STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snyder Nursing Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on staff interview, clinical record review and facility document review the facility staff failed to provide evidence that Advance Care planning information was provided to residents/resident representatives upon admission and reviewed periodically. The findings included:During clinical record reviews, each clinical record reviewed was found to contain a form entitled, Advance Directives/Medical Treatment Decisions Acknowledge of Receipt which read in part, Resident Understanding Acknowledgement-Advance Directive/Medical Treatment Decision. This is to acknowledge that I have been informed in writing in a language that I understand of my rights and all rules and regulations to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate and to issue advance directions to be followed should I become decisionally incapable. I understand it is my responsibility to provide to the facility copies of all pertinent documentation which verify advance directives formulated and/or issued by me for placement in my medical record. None of the forms reviewed were signed by the resident or their representative.Surveyors spoke with the director or nursing (DON) on 10/27/25 at 4:50 pm regarding advance care planning. DON stated that the Advance Directives/Medical Treatment Decisions Acknowledge of Receipt form located in each residents' clinical record is just a worksheet for me and when a resident is admitted to the facility, she goes over their code status with them. DON stated she does not have residents/representatives sign the form to acknowledge receipt of the information.Surveyor requested and was provided with a facility policy entitled Advance Directives (Self Determination Rights for Residents) which read in part, Purpose: To promote resident rights. Upon admission each resident will be advised of and given the opportunity to execute Advanced Directives if they so desire. Procedure: 1. Upon admission, the resident or resident's legal representative will be notified of their right to implement advance directive if he or she chooses to do so. 2. If the resident is incapacitated and unable to receive information about his or her right to formulate an advanced, the information may be provided to the resident's legal representative.The concern of the facility staff failing to provide evidence that advance care planning was provided to each resident/representative was discussed with the administrator and DON on 10/29/25 at 11:00 am.No further information was provided prior to exit.

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
	49E076	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snyder Nursing Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interviews, clinical record reviews, and facility document review, the facility staff failed to develop comprehensive care plans that included the residents code status for all current residents of the facility.The findings included:During the clinical record reviews, the survey team was unable to identify any information regarding the resident's current code status on the comprehensive care plans.On 10/27/2025 at 5:10 p.m., during an interview with Registered Nurse (RN) #2 this staff stated they did not include the residents code status on their comprehensive care plan. On 10/28/2025 at 8:20 a.m., RN #2 approached the surveyor, and stated she had updated the residents care plans to include their current code status. On 10/28/25 at 2:30 p.m., during a meeting with the Director of Nursing (DON) and Administrator the issue with the resident's code status not being care planned was reviewed. On 10/28/25 at 4:40 p.m., the DON provided the survey team with a copy of their policy with the subject Comprehensive Care Plan. This policy read in part, .Each resident will have a person-centered comprehensive care plan developed within 7 days of the completion of the comprehensive assessment and implemented to meet his or her preferences and goals, and address the resident's medical, physical, mental and psychosocial needs. No further information regarding this issue was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snyder Nursing Home	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.

(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. **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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snyder Nursing Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, staff interview, and clinical record review, the facility staff failed to ensure the highest practicable well-being for 2 of 16 current residents of the facility. Resident #39 and #2.The findings included:1. Resident #39 was observed with a chair alarm in place. The clinical record did not include a current provider order for a chair alarm. Resident #39's diagnoses included adult failure to thrive and muscle weakness. Section C (cognitive patterns) of Resident #39's annual minimum data set assessment (MDS) with an assessment reference date (ARD) of 10/03/25 was coded 1/1/2 to indicate Resident #39 had problems with long- and short-term memory and was moderately impaired in cognitive skills for daily decision making. Section GG0120 (mobility devices) was checked to indicate this resident used a wheelchair. Section P (restraints and alarms) was coded to indicate the resident used a bed alarm daily. Resident #39's comprehensive care plan included the focus area at risk for falls. Interventions included bed alarm. There was no intervention for a chair alarm. Resident #39's current provider orders included an order for a bed alarm and low bed with mat. It did not include an order for a chair alarm. On 10/28/2025 at 10:50 a.m., Resident #39 was observed up in their wheelchair in the dining room. Resident #39 was observed to have a chair alarm in place. The surveyor notified the Director of Nursing (DON) who accompanied the surveyor to the dining room and observed the chair alarm in place. The surveyor stated they did not see a provider order for the chair alarm in Resident #39's clinical record. The DON stated they would review Resident #39's clinical record. On 10/28/25 at 11:50 a.m., the DON confirmed that Resident #39 did not have a current order for a chair alarm and the alarm was being removed. On 10/28/25 at 2:30 p.m., during a meeting with the Administrator and DON the issue with Resident #39 having a chair alarm in place without a current provider order was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #2 the facility staff failed to follow a medical provider order to discontinue a bed alarm. Resident #2's diagnosis list indicated diagnoses that included, but were not limited to, Type 2 Diabetes Mellitus, Mild Cognitive Impairment, Macular Degeneration, Weakness, Lack of Coordination, and Lymphedema. The resident's admission minimum data set (MDS) with an assessment reference date (ARD) of 10/22/25 assigned the resident a brief interview for mental status (BIMS) summary score of 13 out of 15 for cognitive abilities, indicating Resident #2 was cognitively intact. On 10/27/25 at 3:36 PM, this surveyor observed Resident #2's bed to have a bed alarm in place. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snyder Nursing Home	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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/25 at 9:34 AM, this surveyor observed and interviewed Resident #2 in her room and observed a bed alarm in place on the resident's bed. Surveyor asked resident what happens when the bed alarm sounds, and the resident informed surveyor that she turns it off. A medical provider order dated 10/20/25 read in part, .D/C (discontinue) bed alarm. On 10/29/25 at 8:48 AM this surveyor spoke with the director of nursing about Resident #2's bed alarm being discontinued, the director of nursing agreed the bed alarm had been discontinued. She stated Resident #2 had been out to the hospital and the care plan had been updated with the new order for the bed alarm to be discontinued. The DON informed surveyor the bed alarm had been removed from Resident #2's bed this morning. 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, Transcribing Orders that read in part, .Purpose: To accurately transcribe and follow new orders.5. Accurately place new order.ensuring proper.treatment.etc. No further information was provided to the survey team prior to exit on 10/29/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E076	A. Building B. Wing	10/29/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Snyder Nursing Home	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.

(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. Based on staff interview, clinical record review, and facility document review, the facility staff failed to maintain a complete and/or accurate clinical record for (1) of (16) sampled residents, Resident #3. The findings included:For Resident #3 the facility staff failed to accurately document the resident's fluid intake on the TAR (treatment administration record) as indicated by a medical provider order for fluid restriction. Resident #3's diagnosis list indicated diagnoses that included but were not limited to Chronic Atrial Fibrillation, Hypothyroidism, Chronic Kidney Disease-Stage 4, Chronic Obstructive Pulmonary Disease, Chronic Diastolic (Congestive) Heart Failure, and Cognitive Communication Deficit. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 10/7/25, assigned the resident a brief interview for mental status (BIMS) summary score of 13 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A medical provider orders with a start date of 9/15/25 read in part, .1500 mL (milliliters) fluid restriction (a 1500 mL fluid restriction is a medical order that limits total daily liquid intake to 1500 milliliters-approximately 50.7 ounces). A review of the September and October 2025 MARs (medication administration records) did not disclose any indication of monitoring Resident #3's fluid restriction. A review of a Quarterly Nutritional Assessment dated 10/7/25 read in part, .1500 mL Fluid Restriction.Edema.Therapeutic diet r/t (related to) CHF (congestive heart failure).on fluid restriction & daily weights [with] extra Lasix per orders. On 10/28/25 at 5:15 PM, the director of nursing (DON) informed surveyor the registered dietician had provided nursing with a break-down of how the fluids were to be consumed and provided surveyor with a copy of the hand-written break-down instructions dated 9/15/25 which read in part, .1500 cc FR (fluid restriction).no water pitcher in room.She (Resident #3) gets 1260 cc fluids on meal trays.she can have 4 oz (ounces) water or other liquid with med (medication) pass x 3 (three times daily).Copy placed in MAR. The DON informed surveyor the fluid restriction is on the TAR not the MAR and nursing staff was honoring the fluid restriction for Resident #3, but they were not documenting it on the TAR. The DON provided surveyor with a copy of the September and October 2025 TARs and one entry was indicated on 9/16/25 for 1500 mL fluid restriction. No other entries were documented on either TAR. On 10/29/25 at 8:18 AM, the DON informed surveyor she updated the October TAR for monitoring of Resident #3's fluid intake and provided surveyor with a copy. A review of the October TAR showed an entry for 10/29/25 for fluid restriction. The DON also provided surveyor with a copy of an Accurate Intake and Output Record, that the DON stated would be utilized to monitor the amount of fluid Resident #3 intakes daily. This concern was discussed at the pre-exit meeting with the administrator and director of nursing on 10/29/25 at 10:35 AM. No further information was provided to the survey team prior to exit on 10/29/25.