STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495046	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 03/18/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAKWOOD HEALTH AND REHAB CENTER	**1613 OAKWOOD STREET , BEDFORD, Virginia, 24523**

(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
F0000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard (complaint) survey was conducted 3/17/26 through 3/18/26. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey. Complaint 268584 was unsubstantiated with a related deficiency cited. Complaint 2733994 was unsubstantiated with a related deficiency cited. The census in this 111 certified bed facility was 109 at the time of the survey. The survey sample consisted of six resident reviews.	F0000		04/10/2026
F0610 SS = D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §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 observation, staff interview, clinical record	F0610	Corrective Actions: The staff who were present for Resident #1 incident on 2/11/2025 no longer work at Oakwood Health and Rehab. The facility will attempt to re-interview all staff associated with resident #1 elopement and present findings in writing. Identification of Deficient Practice(s) and corrective action (s): All residents have the potential to be affected. The facility will conduct a 100% audit of all facility reported incidents for the last 6 months to ensure witness statements were obtained. All discrepancies will be corrected at the time of the findings. Systemic Change (s): The DON and or designee will conduct 100% of all staff in-servicing on facility policies related to elopement/missing person and accidents and incidents -investigating and reporting. All new hires will be educated on elopement policies and policies related to	04/10/2026

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 reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F0610 SS = D	Continued from page 1 review and facility documentation review, the facility staff failed to complete a thorough investigation of an alleged violation (resident elopement) for one of six residents in the survey sample (Resident #1). The findings include: On 3/17/2026 a review of Resident #1 clinical record was conducted. Resident #1 had a diagnosis of Dementia and the Minimum Data Set (MDS), dated 1/13/2025, assessed Resident #1 with severely impaired cognition. A facility incident form dated 2/11/2025 documented staff witnessed Resident #1 go out the exit door on the evening of 2/11/2025. Staff spreading salt on the sidewalks observed Resident #1 going down the ramp and advised staff in the parking lot. The resident was assisted by staff back into the building and was assessed by nursing with no injuries. The facility's investigation dated 2/19/2025 documented the door alarm was sounding as the resident exited the building and the resident had on a functional wander prevention device at the time of the incident. Review of the facility's investigation of the elopement incident revealed there were no documented witness statement or documented interviews from staff that witnessed or were working at the time of the incident. The investigation included an initial report of the incident and a summary of the investigation findings. On 3/17/2026 at 1:55 PM the administration was interviewed about the investigation of the elopement incident for Resident #1. The Administrator stated that the facility investigation did not include staff member names that witnessed or were working at the time of the incident and that no written statements or interviews were obtained. No statements from staff or other witnesses were documented. The Administrator stated that shortly after Resident #1 was back inside, a phone interview was conducted with the maintenance staff member about the incident. On 3/18/2026 at 9:20 AM the Administrator presented facility policies titled, "Elopement/Missing Person" and "Accidents and Incidents – Investigating and Reporting". The "Accidents and Incidents – Investigating and Reporting" policy described specific procedures and guidance that is to be included on the	F0610	Continued from page 1 conducting investigations. All agency staff will complete the education through their education portal prior to working a shift at Oakwood Health and Rehabilitation Center. Monitoring: The Administrator and or designee will audit all reportable events 5x/week for 12 weeks to ensure investigation process for each step is complete. The Administrator and or designee will present these audits to be discussed in the monthly QAPI meetings for further recommendations as indicated. The facility will be back in compliance by April 10th 2026.	

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F0610 SS = D	Continued from page 2 Report of Incident/Accident Form. The procedures listed included obtaining the names of witnesses and their accounts of the incident. These findings were reviewed with the administrator and director of nursing on 3/18/26 at 1:00 p.m. with no further information provided.	F0610		
F0842 SS = D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(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(h) Medical records. §483.70(h)(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(h)(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; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;	F0842	Corrective Action(s): The facility will upload the missing documentation of the NP visits from resident #2. Identification of Deficient Practice(s) and Corrective Action(s): The DON and or designees will audit all current residents for the past 6 months to ensure all medical records match the medical provider documentation from their platform to ensure no other residents are missing notes. Any discrepancies will be addressed and uploaded to correct medical record discovery. Systemic Change(s): The DON or designee will educate all providers and medical records on the medical record policy with emphasis on timely notes and uploading in PCC. Monitoring: The DON and/or designee will audit all provider visited weekly for x4 weeks then monthly x 2 months to ensure accurate and timely provider notes being entered into the electronic medical record. Any discrepancies will be addressed immediately with the provider. DON and/or designee will discuss these audits at QAPI meeting monthly x 3 for further recommendations. The facility will be back in compliance by April 10th 2026.	04/10/2026

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F0842 SS = D	Continued from page 3 (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(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(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(h)(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 staff interview and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for one of six residents in the survey sample (Resident #2). The findings include:	F0842		

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F0842 SS = D	Continued from page 4 Resident #2's closed clinical record did not include two physician progress notes and documented an inaccurate date/time on the resident's discharge summary. Resident #2 (R2) was admitted to the facility with diagnoses that included severe COPD (chronic obstructive pulmonary disease), anemia, non-infectious systemic inflammatory response syndrome, hypomagnesemia, chronic pain, lung nodule, acute and chronic respiratory failure, osteoporosis, emphysema, history of thyrotoxicosis, non-ischemic myocardial injury, anxiety and hypothyroidism. The minimum data set (MDS) dated 6/17/25 assessed R2 as cognitively intact. On 3/17/25 at 3:45 p.m., the nurse practitioner (NP) was interviewed about assessment of R2. The NP stated that he assessed the resident several times during her stay. Review of R2's clinical record revealed one NP progress note on 7/3/25. The clinical record documented R2's discharge summary, describing an emergent transfer to the emergency department, was documented with date/time of 7/8/25 at 1:43 p.m. R2's change in condition and transfer from the facility was listed as 7/8/25 at 10:45 p.m. On 3/18/26 at 9:00 a.m., the director of nursing (DON), regional nurse consultant and administrator were interviewed about R2's clinical record. The DON presented two NP progress notes dated 6/20/25 and 6/30/25 that had not been scanned/uploaded to R2's clinical record. The administrator stated the facility started with new providers in June 2025 and transitioned to a new document system. The administrator stated the NP progress notes dated 6/20/25 and 6/30/25 had not been scanned and uploaded to R2's clinical record. The administrator stated that staff had not realized that the progress notes had not been uploaded to the record. On 3/18/26 at 1:05 p.m., the regional nurse consultant stated the discharge summary on 7/8/25 listed the wrong time. The regional nurse consultant stated the resident was transferred to the hospital on 7/8/25 at 10:45 p.m. The regional nurse consultant stated nursing had documented a note with the incorrect time previously that day and then made a note regarding the correction. The regional nurse consultant stated the NP's note had the incorrect time based upon the nursing note and that the NP did not go back and correct the error. The regional nurse consultant stated the discharge summary date/time should have been corrected or an addendum	F0842		

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F0842 SS = D	Continued from page 5 note made indicating the error. This finding was reviewed with the administrator, DON and regional nurse consultant on 3/18/25 at 1:00 p.m. with no further information provided prior to the end of the survey.	F0842		