STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495168	A. Building B. Wing	01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shenandoah Valley Health and Rehab	3737 Catalpa Ave Buena Vista, VA 24416

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of care regarding medication orders for one of eight residents in the survey sample (Resident #1). The findings include: Facility staff failed to clarify and enter updated admission orders for Resident #1, resulting in medications, that were recommended by the hospital to be discontinued, being ordered and administered to the resident. Resident #1 (R1) was admitted to the facility with diagnoses that included atrial fibrillation, retroperitoneal hematoma, renal hemorrhage, acute blood loss anemia, pleural effusion, hypertension, clostridium difficile (C-diff), acute kidney failure, sepsis, pneumonia, pyelonephritis with renal abscess, protein-calorie malnutrition, breast cancer and alcohol abuse. The minimum data set (MDS) dated [DATE] assessed R1 with moderately impaired cognitive skills. R1's clinical record documented a hospital discharge summary/order sheet dated 9/19/24 listing medication orders after R1's hospital stay from 9/16/24 to 9/19/24. This discharge summary/order sheet documented that R1 was to continue taking the medications apixaban (Eliquis) 5 mg (milligrams) twice per day, diltiazem 180 mg each day, lisinopril 10 mg each day, and enteric-coated aspirin 81 mg each day. R1 was admitted to the nursing facility on 11/7/24 following a hospital stay from 10/11/24 through 11/7/24. Medication orders entered upon R1's admission and signed by the physician on 11/12/24 included apixaban (Eliquis) 5 mg (milligrams) twice per day, diltiazem 180 mg each day, lisinopril 10 mg each day, enteric-coated aspirin 81 mg each day, which was also listed on the 9/19/24 hospital discharge summary. An additional order for Zosyn 4.5 grams intravenously (IV) every 8 hours for six days was entered at that time, which was not included on the 9/19/24 hospital discharge summary. R1's clinical record documented a nursing note dated 11/7/24 stating, .Resident arrived with discharge summary which did not list any IV medications. Called and spoke with discharging nurse who explained medication list for discharge had been updated. MD [hospitalist] with was [was with] nurse while speaking with this nurse on the phone. Faxed over a new list of medications and was told by MD [hospitalist] to use that med list for d/c [discharge] . (continued on next page)

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: 495168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shenandoah Valley Health and Rehab	3737 Catalpa Ave Buena Vista, VA 24416

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's clinical record documented the updated hospital discharge summary/order sheet dated 11/7/24, referencing a hospital stay from 10/11/24 to 11/7/24. The 11/7/24 discharge/order sheet had a note written by licensed practical nurse (LPN) #1 stating, Updated list that was faxed for facility to use per MD for discharge and was signed by LPN #1 on 11/8/24. This discharge order summary documented that R1 was to stop taking apixaban, aspirin, diltiazem, and lisinopril, as well as including an order for the antibiotic Zosyn 4. 5 grams intravenously every 8 hours for six days. R1's clinical record documented an Admission Checklist dated 11/7/24. LPN #1 had checked that all orders had been verified by a second nurse (unit manager). R1's admission orders entered on 11/7/24 were not clarified and/or reconciled based upon the discharge summary/order sheet dated 11/7/24 but were entered from an outdated discharge instruction sheet from the previous hospital stay ending on 9/19/24. The order for the Zosyn was entered on 11/7/24 as listed on the updated order sheet but the orders for the apixaban, aspirin, diltiazem, and lisinopril remained active and were not discontinued. R1's medication administration record (MAR) documented the apixaban aspirin, diltiazem, and lisinopril were administered from 11/8/24 through 11/19/24 per the entered orders. The diltiazem, lisinopril and apixaban were discontinued on 11/19/24. The Zosyn was administered from 11/8/24 through 11/14/24 as ordered. A new order was entered on 11/14/24 to continue the Zosyn with administration documented through 11/19/24. R1's clinical record documented daily skilled nursing notes, and assessment by the physician and/or nurse practitioner (NP) on 11/11/24, 11/12/24, 11/14/24, /11/18/24 and 11/19/24, noting that R1 was assessed with no signs of bleeding or shortness of breath. The NP assessed R1 on 11/18/24 for low blood pressure of 82/50. R1 was ordered and administered a dose of midodrine 5 mg for low blood pressure and parameters were ordered to hold the medications lisinopril and diltiazem, if systolic blood pressure was less than 100. The NP documented a conversation with R1 on 11/19/24 about her medications. A physician's order was entered on 11/19/24 to discontinue the apixaban, diltiazem, and lisinopril and to monitor the resident's blood pressure twice per day for two weeks. On 11/19/24, R1 was assessed with a non-functioning PICC line, with arm swelling, low blood pressure, and was sent to the emergency room via 911 for evaluation and treatment. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/21/25 at 2:00 p.m., the administrator and the director of nursing (RN #2) during R1's stay were interviewed about R1's conflicting admission orders and resulting medication errors. The administrator stated R1 arrived for admission on 11/7/24 with a discharge summary/order sheet dated 9/19/24. The administrator stated LPN #1 saw that R1 had a PICC (peripherally inserted central catheter) upon admission but no orders for intravenous (IV) medications. The administrator stated LPN #1 called the hospital and was provided an updated order summary and medicine list dated 11/7/24. The administrator stated the unit manager (LPN #1) entered the order for the IV medication and failed to reconcile the other orders to discontinue the apixaban, aspirin, diltiazem and lisinopril. RN #2 stated, [LPN #1] focused on the antibiotic order and did not pay attention to the discontinued meds [medicines]. The administrator stated the updated admission order list was not uploaded into the clinical record for view by providers. The administrator stated the nurse should have reviewed all the medicines on the updated list, compared it to what was entered, made corrections to what had already been entered, and provided this updated list to providers. The administrator stated that this error was not discovered until a family member questioned R1's medication orders on 11/18/24. RN #2 stated that the nurse admitting a resident was expected to enter admission orders into the electronic health record. RN #2 stated a unit manager or director of nursing was supposed to perform a review and check of all orders within 24 hours. RN #2 stated RN #1 entered the original orders for R1 on 11/7/24 and LPN #1 was supposed to review/verify the orders for accuracy. RN #2 stated LPN #1 failed to thoroughly review/correct the updated admission orders for R1. On 1/21/25 at 3:30 p.m., the admissions director (other staff #2) was interviewed about R1's admission orders. The admissions director stated the hospital usually uploaded a discharge summary and admission orders in the electronic health care portal prior to admission. The admissions director stated upon R1's admission, the hospital had uploaded an outdated admission order list dated 9/19/24. The admissions director stated she did not notice that the discharge summary did not match the current admitted . On 1/21/25 at 4:32 p.m., RN #1 that admitted R1 on 11/7/24 was interviewed. RN #1 stated the admissions director had provided the chart and discharge summary with admission orders for R1. RN #1 stated she did not recognize that the discharge orders were outdated and from a previous hospitalization . RN #1 stated she entered the medicine orders as listed on the original discharge summary (dated 9/19/24) and the unit manager (LPN #1) was supposed to review them. RN #1 stated LPN #1 called the hospital about an order for the IV antibiotic and entered the order for the IV Zosyn. RN #1 stated she had not been aware of the updated admission orders for the other medicines. (continued on next page)

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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/25 at 8:20 a.m., the physician/medical director (other staff #5) was interviewed about R1's conflicting admission orders. The physician stated he was aware prior to admission that R1 had a history of gastrointestinal bleeding. The physician stated that when he reviewed and signed the admission orders on 11/12/24 which included orders for apixaban, aspirin, diltiazem, and lisinopril, he was not aware that the discharge summary/history uploaded in the health record was outdated. The physician stated he and the nurse practitioner would typically but not always follow recommended medicine orders from the hospitalist. The physician stated R1 had chronic atrial fibrillation and even with a hemorrhage history, there was a risk of stroke/blood clots if the apixaban was discontinued. The physician stated he approved the orders based upon the available discharge summary (dated 9/19/24). The physician stated he was not aware of an updated list of admission orders that had been obtained by LPN #1 that indicated discontinued use of these medicines. The physician stated if he had reviewed the discharge summary and orders dated 11/7/24, he would have most likely discontinued the medicines as recommended by the hospitalist. The physician stated R1 had labs, was routinely assessed/monitored, and had developed no signs of bleeding. The physician stated R1 had the IV antibiotic Zosyn extended for continued treatment of the kidney abscess, in addition to an antibiotic for additional treatment for C-diff. The physician stated when the discrepancy was identified on 11/19/24, the apixaban, diltiazem, and lisinopril were discontinued. The physician stated R1 was discharged to the emergency roiagnom on [DATE] due to a migrated, non-functioning PICC line. The physician stated facility staff should have noticed the 9/19/24 date on the admission orders. The physician stated the outdated admission orders were not caught by staff and the updated list was not implemented. The physician stated facility staff should have had the most recent orders and discharge information for R1 so that medication recommendations could have been followed. On 1/22/5 at 10:07 a.m., LPN #1 that was the unit manager at the time of R1's admission on 11/7/24 was interviewed. LPN #1 stated on 11/7/24, RN #1 had entered the admission orders based upon the orders that came with the resident and that were uploaded in the electronic health record. LPN #1 stated she nor RN #1 noted that the orders were not current (dated 9/19/24). LPN #1 stated when she assisted with R1's skin assessment, she noted the resident had a PICC in the right arm. LPN #1 stated the admission orders she had included no order for IV antibiotics, so she called the hospital for clarification. LPN #1 stated the hospital nurse verified with the hospitalist that the IV Zosyn was to continue, and the hospital nurse faxed a new list of admission orders dated 11/7/24. LPN #1 stated she focused only on the order for the Zosyn and did not reconcile/review the other medication orders listed. LPN #1 stated it was her error as she was the unit manager and was supposed to perform the second check/verification of the admission orders. LPN #1 stated the apixaban, aspirin, diltiazem and lisinopril should have been discontinued upon admission according to the 11/7/24 admission orders. LPN #1 stated she thought she put the updated order list in the communicate book for the providers. LPN #1 stated, This was a very sloppy admission. LPN #1 stated that R1 . came with the wrong orders from the hospital and staff did not pay attention to the dates on the orders. LPN #1 stated, I did the chart check. When I did the check, I did not catch the errors. Apparently, I did not check them all [orders]. LPN #1 stated the apixaban, aspirin, diltiazem and lisinopril should have not been ordered and that she should have reconciled all the orders on the updated list, not just the IV antibiotic. The nurse practitioner (other staff #1) that cared for R1 during her stay was not available for interview as she no longer worked at the facility. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Medication Administration General Guidelines (dated 1/2023) documented, . Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles .Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate . The facility's Admission Checklist (undated) documented, .Place a check mark beside each task after completion. Leave the checklist in the Nurse notebook. All items MUST be complete . Checklist items for admission included, .Medication Orders entered in PCC [Point Click Care] per Hospital/another SNF Discharge Summary ONLY DO NOT USE PRINTED eMAR's .Orders are to be verified by a second Nurse . The Nursing 2022 Drug Handbook documents on page 1588 regarding unclear orders, A drug order with incomplete or unclear information can result in giving the wrong drug or wrong dose, by the wrong route, or at the wrong time .Clarify all incomplete or unclear orders with the prescriber . (1) On 1/22/25 at 2:40 p.m., the administrator stated the errors related to R1's outdated admission orders were reviewed by their quality assurance committee when identified on 11/19/24. The administrator presented a plan of correction to address failure to review/clarify admission orders that resulted in orders entered for medications (apixaban, aspirin, diltiazem and lisinopril) that should not have been entered. The plan documented that current residents and any new admissions had the potential to be affected by the deficient practice. Interventions implemented starting on 11/19/24 and included the following, with a correction date listed as 1/17/25. -DON notified nurse practitioner (NP) of discrepancies regarding discharge summaries. NP discontinued R1's apixaban, diltiazem and lisinopril. The DON documented a medication error report. - LPN #1 was re-educated on verifying orders, reconciliation with the discharge summary/admission orders and uploading documentation into electronic health record. - Admissions director was re-educated on ensuring that the discharge date on the discharge summary/admission orders corresponded to the admitted for all admission and readmissions. - Initiated practice for all orders for new admissions/readmissions to be reviewed in the morning meeting by the clinical team with the discharge summary reviewed in the electronic health record. Education provided to all unit managers and all department heads regarding admission order review protocol. -Audit completed by DON and/or designee of all admissions from 11/7/24 through 1/9/25 ensuring that the discharge date on the summary corresponded to the admitted and all medication orders were reviewed for accuracy with no identified discrepancies. -Weekly audits on all new admissions/readmission conducted starting on 12/31/24 for four weeks verifying correct admission orders, discharge summaries and medication orders with results reported to the quality assurance committee for review. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Date of correction listed as 1/17/25. Actions taken were reviewed. Education was documented as listed in the correction plan. Audits listed for all new admissions and readmissions were documented and revealed accurate admission orders from the hospital and no discrepancies in medication orders. Weekly audits of all new admissions/readmission were documented for week ending 1/4/25, 1/11/25, and 1/18/25, with no identified discrepancies. Interviews with staff that included the administrator, DON, unit managers, admissions director, and physician/medical director revealed knowledge of the admissions order review protocol and verification of admission orders. Seven of the most recent new admissions were reviewed. Admission orders were accurate with properly dated discharge summaries and no discrepancies identified. This included a new admission since the correction date of 1/17/25, with no discrepancies identified with discharge summary, admission orders, or medication orders. This plan was accepted with correction date of 1/17/25. This deficiency was cited as past non-compliance. R1's emergency room records for 11/19/24 were requested but not received prior to the end of the survey. These findings were reviewed with the administrator and regional consultant during a meeting on 1/22/25 at 3:45 p.m. with no further information presented prior to the end of the survey. (1) Woods, [NAME] Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on staff interview, facility document review and clinical record review, the facility staff failed to ensure one of eight residents in the survey sample was free from significant medication errors (Resident #1). The findings include: Resident #1 was ordered and administered the medications apixaban, aspirin, diltiazem and lisinopril for eleven days after admission when updated admission orders recommended these medicines be discontinued. Resident #1 (R1) was admitted to the facility with diagnoses that included atrial fibrillation, retroperitoneal hematoma, renal hemorrhage, acute blood loss anemia, pleural effusion, hypertension, clostridium difficile (C-diff), acute kidney failure, sepsis, pneumonia, pyelonephritis with renal abscess, protein-calorie malnutrition, breast cancer and alcohol abuse. The minimum data set (MDS) dated [DATE] assessed R1 with moderately impaired cognitive skills. R1's clinical record documented a hospital discharge summary/order sheet dated 9/19/24 listing medication orders after R1's hospital stay from 9/16/24 to 9/19/24. This discharge summary/order sheet documented that R1 was to continue taking the medications apixaban (Eliquis) 5 mg (milligrams) twice per day, diltiazem 180 mg each day, lisinopril 10 mg each day, and enteric-coated aspirin 81 mg each day. R1 was admitted to the nursing facility on 11/7/24 following a hospital stay from 10/11/24 through 11/7/24. Medication orders entered upon R1's admission and signed by the physician on 11/12/24 included apixaban (Eliquis) 5 mg (milligrams) twice per day, diltiazem 180 mg each day, lisinopril 10 mg each day, enteric-coated aspirin 81 mg each day, which was also listed on the 9/19/24 hospital discharge summary. An additional order for Zosyn 4.5 grams intravenously (IV) every 8 hours for six days was entered at that time, which was not included on the 9/19/24 hospital discharge summary. R1's clinical record documented a nursing note dated 11/7/24 stating, .Resident arrived with discharge summary which did not list any IV medications. Called and spoke with discharging nurse who explained medication list for discharge had been updated. MD [hospitalist] with was [was with] nurse while speaking with this nurse on the phone. Faxed over a new list of medications and was told by MD [hospitalist] to use that med list for d/c [discharge] . R1's clinical record documented the updated hospital discharge summary/order sheet dated 11/7/24, referencing a hospital stay from 10/11/24 to 11/7/24. The 11/7/24 discharge/order sheet had a note written by licensed practical nurse (LPN) #1 stating, Updated list that was faxed for facility to use per MD for discharge and was signed by LPN #1 on 11/8/24. This discharge order summary documented that R1 was to stop taking apixaban, aspirin, diltiazem, and lisinopril, as well as including an order for the antibiotic Zosyn 4. 5 grams intravenously every 8 hours for six days. R1's clinical record documented an Admission Checklist dated 11/7/24. LPN #1 had checked that all orders had been verified by a second nurse (unit manager). (continued on next page)

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R1's admission orders entered on 11/7/24 were not clarified and/or reconciled based upon the discharge summary/order sheet dated 11/7/24 but were entered from an outdated discharge instruction sheet from the previous hospital stay ending on 9/19/24. The order for the Zosyn was entered on 11/7/24 as listed on the updated order sheet but the orders for the apixaban, aspirin, diltiazem, and lisinopril remained active and were not discontinued. R1's medication administration record (MAR) documented the apixaban aspirin, diltiazem, and lisinopril were administered from 11/8/24 through 11/19/24 per the entered orders. The diltiazem, lisinopril and apixaban were discontinued on 11/19/24. The Zosyn was administered from 11/8/24 through 11/14/24 as ordered. A new order was entered on 11/14/24 to continue the Zosyn with administration documented through 11/19/24. R1's clinical record documented daily skilled nursing notes, and assessment by the physician and/or nurse practitioner (NP) on 11/11/24, 11/12/24, 11/14/24, /11/18/24 and 11/19/24, noting that R1 was assessed with no signs of bleeding or shortness of breath. The NP assessed R1 on 11/18/24 for low blood pressure of 82/50. R1 was ordered and administered a dose of midodrine 5 mg for low blood pressure and parameters were ordered to hold the medications lisinopril and diltiazem, if systolic blood pressure was less than 100. The NP documented a conversation with R1 on 11/19/24 about her medications. A physician's order was entered on 11/19/24 to discontinue the apixaban, diltiazem, and lisinopril and to monitor the resident's blood pressure twice per day for two weeks. On 11/19/24, R1 was assessed with a non-functioning PICC line, with arm swelling, low blood pressure, and was sent to the emergency room via 911 for evaluation and treatment. On 1/21/25 at 2:00 p.m., the administrator and the director of nursing (RN #2) during R1's stay were interviewed about R1's conflicting admission orders and resulting medication errors. The administrator stated R1 arrived for admission on 11/7/24 with a discharge summary/order sheet dated 9/19/24. The administrator stated LPN #1 saw that R1 had a PICC (peripherally inserted central catheter) upon admission but no orders for intravenous (IV) medications. The administrator stated LPN #1 called the hospital and was provided an updated order summary and medicine list dated 11/7/24. The administrator stated the unit manager (LPN #1) entered the order for the IV medication and failed to reconcile the other orders to discontinue the apixaban, aspirin, diltiazem and lisinopril. RN #2 stated, [LPN #1] focused on the antibiotic order and did not pay attention to the discontinued meds [medicines]. The administrator stated the updated admission order list was not uploaded into the clinical record for view by providers. The administrator stated the nurse should have reviewed all the medicines on the updated list, compared to what was entered, made corrections to what had already been entered and provided this updated list to providers. The administrator stated this was not discovered until a family member questioned R1's medication orders on 11/18/24. RN #2 stated the nurse admitting a resident was expected to enter admission orders into the electronic health record. RN #2 stated a unit manager or director of nursing was supposed to perform a review and check of all orders within 24 hours. RN #2 stated RN #1 entered the original orders for R1 on 11/7/24 and LPN #1 was supposed to review/verify the orders for accuracy. RN #2 stated LPN #1 failed to thoroughly review/correct the updated admission orders for R1. On 1/21/25 at 3:30 p.m., the admissions director (other staff #2) was interviewed about R1's admission orders. The admissions director stated the hospital usually uploaded a discharge summary and admission orders in the electronic health care portal prior to admission. The admissions director stated upon R1's admission, the hospital had uploaded an outdated admission order list dated 9/19/24. The admissions director stated she did not notice that the discharge summary did not match the current admitted . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/21/25 at 4:32 p.m., RN #1 that admitted R1 on 11/7/24 was interviewed. RN #1 stated the admissions director had provided the chart and discharge summary with admission orders. RN #1 stated she did not recognize that the discharge orders were outdated and from a previous hospitalization . RN #1 stated she entered the medicine orders as listed on the original discharge summary (dated 9/19/24) and the unit manager (LPN #1) was supposed to review them. RN #1 stated LPN #1 called the hospital about an order for the IV antibiotic and entered the order for the IV Zosyn. RN #1 stated she was not aware of the updated admission orders for the other medicines. On 1/22/25 at 8:20 a.m., the physician/medical director (other staff #5) was interviewed about R1's conflicting admission orders. The physician stated he was aware prior to admission that R1 had a history of gastrointestinal bleeding. The physician stated when he reviewed and signed the admission orders on 11/12/24 that included orders for apixaban, aspirin, diltiazem, and lisinopril, he was not aware that the discharge summary/history uploaded in the health record was outdated. The physician stated he and the nurse practitioner would typically but not always follow recommended medicine orders from the hospitalist. The physician stated R1 had chronic atrial fibrillation and even with a hemorrhage history, there was a risk of stroke/blood clots if the apixaban was discontinued. The physician stated he approved the orders based upon the available discharge summary (dated 9/19/24). The physician stated he was not aware of an updated list of admission orders that had been obtained by LPN #1 that indicated discontinued use of these medicines. The physician stated if he had reviewed the discharge summary and orders dated 11/7/24, he would have most likely discontinued the medicines as recommended by the hospitalist. The physician stated R1 had labs and was routinely assessed/monitored. The physician stated R1 developed no signs of bleeding, had the IV antibiotic Zosyn extended for continued treatment of the kidney abscess in addition to an antibiotic for additional treatment for C-diff. The physician stated when the discrepancy was identified on 11/19/24, the apixaban, diltiazem and lisinopril were discontinued. The physician stated R1 was discharged to the emergency roiagnom on [DATE] due to a migrated, non-functioning PICC line. The physician stated facility staff should have noticed the 9/19/24 date on the admission orders. The physician stated the outdated admission orders were not caught by staff and the updated list was not implemented. The physician stated facility staff should have had the most recent orders and discharge information for R1 so that medication recommendations could have been followed. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Shenandoah Valley Health and Rehab	3737 Catalpa Ave Buena Vista, VA 24416

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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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 1/22/5 at 10:07 a.m., LPN #1 that was the unit manager at the time of R1's admission on 11/7/24 was interviewed. LPN #1 stated on 11/7/24, RN #1 had entered the admission orders based upon the orders that came with the resident and that were uploaded in the electronic health record. LPN #1 stated she nor RN #1 noted that the orders were not current (dated 9/19/24). LPN #1 stated when she assisted with the resident's skin assessment, she noted the resident had a PICC in the right arm. LPN #1 stated the admission orders she had included no order for IV antibiotics, so she called the hospital for clarification. LPN #1 stated the hospital nurse verified with the hospitalist that the IV Zosyn was to continue, and the hospital nurse faxed a new list of admission orders dated 11/7/24. LPN #1 stated she focused only on the order for the Zosyn and did not reconcile/review the other medication orders listed. LPN #1 stated it was her error as she was the unit manager and was supposed to perform the second check/verification of the admission orders. LPN #1 stated the apixaban, aspirin, diltiazem and lisinopril should have been discontinued upon admission according to the 11/7/24 admission orders. LPN #1 stated she thought she put the updated order list in the communicate book for the providers. LPN #1 stated, This was a very sloppy admission. LPN #1 stated R1 came with the wrong orders from the hospital and staff did not pay attention to the dates on the orders. LPN #1 stated, I did the chart check. When I did the check, I did not catch the errors. Apparently, I did not check them all [orders]. LPN #1 stated the apixaban, aspirin, diltiazem and lisinopril should have not been ordered and that she should have reconciled all the orders on the updated list, not just the IV antibiotic. The nurse practitioner (other staff #1) that cared for R1 during her stay was not available for interview as she no longer worked at the facility. The facility's policy titled Medication Administration General Guidelines (dated 1/2023) documented, . Medications are administered as prescribed in accordance with manufacturers' specifications, good nursing principles .Medications are administered in accordance with written orders of the prescriber. If a dose seems excessive considering the resident's age and condition, or a medication order seems to be unrelated to the resident's current diagnosis or condition, the nurse calls the provider pharmacy for clarification prior to the administration of the medication. If necessary, the nurse contacts the prescriber for clarification. This interaction with the pharmacy and the resulting order clarification are documented in the nursing notes and elsewhere in the medical record as appropriate . The facility's Admission Checklist (undated) documented, .Place a check mark beside each task after completion. Leave the checklist in the Nurse notebook. All items MUST be complete . Checklist items for admission included, .Medication Orders entered in PCC [Point Click Care] per Hospital/another SNF Discharge Summary ONLY DO NOT USE PRINTED eMAR's .Orders are to be verified by a second Nurse . The Nursing 2022 Drug Handbook documents on page 1588 regarding unclear orders, A drug order with incomplete or unclear information can result in giving the wrong drug or wrong dose, by the wrong route, or at the wrong time .Clarify all incomplete or unclear orders with the prescriber . (1) On 1/22/25 at 2:40 p.m., the administrator stated the errors related to R1's outdated admission orders were reviewed by their quality assurance committee when identified on 11/19/24. The administrator presented a plan of correction to address failure to review/clarify admission orders that resulted in orders entered for medications (apixaban, aspirin, diltiazem and lisinopril) that should not have been entered. The plan documented that current residents and any new admissions had the potential to be affected by the deficient practice. Interventions implemented starting on 11/19/24 included the following with a correction date listed as 1/17/25. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495168	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/23/2025
NAME OF PROVIDER OR SUPPLIER Shenandoah Valley Health and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 3737 Catalpa Ave Buena Vista, VA 24416	

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 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-DON notified nurse practitioner (NP) of discrepancies regarding discharge summaries. NP discontinued R1's apixaban, diltiazem and lisinopril. The DON documented a medication error report. - LPN #1 was re-educated on verifying orders, reconciliation with the discharge summary/admission orders and uploading documentation into electronic health record. - Admissions director was re-educated on ensuring that the discharge date on the discharge summary/admission orders corresponded to the admitted for all admission and readmissions. - Initiated practice for all orders for new admissions/readmissions to be reviewed in the morning meeting by the clinical team with the discharge summary reviewed in the electronic health record. Education provided to all unit managers and all department heads regarding admission order review protocol. -Audit completed by DON and/or designee of all admissions from 11/7/24 through 1/9/25 ensuring that the discharge date on the summary corresponded to the admitted and all medication orders were reviewed for accuracy with no identified discrepancies. -Weekly audits on all new admissions/readmission conducted starting on 12/31/24 for four weeks verifying correct admission orders, discharge summaries and medication orders with results reported to the quality assurance committee for review. -Date of correction listed as 1/17/25. Actions taken were reviewed. Education was documented a listed in the correction plan. Audits listed for all new admissions and readmissions were documented and revealed accurate admission orders from the hospital and no discrepancies in medication orders. Weekly audits of all new admissions/readmission were documented for week ending 1/4/25, 1/11/25 and 1/18/25 with no identified discrepancies. Interviews with staff that included the administrator, DON, unit managers, admissions director, and physician/medical director revealed knowledge of the admissions order review protocol and verification of admission orders. Seven of the most recent new admissions were reviewed. Admission orders were accurate with properly dated discharge summaries and no discrepancies identified. This included a new admission since the correction date of 1/17/25, with no discrepancies identified with discharge summary, admission orders, or medication orders. This plan was accepted with correction date of 1/17/25. This deficiency was cited as past non-compliance. R1's emergency room records for 11/19/24 were requested but not received prior to the end of the survey. These findings were reviewed with the administrator and regional consultant during a meeting on 1/22/25 at 3:45 p.m. with no further information presented prior to the end of the survey. (1) Woods, [NAME] Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.