STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted on 11/16/2021 through 11/17/2021. Two complaints were investigated during the survey. VA00053636 and VA00052715 were both unsubstantiated, with related deficiencies cited. The facility was not in compliance with 42 CFR Part 483 Federal Long Term Care Requirements. The census in this 93 certified bed facility was 76. The survey sample consisted of 2 closed record reviews (Resident #1 and Resident #2.)	F 000		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to follow abuse prevention policies regarding reporting/investigating an injury of unknown origin for one of two residents in the survey sample, Resident #1. Policies were not implemented regarding reporting/investigating bruising to Resident #1's breast and side of unknown	F 607	F000 "This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the facts alleged or	12/8/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/03/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 1 source. The findings include: Resident #1 was admitted to the facility on 3/19/21 and discharged to the hospital on 7/18/21. Diagnoses for Resident #1 included congestive heart failure, renal failure, diabetes, history of pulmonary embolism, Parkinson's disease, anxiety, adult failure to thrive and encephalopathy. The minimum data set (MDS) dated 7/14/21 assessed Resident #1 with moderately impaired cognitive skills. Resident #1's clinical record documented a nursing note dated 6/30/21 stating, "CNA [certified nurses' aide] alerted undersigned of bruise to left breast. This nurse observed purple bruising to left breast which extended to her L [left] side and 15 cm [centimeters] down side. Resident denies pain and states she does not know what happened to cause bruising. M.D. notified via communication book and family to be notified later in a.m. Will continue to monitor..." A Bruise Investigation form dated 6/30/21 documented location of bruise as, "L Breast that extends to L side + 15 cm down L side...Size: 21 cm from breast to side and 15 cm down L side...Color: purple...Time reported: 0300 [3:00 a.m.]...Resident condition: Alert [with] confusion..." This form documented the resident did not ambulate alone and listed the resident took the anticoagulant medication Eliquis 2.5 milligrams twice per day. The nurse documented on this form, "Resident has been observed Restless + lying side-ways (across bed) Perhaps metal portion of bed was culprit?" Form instructions stated to list the caregivers on	F 607	conclusions set forth on the statement of deficiencies." F607 1. Resident #1 no longer resides at the facility. 2. All residents who sustain an injury of an unknown origin have the potential to be affected. 3. Facility staff were educated by the RVPO, DON/designee on the abuse / neglect policy, to include reporting injuries of an unknown origin. 4. Audits of resident injuries will be conducted 5 times weekly for 4 weeks, then monthly for 2 months by the DON / designee, to ensure that the source of the injury has been identified and abuse policy followed. Results of the audits will be reviewed at the monthly QAPI meeting for three months to sustain compliance. 5. Compliance Date: December 8, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 2	F 607		

previous shifts based on color of bruise and document their response on back of form. Purple colored bruises required a list of caregivers during the last 24 hours. There were no caregivers listed on the form and no interviews and/or statements from any other staff members. The previous director of nursing (DON) signed the supervisor section of the form on 7/13/21 stating in her professional opinion, no abuse, neglect or mistreatment occurred.

There was no documented investigation, no identified caregivers and no interviews or statements from anyone. There was no documented rationale for the DON's conclusion that no abuse, neglect or mistreatment occurred.

Resident #1's plan of care (initiated 4/1/21) documented the resident had behaviors that included crying, screaming, shouting, feeling anxious, restlessness/panic, sad/tearful, accusing others, cursing at others, making disruptive sounds, hoarding and feelings of isolation. Interventions to minimize behaviors included medications as ordered, avoiding situations or people that were upsetting to the resident, notifying the physician when behaviors interfered with daily life, pain management and speaking to resident calmly.

The DON that signed Resident #1's bruise investigation form was not available for interview, as she no longer worked at the facility.

On 11/16/21 at 4:20 p.m., the current DON was interviewed about an investigation or reporting of Resident #1's breast/side bruising of unknown source. The DON stated the nurse that found the bruising completed the initial report but no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 3 investigation was done. The DON stated the nurse wrote down the initial assessment but no caregivers were identified, no interviews or statements were obtained and there was no reporting to the state agency. The facility's policy titled Resident Abuse - Injuries of Unknown Origin (revised 4/2020) documented, "Provide treatment and documentation as indicated for the injuries of unknown origin. Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc., which have no known cause." The procedure for injuries of unknown origin included, "...The Administrator and Director of Nursing are to be notified immediately...The administrator, Director of Nursing, or their designee, must begin a documented investigation for the cause of the injury...The investigation will include interviews with the resident, all staff involved (directly or indirectly), and family, visitors, or volunteers which may have had contact with the resident and may help with the investigation. Obtain written statements as deemed necessary...All injuries of unknown origin must be reported to the appropriate agencies per state specific protocols...If there is no reasonable cause to believe or suspect that an injury has been inflicted upon a resident by a CNA or other individual used by the facility or that neglect occurred...The investigation must be thoroughly documented using the Investigative Report form to show there is no cause to believe that abuse or neglect by staff caused the injury..." This finding was reviewed with the administrator and DON on 11/16/21 at 4:45 p.m. and on 11/17/21 at 8:45 a.m.	F 607		
F 609 SS=D	Reporting of Alleged Violations	F 609		12/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 4 CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to report an injury of unknown origin to the administrator and state agency for one of two residents in the survey sample, Resident #1. Resident #1's breast bruising of unknown source was not reported to the administrator or state	F 609	F609 1. Resident #1 no longer resides at the facility. 2. All residents in the facility have the potential to be affected. 3. Facility staff were educated by the DON / designee on the abuse / neglect policies	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 5 agency and there was no thorough investigation of the injury in attempt to determine the source. The findings include: Resident #1 was admitted to the facility on 3/19/21 and discharged to the hospital on 7/18/21. Diagnoses for Resident #1 included congestive heart failure, renal failure, diabetes, history of pulmonary embolism, Parkinson's disease, anxiety, adult failure to thrive and encephalopathy. The minimum data set (MDS) dated 7/14/21 assessed Resident #1 with moderately impaired cognitive skills. Resident #1's clinical record documented a nursing note dated 6/30/21 stating, "CNA [certified nurses' aide] alerted undersigned of bruise to left breast. This nurse observed purple bruising to left breast which extended to her L [left] side and 15 cm [centimeters] down side. Resident denies pain and states she does not know what happened to cause bruising. M.D. notified via communication book and family to be notified later in a.m. Will continue to monitor..." A Bruise Investigation form dated 6/30/21 documented location of bruise as, "L Breast that extends to L side + 15 cm down L side...Size: 21 cm from breast to side and 15 cm down L side...Color: purple...Time reported: 0300 [3:00 a.m.]...Resident condition: Alert [with] confusion..." This form documented the resident did not ambulate alone and listed the resident took the anticoagulant medication Eliquis 2.5 milligrams twice per day. The nurse documented on this form, "Resident has been observed Restless + lying side-ways (across bed) Perhaps metal portion of bed was culprit?" Form	F 609	regarding investigating and reporting an unknown injury to the Administrator and State Agency. 4. Audits of injuries of unknown origin will be reviewed 5 times weekly for 4 weeks and then monthly for 2 months by the DON /designee, to ensure that the source of the injury has been properly investigated and any injury of unknown origin properly reported. Results of the audits will be reviewed at the monthly QAPI meeting for 3 months to sustain compliance. 5. Compliance Date: December 8, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 6	F 609		

instructions stated to list the caregivers on previous shifts based on color of bruise and document their response on back of form. Purple colored bruises required a list of caregivers during the last 24 hours. There were no caregivers listed on the form and no interviews and/or statements from any other staff members. The previous director of nursing (DON) signed the supervisor section of the form on 7/13/21 stating in her professional opinion, no abuse, neglect or mistreatment occurred.

There was no documented investigation, no identified caregivers and no interviews or statements from anyone. There was no documented rationale for the DON's conclusion that no abuse, neglect or mistreatment occurred and no documentation of that the administrator was notified of the injury.

Resident #1's plan of care (initiated 4/1/21) documented the resident had behaviors that included crying, screaming, shouting, feeling anxious, restlessness/panic, sad/tearful, accusing others, cursing at others, making disruptive sounds, hoarding and feelings of isolation. Interventions to minimize behaviors included medications as ordered, avoiding situations or people that were upsetting to the resident, notifying the physician when behaviors interfered with daily life, pain management and speaking to resident calmly.

The DON that signed Resident #1's bruise investigation form was not available for interview, as she no longer worked at the facility.

On 11/16/21 at 4:20 p.m., the current DON was interviewed about an investigation or reporting of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 7	F 609		

Resident #1's breast/side bruising of unknown source. The DON stated the nurse that found the bruising completed the initial report but no investigation was done. The DON stated the nurse wrote down the initial assessment but no caregivers were identified, no interviews or statements were obtained and there was no reporting to the state agency.

The facility's policy titled Resident Abuse - Injuries of Unknown Origin (revised 4/2020) documented, "Provide treatment and documentation as indicated for the injuries of unknown origin. Injuries of unknown origin are bruises, skin tears, fractures, abrasions, etc., which have no known cause." The procedure for injuries of unknown origin included, "...The Administrator and Director of Nursing are to be notified immediately...The administrator, Director of Nursing, or their designee, must begin a documented investigation for the cause of the injury...The investigation will include interviews with the resident, all staff involved (directly or indirectly), and family, visitors, or volunteers which may have had contact with the resident and may help with the investigation. Obtain written statements as deemed necessary...All injuries of unknown origin must be reported to the appropriate agencies per state specific protocols...If there is no reasonable cause to believe or suspect that an injury has been inflicted upon a resident by a CNA or other individual used by the facility or that neglect occurred...The investigation must be thoroughly documented using the Investigative Report form to show there is no cause to believe that abuse or neglect by staff caused the injury..."

This finding was reviewed with the administrator and DON on 11/16/21 at 4:45 p.m. and on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 609	Continued From page 8 11/17/21 at 8:45 a.m.	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality 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 practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide assessment and monitoring of a skin condition for one of two residents in the survey sample, Resident #1. There were no follow up assessments of Resident #1's blisters and open skin areas on her lower legs and feet. The findings include: Resident #1 was admitted to the facility on 3/19/21 and discharged to the hospital on 7/18/21. Diagnoses for Resident #1 included congestive heart failure, renal failure, diabetes, history of pulmonary embolism, Parkinson's disease, anxiety, adult failure to thrive and encephalopathy. The minimum data set (MDS) dated 7/14/21 assessed Resident #1 with moderately impaired cognitive skills. Resident #1's clinical record documented a nursing note dated 6/21/21 stating, "This nurse noted 4 blisters to rsd [resident's] LLE [left lower	F 684	F684 1. Resident #1 no longer resides at the facility. 2. All residents with skin issues have the potential to be affected. 3. Licensed nurses were educated by DON / designee on completing proper assessment and monitoring of skin conditions. 4. Audits of skin assessments and monitoring of a skin condition will be reviewed 5 times weekly for 4 weeks and then monthly for 2 months by the DON / designee, to ensure skin conditions have an assessment and being monitored. Results of the audits will be reviewed at the monthly QAPI meeting for 3 months to sustain compliance. 5. Compliance Date: December 8, 2021	12/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 9	F 684		

extremity]. Blisters measure 6 cm x 10 cm, 5 cm x 6 cm, 2 cm x 2 cm on proximal lower leg. 2 cm x 2 cm to distal lower leg. Order placed to spray with benzoin, allow to dry and wrap with kerlex. MD and RP informed."

Orders were changed on 6/22/21 to cleanse the blistered skin, pat dry, apply Xerofoam and absorbent dressing then wrap with Kling gauze each day.

Orders were entered on 6/27/21 to apply dressing and Kerlix gauze to both ankles and feet along with Ace wraps daily due to blisters and edema.

Treatment orders were added on 7/5/21 for cleanser, collagen powder and calcium alginate dressing daily to an open area on the back of the lower right leg.

Resident #1's treatment administration records for June 2021 and July 2021 documented the dressing changes and treatments to the resident's lower leg blisters/wounds were completed as ordered.

The wound nurse documented an Initial Non-Decubitus Skin Injury Report on 7/1/21 listing the following assessment of the left lower leg blisters.

7/1/21 - "...Left Medial Foot proximal...Blister with dermis off...7.0 x 6.0 x 0.1 [length x width x depth in centimeters]...Drainage: moderate serous...No odor...Wound bed red..."
7/1/21 - "...Left Medial foot distal...Blister with dermis off...5.0 x 6.0 x 0.1...Drainage: Moderate serous...No odor...Wound bed red..."
7/1/21 - "...Left lateral foot...Blister with Dermis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 10	F 684		

off...4.5 x 4.0 x 01 [0.1]...Drainage: Moderate serous...No odor...wound bed red..."

The clinical record documented no further assessments of the Resident's left foot blisters prior to her discharge to the hospital on 7/18/21. There was no further mention of the fourth left foot blister found on 6/21/21. Treatment orders were initiated on 7/5/21 for an open area on the back of the resident's right lower leg. There was no assessment in the clinical record of this wound or any description of the wound size, appearance or exact location. Nursing notes documented treatments in place for blisters/open areas on the lower extremities but there were no follow-up assessments monitoring the progress of the wounds.

The resident was sent to the emergency room on 7/18/21 for bruising/swelling of the right thigh. The emergency room report dated 7/18/21 documented "small dried wounds to ankle noted" but listed no other wounds and/or blisters to the lower extremities.

Resident #1's plan of care at the time of her discharge on 7/18/21 documented the resident had non-pressure related skin impairments. Interventions to promote healing and prevention complications included, "Conduct weekly skin inspection...Monitor for signs and symptoms of infection such as swelling, redness, warm, discharge, odor notify physician of significant findings...Skin assessment to be completed per [policy]...Treatments as ordered..."

On 11/16/21 at 4:20 p.m., the director of nursing (DON) was interviewed about any follow-up assessments regarding Resident #1's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 11	F 684		

blistered/open skin. The DON stated she reviewed the record and did not find any further assessments of Resident #1's lower leg wounds/blisters after 7/1/21. The DON stated the wound nurse was supposed to complete weekly assessments of the wounds and document assessments on the non-decubitus injury record form. The DON stated wound assessments were required weekly and Resident #1's wounds should have been assessed on 7/8/21 and 7/15/21. The DON stated Resident #1 was not seen or followed by the contracted wound physician.

On 11/16/21 at 8:00 p.m., the licensed practical nurse (LPN #2) that routinely cared for Resident #1 was interviewed by telephone about the lower leg blisters and wounds. LPN #2 stated the resident had dressing changes and Ace wraps as ordered by the nurse practitioner. LPN #2 stated the wound nurse was responsible for weekly assessments of wounds.

The wound nurse and director of nursing caring for Resident #1 during her stay were not available for interview, as they no longer worked at the facility.

The facility's policy titled Non-Pressure Skin Condition Record (revised 8/2019) documented, "To document the presence of skin impairment/new skin impairment not related to Pressure when first observed and weekly thereafter. This includes skin tears, surgical sites, rashes, abrasions, etc..." Procedures in this policy included, "...Residents have a Non-Pressure Ulcer Skin Condition Record completed for each skin impairment that is not related to Pressure...Each week the non-pressure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 12 ulcer skin condition is to be assessed and the following information collected...Date...Progress - i.e. length x width x depth, treatment, granulation, drainage, odor, etc...Date physician notified...Nurse's signature..." This finding was reviewed with the administrator and director of nursing on 11/16/21 at 4:45 p.m. and 11/17/21 at 8:45 a.m.	F 684		
F 842 SS=B	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law;	F 842		12/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 13	F 842		

(ii) Required by Law;
(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;
(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.

§483.70(i)(4) Medical records must be retained for-
(i) The period of time required by State law; or
(ii) Five years from the date of discharge when there is no requirement in State law; or
(iii) For a minor, 3 years after a resident reaches legal age under State law.

§483.70(i)(5) The medical record must contain-
(i) Sufficient information to identify the resident;
(ii) A record of the resident's assessments;
(iii) The comprehensive plan of care and services provided;
(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;
(v) Physician's, nurse's, and other licensed professional's progress notes; and
(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.
This REQUIREMENT is not met as evidenced by:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 14 Based on clinical record review and staff interview, the facility staff failed to maintain a complete and accurate clinical record for one of 2 residents in the survey sample, Resident #2. The Discharge Summary Packet dated October 8, 2021 was not scanned into the electronic record nor was in the closed paper clinical record. The findings include: Resident #2 was admitted to the facility on 09/22/2021 with diagnoses that included hypertension, type 2 diabetes, peripheral vascular disease, muscle weakness, gangrene, and acquired absence of left great toe. The most recent minimum data set (MDS) dated 10/08/2021 was the discharge assessment and assessed Resident #2 as cognitively intact for daily decision making with a score of 15 out of 15. On 11/16/2021 at 11:45 a.m., the interim director of nursing (DON) was asked if the facility utilized electronic and paper records and was asked to provide any paper records the facility had for Resident #2. At approximately 12:30 p.m., the DON provided a plastic accordion file organizer and stated it included Resident #2's paper records. Observed with the paper records was the baseline care plan that was implemented and reviewed with Resident #2 on 09/23/2021 at 11:00 a.m. The baseline care plan included focus areas for dietary, therapy/functional status, activities of daily living (ADL) needs, bowel/bladder needs and a discharge goal documented as: "Return to home." On 11/16/2021, Resident #2's electronic clinical	F 842	F842 1. Resident #2 no longer resides at the facility. The discharge summary / discharge summary packet, for Resident #2, was placed in the clinical record. 2. All discharged resident clinical records have the potential to be affected. 3. Medical Records will be re-educated by the DON / designee on ensuring clinical records are complete and accurate for all discharged residents. 4. Audits will be conducted by DON / designee to ensure clinical records are complete and accurate for discharged residents weekly for 4 weeks and then monthly for 2 months. Audits will be reviewed at the monthly QAPI meeting for 3 months to sustain compliance. 5. Compliance Date: December 8, 2021	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 15	F 842		

record was reviewed. Observed on the order summary report was the following orders: "...Discharge home with a rolling walker with knee sling and 3 in 1 bedside commode; standard wheelchair. Order Date: 10/6/2021."

Observed in the electronic clinical record were the following progress notes:

"10/8/2021 12:05 General Note. Note Text: resident been d/c (discharged) home, rx (prescription) meds given including personal belongings (sic) given as well, took am (morning) meds and had breakfast before leaving in his w/c (wheelchair)"

"10/8/2021 10:21 General Note. Note Text: SSD (Social Services Director) contacted Amedisys clinical office manager Tracy, advised that the surgeon has to order wound vac and have it sent to the patient's home and then amedysis will have nursing put on and manage wound vac as ordered."

Observed scanned into Resident #2's electronic clinical record was the Notice of Medicare Non-Coverage (NOMNC) that documented Resident #2's skilled service benefits would end on 10/08/2021 based on his Medicare Health Plan's determination. The notice was dated 10/06/2021 and signed by Resident #2.

On 11/16/2021 at 2:27 p.m., the facility's social worker (OS #1) was interviewed regarding Resident #2's stay and discharge. OS #1 stated "At the admission we knew [Resident #2] plans were to discharge back home. He was basically here for wound care because of the use of the wound vac and to help him regain his strength

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 16	F 842		

and ability to walk. He had [Insurance Provider] and they generally do not cover skilled care for long, maybe 2-3 weeks max so we were prepared from the admission for discharge." OS #1 was asked about Resident #15's cognitive ability for decision making. OS #1 stated, "He was alert and oriented and was his own responsible party. He didn't display any moods or behaviors." OS #1 was asked if the NOMNC form was explained and reviewed including the appeal process with Resident #2. OS #1 stated, "Yes, when I received the notice that his insurance no longer was going to cover his skilled stay here. I reviewed the form with him and offered the appeal information, but he declined he didn't want to take a chance of being denied the appeal and then having a large bill to pay so he opted to discharge home. Plus, he was doing very good with therapy. He was basically nonweight baring only because the surgeon hadn't released him yet. Therapy offered to do a home visit but he declined because he was doing so well. You can talk with the therapy manager for more information. OS #1 was asked for clarification about the 10/8/21 progress note that documented the order for the wound vac. OS #1 stated, "The home health agency did not supply a wound vac and the one [Resident #2] used while here belonged to the facility. I had to coordinate with the wound clinic to have the surgeon order a wound vac for home use at his discharge from here. To allow him to go home, the surgeon decided to change his dressing changes to a wet to dry dressing until the wound vac was received at home. The home health agency agreed to this. I put this in the discharge summary and I have email conversations with home health about this as well." OS #1 was asked if Resident #2 had a support system and/or plan for help once he discharged home. OS #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 17	F 842		

stated, "He lived alone, but his girlfriend and someone who was watching his dog agreed to help with groceries and checking on him. Home health services were arranged. They were scheduled to see him the day of discharge at home to evaluate and set-up their schedule with him." OS #1 was asked if there was a concern about this being an unsafe discharge because Resident #2 lived alone and had limited access to the main floor which was the second floor of his home. OS #1 stated, "No, because they assured us things were set up on the first floor and he had help of the home health and his friends things were in place for him to discharge safely. He was really doing well with therapy." OS #1 was asked where was the discharge summary located. OS #1 stated, "It should be in the paper chart. I coordinated and made the referrals. The nurse reviewed the information the day of discharge." OS #1 was advised a copy of the discharge summary was not located in the accordion file nor in the electronic record. OS #1 stated , "I should have a copy, I keep copies of everything." OS #1 stated, "I should kick myself for not having all of this information in his clinical record. If it matters I started back in June/July and I'm getting accustomed to this process."

On 11/16/2021 at 3:35 p.m. the unit manager (LPN #1) where Resident #2 resided was interviewed. LPN #1 was interviewed about the discharge process. LPN #1 stated the nurse who documented the discharge progress note on 10/8/21 was no longer employed by the facility. LPN #1 was asked where the discharge summary packet was located. LPN #1 stated, "I do all of the discharges and it is located on the computer. I print out 2 copies, one is reviewed and given to the resident and the other is left for the medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 18	F 842		

records to file in the closed chart." LPN #1 was advised a copy of the discharge summary packet was not located in the accordion file nor the electronic clinical record. LPN #1 reviewed Resident #2's accordion file provided by the DON and stated she did not locate the discharge summary packet. LPN #1 was asked what did the packet include. LPN #1 stated, "It includes the brief summary of the resident's stay, code status, pharmacy and prescription information, immunizations, follow-up appointments, allergies, orders, and therapy/home health information. I will see if I can locate a copy on the computer and bring it to you." LPN #1 was asked if she was aware of any concerns with Resident #2's discharge process. LPN #1 stated, "No, he was being seen by the wound clinic and the social worker worked with them to get a wound vac ordered for him at home. I know he was excited about going home and therapy even felt he was a good candidate for home health."

On 11/16/2021 at approximately 4:00 p.m. OS #1 provided a copy of the discharge summary packet. At approximately 4:15 p.m. OS #1 provided a copy of the face to face certification for home health services completed by the physician on 10/4/2021. OS #1 stated, "I know this isn't the normal routine and I should get all of my documentation into the file."

A review of the discharge summary packet documented Resident #2 was discharged to home on 10/08/2021 via personal vehicle accompanied and transported by a friend. The discharge summary documented Resident #2's functional mobility as independent with the use of DME (durable medical equipment) and a walker. Resident #2's ability for medication management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. BUILDING _____ B. WING _____	C 11/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VALLEY HEALTH AND REHAB	3737 CATALPA AVE BUENA VISTA, VA 24416

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 19	F 842		

was documented as "without any help." Resident #2 was documented as "able to independently plan, organize and remember". Resident #2 was documented as "independent for ability to use a telephone." Under nutrition, the discharge summary documented Resident #2 admission weight was 165.4 lbs and discharge weight was 175.0 lbs, with a documented weight gain of 9.6 lbs. The discharge summary included instructions to schedule a an follow-up appointment with the primary care provider within 2 weeks of discharge and to discuss when to resume driving with the provider. Additional instructions documented, "wound clinic to call for follow-up." The discharge summary documented the agency contact information for the home health services including physical, occupational and nursing services and the pharmacy contact information. Observed on the "Treatments" section was the following: "Wound Care: Wound vac to be changed M-W-F (Monday, Wednesday, Friday). Cleanse wound with Dakins prior to reapplying wound vac. Dressing Changes: Apply wet to dry dressing using Normal Saline until wound vac is placed. Other: NON weight bearing on left foot..."

The above findings were shared with the administrator and interim director of nursing (DON) on 11/16/2021 at 4:45 p.m.