

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495093	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 06/05/2025
NAME OF PROVIDER OR SUPPLIER Harrisonburg Hlth & Rehab Cntr		STREET ADDRESS, CITY, STATE, ZIP CODE 1225 Reservoir Street Harrisonburg, VA 22801	

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)
<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to have medications available for administration for one resident (resident #102-R102) in a survey sample of twenty-three residents.</p> <p>The findings included:</p> <p>For R102, the facility staff failed to have two medications, niacin and oxycodone available for administration as ordered by the medical provider.</p> <p>On 6/3/25 at 11:31 a.m., an interview was conducted with R102. During the interview, R102 expressed concerns regarding care but did not verbalize any concerns with medications.</p> <p>On 6/3/25-6/4/25, a clinical record review was conducted of R102's chart. This review revealed that R102 had an active order for oxycodone-acetaminophen tablet 7.5-325 mg to be given every 12 hours for shoulder pain and low back pain. R102 had another order for oxycodone-acetaminophen tablet 7.5-325 mg to be given every six hours as needed for pain.</p> <p>According to the medication administration records, the oxycodone-acetaminophen was not given on 5/24/25, for the evening dose. According to the nursing progress note dated 5/25/25 at 1:31 a.m., in response to the evening dose of medication not being given on 5/24/25, the nurse documented, Medication unavailable NP [nurse practitioner name redacted] aware of missed dose medication also un available in pixies pharmacy states they will send asap [as soon as possible] resident own RP [responsible party] no c/o [complaint of] pain at this time.</p> <p>According to a progress note written on 5/22/25, the nurse practitioner documented in part, Service Date: 5/21/25 . Patient seen per nursing request for medication management/ glaucoma/ dry skin/ supplements . Patient has a med list from 2024 that his upset that he is not receiving all of the medications on the list. I explained to patient that the med list is medications that he has reported to [doctor's name redacted] office that he has taken in the past. Patient is very argumentative that he should be receiving all of these medications, and it is his right to have them. I went through the med list and marked the medications he is receiving, the medications that are PRN [as needed] and explained if he needs them we can order them as PRN, and the medications that are supplements .I explained that as for the supplements that is up to the facility on which ones can be supplied, I gave a copy of the list to the ADON [assistant director of nursing] who reviewed the list and said the facility can provide niacin 250mg, Vit C 500mg, zinc 50mg, Omega-3 1000mg, multivitamin , and vit D3 25mcg .</p> <p>(continued on next page)</p>

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
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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>According to the physician orders on 5/21/25, the R102 had an order written by the nurse practitioner for niacin 250 mg to be given once daily for supplement. That order was discontinued on 5/23/25 and on 5/24/25 another order was written for the same medication at the same dose.</p> <p>According to the medication administration record (MAR), R102 did not receive the niacin as ordered on 5/22/25, 5/23/25, 5/24/25, and 5/25/25, which was indicated with a code 9. According to the code legend/chart codes on the MAR, code 9 indicated other/see progress notes. On 5/26/25 and 5/27/25, the resident did not receive the niacin medication, and noted the medication was on hold, as indicated by an H in the administration block for those days.</p> <p>According to R102's nursing progress notes, the following entries were made regarding the niacin. On 5/22/24, the note read, Medication in transit. NP notified; Res is his own RP. On 5/23/25, the note read, Medication not available from pharmacy, NP notified. Own RP. On 5/24/25, the nursing note read, Res own RP, NP notified. Still waiting med to arrive. On 5/25/25, the note read, awaiting delivery from pharmacy, unable to pull from Omnicell. NP/RP aware.</p> <p>There were no associated notes from nursing or the provider regarding the hold order or the lack of medication administration on 5/26/25-5/27/25.</p> <p>On 6/4/25 at 9:07 a.m., an interview was conducted with the unit manager, who was a licensed practical nurse (LPN #4). When asked what the code 9 on the MAR indicated, LPN #4 said, The medication or treatment was not administered. Also when they click 9, they can write a progress note. When asked why a resident would not receive medication, LPN #4 said, Maybe the resident was at an appointment or refused.</p> <p>On 6/4/25 at 11:49 a.m., an interview was conducted with a licensed practical nurse (LPN #5). When asked what is done if during medication administration, she notes that a medication is not available, LPN #5 explained that If it is not available in the cart, then I check the Omnicell and let the nurse practitioner/provider know, responsible party know, and mark as not available. When asked why a medication would not be available, LPN #5 stated, If a nurse forgot to reorder. LPN #5 stated that house stock/over the counter medications are kept in the medication cart, medication room, or central supply. LPN #5 showed the surveyor R102's current supply of niacin, which, according to the pharmacy medication labelling, was filled 5/23/25, while the oxycodone was filled 5/25/25. LPN #5 explained that she had just been given a bottle of niacin 100 mg and told that it was going to be a house stock item now. When asked to explain the risks of residents not receiving medications as ordered, LPN #5 said, It depends on the condition and what it is treating. For pain meds, it can cause pain to get worse and cause behaviors. As for the niacin, I am not really sure what it is used for other than a supplement.</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 6/4/25 at 1:39 p.m., a phone call was held with the facility's contracted pharmacy. The surveyor spoke with the quality assurance pharmacist who was able to provide the following details regarding R102's medications. Regarding the Niacin, the pharmacist stated they received an order for this on 5/21/25 but also received an order to cancel the prescription. Then on 5/23/25, they received another request for the niacin for R102. The pharmacist explained that since this is an over-the-counter medication, they don't automatically send it out, and, on 5/23/25, they sent an authorization form to the facility. The pharmacist explained that many facilities receive their over-the-counter medications elsewhere and so they send an authorization that someone at the facility must sign and return to the facility, authorizing them to fill/dispense the medication. The pharmacist stated that in the case of R102's niacin, they did not receive the authorization form back until 5/26/25 at 9 a.m., and the medication was delivered and signed for at the facility on 5/26/25 at 8:11 p.m.</p> <p>Regarding the oxycodone-acetaminophen for R102, on 5/9/25 at 2:06 p.m., the pharmacist stated that the pharmacy received a prescription, and filled/dispensed 30 tablets, which was delivered on 5/10/25 at 11 a.m. Then on 5/25/25 at 12:46 a.m., they received a refill request, which was delivered on 5/25/25 at 7:49 a.m. When asked to explain the process on re-ordering of medications, the pharmacist explained that each facility has their own protocol but when they are close to the last 1-2 days of supply of a medication, they should place the order for a refill. The pharmacist confirmed that despite being out of state, the pharmacy makes two standard deliveries to the facility daily.</p> <p>On 6/4/25, the facility provided the survey team with a copy of the contents of the Omnicell, which is an emergency supply of medications that is maintained on-site. Review of this document noted that niacin was not available in the Omnicell and Oxycodone-Acetaminophen was only available in the strength of 10-325 mg tablet, which was not what was ordered for R102.</p> <p>On 6/4/25 at approximately 4:45 p.m., during an end of day meeting, the above concerns were shared with the facility administrator and director of nursing.</p> <p>On 6/5/25 at 11 a.m., the facility's regional director of clinical services (RDCS) talked with the survey team and stated they could not find any additional information regarding the medications not being administered due to unavailable regarding R102, and stated, they followed the policy and notified the provider and resident representative. The RDCS went on to explain that the Niacin was ordered at the request of the resident and that the nurse practitioner didn't really feel he needed it. The RDCS stated that the facility orders over the counter medications through a supply company, not the pharmacy and they only deliver once weekly. When told that R102's supply of niacin had eventually been provided by the pharmacy, and asked, if it is an over-the-counter medication, couldn't someone have gone to a local drug store to get it, the RDCS replied, I guess they could.</p> <p>A review of the facility policy titled, General Guidelines for Medication Administration with a revision date of 8/2020, revealed in part, . 11. If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit .</p> <p>(continued on next page)</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the facility policy titled, Medication Unavailability with an effective date of 1/29/24, revealed in part, 1. A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary. 2. If alternate medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process and procedures. 3. A licensed nurse will document notification to the provider of the unavailability in the medical record. 4. A licensed nurse will notify the responsible party of any new orders and document notification in the medical record.</p> <p>No additional information was provided.</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public.</p> <p>Based on observation, resident interview, staff interview, and facility documentation review, the facility staff failed to provide a safe, functional and comfortable environment for one resident (Resident #123- R123), in a survey sample of twenty-three residents.</p> <p>The findings included:</p> <p>On 6/3/25 at 4:15 p.m., an interview was conducted with R123 in his room. R123 verbalized concern that his air conditioning in his room has not been working for several weeks. R123 stated that it was supposed to start getting warm, into the mid-upper 80's this week, and was concerned that his room would be too warm, cause him to be uncomfortable and exacerbate his breathing issues. R123 reported he has told staff about the air not working several times, but nothing has been done.</p> <p>R123 also verbalized concern about his and his roommate's closet doors. He reported that the drawers hit the doors above them, and you can't open them. He said it has been like that for over a year, since a prior roommate broke them, and he has been complaining but nothing has been done. R123 also expressed concern about a ceiling tile that was not on the track and appeared as if it could fall. R123 said, I'm scared it is going to fall, and I have reported it three times.</p> <p>The surveyor then attempted to turn on the air conditioning/heat unit within the room and noted it would not turn on. When the surveyor attempted to open the drawer of the closet, the doors above the drawer swung open where it was partially hung and the surveyor had to quickly move to avoid being hit by the door.</p> <p>On 6/3/25, at the end of the day meeting, the surveyor requested a copy of all maintenance work orders that had been submitted in the past six months for the room R123 resided in.</p> <p>On 6/4/25, a review of the maintenance work orders revealed that on 5/2/25 a maintenance work order had been entered regarding the air conditioner/heater/PTAC unit, which remained open and not resolved. On 5/19/25, a second work order was entered for the air conditioner unit, which also had a status of open. On 5/23/25, a work order was entered that noted, doors and the status noted, open.</p> <p>On 6/4/25 at 8:50 a.m., an interview was conducted with the facility's maintenance director. The maintenance director explained that he works at another facility and comes to this facility two days a week to help out. He went on to say that they have a maintenance assistant that works full time but is a little slow at getting items completed. When asked about the process for maintenance work orders, he stated that they don't have a good system. The maintenance director explained there is an electronic system, which he just found out that the maintenance assistant doesn't have access to that, but has now obtained access. The maintenance director said that they have been relying on staff to verbally tell them about needed work. He explained that the facility has had so many issues and concerns that he has been trying to put out fires and address the urgent needs versus the minor repairs.</p> <p>(continued on next page)</p>		

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<p>F 0921</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 6/4/25 9:25 a.m., during a follow-up interview with the entire survey team, the maintenance director again reported that while they have an electronic system, it really isn't monitored and . we haven't addressed them too much, and we are using more of a word of mouth. [Name of maintenance assistant redacted] has a notebook he writes things in. He didn't have a log-in and I just got that set-up. They [the staff] have just been flagging us down. Usually when I am here, I am trying to handle major issues, and I get a list of things for [the assistant's name redacted] to work on when I'm not here. When asked about the heating/air in R123's room, the maintenance director stated he was just made aware of it that morning and had called a contractor who was on-site working on it.</p> <p>On 6/4/25 at approximately 2 p.m., the maintenance director gave an update that the contractor was able to get R123's air conditioning unit to run, but it was making a lot of noise, and they were ordering a new motor. The maintenance director said that despite the loud noise, it will run and work, until they can obtain and replace the motor.</p> <p>On 6/4/25 at 2:20 p.m., the surveyor returned to R123's room and noted that the cover to the air conditioning unit was off and leaning against the closet. When the resident was asked about the air, R123 reported They disabled it. The surveyor again used the control knob and was not able to get the unit to turn on. The surveyor advised the resident that perhaps she could question to the facility about offering a room change. R123 immediately said, No, I like my room, and they told me my insurance doesn't pay to keep my room, and I will lose it if I move. The surveyor explained that she was only suggesting a temporary move, then once the air was fixed, return to this room.</p> <p>On 6/4/25 at 2:25 p.m., the maintenance director accompanied the surveyor to R123's room. The maintenance director was also unable to get the air conditioner to turn on and stated the contractor must have disabled it and that he would have to call the contractor. The maintenance director was shown the closet and confirmed that the door had broken away from the hinge and needed repair.</p> <p>On 6/4/25, during an end of day meeting, the facility's administrator, director of nursing and corporate staff were made aware of the above findings.</p> <p>On 6/5/25, the facility staff stated that R123 had been offered and accepted a room change, after being assured that once the air conditioner was fixed, he could return to the room.</p> <p>No additional information was provided.</p>		