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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Health and Rehab Center	1613 Oakwood Street Bedford, VA 24523

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record 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 [DATE], 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 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.

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.

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

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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oakwood Health and Rehab Center	1613 Oakwood Street Bedford, VA 24523

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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: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 [DATE] 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 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.