## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2023

	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILD	TIPLE CONSTRUCTION	OMB NO. 0938- (X3) DATE SURVE COMPLETED
NAME O	F PROVIDER OR SUPPLIER	495168	B WING		С
Separation 15, and	NDOAH VALLEY HEAL	TH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE	02/23/202
(X4) ID PREFIX	SUMMARY STAT	TEMENT OF DEFICIENCIES		BUENA VISTA, VA 24416	
TAG	REGULATORY OR LS	LEMIENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	
€ 000	Initial Comments		E 00	0	
F 000	02/23/2023. The faci compliance with 42 C Long Term Care facili INITIAL COMMENTS		F 000	This plan of correction is being submitted in compliance with specific regulatory requirements and preparation and/or execution of this plan of	5
	through 02/23/2023. (compliance with 42 Co	ite Medicare/Medicaid conducted 02/21/2023 Corrections are required for FR Part 483 Federal Long ats. The Life Safety Code		correction does not constitute admission or agreement by the provider of the facts alleged or conclusions set forth on the statement of deficiencies.	
u \ 2	VA00054019: Four all nsubstantiated	egations: Allegations #1,			
co re <sup>-</sup> 658 Se	nsisted of sixteen (16)		F 658		
§46 The as mu (i) N This by:	33.21(b)(3) Comprehe e services provided or outlined by the compre st- Meet professional stan s REQUIREMENT is	arranged by the facility, chensive care plan,			¥

TITLE

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 these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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CENTER	S FOR MEDICAL	RE & MEDICAID SERVICES				M APPROVE	
AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDI	FIPLE CONSTRUCTION	OMB NO. 093 (X3) DATE SUR COMPLETE		
NAME OF PROVIDER OR SUPPLIES		495168	8 WING		0.0	С	
SHENAND	OAH VALLEY HE	ALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZIP COD 3737 CATALPA AVE BUENA VISTA, VA 24416	<b>U2</b>	/23/2023	
(X4) ID PREFIX TAG	LEACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OHIDE	(X5) COMPLETION DATE	

### F 658 Continued From page 1

Based on resident interview, staff interview, clinical record review, and facility document review the facility staff failed to follow professional standards of practice during medication administration for one of 19 residents in the survey sample: Resident # 33.

### Findings include:

Resident # 33 was admitted to the facility 2/20/20 with diagnoses to include, but were not limited to: end stage renal disease, heart disease, high blood pressure, and insomnia.

The most recent MDS (minimum set) was quarterly assessment dated 1/15/23. Resident # 33 was assessed as cognitively intact with a total summary score of 15/15.

On 2/21/23 beginning at approximately 3:00 p.m. during review of the clinical record, a nurses note dated 2/15/23 at 3:48 p.m. documented "Resident was given the medication of another resident by mistake. Medication was Bethanechol (helps with urination)10 mg, Xanax (anti-anxiety) 0.5 mg, Cipro (antibiotic) 500 mg, Iron 325 mg, Fluvoxamine (antidepressant) 50 mg, Gabapentin (anticonvulsant) 200 mg, Lisinopril (for high blood pressure), Metformin (lowers blood sugars) 500 mg, Probiotic, and Senna 8.6. NP was notified and neuro checks were ordered every 15 minutes for one hour and then every hour for 4 hours. Then vital signs every 4 hours x 3. Resident had no issues after this medication was given. His vital signs as well as neuro checks have all been within normal limits. Resident is aware of the situation."

### F 658

To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction.

#### F 658

- 1. Resident #33 had a pharmacy review and receives medication per Physician order. Resident had no adverse effects from medication error.
- 2. Medication pass observations were completed on licensed nurses.
- 3. DON/Designee reeducated licensed nurses on the eight rights of medication administration. Medication administration audits will be conducted 3x a week for 4 weeks.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2023 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER. (X3) DATE SURVEY COMPLETED A. BUILDING C 495168 B WING NAME OF PROVIDER OR SUPPLIER 02/23/2023 STREET ADDRESS, CITY, STATE, ZIP CODE SHENANDOAH VALLEY HEALTH AND REHAB 3737 CATALPA AVE **BUENA VISTA, VA 24416** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID (X5) COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 658 Continued From page 2 F 658 On 2/21/23 at approximately 3:30 p.m. the DON (director of nursing) was asked if there was an investigation for the medication error. She stated there was. She was asked to see it, and she 4. Audits will be reviewed stated she would get it to me. in QAPI and any On 2/22/23 at approximately 9:30 a.m. Resident # discrepancies will be 33, who had just returned from dialysis, was corrected immediately. asked about the incident. Resident # 33 stated "Yes; I was sitting in my doorway and the nurse Re-education will be came down the hall and handed me a cup of provided as needed. medicines. Then she came back and said she made a mistake and gave me the wrong 5. Date of compliance is medicines and then she gave me my medicines. March 23, 2023. I was alright though......" On 2/22/23 at approximately 10:00 a.m. the facility's nurse practitioner (NP) was interviewed. She stated "I was notified no more than 15 minutes after it happened. I was already in-house. I went to talk to the nurse; went to patient's room and saw him fact-to-face 30-45 minutes after he got the meds.....any sooner would not have had time for any effect....he was tired, fatigued, and drowsy, so they had started to take effect. The main concern was Xanax and Gabapentin; even though he isn't a diabetic Metformin does not have a big impact on blood sugars so we did not check his blood sugars. I then gave the orders you see for the neuro checks and vital signs. The resident did not have

any adverse event from the incident."

by phone. RN (registered nurse) # 1 was interviewed about the medication error. RN # 1 stated "I had gotten his medications ready, but he

On 2/22/23 at approximately 10:50 a.m. the nurse who administered the medications was contacted

STATEMEN	IT OF DEFICIENCIES	RE & MEDICAID SERVICES	T			M APPROVE 0. 0938-039		
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DA	TE SURVEY		
		495168	B. WING		С			
NAME OF	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP (	1 02	2/23/2023		
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F 658	Continued From	page 3	F 65	ı,				
	another resident's of that (name of F cart for his meds. cart and set it on gotten back from blood pressure artook his vitals, pic was his, and gave the cup but still pic immediately notific a medication incide							
	nurse were interviewasked for the facility administration. The practical nurse) #	proximately 11:15 a.m., the por, unit manager, and regional ewed about the incident, and ity policy for medication ne unit manager, LPN (licensed 2 stated, "I did do verbal ication administration after the 1"						
	medication incider	roximately 11:30, the nt form was reviewed as filled e form identified Resident # 33						

and the date of the incident of 2/15/23. The form included the medications that had been administered in error to Resident # 33, and under "Explanation" RN # 1 had documented " Resident came up to have his medicine given. There was another med cup sitting on top of the cart that had just been pulled. Wrong cup was picked up and given."

The facility policy "Medication Administration General Guidelines" directed "1. Medications are administered in accordance with written orders of the presciber..... 4. Medications are to be

CENT	ERS FOR MEDICAR	TH AND HUMAN SERVICES RE & MEDICAID SERVICES			PRINTED: 03/21/20 FORM APPROV	
STATEME	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT	FIPLE CONSTRUCTION NG	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
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F 658	administered at the Verify medication administering medication from a prepared (c) Before Medications suppled administered to an administration of a skept closed and kept on top of cart on 2/23/23 beginn p.m., the administrational nurse wer findings.	the time they are prepared9. is correct three (3) times before dication (a) When pulling ned cart (b) When dose is re dose is administered 16. ied for one resident are never nother resident 17. During nedications, the medication cart lockedNo medications are	F 65			
SS=D	§483.45(f) Medicat The facility must er §483.45(f) (1) Medicate percent or greater; This REQUIREMEI by: Based on a medical observation, staff in and facility docume failed to ensure a medical than 5 percent. The errors out of 28 medical states and the states are the states and the states are the states ar	ion Errors. Insure that its- cation error rates are not 5  NT is not met as evidenced ation pass and pour interview, clinical record review, and review, the facility staff inedication error rate of less are facility had two medication dication opportunities, which	F 75	To remain in compliance w federal and state regulation center has taken or will tak actions set forth in the follo plan of correction.	ith all ns, the se the	
	resulted in a medica percent. Findings include:	ation error rate of 7.14				

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2023 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. <u>0938-0391</u> (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER (X3) DATE SURVEY A. BUILDING COMPLETED 495168 C B WING NAME OF PROVIDER OR SUPPLIER 02/23/2023 STREET ADDRESS, CITY, STATE, ZIP CODE SHENANDOAH VALLEY HEALTH AND REHAB 3737 CATALPA AVE **BUENA VISTA, VA 24416** SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION

PREFIX

TAG

### F 759 Continued From page 5

TAG

On 02/22/23 at 8:29 AM, a medication pass and pour observation was completed with Licensed Practical Nurse (LPN) #1.

REGULATORY OR LSC IDENTIFYING INFORMATION)

LPN #1 prepared medications for Resident #35, which included Vitamin C 500 milligrams (mg) (one tablet), Ferrous Sulfate 325 /65 mg (one tablet), Losartan Potassium 100 mg (one tablet), Miralax 17 grams (mixed with water) and Pravastatin Sodium Tablet 40 MG (one tablet).

The resident had a total of 4 tablets and the Miralax mixture. The LPN administered the medication to Resident #35.

At approximately 9:45 AM, a medication reconciliation was completed for Resident #35. The resident's physician's orders revealed the resident had an order for Protonix 40 mg once daily. The Protonix 40 mg was ordered on 02/21/23 and was ordered to start on 02/22/23. LPN #1 did not administer Protonix 40 mg to Resident #35 during the medication pass and pour observation. The resident's physician orders did not show a current order for the medication Pravastatin Sodium Tablet 40 MG. Further review of the resident's physician's orders revealed that the Pravastatin Sodium Tablet 40 MG had been discontinued for Resident #35 on 02/09/23.

On 02/22/23 at 10:42 AM, LPN #1 was asked to pull up the resident's MAR (medication administration records) and to pull medication cards from the med cart for Resident #35. The LPN pulled out the medication cards, including the medication card for the Pravastatin 40 mg.

### F 759 F 759

Facility failed to ensure medication errors were below 5%.

(EACH CORRECTIVE ACTION SHOULD BE

CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

- 2. Medication pass observations were completed on licensed nurses.
- DON/Designee reeducated licensed nurses on the eight rights of medication administration. Medication pass observations will be completed for 4 weeks.
- 4. Audits will be reviewed in QAPI and any discrepancies will be corrected immediately. Re-education will be provided as needed.
- 5. Date of compliance is March 23, 2023.

(X5) COMPLETION DATE

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2023 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED C 495168 B. WING 02/23/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE SHENANDOAH VALLEY HEALTH AND REHAB **BUENA VISTA, VA 24416** SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 759 Continued From page 6 F 759 The LPN was made aware that she did not give the ordered Protonix 40 mg, the LPN stated this is it and pointed to the Pravastatin 40 mg card. The LPN then stated, "I gave her the wrong thing." "I made a med error." The medication Pravastatin 40 mg (the discontinued medication) was given instead of Protonix 40 mg (ordered medication). The LPN stated she didn't understand why that medication (the discontinued medication) was still in the medication cart. The LPN was then asked if the medication Protonix 40 mg was available for administration. The LPN looked again in the medication cart and found the card for the Protonix. The LPN was made aware that the medication observation had resulted in two medication errors, the wrong medication (discontinued medication) was administered and the medication that was ordered was not given and was omitted. On 02/22/23 at 11:13 AM, the nurse consultant, administrator and DON (director of nursing) were made aware of the above information in a meeting with the survey team. The facility staff were asked for a policy on medication administration. The facility's policy titled, "Medication Administration General Guidelines" documented. "...Medications are administered as prescribed in accordance with manufacturer's specifications, good nursing principles and practices...prior to administration, review and confirm medication orders for each individual resident...compare the

medication and dosage schedule on the resident's MAR with the medication label...medications are administered in accordance with written orders of the

prescriber...Verify medication is correct three (3)

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STATEMEN	ERS FOR MEDICAR	RE & MEDICAID SERVICES				FORM	MAPPROVE
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTR	RUCTION	The same of the same	D. 0938-039 TE SURVEY
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NAME OF	PROVIDER OR SUPPLIER	3		STREET ADI	DRESS, CITY, STATE, ZIP CODE	02	2/23/2023
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			13		STA, VA 24416		
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F 759	Continued From p	age 7	5/2/00/00/00 P				
	times before admir	nistering the medicationWhen	F 759	9			
	pulling medication	package from med cartwhen		To rem	ain in compliance with all		
	dose is prepared	before dose is administered"					
				contor	and state regulations, the		
	No further informati	tion and/or documentation was			has taken or will take the		
	02/23/23 at 1:30 P	the exit conference on			set forth in the following		
F 760	Residents are Eros	M.			correction.		
SS=D	CFR(s): 483.45(f)(2	e of Significant Med Errors 2)	F 760	F 760			
	The facility must er	nsure that its-		1.	Resident #33 had		
	§483.45(f)(2) Resid	dents are free of any significant			pharmacy review and is		
	medication entris.				receiving medications		
	by:	NT is not met as evidenced			per physician orders.		
		interview, staff interview,			Resident had no adverse		
	clinical record revie	w, and facility document			effects from medication		
	review the facility st	aff failed to ensure one of 10			error.		
	residents in the sur	vev sample was free from a			CITOI.		
	significant medication	on error: Resident # 33.		2.	Medication pass		
				۷.	observations were		
	Findings include:						
	go molade.				completed on licensed		
	Resident # 33 was a	admitted to the facility 2/20/20			nurses.		
	with diagnoses to in	clude, but were not limited to:					
	end stage renal dise	ease, heart disease, high		3.	DON/Designee re-		
	blood pressure, and	insomnia.			educated licensed		
	The most recent ME	OS (minimum set) was			nurses on the eight		
(	quarterly assessmen	nt dated 1/15/23. Resident #			rights of medication		
,	oo was assessed as	Cognitively intact with a total			administration.		
\$	summary score of 1	5/15.			Medication pass		
19	D= 2/24/05 :				observations will be		
	during review of the	g at approximately 3:00 p.m. clinical record, a nurses note			completed for 4 weeks.		
C	lated 2/15/23 at 3:48	8 p.m. documented "Resident ation of another resident by					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2023 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A BUILDING COMPLETED 495168 B WING NAME OF PROVIDER OR SUPPLIER 02/23/2023 STREET ADDRESS, CITY, STATE, ZIP CODE SHENANDOAH VALLEY HEALTH AND REHAB 3737 CATALPA AVE **BUENA VISTA, VA 24416** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 760 Continued From page 8 F 760 mistake. Medication was Bethanechol (helps with Audits will be reviewed urination)10 mg, Xanax (anti-anxiety) 0.5 mg, in QAPI and any Cipro (antibiotic) 500 mg, Iron 325 mg, discrepancies will be Fluvoxamine (antidepressant) 50 mg, Gabapentin corrected immediately. (anticonvulsant) 200 mg, Lisinopril (for high blood pressure), Metformin (lowers blood sugars) 500 Re-education will be mg, Probiotic, and Senna 8.6. NP was notified provided as needed. and neuro checks were ordered every 15 minutes for one hour and then every hour for 4 hours. 5. Date of compliance is Then vital signs every 4 hours x 3. Resident had no issues after this medication was given. His March 23, 2023. vital signs as well as neuro checks have all been within normal limits. Resident is aware of the situation." On 2/21/23 at approximately 3:30 p.m. the DON (director of nursing) was asked if there was an investigation for the medication error. She stated there was. She was asked to see it, and she stated she would get it to me. The DON returned a few minutes later and stated there had been a medication incident form completed, and a check sheet. She was then asked for a copy of the documentation. On 2/22/23 at approximately 8:45 a.m. the DON presented the requested information, as well as a copy of the facility medication administration policy. On 2/22/23 at approximately 9:30 a.m. Resident # 33, who had just returned from dialysis, was asked about the incident. Resident # 33 stated

I was alright though....."

"Yes; I was sitting in my doorway and the nurse came down the hall and handed me a cup of medicines. Then she came back and said she made a mistake and gave me the wrong medicines and then she gave me my medicines.

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	CENTERS FOR MEDICARE & MEDICAID SERVICES				FORM APPROVED OMB NO. 0938-0391
STATEMEN AND PLAN (	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED
		495168	B. WING		No. St.
	PROVIDER OR SUPPLIENT OF SUPPLI			STREET ADDRESS, CITY, STATE, ZI 3737 CATALPA AVE BUENA VISTA, VA 24416	02/23/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 760	Continued From p	page 9	F 760	)	
	On 2/22/23 at app	proximately 10:00 a.m. the			
	She stated "I was	actitioner (NP) was interviewed. notified no more than 15		A STATE OF	
	minutes after it ha	appened. I was already			
	in-house. I went t	to talk to the nurse; went to			
	minutes after he c	d saw him fact-to-face 30-45 got the medsany sooner			
	would not have ha	ad time for any effecthe was			
	tired, fatigued, and	d drowsy, so they had started to			
	Gabanentin: even	nain concern was Xanax and though he isn't a diabetic			
	Metformin does no	ot have a big impact on blood			
	sugars so we did r	not check his blood sugars. I			
	then gave the order	ers you see for the neuro			
	anv adverse even	igns. The resident did not have t from the incident."			
	On 2/22/23 at app	roximately 10:50 a.m. the nurse			
	who administered	the medications was contacted jistered nurse) # 1 was			
	interviewed about	the medication error. RN # 1			
	stated "I had gotte	n his medications ready, but he			
	wasn't ready to tak	ke them so I put the cup in the			
	medication cart dra	awer. I started working on			
	of that (name of R	medications, and in the middle esident # 33) came to the med			
	cart for his meds.	I got the cup of pills from the			
	cart and set it on to	op of the cart. He had just			
	gotten back from d	dialysis, and we always take his divitals when he gets back, so I			
	took his vitals, pick	ked up the cup of pills I thought			
	was his, and gave t	them. I even had his initials on			
	the cup but still pic	ked up the wrong one. 1			
	immediately notifie	ed the unit manager, and we did			
	asked if she had re	ent form" RN # 1 was eceived any education following			
	the incident, and if	she had continued to give			

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STATEMEN	T OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	T (VO) MUII 7	TO E CONSTRUCTION		OMB NO. 0938-0391
ND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED
		495168	B. WING			C 02/22/2022
NAME OF	PROVIDER OR SUPPLIE	R	1	STREET ADDRESS, C	ITY STATE ZIP CODE	02/23/2023
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F 760	Continued From p	nage 10				,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		est of the shift. RN # 1 stated	F 76	60		
	"Yes that hannen	ed around 10 or so in the				
	morning I finishe	ed around 10 or so in the				
	2/16/23 and 2/17/	d my shift, and then was off 23. I came back to work				
	2/18/23 and works	ed that day, and 2/19/23, and				
	2/20/23 The unit	manager came to me with				
	education on med	ication administration, and I				
	signed off on the	policyI'm not positive a med				
	pass observation	being done with me"				
	On 2/22/23 at ann	roximately 11:15 a.m. the DON,				
	administrator, unit	manager, and regional nurse				
	were interviewed a	about the incident, and asked				
	for the facility police	by for medication administration.				
	The unit manager.	LPN (licensed practical nurse)				
	# 2 stated "I did do	verbal education on				
	medication admini	stration after the incident for				
	RN # 1 I don't h	ave anything written." LPN # 2				
	confirmed RN # 1	stayed on the med cart until 7				
	p.m. on 2/15/23, w	as off 2/16/23 and 2/17/23.				
	came back to work	k and gave meds 2/18/23,				
	2/19/23, and the m	norning of 2/20/23. The				
	medication admini	stration policy, which RN # 1				
	and LPN # 2 identi	ified as the formal education				
	piece was dated a	nd signed by RN # 1 on				
	2/20/23. When as	ked about any reporting of the				
	incident and for the	e complete investigation, the				
	DON stated there	was no investigation on paper.				
	the resident so no	stated "There was no harm to reporting was done."				
	On 2/22/23 at appr	oximately 11:30 the medication				
	incident form was	reviewed as filled out by RN #				
	<ol> <li>The form identified</li> </ol>	fied Resident # 33 and the date				
	of the incident of 2	/15/23. The form included the				
	medications that ha	ad been administered in error				
	to Resident # 33, a	and under "Explanation" RN # 1				
	nad documented "	Resident came up to have his				
	medicine given. Ti	here was another med cup				

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		RE & MEDICAID SERVICES	Υ		OMB NO. 0938-039
AND PLAN (	TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I State of the second	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495168	B. WING		C 02/22/2022
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 3737 CATALPA AVE BUENA VISTA, VA 24416	02/23/2023 P CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 760	Continued From p	age 11	F 76	0	
	sitting on top of the cart that had just been pulled. Wrong cup was picked up and given."		F 7 C	U	
	deneral Guideline administered in act the presciber	"Medication Administration s" directed "1. Medications are cordance with written orders of d. Medications are to be getime they are prepared9. s correct three (3) times before lication (a) When pulling led cart (b) When dose is e dose is administered 16. ed for one resident are never other resident 17. During medications, the medication cart lockedNo medications are			
	a.m. the administra	ing at approximately 11:30 ator, DON, LPN # 2, and e informed of the above			
	exit conference.	ion was provided prior to the			
F 842 SS=D	Resident Records CFR(s): 483.20(f)(	- Identifiable Information 5), 483.70(i)(1)-(5)	F 84	2	
Service States	(I) A facility may no resident-identifiable (ii) The facility may resident-identifiable accordance with a garees not to use o	dent-identifiable information.  It release information that is to the public.  release information that is to an agent only in contract under which the agent or disclose the information t the facility itself is permitted			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2023 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A BUILDING 495168 B WING NAME OF PROVIDER OR SUPPLIER 02/23/2023 STREET ADDRESS, CITY, STATE, ZIP CODE SHENANDOAH VALLEY HEALTH AND REHAB 3737 CATALPA AVE **BUENA VISTA, VA 24416** (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION TAG PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 842 Continued From page 12 F 842 To remain in compliance with all §483.70(i) Medical records. federal and state regulations, the §483.70(i)(1) In accordance with accepted professional standards and practices, the facility center has taken or will take the must maintain medical records on each resident actions set forth in the following that areplan of correction. (i) Complete: (ii) Accurately documented; F 842 (iii) Readily accessible; and (iv) Systematically organized Resident #33 records reviewed for completion §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, and accuracy. regardless of the form or storage method of the records, except when release is-2. Resident's that requires (i) To the individual, or their resident neuro checks will have representative where permitted by applicable law; them completed. (ii) Required by Law: (iii) For treatment, payment, or health care operations, as permitted by and in compliance DON/Designee rewith 45 CFR 164.506; educated licensed (iv) For public health activities, reporting of abuse, nurses on completing neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, neuro checks. Audits on law enforcement purposes, organ donation neuro checks will be purposes, research purposes, or to coroners, completed for 4 weeks. medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted Audits will be reviewed by and in compliance with 45 CFR 164.512. in QAPI and any §483.70(i)(3) The facility must safeguard medical discrepancies will be record information against loss, destruction, or corrected immediately. unauthorized use. Re-education will be §483.70(i)(4) Medical records must be retained provided as needed. 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

Date of compliance is

March 23, 2023.

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2023 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED C 495168 B. WING 02/23/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3737 CATALPA AVE SHENANDOAH VALLEY HEALTH AND REHAB **BUENA VISTA, VA 24416**

PREFIX
TAG

(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

(X4) ID

(iii) For a minor, 3 years after a resident reaches legal age under State law.

SUMMARY STATEMENT OF DEFICIENCIES

§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:

Based on resident interview, staff interview, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one of 19 residents in the survey sample: Resident # 33.

Findings include:

Resident # 33 was admitted to the facility 2/20/20 with diagnoses to include, but were not limited to, end stage renal disease, heart disease, high blood pressure, and insomnia.

The most recent MDS (minimum set) was quarterly assessment dated 1/15/23. Resident # 33 was assessed as cognitively intact with a total summary score of 15/15.

On 2/21/23 beginning at approximately 3:00 p.m. during review of the clinical record, a nurses note dated 2/15/23 at 3:48 p.m. documented "Resident

F 842

PRINTED: 03/21/2023

	CENTERS FOR MEDICARE & MEDICAID SERVICES			FORM A OMB NO. (					
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		495168	B. WING	*	02/23/2023				
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  3737 CATALPA AVE  BUENA VISTA, VA 24416						
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION				
F 842	mistake. Medication urination) 10 mg, X Cipro (antibiotic) 5 Fluvoxamine (anticonvulsant) 20 pressure), Metform mg, Probiotic, and and neuro checks for one hour and the Then vital signs eveno issues after this vital signs as well a within normal limits situation."  On 2/22/23 at appr 33, who had just reasked about the income of the property of the	lication of another resident by on was Bethanechol (helps with anax (anti-anxiety) 0.5 mg, 00 mg, Iron 325 mg, depressant) 50 mg, Gabapentin 00 mg, Lisinopril (for high blood nin (lowers blood sugars) 500 Senna 8.6. NP was notified were ordered every 15 minutes are every hour for 4 hours. ery 4 hours x 3. Resident had a medication was given. His as neuro checks have all been be a sendent is aware of the sturned from dialysis, was cident. Resident # 33 stated, in my doorway and the nurse I and handed me a cup of the came back and said she ad gave me the wrong							
	They took my blood timesI was alri On 2/22/23 at appr facility's nurse practility's nurse practility should be stated, "I was	oximately 10:00 a.m. the titioner (NP) was interviewed, notified no more than 15							
	in-house. I went to patient's room and minutes after he go would not have had tired, fatigued, and take effect. The m Gabapentin; even t	pened. I was already talk to the nurse; went to saw him fact-to-face 30-45 of the medsany sooner I time for any effecthe was drowsy, so they had started to ain concern was Xanax and hough he isn't a diabetic t have a big impact on blood							

PRINTED: 03/21/2023

CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION	OMB NO. 0938-039* (X3) DATE SURVEY COMPLETED C
		495168	B. WING		02/23/2023
	PROVIDER OR SUPPLIER	ALTH AND REHAB		STREET ADDRESS, CITY, STATE, ZII 3737 CATALPA AVE BUENA VISTA, VA 24416	P CODE
(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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC)	ON SHOULD BE COMPLETION PATE
F 842	Continued From page 15 sugars so we did not check his blood sugars. I then gave the orders you see for the neuro checks and vital signs." The NP was asked if it was known where the documentation for the neuro checks and vital signs were, as the current MAR (medication administration record) and TAR (treatment administration record) included the orders, but there were no staff initials to document the checks and vitals were done. The NP reviewed the record and stated, "I don't know what was done on here; there's no documentation. Looks like there were 2 sets of vital signs done; there should have been 4there's nothing for the neuro checks"  On 2/22/23 at approximately 10:50 a.m., the nurse who administered the medications was contacted by phone. RN (registered nurse) # 1			42	
	but he wasn't read in the medication on another resider middle of that (nan the med cart for hi from the cart and s just gotten back fro take his blood pres back, so I took his pills I thought was his initials on the cone. I immediately we did a medicatio was asked where t signs were, as wel stated "We did the	gotten his medications ready, by to take them so I put the cup cart drawer. I started working at's medications, and in the one of Resident # 33) came to see to meds. I got the cup of pills set it on top of the cart. He had am dialysis, and we always soure and vitals when he gets vitals, picked up the cup of his, and gave them. I even had up but still picked up the wrong on tified the unit manager, and in incident form" RN # 1 he documentation for the vital as the neuro checks. She vital signs and neuro checks; turned in to the unit			

manager...."

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/21/2023 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER. (X3) DATE SURVEY A BUILDING COMPLETED 495168 B WING NAME OF PROVIDER OR SUPPLIER 02/23/2023 STREET ADDRESS, CITY, STATE, ZIP CODE SHENANDOAH VALLEY HEALTH AND REHAB 3737 CATALPA AVE **BUENA VISTA, VA 24416** (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID (X5) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 842 Continued From page 16 F 842 On 2/22/23 at approximately 11:15 a.m., the DON, administrator, unit manager, and regional nurse were interviewed about the incident. The unit manager, LPN (licensed practical nurse) # 2 was asked about the documentation for the vital signs and neuro checks that was turned in to her. LPN #2 stated she did not receive the documentation. The DON (director of nursing) added, "[name of RN # 1] says she did the neuro checks, but we don't have anything that substantiates they were done.....that includes the vital signs." On 2/23/23 beginning at approximately 12:50 p.m., the administrator, DON, LPN # 2, and To remain in compliance with all regional nurse were informed of the above federal and state regulations, the findings. center has taken or will take the actions set forth in the following No further information was provided prior to the plan of correction. exit conference. F 847 Entering into Binding Arbitration Agreements F 847 SS=F CFR(s): 483.70(n)(2)(i)(ii)(3)-(5) F 847 Resident #43 received §483.70(n) Binding Arbitration Agreements If a facility chooses to ask a resident or his or her an updated Arbitration representative to enter into an agreement for Agreement. binding arbitration, the facility must comply with all of the requirements in this section. 2. Residents admitted after October 24, 2022 §483.70(n)(1) The facility must not require any resident or his or her representative to sign an received new arbitration agreement for binding arbitration as a condition of

admission to, or as a requirement to continue to

inform the resident or his or her representative of his or her right not to sign the agreement as a condition of admission to, or as a requirement to

receive care at, the facility and must explicitly

continue to receive care at, the facility.

agreements and were

days.

granted extension of 30

# DEPARTMENT OF HEALTH AN

SIALEMEN	IT OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUII	TIPI I	E CONSTRI	LICTION		. 0938-03
TINDICAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDI	ING _	L CONSTRI		(X3) DAT	E SURVEY MPLETED
NAME OF	DDOWNER	495168	B WING				C	
	PROVIDER OR SUPPLIER			ST	TREET ADD	RESS, CITY, STATE, ZIP CODE	1 02/	23/2023
	NDOAH VALLEY HEAL			37	37 CATAL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		F (EA	PROVIDER'S PLAN OF CORRECTIO CH CORRECTIVE ACTION SHOULD SS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 847	Continued From pa	ge 17	F 84	47	3.	Senior Vice President of		
	§483.70(n)(2) The f	acility must ensure that:				Business Development		
	(I) The agreement is explained to the resident and					re-educated the		
6	his or her represent	ative in a form and manner				Administrator and		
	language the reside	rstands, including in a				Director of Admissions		
	representative unde	rstands:				and Marketing.		
	(ii) The resident or h	(ii) The resident or his or her representative				Residents admitted after		
	acknowledges that he or she understands the agreement;					February 27, 2023		
	agreement;					received updated		
	§483.70(n)(3) The a	greement must explicitly				arbitration agreements.		
	grant the resident or his or her representative the					New admissions will be		
	right to rescind the a	escind the agreement within 30 calendar				audited weekly to		
	days of signing it.					ensure updated		
	§483.70(n) (4) The a	greement must explicitly				arbitration agreement		
	representative is req	resident nor his or her uired to sign an agreement				completed.		
	for binding arbitration	as a condition of admission			4.	Audits will be reviewed		
	at, the facility.	ent to continue to receive care				in QAPI and any		
	E- VESCHILL ON					discrepancies will be		
	§483.70(n) (5) The a	greement may not contain			(	corrected immediately.		
	any language that pro	ohibits or discourages the			f	Re-education will be		
1	rederal, state, or loca	lse from communicating with all officials, including but not distate surveyors, other			t	provided as needed.		
1	rederal or state health	h department employees				Date of compliance is		
	and representative of Long-Term Care Oml	f the Office of the State budsman, in accordance			N	March 23, 2023.		
- 1	oy:	is not met as evidenced						
r t	Based on staff interview, the facility sta imeframe was in place	iew and facility document  ff failed to ensure the proper ce to rescind a binding for residents in the facility.						

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CENTE	RS FOR MEDICAR	E & MEDICAID SERVICES	FORM APPI OMB NO. 093				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	E CONSTRUCTION	(X3) DA	ATE SURVEY OMPLETED	
		495168	B. WING		0:	2/23/2023	
24.50.50	PROVIDER OR SUPPLIEF		37	REET ADDRESS, CITY, STATE, ZIP C 37 CATALPA AVE UENA VISTA, VA 24416			
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 847	approximately 1:00 asked if residents asked to enter into agreement with th A copy of the facilit requested.  On 02/23/2023 at "VOLUNTARY AR PROGRAM GUID contained the follo ARBITRATION PRAGREEMENT and late have ten (10) busi execution of the Agand void the Agreement and the following that the following: "Right to following: "Right to	ce conference on 02/21/2023 at 0 p.m., the administrator was or his/her representatives were of a binding arbitration of facility. She responded, "Yes." ty arbitration agreement was approximately 9:45 a.m., the BITRATION AGREEMENT E" was reviewed and wing process listed under ROCEDURES: "If you sign the ter change your mind, you will ness days from the date of greement to completely cancel ement."	F 847				
	this agreement up. Agreement may be sent to the Facility return receipt requidays of the date is. On the last page of signature page with the by the resident Resident is aware. Agreement at any days of the date of the administrator at approximately 1	on it being fully executed. This e canceled via a written notice administrator by certified mail, ested, within ten (10) business is executed by the Resident." If the Agreement was a h four bullets to be checked off. The fourth bullet was: "The that he/she may rescind this time within ten (10) business					

# DEPARTMENT OF HE

CENTE	ERS FOR MEDICAR	H AND HUMAN SERVICES RE & MEDICAID SERVICES			FOR	D: 03/21/20 M APPROV	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDIN	IPLE CONSTRUCTION NG	(X3) D/	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
	495168		B WING		С		
NAME OF	PROVIDER OR SUPPLIER	₹		STREET ADDRESS, CITY, STATE, ZIP (	0:	2/23/2023	
SHENA	NDOAH VALLEY HEA	ALTH AND REHAB		3737 CATALPA AVE BUENA VISTA, VA 24416	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	I SHOULD BE	(X5) COMPLETION DATE	
F 847	Continued From p	age 19	F 64				
	to rescind their dea	cision to enter the agreement	F 84				
	She stated she would look into it.			To remain in compliance w	vith all		
	At annual			federal and state regulation			
	stated "We will be	1:00 a.m., the administrator		center has taken or will tal			
	Arbitration Agreem	making changes to the ent about the timeframe for the		actions set forth in the foll			
	residents to rescine	d their decision."		plan of correction.	<u>B</u>		
	No further informat	ion was obtained prior to the					
F 880	exit conference on Infection Prevention	02/23/2023.					
SS=D	CFR(s): 483.80(a)(	1)(2)(4)(e)(f)	F 880	) F 880			
	§483.80 Infection C			<ol> <li>Licensed nurses re</li> </ol>	=0		
	The facility must es	tablish and maintain an		educated on hand			
	infection prevention	and control program		washing technique	es .		
	designed to provide	a safe, sanitary and		during medication	pass		
	comfortable enviror	iment and to help prevent the		observation with			
	diseases and infect	ansmission of communicable ions.		residents 9, 35, an	d 67.		
	§483.80(a) Infection	prevention and control		2. Licensed nurses wi	il		
	program.			demonstrate			
	The facility must est	tablish an infection prevention		handwashing durir	ng		
9	and control program a minimum, the follo	(IPCP) that must include, at		medication pass			
				observations.			
1 5 1 6	reporting, investigati and communicable o staff, volunteers, visi providing services un arrangement based	upon the facility assessment					

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include,

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	OF DEFICIENCIES	RE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	[ (VO) 1444		OMB NO. 0938-039
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
		495168	B WING		C 02/23/2023
NAME OF I	PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE	ZIP CODE
SHENAN	DOAH VALLEY HEA	ALTH AND REHAB		3737 CATALPA AVE BUENA VISTA, VA 24416	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 880	Continued From p	page 20	E 00	20	
	but are not limited to: (i) A system of surveillance designed to identify		F 88	<ol> <li>3. DON/designee re</li> </ol>	man I be the state of the state
				educated license	
	possible commun	icable diseases or		nurses on handw	ashing
	infections before they can spread to other			during medicatio	
	persons in the fac			administration. A	
	(ii) When and to whom possible incidents of communicable disease or infections should be			will be completed	
	reported;			observe for	
	(iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a			handwashing	
				compliance durin	3
	resident; including but not limited to:			medication	Significação metro copreguente do como de la
	<ul> <li>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</li> <li>(B) A requirement that the isolation should be the</li> </ul>			administration fo	4
				weeks.	
				4. Audits will be revi	awad
	least restrictive possible for the resident under the circumstances.  (v) The circumstances under which the facility must prohibit employees with a communicable			in QAPI and any	eweg
				discrepancies will	he
				corrected immedi	
	disease or infected	skin lesions from direct		Re-education will	
	contact with reside	ents or their food, if direct ait the disease; and		provided as neede	
	(vi)The hand hygie	ene procedures to be followed		provided as neede	. III AUGUSTO
	by staff involved in	direct resident contact.		5. Date of compliance	a is
				March 23, 2023.	
	§483.80(a)(4) A sy identified under the	stem for recording incidents a facility's IPCP and the			
	corrective actions	taken by the facility.			
	§483.80(e) Linens.				
	Personnel must handle, store, process, and				
	transport linens so infection.	as to prevent the spread of			
	§483.80(f) Annual	review			
	The facility will con	duct an annual review of its heir program, as necessary.			

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STATEMENT	OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIPLE CONSTRUCTION		OMB NO. 0938-039	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		COMF	(X3) DATE SURVEY COMPLETED	
					,		
		495168	B. WING		1	23/2023	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z			
SHENAN	DOAH VALLEY HEA	LTH AND REHAR		3737 CATALPA AVE			
				BUENA VISTA, VA 24416			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 880	Continued From pa	age 21	F 8	20			
		INT is not met as evidenced	ГО	50			
	by:	is not met as evidenced					
		ation pass and pour					
	observation, staff i	nterview, and facility document					
	review, the facility:	staff failed to ensure infection					
	control practices d	uring the administration of					
	medications.						
	Findings include:						
	mango molace.						
	On 02/22/23 at 8:2	9 AM, a medication pass and					
069	pour observation was conducted with LPN						
	(Licensed Practica	l Nurse) #1.					
	The LPN did not w	ash or sanitize her hands prior					
	to preparing medic	ations for Resident #67. The					
	LPN prepared and	administered the medications					
	to Resident #67, le	ft the resident's room and					
	immediately began	to prepare Resident #35. The					
	LPN did not wash a	and/or sanitize her hands					
	before proceeding	to the next resident.					
	LPN #1 prepared F	Resident #35's medications and					
	administered the m	redications to the resident.					
- 2	LPN #1 left the res	ident's room, did not wash					
	and/or sanitizer her	r hands and immediately					
	began to prepare n	nedications for Resident #9.					
	LPN #1 prepared a	and administered medications					
	to Resident #9, exit	ted the room and then					
	retrieved the hand	sanitizer on the medication					
	cart to cleanse her						
	At this time (0.52 A	M) 1 DN #4					
	that she did not sar	M), LPN #1 was made aware nitize her hands at all between					
	the residents' obse	rved for the medication pass					
	and pour observation	on (as described above). LPN					
	#1 stated. "I just rea	alized that." The LPN					

sanitized her hands at that time.

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/21/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT	F DEFICIENCIES	TOWN PROVIDED WITH THE PROVIDED			OMB NO. 0938-039	
AND PLAN OF	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495168	(X2) MULT A. BUILDIN B. WING	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  SHENANDOAH VALLEY HEALTH AND REHAB			STREET ADDRESS, CITY, STATE, ZIP CO 3737 CATALPA AVE BUENA VISTA, VA 24416		02/23/2023 DDE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	SHOULD BE COMPLETION	

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On 02/22/23 at 11:13 AM, the nurse consultant, the DON (director of nursing) and the administrator were made aware of the above information in a meeting with the survey team. The facility staff were asked for a policy on handwashing practices.

The policy presented titled, "Medication Administration General Guidelines" documented, "...Hands are washed with soap and water again after administration and with any resident contact...anti-microbial sanitizer may be used in place of soap and water as allowed by state nursing regulations and facility policy..."

The policy presented titled, "Policies and Procedures Handwashing Technique" documented, "All personnel will wash hands before beginning the treatment/care of a resident and upon completion of such tasks, to prevent the spread of nosocomial infections..."

No further information and/or documentation was presented prior to the exit conference on 02/23/23 at 1:30 PM.