsibility of licensed nursesDocument neurological observations ent the responsibility of licensed nursesDocument neurological observations are the responseNutor FunctionPain ResponseNutor FunctionPain ResponseNutor FunctionPain ResponseNutor FunctionPain ResponseNutor FunctionPain ResponseNutor FunctionPain Resident #24's neurological checks. The DON stated they did not know why the neuro checks were not completed. On 11/15/23 at 3:35 PM, the survey team met with the Administrator, Chief Nursing Officer, and the Regional Vice President of Operations and discussed the concern of the incomplete neurological checks following Resident #24's fall on 11/03/23. No further information regarding this concern was presented to the survey team prior to the exit conference on 11/16/23. SS=D CFR(s): 483.25 § 483.25 Quality of Care Quality of Care Quality of Care Sully of Care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION
care plan, and the residents' choices. This REQUIREMENT is not met as evidenced	F 684	read in part "Resident injury will have neuro recorded. Neurologic responsibility of licen neurological checks of Assessment Sheet Pupil ResponseN ResponseVital Sig On 11/15/23 at 9:45 // Interim Director of Nu Resident #24's neuro stated they did not kr were not completed. On 11/15/23 at 3:35 f with the Administrato the Regional Vice Pro- discussed the concer neurological checks f on 11/03/23. No further information presented to the surv conference on 11/16/ Quality of Care CFR(s): 483.25 § 483.25 Quality of c Quality of care is a fu applies to all treatme facility residents. Bas assessment of a resid that residents receive accordance with prof practice, the compref care plan, and the resi	t with a suspected head logical signs monitored and cal observations are the sed nursesDocument on the Neurologic .Level of Consciousness Motor FunctionPain nsObservations" AM, surveyor spoke with the ursing (DON) regarding blogical checks. The DON now why the neuro checks PM, the survey team met r, Chief Nursing Officer, and esident of Operations and on of the incomplete following Resident #24's fall in regarding this concern was rey team prior to the exit 23. are indamental principle that int and care provided to used on the comprehensive dent, the facility must ensure a treatment and care in essional standards of nensive person-centered sidents' choices.				12/27/23

Event ID: N6VL11

Facility ID: VA0037

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/19/2023 APPROVED . 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
- F		495250	B. WING		(C 16/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	- '''	10/202 <u>5</u>
GALAX H	EALTH AND REHAB		8	36 GLENDALE RD		
			G	GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL : LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From pag	je 80	F 684			
	by: Based on observati record review, facilit facility staff failed to of 22 residents, Res Resident #242. The findings include 1. For Resident #51 administer the media medication used to t Resident #51's face included but not limi anxiety, depression, Resident #51's most with an assessment assigned the residen status score of 14 of patterns. This indication cognitively intact. Resident #51's comp reviewed and contait taking an antideprest Interventions for this "Medication as order Resident #51's clinic contained a physiciat read in part, "Zoloft" Give 1 tablet by most depressive disorder On 11/14/23 at 7:50 licensed practical nut	on, staff interview, clinical y document review, the follow physician's orders for 3 ident #51, Resident #86, and d: the facility staff failed to cation Zoloft. Zoloft is a reat depression. sheet listed diagnoses which ted to Alzheimer's disease, and dementia. crecent minimum data set reference date of 10/18/23 at a brief interview for mental ut of 15 in section C, cognitive tes that the resident is orehensive care plan was ned a care plan for "I am sant medication."		 F684 1) Resident #51 zoloft medication received from pharmacy on 11/15/2023. Resident #86 identified wound resolved 11/22/2023. Resident #242 Isosorbide and plavix medication order clarified or 11/15/2023 and received by pharmacy 11/15/2023. Resident discharged to community on 11/29/2023. 2) The DON/Designee reviewed curresident's Zoloft, isosorbide, Plavix and wound care orders by the physician for accuracy and completion by 12/27/23. 3) The DON/Designee re-educated licensed nurses on Quality of Care relate to following physician's orders by 12/27/23. 4) The DON/Designee will review 5 resident's new orders for accuracy of following physician's orders per week times 4 weeks. Findings to be reviewed during QAPI meeting. Additional interventions to be initiated as needed. 5) AOC: 12/27/23. 	d on rent d ated	

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	11110/202	
GALAX HI	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 684	Zoloft was not availa LPN #6 stated, "I'II p pharmacy about the #6 to let them know administration. Surv the Zoloft was availa Surveyor requested process for unavaila part, "Medication no 1. Look in backup m (emergency drug kit Notify the physician/ medication is not av give when the medica or to skip that dose. medication is due to Surveyor requested of medications avail and/or EDK. This lis sertraline 25 mg, fou The concern of not a Zoloft per the physic with the administrator regional vice preside at 5 pm. No further informatio	ications but stated that the able in the medication cart. probably have to call the 2 Zoloft." Surveyor asked LPN when the had the Zoloft for reyor was never informed that able or administered. and was provided with the able medications which read in at Available-Nurse's Process. medication. 2. Look in the EDK box for the medication. 3. //practitioner that the ailable-request an order to cation arrives from the that dose. 4. Enter a onetime ation to be given upon delivery a. Note the time the o ensure not given too close." and was provided with a list able in the back medication at contained the medication at contained the medication at ablets. administering Resident #51's cian's order was discussed or, chief nursing officer, and ent of operations on 11/16/23 on was provided prior to exit.	F 684			
	treat an abdominal s					

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB			836 GLENDALE RD GALAX, VA 24333		
	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION	
F 684	Continued From pag	e 82	F 684			
	11/10/23.					
	which included, but r of Right Buttocks, Op Wall, Ventral Hernia Diabetes Mellitus, ar According to Resider sheet, the resident w 11/02/23. An "Admis dated 11/02/23 docu alert and independer tasks of daily living. On 11/13/23 at 5:17 Resident #86 who st wound on their stoms been changed every physician's orders in 11/10/23 to clean are abdomen with norma peri-wound, then app wound bed and cove dressing daily. A pre (with previous admis dressing to abdomer skin scabs remained 11/02/23 and was dis According to the Nov Administration Record been applied since a first documented treat	 posis list indicated diagnoses, not limited to Pressure Ulcer ben Wound of Abdominal with Obstruction, Type 2 and Muscle Weakness. and #86's demographic face ras admitted to the facility on ssion Data Collection Form" mented the resident as being at in decisions regarding PM, surveyor spoke with ated they had a surgical ach and the dressing had not day. The resident's current cluded an active order dated the surgical wound of al saline, apply sure prep to bly Collagen powder to rr with bordered gauze evicus order dated 10/27/23 sion) for zinc oxide paste to topically as needed for dry active with admission on scontinued on 11/10/23. The atment to Resident #86's round following admission on to 11/12/23. 				
		sessed by the wound				

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	2: 12/19/2023 1 APPROVED 2: 0938-0391
STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		(11/ [,]	C 16/2023
NAME OF PR	OVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
GALAX HE	ALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	serous exudate and 8 Treatment plan was of powder with a gauze and skin prep to the p days. Resident #86 was reas specialist on 11/08/23 documented the abdo measuring 0.8 x 0.5 of exudate and 50% gra treatment plan remai a gauze island with b to the peri wound one On 11/15/23 at 11:30 Interim Director of Nu reason for the reside treatment not being s DON stated they wou additional information On 11/15/23 at 3:35 I with the Administrato Operations, and the 0 discussed the concel receiving treatment a specialist. No further information presented to the surv conference on 11/16/ 3. For Resident #242	urgical wound to the 6.4 x 2.9 x 0.1 cm with light 50% granulation tissue. documented as Collagen island with border dressing beri wound once daily for 30 assessed by the wound 3, the progress note ominal surgical wound as k 0.1 cm with light serous anulation tissue. The ned as Collagen powder with order dressing and skin prep be daily for 25 days. AM, surveyor spoke with the ursing (DON) regarding nt's surgical wound tarted until 11/11/23, the ld look into it. However, no n was provided. PM, the survey team met r, Regional Vice President of Chief Nursing Officer and n of Resident #86 not s directed by the wound h regarding this concern was rey team prior to the exit 23. , the facility nursing staff ne medications Plavix and	F 684			

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		ND HUMAN SERVICES			PRINTED: 12/19/202 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE	11/10/202 <u>5</u>
GALAX H	EALTH AND REHAB			GLENDALE RD	
			I	LAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 684	Continued From pag	je 84	F 684		
		gnoses included, but were not ion, chronic kidney disease, ulmonary disease.			
		leted minimum data set for this Resident. Resident prientated to self.			
	orders for Plavix 75 bedtime and Isosorb tablet three times a	ical record included provider mg 1 tablet by mouth at bide Mononitrate 10 mg 1 day for hypertension. The nedications was documented			
	medication administ revealed that the nu 7 for the administrat	Plavix-A review of the ration records (MARs) rsing staff had documented a ion of the Plavix on 11/08/23 he preprinted code on these he nurses notes.			
	facility nursing staff l new admission awai pharmacy. On 11/12 documented medica from pharmacy. A re	tion not available on order eview of the stat box list edication was available in the			
	clinical record revea documented they ha medication on 11/09 p.m., 11/10/23 at 8:0 11/11/23 at 8:00 a.m 11/12/23 at 8:00 a.m	sosorbide-A review of the led that the nursing staff had id administered this /23 at 8:00 a.m. and 2:00 00 a.m. and 2:00 p.m., a., 2:00 p.m. and 8:00 p.m., a. and 2:00 p.m., and again a.m. 2:00 p.m. and 8:00 p.m.			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HI	EALTH AND REHAB		-	36 GLENDALE RD GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 684	Continued From pag	e 85	F 684		
	11/08/23 at 2:00 p.m 11/09/23 and 11/10/2 11/12/23 at 8:00 p.m the MAR a 7=other/s 3=hold/see nurses m A review of the progr nursing staff had doc on hold/awaiting deli pharmacy. The clinical record in pharmacy dated 11/0 Mononitrate oral tabl mouth three times a frequency of 3 times frequency of 2 times On 11/14/23 at 8:45 Nurse (LPN) #7 and medication cart for th medication was not I cart. LPN #7 stated to medication had not b the order needed to I On 11/14/23 at 10:00 with Resident #242 t unaware if they got th cup full.	ress notes indicated the cumented the medication was very and/or on order from the 08/23 that read Isosorbide et 10 mg give 1 tablet by day for hypertension. The per day exceeds the usual per day. a.m., Licensed Practical the surveyor checked the ne Isosorbide. This ocated on the medication hey would have to order the a.m., during an interview with n #1 this staff stated this been sent to the facility and be clarified. 0 a.m., during an interview his resident stated they were heir medication, they got a			
) a.m., during an interview f stated they had not clarified			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/202 FORM APPROVEI OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
- E		495250	B. WING		C 11/16/2023
NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 684 F 686 SS=D	When asked how the medication if it was n can't administer it if y On 11/15/23 at 3:30 day meeting with the President of Operatio Officer the issue with reviewed. On 11/16/23 at 12:25 provided the survey f titled, "Medication Ac Guidelines." This pol read in part, "If two medication are withh is notified" No further informatio provided to the surve conference. Treatment/Svcs to Pf CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Presso	and they needed to do that. ey administered this not available, they stated you you ain't got it. p.m., during an end of the Administrator, Regional Vice ons, and Chief Nursing the medications was 5 p.m., the Administrator team with a copy of a policy dministration General icy was dated 01/23 and o consecutive doses of a vital eld or refused, the physician n regarding this issue was ey team prior to the exit revent/Heal Pressure Ulcer 0(i)(ii) grity ure ulcers.	F 684		12/27/23
	resident, the facility r (i) A resident receive professional standard pressure ulcers and ulcers unless the ind demonstrates that th (ii) A resident with prinecessary treatment with professional star	ehensive assessment of a nust ensure that- s care, consistent with ds of practice, to prevent does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent ndards of practice, to vent infection and prevent			

Facility ID: VA0037

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	12/19/2023 APPROVED 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE S COMPLE	
		495250	B. WING		C 11/1	6/2023
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB		-	36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 686	by: Based on resident in clinical record review review, the facility st with pressure ulcers treatment and servic of 22 residents in the #86. The findings included For Resident #86, th stage 3 pressure ulc by the wound specia 11/10/23. Resident #86's diagr which included, but r of Right Buttocks, Of Wall, Ventral Hernia Diabetes Mellitus, an According to Resided sheet, the resident w 11/02/23. An "Admis dated 11/02/23 docu alert and independen tasks of daily living. On 11/13/23 at 5:17 Resident #86 who st bottom was not being resident's current ph active order dated 17 medial sacrum with r prep to peri-wound, f	eloping. T is not met as evidenced nterview, staff interview, y, and facility document aff failed to ensure a resident receives necessary es to promote healing for 1 e survey sample, Resident	F 686	 F686 1) Resident #86 identified wound resolved on 11/22/2023. 2) The center identified current resident's with pressure ulcers to be a risk. The DON/Designee reviewed the treatment records of current residents with pressure ulcers to validate the resident received treatments and serve to promote wound healing with no negative findings by 12/27/23. 3) The DON/Designee re-educated licensed nurses regarding providing necessary treatments and services to promote wound healing as indicated to 12/27/23. 4) The DON/Designee will review 3 resident treatment orders per week x weeks to validate necessary treatment and services for wound healing are completed as indicated. Findings to b reviewed during QAPI meeting. Additi interventions to be initiated as needed 5) AOC: 12/27/23 	e rices the by 4 ts ional	

Facility ID: VA0037

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0392
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING		(X3) DATE SURVEY COMPLETED
- E		495250	B. WING		C 11/16/2023
NAME OF P	AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COE 836 GLENDALE RD GALAX HEALTH AND REHAB GALAX VA 24333			<u> </u>	
GALAX HEALTH AND REHAB				ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 686	Continued From pag dressing daily.	je 88	F 686		
	specialist on 11/03/2 documented a stage medial sacrum meas light serous exudate tissue. The dressing powder, gauze island to peri-wound once of resident was reasses on 11/08/23, the pro- area as 0.4 x 0.4 x 0 exudate and 100% g treatment plan rema gauze island with bo peri-wound once dai Surveyor reviewed F and was unable to lot to the sacral pressur 11/02/23 through 11/ resident's November Administration Reco sacral pressure wou On 11/15/23 at 11:30 Interim Director of N explanation for the re treatment to the sacra 11/02/23 through 11/ would look into it. H information was prov Surveyor requested policy titled "Skin Pro-	Resident #86's clinical record boate an order for treatment re ulcer from admission on /10/23. According to the r 2023 Treatment rd (TAR), treatment to the ind began on 11/11/23. D AM, surveyor spoke with the lursing (DON) regarding esident not receiving ral pressure wound from /10/23. The DON stated they owever, no additional			

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM): 12/19/2023 APPROVED). 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING			C 16/2023
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 686	with the Administrate Operations, and the discussed the conce receiving treatment a specialist. No further informatio	PM, the survey team met or, Regional Vice President of Chief Nursing Officer and rn of Resident #86 not as directed by the wound n regarding this concern was vey team prior to the exit	F 686			
F 689 SS=D	CFR(s): 483.25(d)(1 §483.25(d) Accident The facility must ens §483.25(d)(1) The re as free of accident h §483.25(d)(2)Each re supervision and assi accidents. This REQUIREMEN by: Based on observation interview, clinical rec document review, th each resident receive prevent accidents for survey sample, Resi The findings included For Resident #24, th placement of Dycem resident's wheelchai	s. ure that - esident environment remains azards as is possible; and esident receives adequate stance devices to prevent T is not met as evidenced on, resident interview, staff cord review, and facility e facility staff failed to ensure ed assistance devices to r 1 of 22 residents in the dent #24.	F 689	 F730 1) Current eligible CNAs performan evaluations will be completed by the appropriate supervisor on or before 12/27/23. Current CNAs will complete hour education/in-services on or befor 12/27/23. 2) The Administrator/Designee reviewed current CNA records to determine due dates for completion of hour education/in-services and performance evaluations and notified current CNAs for timely completion. 3) The Administrator/Designee will 	e 12 e	12/27/23

Event ID: N6VL11

Facility ID: VA0037

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	X3) DATE SURVEY COMPLETED
		495250	B. WING		С
		433230			11/16/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HI	EALTH AND REHAB			6 GLENDALE RD ALAX, VA 24333	
	SUMMARY	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFINITION DEFINITION DEFINITION	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETIC
F 689	Continued From pa	age 90	F 689		
	which included, bu Syndrome of the R Depressive Disord Generalized Anxie Disorder, Parkinso Feet, and Muscle M The most recent qu (MDS) with an ass of 9/15/23 assigne for mental status (I out of 15 indicating intact. Resident #2 limited assistance personal hygiene. having one fall with assessment. Resident #24's cur person-centered co stating in part "[Na fall-related injury d medication, History	gnosis list indicated diagnoses, it not limited to Iliotibial Band Right Leg, Dementia, Major er, Mood Disorder, ty Disorder, Nightmare on's Disease, Unsteadiness on Weakness. uarterly minimum data set essment reference date (ARD) d the resident a brief interview BIMS) summary score of 15 g the resident was cognitively 24 was coded as requiring with transfers, dressing, and The resident was coded as in no injury since the prior MDS rrent comprehensive are plan included a focus area me omitted] is at risk for ue to: Parkinson's, Use of y of falls. Resident continue form tasks without asking staff		re-educate current CNAs on completion 12 hour education/in-services and Relia program information on or before 12/27/23. Nursing supervisors will be re-educated by the Administrator/Designee on timely completion of CNA performance evaluations on or before 12/27/23. 4) The Administrator/Designee will review 3 CNA employee records per we times 4 weeks to validate timely completion of required education/in-services and performance evaluation completion. Findings to be reviewed during QAPI meeting. Addition interventions to be initiated as needed. 5) AOC: 12/27/23	s
	changing positions at times, [he/she] h times. [He/She] is band syndrome on [history] of seizure unresponsive and Resident at times s 'fainting spells.' Re things up off floor a floor" The reside	tempts to perform task without s. Resident cognition fluctuates has a poor safety awareness at also noted to have IT [lliotibial] in right leg. Resident with hx like episode and become [sic] slides out of w/c [wheelchair]. states [he/she] is having esident often attempts to pick and slides out of wheelchair to ent's fall risk care plan included ted 4/12/23 for Dycem to			

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PRINTED: 12/19/2023

		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HI	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 689	Resident #24 who sit they reach in the flow On 11/15/23 at 11:19 assistant (CNA) #7 at (LPN) #6 assisted R their wheelchair, the the wheelchair seat. absence of the Dyce seat. CNA #7 and L back to the wheelch Surveyor requested policy titled "Falls Pri- read in part "The needs to be held acc Care Plan to elimina " On 11/16/23 at 4:59 with the Administrate the Regional Vice Pri- discussed the conce	0 AM, surveyor spoke with tated they have falls because or for things. 5 AM, certified nursing and licensed practical nurse esident #24 to stand up from re was no Dycem present in CNA #7 verified the em non-slip material in the PN #6 assisted the resident	F 689		
F 730 SS=E	No further informatic presented to the sur conference on 11/16 Nurse Aide Peform F CFR(s): 483.35(d)(7 §483.35(d)(7) Regul The facility must cor of every nurse aide a months, and must pr	Review-12 hr/yr In-Service	F 730		12/27/23

Facility ID: VA0037

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 12/19/2023 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING			C 16/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAXH	EALTH AND REHAB		8	36 GLENDALE RD		
GALAA H			G	GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 730	Continued From pag	je 92	F 730			
	requirements of §48 This REQUIREMEN by: Based on staff inter review, the facility st of nurse aide's at lea failed to provide in-s the outcome of these The findings include The facility administ performance reviews 12 months and failed education based on reviews/evaluations. During the task suffi staffing the surveyor regarding nurse aide in-service training. On 11/14/23 at 4:30 day meeting with the	T is not met as evidenced view and facility document aff failed to complete reviews ast every 12 months and ervice education based on e reviews. d: rative staff failed to complete s of nurse aides at least every d to provide regular in-service the outcomes of cient and competent nurse requested information e reviews/evaluations and p.m., during an end of the e Administrator, Regional Vice		 F689 1) DON/Designee reviewed resider #24 fall interventions and validated cut fall intervention of dycem in wheelcha appropriate and present on 11/15/23. 2) The center identified current residents with dycem in wheelchair as fall intervention at risk. The DON/Designee reviewed current resident's with dycem in wheelchair as fall intervention, validated it was prese on or before 12/27/2023. 3) The DON/Designee re-educated licensed nurses and IDT regarding fall intervention guidance on or before 12/27/2023. 4) The DON/Designee will monitor resident fall care plan interventions ar validate presence of interventions were x 4 weeks. Findings to be reviewed 	rrent ir is s a s a ent I 3 ad	
	Nursing Officer the F doing yearly evaluat On 11/15/23 at 8:26 the Administrator thi evaluations have no supervisor was the p responsible for comp On 11/15/23 at 9:10 Assistant (C.N.A.) # employed at the faci	a.m., during an interview with s staff stated performance t been completed and the person who would be		during QAPI meeting. Additional interventions to be initiated as needed 5) AOC: 12/27/2023	I.	

Facility ID: VA0037

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
- E		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER			IREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HE	EALTH AND REHAB			ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 730	Continued From pag	e 93	F 730		
	training was appropri performance evaluat	ate, and they had not had a ion/review.			
		a.m., the Administrator stated luations had not been			
	surveyor with a copy Performance Evaluat 11/28/17. This policy Performance evaluat for the supervisor an	tions with an effective date read in part, "The ion provides a formal vehicle d the employee to discuss I work performance and as it relates to the			
	a copy of a blank doo Performance Review score the employee of knowledge. There wa administrative staff co	Form. This document would on their performance and job as an area where the ould document areas of pmental plans and/or			
F 755 SS=D	provided to the surve conference.	n regarding this issue was y team prior to the exit cedures/Pharmacist/Records (1)-(3)	F 755		12/27/23
	drugs and biologicals them under an agree	vide routine and emergency to its residents, or obtain ment described in lity may permit unlicensed			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HEALTH AND REHAB				36 GLENDALE RD ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 755	Continued From pag	e 94	F 755		
	permits, but only unc a licensed nurse.	ler the general supervision of			
	pharmaceutical servi that assure the accu dispensing, and adm	es. A facility must provide ces (including procedures rate acquiring, receiving, inistering of all drugs and he needs of each resident.			
	,	Consultation. The facility in the services of a licensed			
		es consultation on all ion of pharmacy services in			
		ishes a system of records of on of all controlled drugs in able an accurate			
	order and that an act is maintained and per This REQUIREMEN by:	T is not met as evidenced			
	facility document rev pass and pour the fa medications were av	view, clinical record review, iew and during a medication cility staff failed to ensure ailable for administration of 2 dent #3 and Resident #294.		F755 1) Resident #3 Vitamin D medication order clarified and medication received 11/15/2023. Resident #294 Merrem medication completed with no new ord	t
		d: ne facility staff failed to on Vitamin D was available		regarding treatment for associated diagnosis. 2) The center identified current residents with orders for Vitamin D and Merrem to be at risk. The DON/Design will complete a MAR to cart audit on for	d nee

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Facility ID: VA0037

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CENTER	-	I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		(05050	R WINC	С	
		495250	B. WING		11/16/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE 36 GLENDALE RD	
GALAX HI	EALTH AND REHAB			ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLÉTIO
F 755	Continued From p	page 95	F 755		
	included but not li unspecified. Resident #3's mos an assessment re assigned the resid status score of 5 of patterns. This indi severely cognitive Surveyor observe #6 during a medic 11/14/23 at 7:55 a #3's medications I Vitamin D was not cart, and they wou medication room. 400 iu and Vitamin Resident #6 takes asked LPN #6 to I the medication av	d licensed practical nurse (LPN) cation pass and pour on am. LPN #6 prepared Resident but stated that the resident's t available in the medication uld have to get it from the LPN #6 stated that Vitamin D n D 500 iu was in the cart, but s Vitamin D 4000 iu. Surveyor let them know when they had ailable for administration. ver informed that the Vitamin D		 Vitamin D and Merrem or before 12/2" to verify medication availability. 3) The DON/Designee will re-educal licensed nurses on medication available and guidance on next steps when medication is not available on or before 12/27/23. 4) The DON/Designee will monitor aresident MARs per week times 4 weel validate Medication availability. Finding Will be reviewed during QAPI meeting Additional interventions to be initiated needed. 5) AOC: 12/27/23 	ate bility re 5 ks to ngs
	with the clinical re record contained a which read in part (cholecalciferol). (a day for supplem Surveyor requeste process for unava part, "Medication 1. Look in backup (emergency drug	ed Resident #3's medications cord. Resident #3's clinical a physician's order summary ;, "Vitamin D Tablet Give 4000 iu by mouth one time ientation." ed and was provided with the illable medications which read in not Available-Nurse's Process. medication. 2. Look in the EDK kit) box for the medication. 3. an/practitioner that the			

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT (STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	11/10/202 <u>3</u>
GALAX H	EALTH AND REHAB			6 GLENDALE RD ALAX, VA 24333	
	SLIMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 755	Continued From pag	je 96	F 755		
	•	cation arrives from the			
		that dose. 4. Enter a onetime tion to be given upon delivery			
	or to skip that dose.	a. Note the time the			
	medication is due to	ensure not given too close."			
	Surveyor requested	and was provided with a list			
		able in the backup medication D 4000 iu was not listed as			
		up medication and/or EDK.			
	discussed with the a	e for administration was dministrator, chief nursing vice president of operations			
	No further informatio	on was provided prior to exit.			
	ensure the medication administration result	4 the facility staff failed to on, Merrem was available for ing in the resident missing ses. Merrem is an antibiotic ns.			
		e sheet listed diagnoses not limited to sepsis and of pancreatic duct.			
	completed; however	imum data set was not yet , Resident # 294 was alert on, place, time, and situation.			
	contained a physicia read in part, "Merren Reconstituted 500 m	ical record was reviewed and in's order summary which n Intravenous Solution ng (Meropenem). Use 2000 ery 8 hours for sepsis for 5			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:		(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING	ETN/	C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	11/16/202 <u>3</u>	
	EALTH AND REHAB		83	6 GLENDALE RD		
GALAA H			G	ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES EY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 755	Continued From pag days."	e 97	F 755			
	2023 was reviewed a read in part, "Merrem Reconstituted 500 m mg intravenously eve days." This entry was 11/04/23, and coded Chart code "7" is equ Notes." Chart code "7" Nurse Notes."	I for the month of November and contained an entry which n Intravenous Solution g (Meropenem). Use 2000 ery 8 hours for sepsis for 5 s coded "7" on 11/03/23 and "3" at 12:00 am on 11/05/23. uivalent to "Other/See Nurse 3" is equivalent to "Hold/See				
	reviewed and contair "Effective Date: 11/0 new admission, med pharmacy.", Effective Note Text: Merrem I Reconstituted 500 m intravenously every & new admission, med pharmacy.", "Effective Text: Merrem Intrave 500 mg. Use 2000 m hours for sepsis for 5 pharmacy.", "Effective Note Text: Merrem I Reconstituted 500 m intravenously every & waiting for med from 11/03/2023 23:04 No Solution Reconstitute intravenously every & awaiting delivery fror Date: 11/04/2023 08 Intravenous Solution	e Date: 11/02/2023 23:56 ntravenous Solution g. Use 2000 mg 3 hours for sepsis for 5 days. s not available from re Date: 11/03/2023 Note enous Solution Reconstituted ng intravenously every 8 5 days. not available from re Date: 11/03/2023 16:54 ntravenous Solution				

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MEDICAID SERVICES		(FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER:			(X3) DATE SURVEY COMPLETED	
495250	B. WING		C 11/16/2023	
	STF	REET ADDRESS, CITY, STATE, ZIP CODE	11/10/202	
	I	•	(X5)	
CY MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
e 98	F 755			
r pharmacy to send mes re Date: 11/04/2023 16:01 ntravenous Solution g. Use 2000 mg 3 hours for sepsis for 5 days. pharmacy", and "Effective ote Text: Merrem Reconstituted 500 mg. Use sly every 8 hours for sepsis delivery." and was provided with the ole medications which read in Available-Nurse's Process. edication. 2. Look in the EDK box for the medication. 3. oractitioner that the ailable-request an order to ation arrives from the that dose. 4. Enter a onetime ion to be given upon delivery a. Note the time the ensure not given too close." and was provided with a list able in the backup medication in intravenous solution was e in the backup medication h the administrator, chief egional vice-president of 23 at 3:30 pm, surveyor ad a back-up pharmacy, and vas to obtain needed rm. Regional vice president if they need medications,	F 755			
	IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE C A BUILDING 495250 B. WING 495250 B. WING TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) ID PREFIX TAG e 98 F 755 r pharmacy to send mes re Date: 11/04/2023 16:01 ntravenous Solution g. Use 2000 mg F 755 8 hours for sepsis for 5 days. pharmacy", and "Effective ote Text: Merrem Reconstituted 500 mg. Use sly every 8 hours for sepsis delivery." F and was provided with the ole medications which read in Available-Nurse's Process. edication. 2. Look in the EDK box for the medication. 3. oractitioner that the ailable-request an order to ation arrives from the that dose. 4. Enter a onetime tion to be given upon delivery a. Note the time the ensure not given too close." and was provided with a list able in the backup medication n intravenous solution was e in the backup medication h the administrator, chief egional vice-president of 23 at 3:30 pm, surveyor ad a back-up pharmacy, and was to obtain needed mm. Regional vice president if they need medications, ne pharmacy, and the	(x1) PROVIDERSUPPLEXECUA IDENTIFICATION NUMBER: (x2) MULTIPLE CONSTRUCTION A BUILDING 495250 Image: Construction Number Street ADDRESS, CITY, STATE, ZIP CODE BS GLENDALE RD GALAX, VA 24333 CATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL ISC IDENTIFYING INFORMATION) ID PREFX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIA DEFICIENCY) e 98 F 755 r pharmacy to send mes re Date: 11/04/2023 18:01 Intravenous Solution g. Use 2000 mg F 755 shours for sepsis for 5 days. pharmacy, and "Effective ote Text: Merrem Reconstituted 500 mg. Use give evry 8 hours for sepsis delivery." F 755 and was provided with the ole medications. Which read in Available-Nurse's Process. edication. 2. Look in the EDK box for the medication. 3. oractitioner that the aliable-request an order to aton arrives from the that dose. 4. Enter a onetime ion to be given upon delivery a. Note the time the ensure not given too close." and was provided with a list bie in the backup medication in intravenous solution was e in the backup medication h the administrator, chief egional vice-president of 23 at 330 pm, surveyor ad a back-up pharmacy, and was to obtain needed m. Regional vice president if they need medications, the pharmacy, and the	

Facility ID: VA0037

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		AND HUMAN SERVICES			FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495250		(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED C 11/16/2023	
		B. WING			
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HEALTH AND REHAB			GLENDALE RD AX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 755	pharmacy directo part, "For a backu would need to do number (unless w regarding a stock prior to our next of backup pharmacy pharmacies in you transfer an order and delivery to you know you need it take care of the re The concern of ne medication was a discussed with th	vided with an email from r of accounts, which read in up pharmacy what your team is: Call the main pharmacy ve've already reached out to you issue). Let us know you need it lelivery and want it from a v. We will contact local ur area to locate the product, over, and arrange for pickup our building. Once you let us from a backup pharmacy, we est." ot ensuring Resident #294's vailable for administration was e administrator, chief nursing nal vice-president of operations	F 755		
F 756 SS=D	Drug Regimen Re CFR(s): 483.45(c) §483.45(c) Drug I §483.45(c)(1) The must be reviewed licensed pharmad §483.45(c)(2) Thi of the resident's r §483.45(c)(4) The irregularities to th facility's medical o and these reports (i) Irregularities in	Regimen Review. e drug regimen of each resident I at least once a month by a sist. s review must include a review	F 756		12/27/23

Facility ID: VA0037

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	-	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 12/19/202 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
495250		B. WING		C 11/16/202 <u>3</u>	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
			83	6 GLENDALE RD	
GALAX HEALTH AND REHAB			G/	ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 756	Continued From	page 100	F 756		
	-	for an unnecessary drug.			
		ies noted by the pharmacist			
		must be documented on a			
		report that is sent to the			
		an and the facility's medical			
		tor of nursing and lists, at a			
	minimum, the resident's name, the relevant drug,				
		ty the pharmacist identified.			
		physician must document in the I record that the identified			
		een reviewed and what, if any,			
		aken to address it. If there is to			
		the medication, the attending			
	the resident's me	document his or her rationale in dical record.			
		e facility must develop and			
		and procedures for the monthly			
		iew that include, but are not			
		ames for the different steps in			
		steps the pharmacist must take			
		dentifies an irregularity that			
		ction to protect the resident.			
		ENT is not met as evidenced			
	by:				
		terview, clinical record review,		F756	
		nent review, the facility staff			
	· ·	drug regimen review		 Resident #24 AIMS was complete 	d
		s for 1 of 22 residents in the		per the 07/25/2023 pharmacy	
	survey sample, R	Resident #24.		recommendation on 07/28/2023 and	
				uploaded to the document section of P	CC
	The findings inclu	ıded:		on 07/31/2023. Off cycle AIMS was	
				completed on 11/30/2023 by licensed	
	For Resident #24	, the facility staff failed to carry		nurse.	
	out a physician a	pproved drug regimen review		2) The DON/Designee reviewed	
		for a movement test, such as		pharmacy recommendations and	
	AIMS or DISCUS	, to be performed at least every		completed orders per the physician ord	ers
	six months.	-		on or before 12/27/23.	
	1			3) The DON/ Designee re-educated	

Event ID: N6VL11

Facility ID: VA0037

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CENTER	-	I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
TATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
A95250 NAME OF PROVIDER OR SUPPLIER GALAX HEALTH AND REHAB		B. WING		C 11/16/2023	
		S [.]	IREET ADDRESS, CITY, STATE, ZIP CODE		
			36 GLENDALE RD ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 756	Continued From p	age 101	F 756		
	Resident #24's dia which included, bu Syndrome of the F Depressive Disord Generalized Anxie Disorder, Parkinso Feet, and Muscle The most recent of (MDS) with an ass of 9/15/23 assigne for mental status (out of 15 indicatin intact. Resident # limited assistance personal hygiene. having one fall wit assessment. Surveyor reviewed regimen review da Antipsychotics F tardive dyskinesia Recommend mov DISCUS, be perfor while this resident therapy. This resi The last AIMS/DIS was dated March checked the box in recommendation, 7/27/23. On 11/15/23, surv clinical record and or DISCUS test fo signed drug regime	agnosis list indicated diagnoses, ut not limited to Iliotibial Band Right Leg, Dementia, Major der, Mood Disorder, ety Disorder, Nightmare on's Disease, Unsteadiness on		interdisciplinary team (IDT) regarding pharmacy recommendation process at timely completion of accepted recommendations on or before 12/27/2 4) The DON/Designee will monitor 5 resident records per week times 4 wee for completion of pharmacy recommendations. Findings will be reviewed weekly in QAPI meeting. Additional interventions to be initiated needed. 5) AOC: 12/27/23	23. 5 sks

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB		-	36 GLENDALE RD GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	
F 756	Continued From pag	e 102	F 756		
	with the Administrato the Regional Vice Pr discussed the conce an AIMS or DISCUS physician.	PM, the survey team met or, Chief Nursing Officer, and esident of Operations and rn of staff failing to complete test as agreed upon by the			
F 758 SS=D	presented to the survice on 11/16	ychotropic Meds/PRN Use	F 758		12/27/23
	affects brain activitie processes and beha	chotropic drug is any drug that s associated with mental vior. These drugs include, , drugs in the following			
	Based on a compreh resident, the facility r	ensive assessment of a nust ensure that			
	psychotropic drugs a unless the medicatio	ents who have not used are not given these drugs n is necessary to treat a diagnosed and documented			
	drugs receive gradua behavioral interventio	ents who use psychotropic al dose reductions, and ons, unless clinically n effort to discontinue these			

Facility ID: VA0037

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES				(X3) DATE SURVEY COMPLETED
		495250	B. WING		C
NAME OF PI	ROVIDER OR SUPPLIER	100200		TREET ADDRESS, CITY, STATE, ZIP CODE	11/16/202 <u>3</u>
				36 GLENDALE RD	
GALAX H	EALTH AND REHAB		G	ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 758	Continued From pag drugs;	e 103	F 758		
	unless that medication diagnosed specific c in the clinical record;	oursuant to a PRN order on is necessary to treat a ondition that is documented and			
	are limited to 14 day §483.45(e)(5), if the prescribing practition appropriate for the P beyond 14 days, he	RN order to be extended or she should document their ent's medical record and			
	drugs are limited to renewed unless the prescribing practition the appropriateness This REQUIREMEN by:	T is not met as evidenced			
	review, the facility st needed) orders for p limited to 14 days for survey sample, Resi The findings included For Resident #24, th the order for the med duration limited to 14 antihistamine drug w anxiety and tension.	d: e facility staff failed to ensure dication Vistaril included a		F758 1) Resident #24 Vistaril order was assessed by prescribing Geripsych physician on 11/07/2023 with recommendation to continue medicatio regimen for treatment of diagnosis of anxiety including continued use of prn Vistaril. Resident assessed by prescrik Geripsych physician on 11/29/2023 with recommendation to continue medicatio regimen for treatment of diagnosis of anxiety including continue prn use of Vistaril, the MD was notified of the recommendation and corrections will be	bing h n

Facility ID: VA0037

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495250	83	IREET ADDRESS, CITY, STATE, ZIP CODE G GLENDALE RD ALAX, VA 24333	C C 11/16/202 <u>3</u>	
TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ST 83 G	6 GLENDALE RD	11/16/202 <u>3</u>	
MUST BE PRECEDED BY FULL	83 G.	6 GLENDALE RD		
MUST BE PRECEDED BY FULL	G			
MUST BE PRECEDED BY FULL		ALAA, VA 24333		
,	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETIC DATE	
104	F 758			
t limited to lliotibial Band Leg, Dementia, Major Mood Disorder, isorder, Nightmare Disease, Unsteadiness on kness. erly minimum data set ment reference date (ARD) e resident a brief interview S) summary score of 15 e resident was cognitively record included a current d 10/31/23 for Vistaril 50 as needed for increased ing nursing progress note M read in part "Resident ed anxiety and stated it ast two days. [name nd gave orders for Vistaril d] TID [three times a day] #24's clinical record as of had received the PRN arate occasions since 10/31/23. resident's clinical record ate documentation of the rationale indicating the tion of Vistaril. M, the survey team met		orders for prn psychotropic medication weekly times 4 weeks then monthly x 2 to 14 day stop date and/or physician documented rationale for extended orde timeframe. Findings to be reviewed	e v for r	
S Idain Aeard #hai	 s) summary score of 15 resident was cognitively record included a current 10/31/23 for Vistaril 50 s needed for increased ng nursing progress note A read in part "Resident ed anxiety and stated it test two days. [name nd gave orders for Vistaril I] TID [three times a day] #24's clinical record as of nad received the PRN arate occasions since 10/31/23. resident's clinical record te documentation of the ationale indicating the 	 s) summary score of 15 resident was cognitively record included a current 10/31/23 for Vistaril 50 s needed for increased ng nursing progress note A read in part "Resident ed anxiety and stated it ist two days. [name nd gave orders for Vistaril I] TID [three times a day] #24's clinical record as of had received the PRN arate occasions since 10/31/23. resident's clinical record te documentation of the ationale indicating the 	 a) summary score of 15 resident was cognitively a) The DON/Designee re-educated current licensed nurses and provided information to the physicians/mid-levels with prescribing authority in the center regarding prn psychotropic medications on or before 12/27/23. b) The DON/Designee will review new orders for prn psychotropic medication weekly times 4 weeks then monthly x 2 for 4 anxiety and stated it ust two days. [name and gave orders for Vistaril c) TID [three times a day] #24's clinical record as of the arate occasions since 10/31/23. a) The DON/Designee re-educated current licensed nurses and provided information to the physicians/mid-levels with prescribing authority in the center regarding prn psychotropic medications on or before 12/27/23. 4) The DON/Designee will review new orders for prn psychotropic medication weekly times 4 weeks then monthly x 2 for 4 anxiety and stated it ust two days. [name and gave orders for Vistaril c) TID [three times a day] #24's clinical record as of the trade occasions since 10/31/23. resident's clinical record te documentation of the ationale indicating the 	

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CENTER	S FOR MEDICARE 8	ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/20 FORM APPROVE OMB NO. 0938-039	
	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER		S.	TREET ADDRESS, CITY, STATE, ZIP CODE	11/10/202 <u>5</u>	
	EALTH AND REHAB		8	36 GLENDALE RD		
GALAX III			G	GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETIO	
F 758	Continued From pag	ie 105	F 758			
		a specified duration.				
		on regarding this concern was vey team prior to the exit //23.				
F 759 SS=D	Free of Medication E CFR(s): 483.45(f)(1)	Error Rts 5 Prcnt or More	F 759		12/27/23	
	§483.45(f) Medication The facility must eng					
	percent or greater; This REQUIREMEN	ation error rates are not 5 T is not met as evidenced				
		on, staff interview, clinical uring a medication pass and		F759		
		failed to ensure a medication		1) Resident #51 Zoloft medication		
		n 5%. There were 2 errors in		validated for administration as ordered	1.	
		a medication error rate of		Resident #3 Vitamin D medication		
	6.67%. These errors Resident #12.	affected Resident #3 and		validated for administration as ordered Validated by the DON/Designee on	1.	
	The findings include	d:		11/15/23.2) The center identified current resident's with Zoloft and Vitamin D		
	On 11/14/23 at 7:50	am, surveyor observed		orders to be at risk. The DON/Design	ee	
		rse (LPN) #6 during a		completed a MAR to cart audit validati		
		pour. LPN #6 prepared		Zoloft and Vitamin D medication		
		cations but stated that the		availability for administration as ordere	ed	
		ble in the medication cart.		on or before 12/27/23.		
		robably have to call the		3) The DON\Designee re-educated		
		Zoloft." Surveyor asked LPN		licensed nurses on medication not		
		when the had the Zoloft for		available guidance on or before		
		eyor was never informed that		12/27/2023.		
	the Zoloft was availa	ble or administered.		4) The DON/Designee will audit 5		
	0			resident MARs per week x 4 weeks to		
	-	Resident #51's medications		validate medication availability. Findir		
	with the clinical reco	rd. Resident #51's clinical		will be reviewed during QAPI meeting.	•	

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	-	AND HUMAN SERVICES			FORM APPROV OMB NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED
495250		B. WING		C 11/16/2023	
NAME OF PI	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HI	EALTH AND REHAB			GLENDALE RD LAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 759	Continued From	page 106	F 759		
	record contained which read in par (Sertraline HCl).	a physician's order summary t, "Zoloft Tablet 50 mg Give 1 tablet by mouth one time epressive disorder, recurrent,		Additional interventions to be initiated a needed. 5) AOC: 12/27/2023	IS
	#6 during a media 11/14/23 at 7:55 a #3's medications Vitamin D was no cart, and they wo medication room. 400 iu and Vitami Resident #6 takes asked LPN #6 to the medication av	ed licensed practical nurse (LPN) cation pass and pour on am. LPN #6 prepared Resident but stated that the resident's it available in the medication uld have to get it from the LPN #6 stated that Vitamin D n D 500 iu was in the cart, but is Vitamin D 4000 iu. Surveyor let them know when they had vailable for administration. ver informed that the Vitamin D administered.			
	with the clinical re record contained which read in par	ed Resident #3's medications ecord. Resident #3's clinical a physician's order summary t, "Vitamin D Tablet Give 4000 iu by mouth one time nentation."			
	rate of less than administrator, chi	ot ensuring a medication error 5% was discussed with the ef nursing officer, and regional operations on 11/16/23 at 5 pm.			
F 760 SS=E		ation was provided prior to exit. ee of Significant Med Errors (2)	F 760		12/27/23
	The facility must §483.45(f)(2) Res	ensure that its- idents are free of any significant			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/202 <u>3</u>	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	EALTH AND REHAB			836 GLENDALE RD		
0/12/0711				GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETION	
F 760	by:	Γ is not met as evidenced	F 760			
	Based on staff intervand facility document failed to ensure 4 of 2 significant medication #294, #48, and #34. The findings included 1. For Resident #242 administer Plavix as Plavix prevents plate sticking together to for that could block an a Resident #242's diag limited to, chronic kid anxiety, and acute pu There was no comple (MDS) assessment for #242 was alert and o Resident #242's clini provider order dated Plavix 75 mg 1 tablet A review of the media (MAR's) revealed that documented a 7 for t Plavix on 11/08/23 an preprinted code on the nurses notes.	2, the facility staff failed to ordered by the provider. lets in your blood from orm an unwanted blood clot rtery. noses included, but were not lney disease, dementia, ulmonary disease. eted minimum data set or this Resident. Resident or this Resident. Resident rientated to self. cal record included a 11/08/23 for the medication t by mouth at bedtime. cation administration records at the nursing staff had he administration of the		 F760 1) Resident #242 no longer resides the center. Resident #48 continues of Metoprolol Tartrate with no negative outcome. Resident #294 Merrem medication regimen completed with n negative effects noted. Resident #34 continues on Coreg medication with r negative outcome. Medication review completed on 11/28/23. 2) DON/Designee reviewed current resident's receiving Metoprolol Tartrate Merrem, Coreg and Plavix orders to validate administration instructions ar MAR to Cart audit completed with no negative findings on or before 12/27/2. 3) The DON/Designee re-educated licensed nurses on the process when medication parameters guidance on or before 12/27/23. 4) The DON/Designee will monitor resident MARs per week times 4 wee validate Medication availability and medication parameter guidance. Find will be reviewed during QAPI meeting Additional interventions to be initiated needed. 5) AOC: 12/27/23. 	n h h h h h h h h h h h h h h h h h h h	
		ng notes revealed that the had documented on 11/08/23				

Facility ID: VA0037

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STATE-BALL OF DERCENCIES (M) PROVIDERSIPPLIEROLA DERLINECTION NUMBER: (D) UNLIFE DEVENDING A BUILDING			ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/202 FORM APPROVE OMB NO. 0938-039	ΞD
Interest Participation Participation Participation CALAX HEALTH AND REHAB SIMEWAY STATEMENT OF DEFICIENCIES ORLAX, VA 24333 SIMEWAY STATEMENT OF DEFICIENCIES (RECURDENCY MUST BE PRECIDED BY FULL RECURDENCY MUST BE PRECIDED BY FULL RECURDENCY OUT BE DEFICIENCY WITH BE PRECIDED BY FULL RECURDENCY OUT BE DEFICIENCY OUT BE PRECIDED BY FULL RECURDENCY OUT BE DEFICIENCY OUT BE DEFICIENCY OUT BE DEFICIENCY IF 760 F 760 F 760 Continued From page 108 new admission awaiting medications from pharmacy. A review of the state box list revealed that this medication was available in the STAT box for administration. On 11/1/12/23 at 0:30 p.m. during an interview with Resident #242 this resident stated they were unaware if they got their medication, they got a cup full. F 760 F 760 On 11/1/12/3 at 0:30 p.m. during an end of the day meeting with the Plaxix not being administered and being available in the state box was reviewed. F No further information regarding this issue was provided to the survey team prior to the exit conference. F 2. For Resident #294 the facility staff failed to ensure the medication, Merrem was available for administration resulting in the resident missing seven scheduled does. Merrem was available for administration resulting in the resident missing seven scheduled doese. Merrem was available for administration resulting in the resi	STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION		
Numeric Procynder of SupPluer Street Address, orty Strut, 2P code Struct Struct </th <th></th> <th></th> <th>495250</th> <th>B. WING</th> <th></th> <th></th> <th></th>			495250	B. WING			
GALAX FRAITH AND REHAB GALAX, VA 24333 [01] ID PHEEX TAG ISJUMMARY STATEMENT OF DEFICIENCIES. IREGULTORY CRESS PLANOF CORRECTIVE AUGUST REPRECIDED IN LLL REGULTORY CRESS DEVICE VIEW OF EXPECTED IN LLL REGULTORY CRESS DEVICE VIEW OF EXPECTED IN THE REGULTORY OF EXPECTED IN THE APPROPRIATE DEFICIENCY 0 (01) (01) (01) (01) (01) (01) (01) (01)	NAME OF PI	ROVIDER OR SUPPLIER					
CMUL INC Summary contractions providence contractions reconstructions with the feasibility income in the set of the set of the set construction in the set of the set conference. Content of the set construction in the set conference. Construction is the set construction in the set construction in the set of the set conference. Construction is the set conference.	GALAX HI	EALTH AND REHAB		-			
new admission awaiting medications from pharmacy. On 11/12/23 the nursing staff documented medication not available on order from pharmacy. A review of the stat box list revealed that this medication was available in the STAT box for administration. On 11/14/23 at 10:00 a.m., during an interview with Resident #242 this resident stated they were unaware if they got their medication, they got a cup full. On 11/15/23 at 3:30 p.m., during an end of the day meeting with the Administrator. Regional Vice President of Operations, and Orief Nursing Officer the issue with the Plavix not being administered and being available in the stat box was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #294 the facility staff failed to ensure the medication, Merrem was available for administration resulting in the resident missing seven scheduled doses. Merrem is an antibiotic used to treat infections.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	E COMPLETION	١
1×2	F 760	new admission await pharmacy. On 11/12 documented medicat from pharmacy. A re- revealed that this me STAT box for adminis On 11/14/23 at 10:00 with Resident #242 t unaware if they got the cup full. On 11/15/23 at 3:30 day meeting with the President of Operation Officer the issue with administered and be was reviewed. No further information provided to the surver conference.	ing medications from 1/23 the nursing staff ition not available on order view of the stat box list dication was available in the stration. • a.m., during an interview his resident stated they were heir medication, they got a • .m., during an end of the Administrator, Regional Vice ons, and Chief Nursing the Plavix not being ing available in the stat box • n regarding this issue was by team prior to the exit • the facility staff failed to on, Merrem was available for ng in the resident missing ses. Merrem is an antibiotic ns.	F 760			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	11/10/2023
GALAX H	EALTH AND REHAB			36 GLENDALE RD	
			G	GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 760	Continued From pag	e 109	F 760		
		ot limited to sepsis and			
	completed; however,	imum data set was not yet Resident # 294 was alert on, place, time, and situation.			
	contained a physicia read in part, "Merren Reconstituted 500 m	cal record was reviewed and n's order summary which n Intravenous Solution g (Meropenem). Use 2000 ery 8 hours for sepsis for 5			
	2023 was reviewed a read in part, "Merren Reconstituted 500 m mg intravenously eve days." This entry was 11/04/23, and coded Chart code "7" is equ	tronic medication for the month of November and contained an entry which Intravenous Solution g (Meropenem). Use 2000 ery 8 hours for sepsis for 5 s coded "7" on 11/03/23 and "3" at 12:00 am on 11/05/23. uivalent to "Other/See Nurse 3" is equivalent to "Hold/See			
	reviewed and contain "Effective Date: 11/0 new admission, med pharmacy.", Effective Note Text: Merrem I Reconstituted 500 m intravenously every 8 new admission, med pharmacy.", "Effective Text: Merrem Intrave 500 mg. Use 2000 m	e Date: 11/02/2023 23:56 ntravenous Solution g. Use 2000 mg 3 hours for sepsis for 5 days.			

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB		-	336 GLENDALE RD GALAX, VA 24333	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(XE)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 760	Continued From pag	ge 110	F 760		
		ve Date: 11/03/2023 16:54			
		Intravenous Solution			
	Reconstituted 500 n	ng. Use 2000 mg 8 hours for sepsis for 5 days.			
		n pharmacy.", "Effective Date:			
		ote Text: Merrem Intravenous			
		ted 500 mg. Use 2000 mg 8 hours for sepsis for 5 days.			
		m pharmacy.", "Effective			
		8:49 Note Text: Merrem			
		n Reconstituted 500 mg. Use			
	-	sly every 8 hours for sepsis or pharmacy to send mes			
		ve Date: 11/04/2023 16:01			
		Intravenous Solution			
	Reconstituted 500 n				
		8 hours for sepsis for 5 days. h pharmacy", and "Effective			
	Date: 11/05/2023 N				
		n Reconstituted 500 mg. Use			
	2000 mg intravenou for 5 days. Awaiting	sly every 8 hours for sepsis			
	ior 5 days. Awalting	delivery.			
		and was provided with the			
		able medications which read in			
		t Available-Nurse's Process. nedication. 2. Look in the EDK			
		box for the medication. 3.			
	Notify the physician/	practitioner that the			
		ailable-request an order to			
	-	cation arrives from the that dose. 4. Enter a onetime			
		ation to be given upon delivery			
	or to skip that dose.	a. Note the time the			
	medication is due to	ensure not given too close."			
	Survevor requested	and was provided with a list			
		able in the backup medication			
	and/or EDK. Merren	m intravenous solution was			

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		ND HUMAN SERVICES			FORM): 12/19/2023 1APPROVED): 0938-0391
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _		<u> </u>	LETED
		495250	B. WING		(11/*	C 16/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GALAX H	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	COMPLETION DATE
F 760	Continued From pag	ge 111	F 760			
	not listed as availab and/or EDK.	le in the backup medication				
	nursing officer, and operations on 11/15 asked if the facility H what the procedure medications from th of operations stated they would contact H pharmacy would tak surveyor was provic pharmacy director of part, "For a backup would need to do is: number (unless we' regarding a stock is prior to our next deli backup pharmacy. N pharmacies in your transfer an order ov and delivery to your know you need it fro take care of the rest The concern of not of free of significant m with the administrative regional vice-presid at 5 pm.	area to locate the product, er, and arrange for pickup building. Once you let us om a backup pharmacy, we				

Facility ID: VA0037

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		ND HUMAN SERVICES			FORM	12/19/2023 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE S COMPLI	ETED
		495250	B. WING		C 11/1	6/2023
NAME OF P	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE		5/202 <u>5</u>
GALAX H	EALTH AND REHAB			GLENDALE RD LAX, VA 24333		_
	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 760	Continued From pag	je 112	F 760			
		, facility staff failed to ypertensive medication per neters.				
	diagnoses including 2 diabetes mellitus w cerebrovascular dise dysphagia, and musi Minimum Data Set A Reference Date 10/1 3/15 on the Brief Inter was assessed with s fluctuating inattention Clinical record review dated 7/8/2022 for m milligrams (mg). Give a day related to esse SBP (systolic blood p (diastolic blood press <55. The Medication Adm November 2023 doc heart rate for each a whether the medicat 11/3/2023 at 21:00, t 90/63 and the nurse the medication. On 1 documented BP was documented held for The surveyor notified nursing officer, and t	ease, major depression, cular weakness. On the assessment with Assessment 10/23, the resident scored erview for Mental Status and signs of delirium with n and disorganized thinking. w revealed a physician order netoprolol tartrate tablet 25 e 25 mg by mouth two times ential hypertension hold if pressure) <100 or DBP sure)<60 or HR (heart rate) ninistration Record (MAR) for sumented blood pressure and idministration time and coumented BP was documented BP was documented administering 11/5/23 at 9:30 AM, the s 106/60 and the nurse				

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		STRE	ET ADDRESS, CITY, STATE, ZIP CODE	11/10/202
GALAX H	EALTH AND REHAB			GLENDALE RD AX, VA 24333	
0(0)5		TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	(1/5)
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 760	Continued From pag	le 113	F 760		
	administer Coreg, a	, the facility staff failed to beta-blocker used to treat separate occasions.			
	which included, but Mellitus, Chronic Kic	nosis list indicated diagnoses, not limited to Type 2 Diabetes Iney Disease Stage 4, , Chronic Congestive Heart yroidism.			
	with an assessment 11/01/23 assigned th for mental status (BI	nual minimum data set (MDS) reference date (ARD) of ne resident a brief interview MS) summary score of 9 out esident was moderately			
	included an order da mg by mouth two tim failure (CHF). The c	ent physician's orders ted 1/21/22 for Coreg 3.125 nes a day for congestive heart order did not include he medication based on any S.			
	Coreg was not admi AM. On 11/15/23 at with licensed practic the 10/30/23 adminis Coreg was not availa with the overstocked asked LPN #3 if they available Coreg and sure if they checked				
		he facility onsite medication , the inventory listing included			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/1 FORM APPF OMB NO. 0938	ROVED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		495250	B. WING		C 11/16/202	
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	11/10/202	.5
GALAX HI	EALTH AND REHAB			6 GLENDALE RD		l.
	STIWWARA S	TATEMENT OF DEFICIENCIES	ID	ALAX, VA 24333 PROVIDER'S PLAN OF CORRECTION	0	X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMP	AG) PLETION ATE
F 760	Continued From pag	e 114	F 760			
		or Coreg) 3.125 mg tablets.				
	Medication Administr revealed the Coreg v PM (blood pressure	: #34's November 2023 ration Record (MAR) vas held on 11/03/23 8:00 (BP) 94/55), 11/05/23 9:00 d 11/08/23 8:00 PM BP				
	Chief Nursing Officer resident's Coreg bein and the CNO stated	AM, surveyor spoke with the r (CNO) regarding the ng held on multiple occasions it was being held at those judgement related to the ssure.				
	LPN #6 regarding ho at 9:00 AM, LPN #6 medication due to th pressure. LPN #6 ac not include parameter	e resident's low blood cknowledged the order did ers to hold the Coreg. LPN ot notify the physician but				
	reach LPN #5 regard 11/03/23 8:00 PM an	as unavailable and did not				
	to speak with Reside	AM, surveyor left a message ent #34's physician, however, ceived prior to the survey				
	with the Administrate	PM, the survey team met or, Chief Nursing Officer, and esident of Operations and				

Facility ID: VA0037

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	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
E		495250	B. WING		C 11/16/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HI	EALTH AND REHAB			6 GLENDALE RD	
			I	ALAX, VA 24333	(17)
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 760	Continued From pag	ge 115	F 760		
	discussed the conce administer Coreg as	ern of nursing staff failing to ordered.			
		on regarding this concern was vey team prior to the exit 5/23.			
F 812 SS=E		Store/Prepare/Serve-Sanitary)(2)	F 812		12/27/23
	§483.60(i) Food safe The facility must -	ety requirements.			
	approved or conside state or local author				
	from local producers and local laws or reg				
	facilities from using	bes not prohibit or prevent produce grown in facility compliance with applicable			
	(iii) This provision de	od-handling practices. bes not preclude residents ds not procured by the facility.			
		e, prepare, distribute and lance with professional ervice safety.			
	This REQUIREMEN	on, staff interview, and facility		F812	
	document review, th	he facility staff failed to store, te food in accordance with		1) The center disposed of identified	
		rds for food service safety.		food/beverage items without labels, dat and/or improperly stored items upon	es
	The findings include	:		discovering 11/13/23 and 11/14/23. 2) The Dietary Manager audited curre	ent
	On 11/13/23 at 4:20	PM during the initial tour of		food/beverage items for proper	

Event ID: N6VL11

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PRINTED: 12/19/2023

	-	I AND HUMAN SERVICES			PRINTED: 12/19/20 FORM APPROVE OMB NO. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		495250	B. WING		11/16/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HI	EALTH AND REHAB			836 GLENDALE RD GALAX, VA 24333	
(X4) ID	SUMMAR	Y STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
PREFIX TAG	(EACH DEFICI	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETIC
F 812	Continued From p	page 116	F 812	2	
	the kitchen with of surveyor observed green lid in the rea yellow substance label or date on the cooler, this survey with a red lid conta no label or date of chaffing pan conta was not labeled of empty. There was ham and ground r dry and there was pans were loosely Other staff member contents of each of "Everything should all away."	ther staff member # 2, this d a clear plastic container with a ach in cooler. There was a pale in the container. There was no be container. In the walk-in yor observed a clear container aining mushrooms. There was n the container. There was a aining macaroni and cheese that r dated. The pan was half a chaffing pan with 4 slices of meat. The ham appeared very a no label or date. Both chaffing y covered with plastic wrap. er # 2 was able to identify the container. They sated, d have been dated. I'll throw it		 labeling/dating and storage on 11/1 3) The Administrator/Designee re-educated the current dietary stat current nursing staff on proper food/beverage labeling/dating and son or before 12/27/23. 4) The Administrator/Designee w monitor the dietary food storage are and unit food storage areas 3 times week times 4 weeks for proper food/beverage labeling/dating and storage. Findings to be reviewed of QAPI meeting. Additional intervent be initiated as needed. 5) AOC: 12/27/23 	ff and storage vill eas s per
	Dining Services w	ved the Interim Director of ho stated, "I pulled all those out ess the staff didn't know why all back in there."			
	the nourishment re Director. In the ref 6 sandwiches, two water, 6 facility cu	245 AM this surveyor entered oom on unit B with the Interim frigerator, there was a tray with b half sandwiches, 4 thickened ups with lids manager stated			
	and no dates on a waters. One of the with a resident na indicating it was s date. Surveyor as	dding. There were no labels anything except one of the e cups of water had a label on it me and a date of 11/8/23, ent from the kitchen on that ked if it was reasonable to of the items were sent out on the			
	same day, they st	ated, "I don't know, they should I throw it all out." In the Unit A			

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 12/19/2023 APPROVED D: 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
- E		495250	B. WING			C 16/2023
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
GALAX HI	EALTH AND REHAB			36 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 812 F 838 SS=C	spicey chicken wings 10/20/23 observed. T Dining Services Man This surveyor discus the Administrator, Re Operations and the O 11/14/23 and reques The policy entitled, "I provided and read in Director/Cook insure stored properly in cor and dated, and arran cross contamination. No further informatio team prior to the exit Facility Assessment CFR(s): 483.70(e)(1) §483.70(e) Facility as The facility must con facility-wide assessm resources are necess competently during b and emergencies. Th update that assessm facility plans for, any	as a package of "hot and s" with a use by date of These were discarded by the ager. sed the above concerns with egional Vice President of Chief Nursing Officer on ted a policy for food storage. Food Storage: Cold" was part, "5. The Food Services s that all food items are vered containers, labeled aged in a manner to prevent " n was provided to the survey conference. o-(3) ssessment. duct and document a nent to determine what sary to care for its residents both day-to-day operations ne facility must review and ent, as necessary, and at acility must also review and ent whenever there is, or the change that would require a	F 812	DEFICIENCY)		12/27/23
	assessment. The fac address or include: §483.70(e)(1) The fa including, but not lim	ion to any part of this ility assessment must cility's resident population, ited to, of residents and the facility's				

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		ND HUMAN SERVICES			FORM	0: 12/19/2023 APPROVED 0: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING			LETED
		495250	B. WING			C 16/2023
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 838	resident capacity; (ii) The care required considering the type physical and cognitiv and other pertinent fit that population; (iii) The staff compet provide the level and resident population; (iv) The physical envi- services, and other p that are necessary to (v) Any ethnic, cultur may potentially affect facility, including, but food and nutrition se §483.70(e)(2) The fat but not limited to, (i) All buildings and/o and vehicles; (ii) Equipment (medii (iii) Services provide pharmacy, and spect (iv) All personnel, ind employees and those contract), and volunt education and/or trai- related to resident ca (v) Contracts, memo or other agreements services or equipme normal operations an (vi) Health informatic such as systems for	d by the resident population as of diseases, conditions, ve disabilities, overall acuity, facts that are present within tencies that are necessary to d types of care needed for the vironment, equipment, physical plant considerations o care for this population; and ral, or religious factors that ct the care provided by the t not limited to, activities and ervices. acility's resources, including or other physical structures ical and non- medical); ed, such as physical therapy, cific rehabilitation therapies; cluding managers, staff (both we who provide services under teers, as well as their ining and any competencies are; orandums of understanding, s with third parties to provide int to the facility during both nd emergencies; and on technology resources, electronically managing electronically sharing	F 838			

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 12/19/2023 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE COMPI	
		495250	B. WING		(11/*) 16/202 <u>3</u>
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB			36 GLENDALE RD		
			G	ALAX, VA 24333	r	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 838	all-hazards approach This REQUIREMEN by: Based on staff inter review the facility sta document a facility-v determine what reso care for its residents The findings were: The administrator pr facility assessment (to the team coordina not been taken throu program yet. On 11/16/23 at 12:27 the FA and discusse the document did no information; the doct template of an asses The administrator re gone through their q would speak with the figure out what need administrator stated past and acknowled survey team had not indicate this facility's At the end of day me	 ity-based and sk assessment, utilizing an n. T is not met as evidenced view and facility document aff failed to conduct and vide assessment to ources were necessary to ources the the facility's quality 7 p.m., a surveyor reviewed d with the administrator how the tacility process yet and that he effacility is "clinical folks" and the our provided to the there had been a FA in the ged the one provided to the there had been a FA in the ged the one provided to the there had been a FA in the ged the one provided to the there had been a FA in the ged the ources the ourc	F 838	 DEFICIENCY) F838 1. Facilty Assessment was reviewed and updated on 12/15/23 during QAPI 2. The center identified the Facility Assessment had not been updated in 2023. The NHA/designee will ensure Facility Assessment is reviewed and updated based on current resources needed to care for the residents. 3. The Regional Vice President of Operations will re-educate the NHA or Facility Assessment policy on or before 12/27/23. 4. The NHA will review the Facility Assessment during the QAPI meeting. Additional interventions to be initiated needed. 5. AOC: 12/27/23 	the n the e	
		vided prior to the exit				

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	-	ND HUMAN SERVICES MEDICAID SERVICES			FORM	0: 12/19/2023 APPROVED 0: 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING			
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		16/202 <u>3</u>
GALAXH	GALAX HEALTH AND REHAB		83	6 GLENDALE RD		
			G	ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842 SS=E		dentifiable Information , 483.70(i)(1)-(5)	F 842			12/27/23
	 (i) A facility may not it resident-identifiable if (ii) The facility may reresident-identifiable if accordance with a coagrees not to use or except to the extent it to do so. §483.70(i) Medical registron standard must maintain medicities in the extent it of complete; (ii) Complete; (ii) Accurately docum (iii) Readily accessib (iv) Systematically or §483.70(i)(2) The fac all information contained regardless of the form records, except where (i) Required by Law; (iii) For treatment, particular of the individual, or representative where (ii) Required by Law; (iii) For public health neglect, or domestic activities, judicial and law enforcement pur purposes, research purposes,	elease information that is to an agent only in pontract under which the agent disclose the information the facility itself is permitted ecords. ordance with accepted ds and practices, the facility al records on each resident hented; le; and ganized cility must keep confidential ned in the resident's records, m or storage method of the n release is- or their resident e permitted by applicable law; ayment, or health care tted by and in compliance				

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		С	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			IREET ADDRESS, CITY, STATE, ZIP CODE	11/16/202 <u>3</u>	
			83	6 GLENDALE RD		
GALAX H	EALTH AND REHAB		G	ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 842	Continued From pag	le 121	F 842			
		e with 45 CFR 164.512.				
		cility must safeguard medical gainst loss, destruction, or				
	for- (i) The period of time (ii) Five years from t there is no requirem	ears after a resident reaches				
	 (i) Sufficient information (ii) A record of the resident of the resident of the resident of the resident review determinations conditional (v) Physician's, nursion (vi) Laboratory, radio 	ucted by the State; e's, and other licensed				
	Based on staff inter review, the facility st complete and accura residents, Resident's The findings include 1. For Resident #71,	ate clinical record for 5 of 22 s #71, #34, #46, #8 and #69. d: facility staff failed to ensure tion was maintained in the		 842 1) Resident #71 and #46 hospice records obtained by hospice representative on 11/14/23. Resident no longer resides in the center. Resid #69 docusate dose was clarified on 11/16/2023 by licensed nurse. Reside #34 continues on Coreg medication at orders verified. Medication reviewed completed on 11/28/23. 	ent	

Event ID: N6VL11

Facility ID: VA0037

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			0/00		OMB NO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					С
		495250	B. WING		11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		st	TREET ADDRESS, CITY, STATE, ZIP CODE	
GALAX H	EALTH AND REHAB			36 GLENDALE RD	
			I	ALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL ' OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
F 842	Continued From	page 122	F 842		
	Resident #71's di	agnoses included, but were not		2) The DON/Designee met with hosp	bice
		prostatic hyperplasia,		rep on 11/14/23 to acquire current hosp	
	hypertension, and	d Alzheimer's.		resident's hospice records to be obtain	
	Soction C (accrit	ive patterns) of Resident #71's		by the center and a process for records retention going forward. The SSD will	5
		e minimum data set (MDS)		review current resident advance directi	
		an assessment reference date		on or before 12/27/23 to validate	103
		3 was coded 1/1/3 to indicate		completion. The DON/Designee will	
		problems with long- and		review the medication records for curre	ent
		ry and was severely impaired in		resident's with orders for ducosate and	
		r daily decision making. Section		coreg for accuracy with clarifications	
		ents, procedures, and		completed as needed on or before	
	was receiving Ho	oded to indicate this Resident		12/27/23. 3) The DON/Designee re-educated t	ho
	was receiving no	spice services.		hospice representative and licensed	
	Resident #71's co	omprehensive care plan included		nurses on hospice record availability in	
		ospice due to end of life care.		the center on or before 12/27/23. The	
				DON/Designee re-educated the license	d
	•	l record review, the surveyor		nurses and SSD on advanced directive	
		d any documentation from		guidance, medication unavailable next	
	Hospice the Hosp	bice staff.		steps and medication parameter guidar	nce
	On $\frac{11}{14}$ at 11	1:15 a.m. during an interview		on or before 12/27/23. 4) The SSD will monitor 3 resident	
		I:15 a.m., during an interview ager this staff stated the		advanced directives per week times 4	
		their notes in a tablet and took		weeks for completion. The SSD will	
		hen they left the facility.		monitor 3 resident hospice records whe present in the center per week times 4	en
	On 11/14/23 at 12	2:50 p.m., during an interview		weeks for completion The DON/Design	ee
		Records staff this staff stated		will monitor 5 resident MARs per week	
	-	a Hospice book for this		times 4 weeks to validate medication	
	resident.			availability and accuracy. Findings will reviewed during QAPI meeting. Addition	
	On 11/14/23 at 12	2:52 p.m., the Unit Manager		interventions to be initiated as needed.	
		e services had sent over the		5) AOC: 12/27/23	
		oday and they did not have them			
		30 p.m., during an end of the the Administrator, Regional Vice			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	
- E		495250	B. WING		C 11/16/2023	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			GLENDALE RD LAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 842	President of Operation Officer the missing H reviewed. No further information	ons, and Chief Nursing lospice information was n regarding the missing ion was provided to the	F 842			
	ensure the clinical re administration of Con treat heart failure, or Resident #34's diagr which included, but r Mellitus, Chronic Kid Alzheimer's Disease Failure, and Hypothy The most recent ann with an assessment 11/01/23 assigned th for mental status (BI	, the facility staff failed to ecord was accurate regarding reg, a beta-blocker used to a three separate occasions. nosis list indicated diagnoses, not limited to Type 2 Diabetes ney Disease Stage 4, , Chronic Congestive Heart vroidism. nual minimum data set (MDS) reference date (ARD) of ne resident a brief interview MS) summary score of 9 out esident was moderately				

Facility ID: VA0037

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	MENT OF HEALTH AND I				FORM APPROVED
	S FOR MEDICARE & ME				OMB NO. 0938-0391
	OF DEFICIENCIES (X1 F CORRECTION) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED
		495250	B. WING		C 11/16/202 <u>3</u>
NAME OF P	NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
GALAXH	EALTH AND REHAB		8	36 GLENDALE RD	
UALAX II			G	GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENCY MI	MENT OF DEFICIENCIES JST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE
F 842	cognitively impaired. Resident #34's current p included an order dated mg by mouth two times a failure (CHF). The order instructions to hold the n vital sign parameters. According to Resident #3 Medication Administratio was held on 11/02/23 9:0 (BP) 140/65), 11/05/23 8 11/06/23 8:00 PM (BP 10 On 11/14/23 at 2:17 PM, licensed practical nurse 11/02/23 administration. Coreg was not given bed resident did not have any inquired if they checked available Coreg and LPN look in the stat box. LPN surveyor at approximate they now remember goir and administering it to th document it. On 11/15/23 at 3:45 AM, LPN #4 regarding holdin and 11/06/23 and LPN # to the resident's low bloc acknowledged the order parameters but stated th provider but failed to door record.	hysician's orders 1/21/22 for Coreg 3.125 a day for congestive heart did not include hedication based on any 34's November 2023 in Record (MAR), Coreg 00 AM (blood pressure :00 PM (BP 94/60), and 00/50). surveyor spoke with (LPN) #7 regarding the LPN #7 stated the cause they thought the y available, surveyor in the stat box for any I #7 stated they did not I #7 returned to the y 3:30 PM and stated ig and getting the Coreg e resident but failed to surveyor spoke with g the Coreg on 11/05/23 4 stated they held it due id pressure. LPN #4 did not include hold ey contacted the on-call sument it in the clinical	F 842	DEFICIENCY)	
		surveyor left a message 34's physician, however,			

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PRINTED: 12/19/2023

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF P	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GALAX H	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	D ATE	
F 842	Continued From pag no return call was red exit.	e 125 ceived prior to the survey	F 842			
	policy titled "Medicat Guidelines" which re who administers the administration on the following the medicat should the individual	and received the facility ion Administration General ad in part "The individual medication dose, records the e resident's MAR immediately tion being given. In no case who administered the ff-duty without first recording any medications"				
	with the Administrato the Regional Vice Pr discussed the conce	PM, the survey team met or, Chief Nursing Officer, and esident of Operations and rn of nursing staff failing to umentation regarding Coreg esident #34.				
		n regarding this concern was vey team prior to the exit /23.				
		, the facility staff failed to imentation was present in the riew.				
	The findings were:					
	diagnoses as includir obstructive pulmonar mellitus, schizoaffect disorder, dementia, a onset. The significar (MDS) with an asses	ssion Record listed the ng but not limited to, chronic ry disease, type 2 diabetes tive disorder, bipolar and Alzheimer's disease late nt change minimum data set ssment reference date of resident's brief interview for				

Facility ID: VA0037

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		ND HUMAN SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	<u>_</u>	
GALAX H	EALTH AND REHAB			6 GLENDALE RD ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 842	 (cognitive patterns). treatments, proceduresident as receiving During Resident #44 clinical record review to locate documenta services. When nure Resident #46's hosp CNA #3 retrieved it to provided it to the sure had been faxed to the agency after another hospice documentation not be resident's clinical rewas faxed to the face requested it was dischief nursing officer operation. No further information hospice documentation and the sure survey team prior to a function of the survey team prior to a face the virginiant of the survey team prior to book the su	of 06 out of 15 in Section C Section O (special ares, and programs) coded the g hospice services. 5's electronic and paper w on, the surveyor was unable ation for provided hospice rsing staff was asked where bice documentation was kept, from the unit manager and rveyor. The documentation he facility from the hospice r surveyor had requested tion for a different resident.	F 842			

Toc REGULATORY OR LSC IDENTIFYING INFORMATION) Toc CROSS-REFERENCED TO THE APPROPRIATE DEFICENCY) F 842 Continued From page 127 chronic pain syndrome, and pressure ulcer to sacral region. F 842 Resident #8's most recent minimum data set with an assessment reference date of 09/18/23 assigned the resident a brief interview for mental status score of 15 out of 15 in sector 0, cognitive patterns. This indicates that the resident is cognitively intact. F 842 Resident #8's comprehensive care plan was reviewed and contained a care plan for " has an Advance Directive wise videnced by: Do Not Resuscitate." Interventions for this care plan included "Obtain Advance Directive with physician order and resident/responsible party signature." Resident #8's clinical record was reviewed and contained a physician's order summary which read in part, "DNR-Do Not Resuscitate." Resident #8's clinical record contained a Virginia Department of Health DDNR form which read in part, "1, the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have certified in the patient named above. I have certified on the patient named above. I have certified on the patient's behalf had directed that life-procedures be withheld or withdraw in the event of cardiac or respiratory arrest. I further certify (must check 1 or 2)." Neither 1 nor 2 was checked. The concern of not ensuring a complete DDNR form was discussed with the administrator, chief nursing officer, and regional vice president of			ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
11/16/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY, STATE, IP CODE STREET ADDRESS. CITY, STATE, IP CODE SUMMAY STATEMENT OF DEPICIENCIES OWNO SUMMAY STATEMENT OF DEPICIENCIES IP CONDERS PLAN OF CORRECTION IP CONDERS P							
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GALAX HEALTH AND REHAB ass GLENDALE RD CALAX, VA 24333 (PA) D PREFIX TAG UNMARY STATEMENT OF DEFICIENCIES (EACH EDFICIENCY MUST BE PROCEEDED BY TULL RECAL DRIFCEDW MIST BE RECEDED BY TULL RECAL CONTENTUME INFORMATION) PROVEMENT INFORMATION PROVEMENT INFORMATION 000 F 842 Continued From page 127 chronic pain syndrome, and pressure ulcer to sacraf region. F 842 F 842 Resident #8's most recent minimum data set with an assessment reference date 00/01/8/23 assigned the resident a brief interview for mental status score of 15 out 05 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. F 842 Resident #8's comprehensive care plan included "Obtain Advance Directive with physician order and resident/responsible party signature." F 842 Resident #8's clinical record ontained a Virginia Department of Health DDNR form which read in part, "1, the undersigned, state that have a bona fide physician/oatient or earsite parts indicated on the patients behalf had directed that life-proceares be withheid or withdrawn in the patient named above. I have certified in the patient named above. I have certified in the patient named above. The directord contained a Virginia Department of Health DDNR form which read in part. The undersigned, state that have a bona fide physician/patient relationship with the patient named above. I have certified in the patient named above. I have certified in the patient named above. The directord chalt the-proceeners be withheid or withdrawn in the event of cardiac or respiratory area (legonda) vice			495250	B. WING			
GALAX (FALTH AND REHAB GALAX, VA 24333 (PA) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH EPRICEDY MUST BE PARCEDDED BY TULL RECOULTORY OR LSCIDENTIFYING INFORMATION) ID PROFILE PREFIX RECOULTORY OR LSCIDENTIFYING INFORMATION) ID PROFILE (EACH EPRICEDY MUST BE PARCERDED BY TULL RECOULTORY OR LSCIDENTIFYING INFORMATION) ID PROFILE (EACH EPRICED TO THE APROPRIATE DEFICIENCY) COMMENTIFY TAG F 842 F 842 Continued From page 127 chronic pain syndrome, and pressure ulcer to sacral region. F 842 F 842 Resident #8's most recent minimum data set with an assessment reference date of 09/18/20 gating the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. F 842 Resident #8's comprehensive care plan included "Obtain Advance Directive with physician order and resident/responsible party signature." F Resident #8's clinical record was reviewed and contained a physician's order summary which read in part, "I, The undersigned, state that I have a bona fide physical stored contained a Vignia Department of Health DDNR form which read in part, "I, the undersigned, state that I have a bona fide physical store are person authorized on the patient's behalf had directed that II (-procedures be withheld or withdrawn in the event of cardiac or respiratory ares. I further certify (must check 1 or 2)" Neither 1 nor 2 was checked. The concern of not ensuring a complete DDNR form was discussed with the administrator, chief nursing officer, and regional vice president of	NAME OF P	NAME OF PROVIDER OR SUPPLIER					
Precisive TXG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREINT TAG (EACH CORRECTIVE ACTION HOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPETING INFORMATION F 842 Continued From page 127 chronic pain syndrome, and pressure ulcer to sacral region. F 842 F 842 Resident #8's most recent minimum data set with an assessment reference date of 09/18/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. F 842 Resident #8's comprehensive care plan was reviewed and contained a care plan for " has an Advance Directive as evidenced by: Do Not Resuscitate." Interventions for this care plan included "Obtained Advance Directive with physician order and resident/responsible party signature." Resident #8's clinical record was reviewed and contained a physician's order summary which read in part, "DNR-Do Not Resuscitate." Resident #8's clinical record contained a Virginia Department of Health DDNR form which read in part, ", the undersigned, state that I have a bona fide physician/patient relationship with the patient named above. I have cettified in the patient named above. I have cettified on the patient's behalf had directed that life-procedures be withheid or withdrawn in the event of cardiac or respiratory arrest. If uther certify (must check 1 or 2)." Neither 1 nor 2 was checked. The concern of not ensuring a complete DDNR form was discussed with the administrator, chief nursing officer, and regional vice president of	GALAX HI	EALTH AND REHAB		-			
chronic pain syndrome, and pressure ulcer to sacral region. Resident #8's most recent minimum data set with an assessment reference date of 09/18/23 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #8's comprehensive care plan was reviewed and contained a care plan for " has an Advance Directive as evidenced by: Do Not Resuscitate." Interventions for this care plan included "Obtain Advance Directive with physician order and resident/responsible party signature." Resident #8's clinical record was reviewed and contained a physician's order summary which read in part, "DNR-Do Not Resuscitate." Resident #8's clinical record contained a Virginia Department of Health DDNR form which read in part, ", the undersigned, state that I have a bona fide physician/patient relationship with the patient's medical that he/she or a person authorized on the patient's behalf had directed that life-procedures be withheld or withdrawn in the event of cardiac or respiratory arrest. I further certify (must check 1 or 2)." Neither 1 nor 2 was checked. The concern of not ensuring a complete DDNR form was discussed with the administrator, chief nursing officer, and regional vice president of	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	E COMPLETION	
No further information was provided prior to exit.	F 842	chronic pain syndrom sacral region. Resident #8's most re an assessment refer assigned the residen status score of 15 ou patterns. This indicat cognitively intact. Resident #8's compre- reviewed and contain Advance Directive as Resuscitate." Interve included "Obtain Advorder and resident/ref Resident #8's clinica contained a physiciar read in part, "DNR-D Resident #8's clinica Department of Health part, "I, the undersign fide physician/patient named above. I have medical that he/she of patient's behalf had of be withheld or withdr or respiratory arrest. 1 or 2):" Neither 1 no The concern of not ef form was discussed of nursing officer, and re operations on 11/16/	ecent minimum data set with ence date of 09/18/23 it a brief interview for mental at of 15 in section C, cognitive tes that the resident is ehensive care plan was ned a care plan for " has an a evidenced by: Do Not entions for this care plan vance Directive with physician esponsible party signature." I record was reviewed and n's order summary which o Not Resuscitate." I record contained a Virginia n DDNR form which read in ned, state that I have a bona t relationship with the patient e certified in the patient's or a person authorized on the directed that life-procedures rawn in the event of cardiac I further certify (must check or 2 was checked. nsuring a complete DDNR with the administrator, chief egional vice president of 23 at 5 pm.	F 842			

		ND HUMAN SERVICES			FORM	: 12/19/2023 APPROVED . 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		(11/*) 16/2023
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		<u>-</u>
GALAX HI	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 842	Continued From pag	je 128	F 842			
	ensure a dosage wa order. Resident #69's face included but not limit mellitus, dysphasia, Resident #69's most with an assessment assigned the resider status score of 15 ou patterns. This indica cognitively intact. Resident #69's clinic contained a physicia read in part, "Docusa (Docusate Sodium). times a day for stool contain a dosage. Po	the facility staff failed to is included on medication sheet listed diagnoses which ted to type II diabetes and hypertension. The recent minimum data set reference date of 11/01/23 and a brief interview for mental at of 15 in section C, cognitive tes that the resident is cal record was reviewed and in's order summary which ate Sodium Oral Tablet Give 1 tablet by mouth two softener." This order did not er Drugs.com, docusate n 50 mg, 100 mg, and 250				
F 880 SS=D	not containing a dos administrator, chief i vice president of ope No further informatic Infection Prevention CFR(s): 483.80(a)(1 §483.80 Infection Co The facility must est infection prevention designed to provide)(2)(4)(e)(f) ontrol ablish and maintain an and control program	F 880			12/27/23

Facility ID: VA0037

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/2023 FORM APPROVED OMB NO. 0938-0391	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF PI	NAME OF PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE		
GALAX HI	EALTH AND REHAB			GLENDALE RD NLAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 880	Continued From page	e 129	F 880			
	development and tra diseases and infectio	nsmission of communicable ons.				
	program.	prevention and control				
		ablish an infection prevention (IPCP) that must include, at wing elements:				
	reporting, investigatin and communicable d staff, volunteers, visit providing services un arrangement based u	upon the facility assessment ı to §483.70(e) and following				
	procedures for the pr but are not limited to (i) A system of survei possible communical	illance designed to identify				
	communicable diseat reported; (iii) Standard and tran to be followed to prev (iv)When and how iss resident; including bu (A) The type and dur	m possible incidents of se or infections should be nsmission-based precautions vent spread of infections; olation should be used for a ut not limited to:				
	involved, and (B) A requirement that	at the isolation should be the ible for the resident under the				

Facility ID: VA0037

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		E & MEDICAID SERVICES			OMB NO. 0938-039	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023	
NAME OF PI	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
0 4 I 4 Y 1 I			83	6 GLENDALE RD		
GALAX HEALTH AND REHAB		G	ALAX, VA 24333			
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL (OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 880	Continued From	page 130	F 880			
	(v) The circumsta	nces under which the facility				
		ployees with a communicable ed skin lesions from direct				
		lents or their food, if direct				
		mit the disease; and				
	(vi)The hand hyg	iene procedures to be followed				
	by staff involved i	in direct resident contact.				
	8/83 80(a)(/) Δ a	system for recording incidents				
		he facility's IPCP and the				
		s taken by the facility.				
	§483.80(e) Linen	S.				
		nandle, store, process, and				
	transport linens s infection.	o as to prevent the spread of				
	§483.80(f) Annua					
		onduct an annual review of its				
		their program, as necessary.				
	by:	ENT is not met as evidenced				
	Based on facility	document review and staff		F880		
	program was revi	staff failed to ensure the IPCP		1) The center reviewed the revised		
	Program was rev	annuary.		Infection Control Program (ICP) during		
	The surveyor was	s provided the Infection Control		QAA meeting on 12/15/23.		
	Program- Antibio	tic Stewardship F881 policy and		2) No negative outcomes identified		
		fective date 2/2017. The		upon interdisciplinary team QAA review	on	
	surveyor spoke with the regional vice president of			12/15/23.		
		C) about the need for an		3) The DON/Designee re-educated th	ne	
		ion and Control Program (IPCP) policies to be reviewed and		interdisciplinary team (IDT) regarding annual review of the ICP in QAA meetin	ia l	
		The Antibiotic Stewardship		on 12/15/23.	'ช	
		had also was effective 2/2017		4) The DON/Designee will review the	,	
	and had not beer			ICP program upates weekly times 4		
				weeks. Findings to be reviewed during		
		me the acting ICP on 11/25/23,		QAPI meeting. Additional interventions	to	
	tound a manual f	or Infection Control Program		be initiated as needed.		

Event ID: N6VL11

Facility ID: VA0037

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	-	ND HUMAN SERVICES			FORM APPROVED	
	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING		(X3) DATE SURVEY COMPLETED	
- E		495250	B. WING		C 11/16/2023	
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
			8	36 GLENDALE RD		
GALAX H	EALTH AND REHAB		G	ALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE	
F 883 SS=D	Continued From pag Version 4 revised Od The October 2020 V most recently revised available in the facili The surveyor repeat reviewing and revisin Program manual and meeting on 11/14/23 administrator, Direct Influenza and Pneur CFR(s): 483.80(d)(1) §483.80(d) Influenza immunizations §483.80(d)(1) Influenza immunizations §483.80(d)(1) Influenza immunizations §483.80(d)(1) Influenza immunizations §483.80(d)(1) Influenza immunizations (i) Before offering the each resident or the receives education r potential side effects (ii) Each resident is of immunized during th (iii) The resident or the has the opportunity to (iv)The resident's me documentation that if following:	ye 131 ctober 2020. Version 4 represented the d infection control policies ty. ed the concern with not ing the Infection Contol nually during a summary attended by the cor of Nursing and RVPO. mococcal Immunizations)(2) a and pneumococcal mza. The facility must develop ures to ensure that- e influenza immunization, resident's representative egarding the benefits and s of the immunization; offered an influenza er 1 through March 31 immunization is medically use resident has already been is time period; he resident's representative to refuse immunization; and edical record includes indicates, at a minimum, the	F 880		12/27/23	
	was provided education and potential side efficient immunization; and (B) That the resident	t or resident's representative tion regarding the benefits fects of influenza t either received the influenza not receive the influenza				

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PRINTED: 12/19/2023

CENTER	S FOR MEDICAR	E & MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-03	
INTATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER: 495250 NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE A. BUILDING	(X3) DATE SURVEY COMPLETED			
		B. WING	C 11/16/2023			
		STREET ADDRESS, CITY, STATE, ZIP CODE 836 GLENDALE RD GALAX, VA 24333		AL		
					GALAX HEALTH AND REHAB	
(X4) ID PREFIX TAG	(EACH DEFIC			RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)
F 883	Continued From page 132 immunization due to medical contraindications or refusal.		F 883			
	must develop pol that- (i) Before offering immunization, ea representative re benefits and pote immunization; (ii) Each resident immunization, un medically contrai already been imm (iii) The resident has the opportun (iv)The resident's	eumococcal disease. The facility icies and procedures to ensure g the pneumococcal ich resident or the resident's ceives education regarding the ential side effects of the this offered a pneumococcal less the immunization is indicated or the resident has nunized; or the resident's representative ity to refuse immunization; and a medical record includes nat indicates, at a minimum, the				
	(A) That the resid was provided edu and potential side immunization; an	dent or resident's representative ucation regarding the benefits e effects of pneumococcal d dent either received the				
	pneumococcal in the pneumococca contraindication of	nmunization or did not receive al immunization due to medical				
	Based on staff in facility staff failed immunization wa	nterview and clinical review I to ensure the pneumococcal s offered to 1 of 5 residents nunizations (Resident #82).		F883 1) Resident #82 was offered the Pneumococcal vaccine on 12/06/2023 DON and refused. 2) The DON/Designee reviewed ar		
	diagnoses which	s admitted to the facility with included cerebral infarction with emiparesis, diabetes mellitus		offered applicable immunizations to current residents on or before 12/27/2 3) The DON/Designee re-educated	3.	

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	-	HAND HUMAN SERVICES			FORM APPROVI OMB NO. 0938-03
CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ND PLAN OF CORRECTION IDENTIFICATION NUMBER: 495250 NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING	11/16/202 <u>3</u>		
		STREET ADDRESS, CITY, STATE, ZIP CODE			
GALAX HI	EALTH AND REHAB			36 GLENDALE RD ALAX, VA 24333	
(X4) ID	SUMMAR	RY STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFIC	IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETIO
F 883	Continued From page 133		F 883		
	-	erotic heart disease, and		licensed nurses on immunization	
		disease. On the most recent		guidance on or before 12/27/23. New	
	Minimum Data Se	et assessment with Assessment		admissions will be offered applicable	
	Reference date 1	0/4/23, the resident scored		immunizations upon admission by the	
	11/14 on the brief interview for mental status and			admitting nurse/designee.	
		without signs of delirium,		4) The DON/Designee will review 3	
	psychosis, or ber	naviors affecting care.		resident records for offering applicable	
	The resident's di	nical record was reviewed for		immunizations and administration of immunization as ordered/accepted wee	khy.
		and receipt of required		times 4 weeks. Finding to be reviewed	NIY
		e record indicated the resident		during QAPI meeting. Additional	
		a vaccine October 2023 and		interventions to be initiated as needed.	
	Covid 19 Jansser	n in 2021 and a booster July		5) AOC: 12/27/23	
	2023. There was	s no record of offering or			
	receiving pneumo	ococcal vaccine.			
		ified the Administrator and			
	No additional info	ummary meeting on 11/15/23. In the state of the second			
	#82 was offered.				
	Required In-Serv CFR(s): 483.95(g	ice Training for Nurse Aides ı)(1)-(4)	F 947		12/27/23
	§483.95(g) Requ	ired in-service training for nurse			
	aides.				
	In-service training	g must-			
	§483.95(g)(1) Be	sufficient to ensure the			
		etence of nurse aides, but must			
	be no less than 1	2 hours per year.			
	\$483.95(a)(2) Inc	lude dementia management			
		lent abuse prevention training.			
	§483.95(g)(3) Address areas of weakness as				
		rse aides' performance reviews			
	and facility asses	sment at § 483.70(e) and may			
	address the spec	ial needs of residents as			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/19/202 FORM APPROVE OMB NO. 0938-039
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/2023
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	11/10/202 <u>3</u>
GALAX H	EALTH AND REHAB		_	36 GLENDALE RD	
				GALAX, VA 24333	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 947	Continued From pag	e 134	F 947		
	determined by the fa		1.017		
	to individuals with co address the care of t This REQUIREMEN' by: Based on staff intervi- review, the facility sta of in-service training The findings included The facility staff faile 12 hours of in-service On 11/15/23 at 8:26 asked for verification Certified Nursing Ass #4, and #5. On 11/15/23 at 9:10 had been employed they received training program and the train 11/15/23 at 9:23 a.m the surveyor they dic education for the em requested by the sur currently have a Staff On 11/15/23 at 9:36 C.N.A. #6 this staff s training and had the complete their job du On 11/15/23 at 2:31	d: d to provide nurse aides with e training. a.m., the Administrator was of 12 hours of training for 5 sistants (C.N.A.'s) #1, #2, #3, a.m., C.N.A. #3 stated they at the facility over a year, g through a computer-based ning was appropriate. ., the Administrator stated to a not have 12 hours of ployees that had been veyor and they did not f Development Coordinator. a.m., during an interview with tated they received ongoing training they needed to ities. p.m., during an interview with		 F947 1) Current CNAs will complete 12 h education/in-services on or before 12/27/23. 2) The Administrator/Designee reviewed current CNA records to determine due dates for completion of hour education/in-services and notified current CNAs for timely completion 12/13/23. 3) The Administrator/Designee re-educated current CNAs on complet of 12 hour education/in-services and Relias program information 12/13/23. 4) The Administrator/Designee will review 3 CNA employee records per witimes x 4 weeks to validate timely completion of required education/in-services. Findings to be reviewed during QAPI meeting. Additi interventions to be initiated as needed 5) AOC: 12/27/23 	12 j ion /eek onal
		p.m., during an interview with tated they received training			

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					FORM APPROVED
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE C A. BUILDING	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495250	B. WING		C 11/16/202 <u>3</u>
NAME OF F	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CODE	
GALAX HEALTH AND REHAB			836 GLENDALE RD GALAX, VA 24333		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 947	for help if needed. On 11/15/23 at 3:30 day meeting with th President of Operat Officer the issue wit training's were revie No further information	ys someone they could ask p.m., during an end of the e Administrator, Regional Vice ions, and Chief Nursing h the missing in-service	F 947		

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