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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 49E076 | (X2) MULTIPLE CONSTRUCTION A. Building B. Wing | (X3) DATE SURVEY COMPLETED 10/29/2025 |
| NAME OF PROVIDER OR SUPPLIER Snyder Nursing Home | | STREET ADDRESS, CITY, STATE, ZIP CODE 11 North Broad St Salem, VA 24153 | |

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

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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 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few | Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/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.

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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| <p>F 0627</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide a valid basis for a declination of readmission of the resident after a hospitalization with return anticipated and the facility staff failed to develop and implement an appropriate discharge process to the resident and/or resident representative for (1) one of (2) closed record reviews, Resident #45. The findings included:For Resident #45 the facility staff declined readmission following a hospital stay with a paid bed hold due to the resident electing hospice services. readmission was declined despite the facility offering individualized hospice service contracts. Resident #45's diagnosis list indicated diagnoses that included, but were not limited to, Multiple Sclerosis, Paraplegia, Osteoarthritis, Repeated Falls, Weakness, Depression, TIA (Transient Ischemic Attack), Cerebral Infarction, History of Disease of Digestive Tract, Anxiety Disorder, and Congestive Heart Failure. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/12/23, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the clinical record disclosed Resident #45 was discharged to the hospital on [DATE]. A review of a discharge MDS dated [DATE] was coded in Section A (Identification Information) A0310-F. as 11 (Discharge assessment-return anticipated). A communication fax from the hospital dated 12/18/23 contained a fax cover sheet with hand-written notes from the hospital case manager which read in part, .per our conversations the patient and the family wish to return with bipap and [name of hospice omitted].Please coordinate w/family & [hospice] regarding next steps in contract, expectations, etc. Hospital notes within the fax mentioned above read in part, .(page 5).Pending [nursing home name omitted] acceptance Monday, and organization of hospice contract by family and [nursing home].(page 9).Patient and family would like to pursue hospice.at discharge, and is currently awaiting acceptance back to.nursing home with plans for discharge 12/18 (2023).Would like to pursue hospice outpatient at discharge.Will discuss discharge planning with family.Per facility and CM (case manager), [nursing home] cannot accept patient pt (patient) till Monday .afternoon discussion with son. pt and CM.plan moving forward to include coordination between [nursing home] and [hospice] regarding responsibilities of hospice going forward. 12/20/23 12:30 PM.Nurse's Note.Son.in to pick up res's belongings. On 10/28/25 at 1:15 PM, surveyor interviewed the facility administrator and he informed surveyor that Resident #45 was not readmitted to the facility and informed surveyor the facility does not have a universal hospice contract and the facility does hospice contracts on an individual basis. The administrator agreed the resident had paid a bed hold. The administrator informed this surveyor the discharge planner at the hospital informed him the doctor had made the resident hospice and the resident had an order for hospice and that's when the issues started, as he did not have a hospice contract. Surveyor inquired why Resident #45 was not permitted to readmit back to the facility, as she had paid a bed hold and the administrator informed surveyor the resident could not readmit because she had an order for hospice. Surveyor inquired if a discharge notice was given after the resident was not permitted to readmit to the facility and the administrator informed surveyor a discharge notice was given when the resident was transferred to the hospital. This concern was discussed at the pre-exit meeting with the administrator and director of nursing on 10/29/25 at 10:35 AM. Surveyor requested and received a facility policy titled Discharge Planning which read in part, .Nursing Home will ensure that all residents receive appropriate discharge planning, preparation.upon discharge.At a minimum, documentation supporting the.discharge will include.The basis for the transfer.Specific needs that cannot be met. No further information was provided to the survey team prior to exit on 10/29/25.</p> | | |