	-	ID HUMAN SERVICES				DRM APPROVED
		MEDICAID SERVICES				<u>NO. 0938-0391</u>
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
		495262	B. WING			C 03/10/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	· · ·	
SHENAND	OAH NURSING HOME			339 WESTMINISTER DRIVE		
SHENAND	OAH NORSING HOME			FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	survey was conducte 3/10/2022. The facili Preparedness Plan w in compliance with Cl	ty's Emergency ras reviewed and found to be FR 483.73, the Federal ergency Preparedness in ties.	F 00	00		
	survey was conducte 03/10/2022. Two com during the survey. Co substantiated with de VA00050504 was sub practice. Corrections with 42 CFR Part 483	dicare/Medicaid standard d 03/08/2022 through mplaints were investigated omplaint VA00053497 was ficient practice. Complaint ostantiated without deficient are required for compliance B Federal Long Term Care ie Safety Code survey/report				
F 657 SS=D	at the time of the surv consisted of fifteen (1 and two (2) closed re Care Plan Timing and	Revision	F 65	57		3/30/22
	be- (i) Developed within 7 the comprehensive a (ii) Prepared by an in- includes but is not lim (A) The attending phy (B) A registered nurse resident.	orehensive care plan must 7 days after completion of ssessment. terdisciplinary team, that ited to vsician. e with responsibility for the				
		SUPPLIER REPRESENTATIVE'S SIGNATURE	Ξ	TITLE		(X6) DATE
Electroni	cally Signed					03/23/2022

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: 04/25/2022

		D HUMAN SERVICES MEDICAID SERVICES					FORM	: 04/25/2022 APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		X3) DATE S COMPL	SURVEY _ETED
		495262	B. WING _				C 03/1	; 10/2022
NAME OF PF	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
				339	9 WESTMINISTER DRIVE			
SHENAND	OAH NURSING HOME			FIS	SHERSVILLE, VA 22939			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	Ē	(X5) COMPLETION DATE
F 657	Continued From page (C) A nurse aide with resident. (D) A member of food (E) To the extent pract the resident and the resident and the resident and the resident reprises and their resident reprises and their resident's care plan. (F) Other appropriate disciplines as determined or as requested by the (iii)Reviewed and revises comprehensive and quassessments. This REQUIREMENT by: Based on observation record review, the fact revise the comprehent one of 17 residents in Resident #31. Findings include: Resident #31 was addr on 02/22/21. Diagnos included, but were no CHF (congestive heat	e 1 responsibility for the and nutrition services staff. ticable, the participation of esident's representative(s). be included in a resident's barticipation of the resident resentative is determined development of the staff or professionals in ned by the resident's needs e resident. sed by the interdisciplinary asment, including both the uarterly review is not met as evidenced h, staff interview and clinical ility staff failed to review and sive care plan (CCP) for the survey sample,	F 6	357		31 has of her on all ts to ted on e. oy the cal or on plans th		
	history of a stroke with hemiparesis/hemipleg contracture. The most recent MDS an annual assessmen	n left side			resident device list and audit the to ensure that the resident has a comprehensive plan of care for braces/splints monthly x3. Resu these audits will be discussed at meetings monthly for three mont	carepla lts of QAPI	in	

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	0: 04/25/2022 APPROVED 0: 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>'</i>	PLE CONSTRUCTION	-		LETED
		495262	B. WING				C 10/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	STATE, ZIP CODE		
SHENAN	OOAH NURSING HOME			339 WESTMINISTER DRIV FISHERSVILLE, VA 22			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE	'S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	of 12, indicating the re- impairment in daily de- resident was also assistance person for most all AL living). On 03/08/22 at 2:47 p observed in her room Resident #31 was asl left hand (left hand wa #31 stated, "I have a a took her right hand ar hand by pulling and p hand back. Resident splint or brace for the contracture. Resident have a brace or splint On 03/08/22 at 3:45 p again observed witho in place to the left har Resident #31's currer documented, "Focu breakdown due to lim L (left) cock up splir night) as toleratedre splint during the day a 02/23/21)(Revision: ordered" On 03/09/22 at 03:46 therapy) was interview 31. The OT stated that resting splint and a pa of those should be in OT stated that the pal	esident had moderate ecision making skills. The essed as requiring from at least one staff DL's (activities of daily o.m., Resident #31 was , sitting in her wheelchair. ked what happened to her as contracted). Resident dead hand." Resident #31 nd attempted to open the left #31 was asked if she had a left hand to help with the t #31 stated that she did not c. o.m., Resident #31 was ut any type of brace or splint nd. t CCP was reviewed and s: potential for skin ited mobilityInterventions: at stolerated QHS (every esident will choose to wear at times(Date initiated: 06/11/21)treatments as p.m., OT (occupational wed regarding Resident #	F 65	57			

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	MENT OF HEALTH AN S FOR MEDICARE & I	D HUMAN SERVICES					FORM	): 04/25/2022 APPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495262	B. WING			_		C 10/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, ST	ATE, ZIP CODE		
SHENAND	OOAH NURSING HOME				9 WESTMINISTER DRIVE SHERSVILLE, VA 229			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 657	day and then there is with finger extension i wear at night. The O was seen in January 2 had also been seen for Resident #31 was ori 2021). The OT provio regarding the resident discharge summary. instructed staff that the be worn during the da at night. The OT was know if Resident #31 recommended treatm stated, "I wouldn't un- look." The OT was m #31 had not had a spid during the last two da had stated that she di that hand. The OT st allowed to put anythin instruction and that sh staff. The OT was as were on the physician that she didn't think so to nursing once the re The OT stated that sh #31 had on the splint/ went down there to se not. The resident's OT eva treatment dated 12/30 forearm splintpatient splint wearing schedu timepatient has rest	a rigid black brace/splint that the resident should T stated that Resident #31 2022 for the left hand, but or the left hand when iginally admitted (February ded documentation t's evaluation, treatment and The OT stated that she e blue splint/brace was to by and the black splint/brace asked, how she would was actually receiving the ent and services. The OT ess I walk down there and ade aware that Resident int/brace on when observed ys and that Resident #31 d not have a brace/splint for ated that staff are not ag on the walls as far as ne verbally educated nursing ked if recommendations l's order set. The OT stated to, that information is given ecommendation is done. wouldn't know if Resident brace unless she physically ee if the resident had it on or	F 6	57				

Facility ID: VA0222

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	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/25/2022 MAPPROVED ). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	`, ´		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495262	B. WING _				C 10/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
SHENAN	DOAH NURSING HOME				39 WESTMINISTER DRIVE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 657	A therapy note dated "staff training on spi on donning with patie planning. Orders place The OT discharge sur "Discharge 01/10/2 resting hand splint wir abduction and finger overnight with no sign redness/sorenessst plan and goals. Orden wear schedulerestin roll" On 03/10/22 at 9:30 a #3 was interviewed re hand brace/splint and regarding the brace of that she will review pl staff, talk with differen residents, and update RN #3 stated that infor missed. On 03/10/22 at 10:50 nursing) and the adm in a meeting with the #31's CCP was not up resident's current staff current OT treatment No further information presented prior to the Increase/Prevent Dec	01/10/22 documented, iint schedules and education int participationdischarge ed with nursing" mmary documented, 22patient has worn left th rigid form, with thenar extensionincreasing to is/symptoms of aff have been educated on is placed with nursing for ing hand splint with palm a.m., RN (registered nurse) egarding Resident #31's left the incorrect information in the CCP. RN #3 stated hysician's orders, talk with it disciplines, talk with the e the care plan accordingly. formation must have been a.m., the DON (director of inistrator were made aware survey team that Resident odated to reflect the us and the resident's recommendations. and/or documentation was exit conference. crease in ROM/Mobility		657			3/30/22
SS=D	CFR(s): 483.25(c)(1)- §483.25(c) Mobility.	(3)					

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	MENT OF HEALTH AN S FOR MEDICARE & I				FOR	D: 04/25/2022 MAPPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495262	B. WING			C /10/2022
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
	OAH NURSING HOME		3	39 WESTMINISTER DRIVE		
SHEMANL	JOAN NORSING HOME		F	FISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 688	<ul> <li>§483.25(c)(1) The factor resident who enters the range of motion does range of motion unless condition demonstrate of motion is unavoidal</li> <li>§483.25(c)(2) A reside motion receives appropriate satisfies to increase represent further decreases assistance to maintain the maximum practical reduction in mobility is This REQUIREMENT by:</li> <li>Based on observation record review, the fact assistive devices were prevention of decreases for one of 17 residents Resident #31.</li> <li>Findings include:</li> <li>Resident #31 was addr on 02/22/21. Diagnoss included, but were nor CHF (congestive heat pressure, diabetes methistory of a stroke with hemiparesis/hemipleg contracture.</li> <li>The most recent MDS</li> </ul>	ility must ensure that a ne facility without limited not experience reduction in is the resident's clinical es that a reduction in range ble; and ent with limited range of opriate treatment and ange of motion and/or to ase in range of motion. ent with limited mobility services, equipment, and n or improve mobility with able independence unless a is demonstrably unavoidable. If is not met as evidenced in, staff interview and clinical ility staff failed to ensure e implemented for the led range of motion (ROM) is in the survey sample, mitted to the facility originally ses for Resident #31 t limited to: atrial fibrillation, rt failure), high blood ellitus, anxiety, depression, h left side	F 688	<ol> <li>Splint was applied to Resident # the time of the survey.</li> <li>A 100% audit of all other resident braces/splints to visually validate tha residents are wearing braces/splints ordered.</li> <li>Therapy staff will be inserviced b Director of Rehab or designee on completing therapy to nursing communication forms for new splint/ with recommended wearing times.</li> <li>DON or designee will make observation rounds weekly for thirty then monthly for 60 days to ensure t residents are wearing braces/splints indicated. Results of these audits w discussed at QAPI meetings monthly three months.</li> </ol>	s with t as / the prace days nat as II be	

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/25/2022 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495262	B. WING		_	( 03/'	C 10/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE		
SHENAND	OOAH NURSING HOME			339 WESTMINISTER DRIV FISHERSVILLE, VA 229			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	MDS assessed the re of 12, indicating the re impairment in daily de resident was also ass extensive assistance person for most all AL living). On 03/08/22 at 2:47 p observed in her room Resident #31 was asl left hand (left hand wa #31 stated, "I have a took her right hand ar hand by pulling and p hand back. Resident splint or brace for the contracture. Resident have a brace or splint On 03/08/22 at 3:45 p again observed witho in place to the left har Resident #31's physic There were no physic splint or brace for the The MARs/TARs (me records/treatment adr reviewed and did not treatments and/or inte #31's left hand. Resident #31's currer documented, "Focu breakdown due to lim L (left) cock up splir	sident with a cognitive score esident had moderate ecision making skills. The essed as requiring from at least one staff DL's (activities of daily a.m., Resident #31 was , sitting in her wheelchair. (activities of daily a.m., Resident #31 was , sitting in her wheelchair. (activities of the left dead hand." Resident #31 and attempted to open the left #31 was asked if she had a left hand to help with the t #31 stated that she did not a. (b.m., Resident #31 was ut any type of brace or splint a. (b.m., Resident #31 was at any type of brace or splint a. (b.m., Resident #31 was at any type of brace or splint a. (b.m.) administration ministration records) were reveal any type of erventions for Resident at CCP was reviewed and	F 688				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	: 04/25/2022 APPROVED
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION		(X3) DATE : COMPI	ETED
		495262	B. WING			03/1	; 10/2022
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STAT	E, ZIP CODE		
			3	39 WESTMINISTER DRIVE			
SHENAND	OAH NURSING HOME		F	SHERSVILLE, VA 22939	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIA FICIENCY)		(X5) COMPLETION DATE
F 688	Continued From page splint during the day a 02/23/21)(Revision: ordered" On 03/09/22 at 3:12 F (LPN) #2 was intervie #31's left hand. LPN know right off what wa hand and that she wo information up. LPN #31 wore a splint or b #2 stated that she wa would have to look that she doesn't normally although is familiar witknow that information On 03/09/22 at 03:46 therapy) was interview 31. The OT stated that resting splint and a pa- of those should be in OT stated that the pal relaxed and Resident day and then there is with finger extension f wear at night. The OT was seen in January 2 had also been seen for Resident #31 was ori 2021). The OT provio regarding the resident discharge summary.	7 at times(Date initiated: 06/11/21)treatments as PM, licensed practical nurse wed regarding Resident #2 stated that she didn't as wrong with the resident's uld have to look that #2 was asked if Resident race to the left hand. LPN is not sure and that she at up. LPN #2 stated that work on that hall and th Resident #31, did not  p.m., OT (occupational ved regarding Resident # t Resident #31 has a atim roll splint and that both the resident's room. The m roll splint/brace is more #31 wears that during the a rigid black brace/splint hat the resident #31 2022 for the left hand, but or the left hand when ginally admitted (February	F 688	DE			
	know if Resident #31 recommended treatm	asked, how she would was actually receiving the ent and services. The OT ess I walk down there and					

Facility ID: VA0222

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	2: 04/25/2022 1 APPROVED 2: 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495262	B. WING		_	( 03/	C 10/2022
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SHENAND	OOAH NURSING HOME			39 WESTMINISTER DRIVI SISHERSVILLE, VA 229			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE) CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	look." The OT was m #31 had not had a spl during the last two da had stated that she di that hand. The OT st allowed to put anythin instruction and that sh staff. The OT was as were on the physician that she didn't think so to nursing once the re The OT stated that sh #31 had on the splint/ went down there to se not. The resident's OT eva treatment dated 12/30 forearm splintpatien splint wearing schedu timepatient has rest rollcould accommod hand splint" Therapy notes docum 01/05/22, "fitted with hand" 01/06/22, "patient w resting hand splint in distally"	ade aware that Resident lint/brace on when observed ys and that Resident #31 d not have a brace/splint for ated that staff are not og on the walls as far as ne verbally educated nursing ked if recommendations l's order set. The OT stated o, that information is given ecommendation is done. The wouldn't know if Resident brace unless she physically be if the resident had it on or aluation and plan of 0/21 documented,"apply it and staff will participate in le to increase wear ing hand splint with palm date a more open resting mented the following: In resting hand splint on left vas still wearing night time late AM, splint had shifted till had rigid splint on in late wrist support with palm roll	F 688				

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	): 04/25/2022 MAPPROVED ). 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495262	B. WING		_		C 10/2022
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	TATE, ZIP CODE		
SHENAND	OOAH NURSING HOME			339 WESTMINISTER DRIV FISHERSVILLE, VA 229			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 688	education on donning participationdischar with nursing" Resident #31's OT dis documented, "Disch has worn left resting h with thenar abduction extensionincreasing signs/symptoms of re been educated on pla with nursing for wear splint with palm roll' Resident #31's nursin reviewed from Januar (03/10/22). No docur indicating that Reside the recommended tre for her left hand. On 03/10/22 at 7:30 a observed in bed with hand splint with palm On 03/10/22 at 9:15 a #4 (working with Resi and asked about the la she did not have know see if that had been in On 03/10/22 at 9:25 a assistant) #8 stated th put on a brace/split if get the information in	ning on splint schedules and with patient ge planning. Orders placed scharge summary harge 01/10/22patient hand splint with rigid form, and finger to overnight with no dness/sorenessstaff have in and goals. Orders placed scheduleresting hand diversion was found int #31 refused the use of atment interventions by OT a.m., Resident #31 was the blue splint/brace (resting roll). a.m., RN (registered nurse) dent #31) was interviewed resident requiring or wearing eft hand. RN #4 stated that wledge and would have to initiated. a.m., CNA (certified nursing hat the CNAs and nurses will they have one and that they	F 68	8			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FO	ED: 04/25/2022 RM APPROVED NO. 0938-0391
STATEMENT (	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495262	B. WING				C 3/10/2022
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
SHENAND	OOAH NURSING HOME				39 WESTMINISTER DRIVE ISHERSVILLE, VA 22939		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 688	is for night time for Re resident uses a rolled CNA #6 stated they fin their documentation of On 03/10/22 at 10:15 interviewed again. Re with the OT present. If splint/brace (resting p stated that is for day of is for night. The OT v Resident #31 had bee throughout the survey applied. The morning was the first observat wearing the brace/spl On 03/10/22 at 10:50 nursing) and the adm of the above informati survey team. The DC physician's order and from OT for trials and	that she was told the splint esident #31 and that the cloth/towel during the day. Ind the information out in in the computer. a.m., the OT was esident #31 was observed Resident #31 had the blue alm roll) applied. The OT use and the rigid/black one was again made aware that en observed multiple times without a brace/splint of 03/10/22 at 7:30 a.m. ion with Resident #31 int. a.m., the DON (director of inistrator were made aware ion in a meeting with the DN stated that it is not a they will get information recommendations.	F	588			

Facility ID: VA0222

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