STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ridge Rehabilitation and Nursing	94 South Avenue 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)
F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview, and clinical record review, the facility staff failed to provide dignity when moving personal property for one of thirty-one residents in the survey sample (Resident #200). The findings include: Resident #200's personal property/items were moved to another room while the resident was out of the facility at an appointment. There was no advance notice of the room/property move and the resident was not given an opportunity to assist or accompany staff during transfer of personal items to a different room. Resident #200 (R200) was admitted to the facility with diagnoses that included congestive heart failure, hip fracture, neurogenic bladder, diabetes, anxiety and depression. The minimum data set (MDS) dated [DATE] assessed R200 as being cognitively intact. R200's closed clinical record documented a room change on 5/21/24. There was no documentation of a verbal or written notice provided to the resident prior to the 5/21/24 room change. A nursing note dated 5/21/24 at 11:01 a.m. documented a voice message was left for the resident's spouse about a room move. R200's clinical record documented the resident was out of the facility on 5/21/24 for a urology appointment. A nursing note dated 5/21/24 at 4:58 p.m., documented, .returned from urology appointment . A psychology progress note dated 5/27/24 documented that R200 felt the facility should do a better job of communicating with him, in addition to gain his permission before action is taken. Patient does not appreciate his 'pretzels' being misplaced . On 8/27/24 at 3:22 p.m., R200 was interviewed about the personal property/room move on 5/21/24. R200 stated he received no verbal or written notification prior to the room change. R200 stated the room change was done because of his complaints about a roommate. R200 stated he was out of the facility at a doctor's appointment and when he returned, his personal items/property had been moved to another room without his supervision or input. (continued on next page)

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

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F 0557 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/28/24 at 10:02 a.m., the facility's social worker (other staff #4) was interviewed about R200's property moved without resident notice or input. The social worker stated she thought the room change on 5/21/24 was made because R200 had conflicts and complaints about the roommate. The social worker stated she recalled that on 5/21/24, the resident returned from an outside appointment. The social worker stated the unit manager at that time reported R200 was upset about his items being moved and was especially upset that his pretzels had been discarded. The social worker stated she went to the store and bought R200 a new container of pretzels. The social worker stated she replaced the pretzels twice because the first replacement was not R200's preference. The social worker stated R200 was upset about his property being moved and especially the discarded pretzels. The social worker stated R200 mentioned the discarded pretzels to his psychologist. The social worker stated a voice message was left for the resident's spouse on the day of the move (5/21/24) but that there was no written or verbal notification to R200 prior to the move. The social worker stated she did not know why staff chose to move the resident that day or why the resident's property was moved when he was out of the facility. R200's unit manager on the date of the room change on 5/21/24 was not available for interview as she no longer worked at the facility. On 8/28/24 at 11:26 a.m., the licensed practical nurse unit manager (LPN #3) that cared for R200 was interviewed about the moving of personal property without the resident's consent or supervision. LPN #3 stated she did not recall why R200's personal items were moved while he was an appointment. On 8/28/24 at 11:36 a.m., certified nurses' aide (CNA) #3 that cared for R200 during his stay was interviewed. CNA #3 stated R200 was upset about the room change on 5/21/24. CNA #3 stated R200 complained frequently about the roommate and still complained after the room change. CNA #3 stated R200 was upset that he got moved while he was out of the facility at an appointment. On 8/28/24 at 11:49 a.m., the director of nursing (DON) was interviewed about R200's property handled/moved without the resident's permission or oversight. The DON stated she remembered the resident was moved but did not recall the events of that day (5/21/24). The DON stated R200 was moved due to complaints and issues with the roommate. The DON stated she did not recall the time of day the items were moved. The DON stated, I don't think it [room change] was done with malice. On 8/28/24 at 2:46 p.m., the administrator was interviewed about R200's room change and personal property transfer without notice. The administrator stated it was not the expectation for staff to move personal items without the resident's permission or oversight. The administrator stated residents were supposed to be notified ahead of time and be allowed time to plan for room and/or roommate changes. This finding was reviewed with the administrator, DON and regional director of clinical services during a meeting on 8/28/24 at 2:00 p.m. with no further information presented prior to the end of the survey.

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21875 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to provide written notice prior to room changes for five of thirty-one residents in the survey sample (Residents #12, #13, #53, #57 and #200). The findings include: 1. No written notice was provided to Resident #53 prior to room changes on 5/10/24 and 7/1/24. Resident #53 (R53) was admitted to the facility with diagnoses that included coronary artery disease, hypertension, diabetes and depression. The minimum data set (MDS) dated [DATE] assessed R53 as cognitively intact. On 8/26/24 at 6:46 p.m., R53 was interviewed about quality of life/care in the facility. R53 stated she had moved rooms twice and had no notice prior to the changes. R53 stated, They just come in and tell you, you are moving. R53 stated she felt her room changes were due to issues with roommates. R53 again stated that she received no verbal or written notice prior to the room/roommate changes. R53's clinical record documented no notification about the room changes on 5/10/24 and 7/1/24. Nursing notes made no mention that the resident changed rooms and/or roommates. On 8/28/24 at 9:53 a.m., the facility's social worker (other staff #4) was interviewed about notification to R53 about room changes. The social worker stated the room changes were due to roommate conflicts. The social worker stated no written notices were provided to R53 prior to the room changes. On 8/28/24 at 2:46 p.m., the administrator was interviewed about room changes without prior notice. The administrator stated residents were supposed to be notified ahead of time regarding room changes and be allowed time to plan for room moves. The facility's policy titled Change of Room or Roommate (revised 12/1/22) documented, .The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required . This finding was reviewed with the administrator, DON, and regional director of clinical services, during a meeting on 8/28/24 at 2:00 p.m., with no further information presented prior to the end of the survey. 2. No written notice was provided to Resident #200 prior to room changes on 1/8/24, 2/6/24, and 5/21/24. Resident #200 (R200) was admitted to the facility with diagnoses that included congestive heart failure, hip fracture, neurogenic bladder, diabetes, anxiety and depression. The minimum data set (MDS) dated [DATE] assessed R200 as cognitively intact. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R200's closed clinical record documented room changes on 1/8/24, 2/6/24 and 5/21/24. The clinical record documented no written notice to R200 prior to these room changes. There was no written notification provided to the resident indicating the reason for the room changes. On 8/27/24 at 3:22 p.m., R200 was interviewed about notification of room changes. R200 stated he moved rooms three times during his stay at the facility and received no verbal or written notification prior to the room moves. On 8/28/24 at 10:02 a.m., the facility's social worker (other staff #4) was interviewed about written notification to R200 prior to room changes. The social worker stated no written notices were provided to R200 prior to the room changes. The social worker stated she verbally told R200 on 2/5/24 about the room change on 2/6/24. The social worker stated she saw no other notifications to the resident about the room changes. On 8/28/24 at 2:46 p.m., the administrator was interviewed about room changes without notice. The administrator stated residents were supposed to be notified ahead of time regarding room changes and be allowed time to plan for room moves. The facility's policy titled Change of Room or Roommate (revised 12/1/22) documented, .The notice of a change in room or roommate will be provided in writing, in a language and manner the resident and representative understands and will include the reason(s) why the move or change is required . This finding was reviewed with the administrator, DON and regional director of clinical services during a meeting on 8/28/24 at 2:00 p.m. with no further information presented prior to the end of the survey. 41449 3. For resident #57 (R57), the facility failed to provide written notification prior to a room change. On 8/27/24 at 8:08 a.m., an interview was conducted with R57. When asked about a recent room change, R57 said he had a room change to be on isolation. On 8/27/24, a clinical record review was conducted. According to the census tab of R57's chart, he had a room change on 8/13/24. Then on 8/26/24, was moved back to the original room. According to the progress notes an entry was made by the social worker on 8/13/24 at 2:50 p.m., that read, Both myself and DON (Director of Nursing) spoke with [resident's wife's name redacted] about pt [patient] room move and isolation protocol and treatments. There was no indication that the room change had been discussed with the resident prior to the move on 8/13/24 or 8/26/24. There was no evidence that the room change was provided in writing to the resident. 4. For resident #12 (R12), the facility failed to provide written notification prior to a room change. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at approximately 7 p.m., an interview was conducted with R12. R12 reported that she had been separated from her prior roommate, who she identified as resident #22 (R22), and expressed a desire to room with her again. When asked if she was notified in writing of the change, R12 said, No, nothing was provided in writing. R12 went on to say she was told they were moving her because they were going to do renovations but reports no renovations had taken place. On 8/27/24, a clinical record review was conducted of R12's chart. This review revealed that 6/29/22, R12 was moved into room [ROOM NUMBER], where she remained until she was moved to another unit on 3/8/23. According to the progress notes, an entry was made by the facility administrator on 3/7/23, that read, This writer and director of nursing notified resident this evening of need for a room change so that room renovations can begin. Resident in agreement and is going to begin organizing things for the room move to take place tomorrow, 3/8/23. There was no evidence within the clinical record that a written notice was provided. 5. For resident #13 (R13), the facility failed to provide written notification prior to a room change and failed to address her preference to room with her prior roommate. On 8/27/24 at approximately 11:30 a.m., R13 stopped the surveyor and wanted to express concerns. R13 shared concern that she and her roommate had been split up, in the facility's efforts to make a male room, but says that didn't occur and that she missed her former roommate. R13 reported that they liked being roommates and she, R13 was able to encourage the roommate to attend out of the room activities, which the roommate's family was appreciative of. When asked if R13 received anything in writing about the room change, R13 reported she had not. On 8/27/24 and 8/28/24, a clinical record review was conducted. According to the census tab of R13's chart, she was moved to room [ROOM NUMBER] on 9/15/23. On 2/5/24, she received a new roommate who was being admitted to the facility. They remained roommates until 8/12/24, when both were moved to different rooms, and R13 was moved to a separate unit. Review of the progress notes, assessment tab, and misc. tab of R13's clinical record revealed no information with regards to the room change nor that R13 was given written information about the change. On 8/28/24 at approximately 1:30 p.m., the facility administrator and director of nursing were made aware of the above findings with regards to the lack of written notification for room changes. The concern expressed by R13 and her desire to room with her prior roommate was also discussed. The facility administrator reported that R13's prior roommate had expressed concerns about being roommates and didn't desire to room with R13. The administrator stated that she had statements about this. The survey team asked the administrator to provide any information she had. Following the above meeting, the surveyor went and visited the prior roommate of R13 in her room. When asked about the prior roommate, this resident said that she missed R13. When asked if she would like to be roommates with her again, she said, Yes. No concerns or complaints regarding R13 was shared. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/28/24 at approximately 2:30 p.m., the facility administrator provided the survey team with a statement written 8/7/24, by the wound treatment nurse. The statement read in part, This nurse has observed on several occasions during treatment and care, [R13's prior roommate's name redacted] performing task for [R13's name redacted] . This nurse feels that [R13's name redacted] takes advantage of and could potentially cause harm, even unintentionally, towards [roommate's name redacted] . I have attempted to speak with both residents regarding these actions . This nurse feels that is in [sic] the best interest of both residents that they do continue to be roommates. I am concerned that [R13's prior roommate's name redacted] could hurt herself, fall, or have a serious injury. There was no evidence of this within R13's clinical record or that the care plan team had discussed such concerns with the residents and/or resident's family members. There was nothing in the statement that the former roommate had expressed concerns or indicated not wanting to room with R13. On 8/27/24, in the afternoon, an interview was conducted with the facility's social worker (SW). The SW was asked about room changes and reported that they discussed room changes as a team to attempt to determine compatibility. The SW went on to say that she is usually the one that will notify the resident of the room change. When asked if she provides anything in writing regarding the reason for the room change, the SW said no, that that she has never given anything in writing. Review of the facility policy titled Change of Room or Roommate with a review date of 12/1/2022 read in part, . It is the policy of this facility to conduct room changes or roommate assignments when considered to be necessary by the facility and/or when requested by the resident or resident representative .4. Prior to making a room change or roommate assignment, all persons involved in the change/assignment, such as residents and their representatives, will be given advance notice of such a change as is possible. 5. The notice of a change in room or roommate will be provided in writing, in a language and manner the residents and representative understands and will include the reason(s) why the move or change is required No further information was provided.

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to manage his or her financial affairs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on resident interview, staff interviews, and facility documentation review, the facility staff failed to maintain adequate funds on-site so that two residents (resident #226 - R226 and resident #53 - R53) had access to their personal funds/trust accounts, which had the potential to affect 41 residents with a trust account. The findings included: 1. For R226, the facility failed to maintain sufficient funds and denied the resident's request to make withdrawals from his account. On 8/27/24 at approximately 8:15 a.m., R226 asked the surveyor to come into his room. R226 reported that he had failed to mention on the prior evening a concern with regards to him having access to his bank account. R226 went on to say that on multiple occasions he had attempted to get money out of his trust account for shopping but had been denied the ability to make withdrawals. R226 went on to say that he could get money previously but now he is told he must make a list of what he wants first or talk to the activities person or is told they don't have the money. On 8/27/24 at 4:22 p.m., an interview was conducted with the business office manager (BOM) (other employee #5). The BOM was asked to explain the process when a resident wants to withdraw funds from their trust account. The BOM explained that she would check to see if they have an account, if they have funds and then will fill out a receipt and give them cash. She said the residents are permitted to withdraw $40 per day. The BOM went on to say, Resident shopping is a different program, the activity director will go around and ask if they want to purchase anything. Those are collectively entered under resident shopping and a check is requested from corporate. Once they approve and send me the check, we cash the check and [activities director's name redacted] gets the cash and list and goes shopping. When asked what the turnaround time is for her to get the check, the BOM said, It varies, depending on what is going on in the building. We just started this process a few weeks ago and I am reinstituting it. We only keep $245 here and we last got that on August 2. We went through that within a week. We have some residents who will withdraw their $40 per day and that doesn't leave much for the others. When asked again for clarification that if a resident requests money for shopping, are they denied that request because there is a process where a check is requested from corporate, the business office manager said, Yes. During the above interview, the BOM was asked about resident's access to funds and where they go to make withdrawals. The BOM said she handles that now, but the position was vacant for eight months. When asked about if a resident's family comes on the weekend and the resident wants to withdraw funds, what is done, the BOM said, They have to get it ahead of time or the family can provide receipts to get reimbursed. The BOM went on to say that she is only at the facility Monday through Friday. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The BOM was asked about R226. The BOM said, He does have an account, but I don't have any petty cash on hand right now. We only have $5. I am waiting for it to get replenished. There has been some confusion for him. He said someone was going shopping for him. He kept saying [activities director name redacted] was going shopping, which means resident shopping which is once a month. I explained the procedure is that she would get a list from him, and I thought he was talking about resident shopping. I told him we only have $5, and we just changed banks last week. We got it set up where the administrator can cash checks. The BOM provided the surveyor with a transaction history for R226. Review of this revealed R226 had last had a withdrawal on 7/24/24. On 8/27/24 at 4:45 p.m., an interview was conducted with the activity assistant. The activity assistant was asked about resident shopping and said, I go around and write down a list of what they want, and they give me $40 because that is as much as they can get. A lot of times they will tell me, they didn't get money this week. They don't have any money right now, they switched banks, so no one can get money right now. When asked specifically about R226, the activity assistant said, He is always the short end of the stick somehow. The last 2 shopping trips they ran out of money before he could get any. So I just went on my day off. I've had to buy things for him myself because I felt bad, but I never got reimbursed and I can't afford that. So I can't keep doing that. The activity assistant went on to explain that they were just notified that the process for resident shopping was changing, and they would no longer get money from residents. She explained that they will get a list of what residents want, must go online to get prices for everything, and then they will get a check for everything. The activity assistant explained that this was a new process they were just told about. The BOM stated that a sign was posted in the lobby of when residents could access/withdraw money from the trust account. The lobby was searched, and no posting was noted. At 5:12 p.m., the administrator had the maintenance director put up a sign outside of the BOM's office that indicated banking hours were Monday-Saturday, 7am-7pm. When asked about this, the administrator stated that she had found the sign in the activity's office. When asked how residents will access funds during those hours, the administrator said that the receptionist will keep the money since that is their hours. When asked about this, the BOM confirmed that currently she had the money box, that the receptionist did not have it, and that money is only available Monday-Friday, when they have money to give to residents. On 8/28/24 at 1:30 p.m., during a meeting with the facility administrator and director of nursing, the facility was made aware of the above findings. The facility provided a policy regarding resident trust accounts, but it did not address resident's access to the funds, it only stated the procedures of the business office with regards to trust accounts. No additional information was provided. 21875 2. R53 did not have timely access to money from her personal fund account. Resident #53 (R53) was admitted to the facility with diagnoses that included coronary artery disease, hypertension, diabetes and depression. The minimum data set (MDS) dated [DATE] assessed R53 as cognitively intact. (continued on next page)

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F 0567 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 8/26/24 at 7:04 p.m., R53 was interviewed about quality of life/care in the facility. R53 stated during this interview that money from her personal fund account at the facility was not always available when requested. R53 stated, You never get it [money] when you ask. R53 stated sometimes it took several days to get money from her account. R53 stated she had asked for money and was told there was not enough cash or nobody was there to issue the money. R53 stated that if she had an outing planned, she asked for the money a week ahead to get it in time. R53's personal fund account documented the resident had available funds with amounts of $50.00 or less provided on 3/21/24 and 6/5/24. On 8/27/24 at 4:55 p.m., the business office manager (other staff #5) was interviewed about R53 having to wait days to access her funds. The business office manager stated she just started work at the facility on 8/1/24 and did not know what the issues were for accessing resident funds prior to that date. The business manager stated as of today (8/27/24) there was $5.00 in the available cash for residents. The business office manager stated the facility recently switched banks and there had been a down time for cashing checks. The business office manager stated, I just don't think we are keeping enough money in the petty cash account. This finding was reviewed with the administrator, director of nursing, and regional director of clinical services, during a meeting on 8/28/24 at 2:00 p.m., with no further information presented prior to the end of the survey.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41449 Based on observation, resident and staff interviews, clinical record reviews, and facility documentation reviews, the facility staff failed to provide activities of daily living (ADL) care to residents who required staff's assistance, for five residents (resident #12- R12, resident #22- R22, resident #57-R57, resident #40-R40, and resident #49-R49), in a survey sample of 31 residents. The findings included: 1. For R12, who was dependent upon facility staff for toileting assistance, the facility staff failed to respond timely to the resident's call light, which resulted in R12 urinating on the floor on one occasion. On 8/26/24 at 6:30 p.m., R12 was observed with her call bell on. R12 was sitting at her doorway waiting for staff to respond. When the certified nursing assistant (CNA) responded, at 6:48 p.m., the CNA noticed a wet spot on the room floor with a towel over it. R12 reported that she had not been able to hold it and had urinated on the floor. The CNA assisted R12 with being cleaned up and put in the bed. On 8/26/24 at 7 pm., the surveyor interviewed R12 in her room. R12 reported that frequently she must wait hours for staff to respond to her call bell. On 8/27/24 at 10:40 a.m., upon the surveyor's arrival on the unit, R12's call bell was observed to be engaged, the light outside of the room was illuminated and an auditory alarm sounding. Numerous staff were observed on the hallway, a nurse performing medication administration, a housekeeper cleaning, and four nursing assistants, who were in and out of rooms on the unit. It was 11:28 a.m., before a staff member responded to R12's room to see what she needed. This was 48 minutes after the surveyor observed the call bell, which was already on when the surveyor made the observation at 10:40 a.m. Following R12 receiving care at 11:28 a.m., the surveyor interviewed R12 in her room. R12 reported she had been waiting for staff to clean her up/provide incontinence care. On 8/27/24, a clinical record review was conducted of R12's chart. R12's most recent minimum data set (an assessment tool) with an assessment reference date of 6/29/24, was reviewed. According to section G of this assessment, R12 required extensive assistance of facility staff for bed mobility, transfers, and toileting. R12 was also coded on this assessment as having had a brief interview for mental status score of 15 out of 15, which indicated she was cognitively intact. According to R12's care plan, she was noted to have a self-care performance deficit Interventions included, but were not limited to, Toilet use: nursing staff to provide assistance as needed, [R12's name redacted] uses a bed pan at times . (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/27/24 at 2:09 p.m., R12's call bell was again observed engaged. At 2:15 p.m., a nurse entered the room and came out and told certified nursing assistant (CNA) #8 that the resident needed to be cleaned up. CNA #8 was interviewed about call bell responses, and she stated, they should be answered as soon as we can. When asked about R12 having to wait 48 minutes earlier in the day, CNA #8 said, Yeah, that's too long, I don't know what happened, that's a long time, too long. I went and answered another call bell, but I know for them 5 min seems like 5 hours. At 2:20 pm CNA #8 entered R12's room to provide care. 2. For R22, a female resident who had significant facial hair approximately 1 inch long, the facility staff failed to provide assistance to remove the facial hair. On 8/27/24 at 11:25 a.m., during an observation of the nurse administering tube feeding and medication, R22 was observed with a significant amount of facial hair on her chin approximately an inch long. When asked about the facial hair, R22 said, I know, I do [have the facial hairs]. They look terrible and make me look ugly. Can I get them off? LPN #5, the nurse said, Yes, we will get it today. R22 said, That sounds wonderful. That will make me happy, and it will make me feel good. On 8/27/24, a clinical record review was conducted of R22's chart. According to R22's care plan, it noted the resident had a self-care performance deficit and the interventions included, Personal Hygiene/oral care: [R22's name redacted] requires extensive to total assist for grooming and oral care. On 8/28/24 at8:06 a.m., R22 was observed again in bed and the chin/facial hairs were still present. On 8/28/24 at 8:10 a.m., an interview was conducted with LPN #5. When asked when residents are to be shaved, LPN #5 said, I would assume in the shower or whenever they [the staff] have a minute. When asked why R22 had not been shaved when she had requested it yesterday, LPN #5 said, We didn't have time and then she was in therapy by the time we got to her. She scooted off to therapy and we just didn't get back down that way. On 8/28/24 at 8:13 a.m., an interview was conducted with the unit manager. When asked when residents are shaved, the unit manager said, Usually on their shower days, unless they request it in between. None that we have now do it every day. When asked about women with facial hair, the unit manager said, It should be on their shower days. The unit manager was notified that R22 had requested yesterday to be shaved, the unit manager said, It should have been done. Also, she probably changed her mind, She agrees that it needs to be done but often when you go to do the activity, often she doesn't participate. I would have to do some checking to see what transpired. On 8/28/24 at 10:42 a.m., R22 was again observed in bed, with the facial hair still present. On 8/28/24 at 1:30 p.m., during a meeting with the facility administrator and director of nursing, they were made aware of the above findings. On 8/28/24 at approximately 2:30 p.m., the director of nursing reported to the surveyor that R22 was in the activity being held and they would get the resident shaved after the activity. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. For R57, who had been left unsupervised/unattended sitting on the toilet, had engaged the call bell, and was yelling out for assistance, the facility staff failed to respond timely to assist the resident off the commode. On 8/27/24 at 10:40 a.m., the surveyor arrived on the unit. R57's call bell was engaged at 10:52 a.m., noting that a light was blinking outside of the room and an auditory alarm was sounding in the hallway. R57 could be heard yelling out for help. LPN #5 was observed in the hallway outside of R57's room at the medication cart. Three CNAs were observed on the unit, entering and exiting the utility room, various resident rooms, and up and down the hallway. A housekeeper was also observed on the hallway cleaning. At 11:05 a.m., LPN #5 entered the room and was heard to tell the resident, You don't have to keep yelling, give us a minute. Following the above observation, LPN #5 was approached by the surveyor and asked why R57 was yelling. LPN #5 reported that R57 was sitting on the toilet and waiting for the staff to get him off. At 11:28 a.m., two CNAs were observed to enter R57's room to assist with getting the resident off the commode. On 8/27/24 at 2:09 p.m., an interview was conducted with LPN #5. When asked if residents can be left unassisted and unsupervised on the toilet, LPN#5 said, They can leave him in the bathroom, they were just busy and didn't have to change to get there yet. LPN #5 was asked if she can assist residents with toileting, LPN #5 said, I am able to help out but if I'm on the cart and have narcotics, I can't leave them. When asked if residents should have to wait 36 minutes to be assisted off the toilet, LPN#5 said, I'm agency, so I've only been here a few times, but of course not. Five to ten minutes is reasonable. LPN #5 went on to confirm that they had adequate staffing for the shift and that staff were just busy. According to R57's care plan, the interventions read, Toilet use: Nursing staff to provide assistance as needed. [R57's name redacted] has incontinence and staff assist with changing him . Encourage [R57's name redacted] to use bell to call for assistance . Review of the facility policy titled, Call Lights: Accessibility and Timely Response was conducted. This policy read in part, . 8. All staff members who see or hear an activated call light are responsible for responding. If the staff member cannot provide what the resident desires, the appropriate personnel should be notified . On 8/28/24 at 1:30 p.m., the facility administrator and director of nursing were made aware of the above findings. No additional information was provided. 21875 4. Facility staff failed to cut/trim Resident #40's toenails as required in the plan of care. Resident #40 (R40) was admitted to the facility with diagnoses that included lower leg fracture, atrial fibrillation, heart failure, urinary tract infection and depression. The minimum data set (MDS) dated [DATE] assessed R40 as cognitively intact and as requiring substantial/maximum assistance with personal hygiene. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at 7:12 p.m., R40 was observed in bed with feet/toenails visible. R40's toenails were thick, yellow, and jagged with several extending approximately 1/8 inch beyond the end of the toes. The left great toenail had layers of brown nail material between the nail surface and the toe. R40 was interviewed at this time about the length and condition of the nails. R40 stated her toenails were too long and needed cutting. R40 stated an aide tried to cut them during a shower but was unable to do it. On 8/27/24 at 4:30 p.m., the certified nurses' aide (CNA #1) caring for R40 was interviewed about the resident's long toenails. CNA #1 stated the resident's nails needed trimming. CNA #1 stated nails were usually trimmed during showers and that she thought R40's showers were scheduled for the day shift. On 8/27/24 at 4:35 p.m., the registered nurse (RN #2) caring for R40 was interviewed about the resident's toenails. RN #2 stated he assessed the resident upon admission and the nails were not in good shape when she arrived at the facility. Accompanied by RN #2 and with the resident's permission, R40's toenails were observed. The nails were thick, jagged, uneven and extended beyond the ends of the toes. RN #2 stated he thought someone had attempted to cut them and he was not sure what options were available to address the nails. R40 stated again at this time that the toenails needed trimming. On 8/28/24 at 8:21 a.m., CNA #2, who was caring for R40, was interviewed about the long toenails. CNA #2 stated she had seen the nails and that they needed trimming. CNA #2 stated that aides were expected to trim nails during showers, if the resident was not diabetic. On 8/28/24 at 8:37 a.m., the director of nursing (DON) was interviewed about R40's toenails. The DON stated R40 was not diabetic and that the aides were expected to cut nails during shower time. The DON stated if the aides had difficulty cutting the nails, nurses was expected to assist with cutting/trimming nails. The DON stated if aides/nurses were unable to trim the nails, podiatry was an option. R40's plan of care (revised 7/12/24) documented the resident required assistance with activities of daily living (ADLs) due to fracture, weakness and difficulty moving. Interventions to maintain ADLs included, . Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse . This finding was reviewed with the administrator, DON, and regional director of clinical services, during a meeting on 8/28/24 at 2:00 p.m., with no further information presented prior to the end of the survey. 49456 5. The facility staff failed to ensure Resident #49's call bell within reach. Resident #49 (R49) was not able to call for assistance. On 8/26/24 a tour of the facility was conducted. During the tour, it was observed that R49's room door was closed, and she was yelling out continuously for someone come help me. When this surveyor entered the room, R49's call bell was on the floor under the bed. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 8/26/24 at 6:45 p.m., an interview was conducted with R49's nurse. The licensed practical nurse, LPN #4 stated, The call bell should not be under the bed but within her reach. LPN #4 (LPN4) indicated that she was going to get an aide to come in and assist R49 with a bath. On 08/26/24 7:30 p.m., an interview was conducted with R49. When asked why she had been yelling, R49 said that she was yelling out for help because I needed someone. R49 then stated, I stink. I need a bath. I smell. On 8/27/24 at 9:00 a.m., an observation was made of R49's call bell, which was again out of her reach. The call bell was laying over the bedside table, where R49 was not able to reach, and was unable to use the call bell to call for assistance. On 8/27/24 at 9:10 a.m. an interview was conducted with LPN #6 (LPN6). LPN6 stated, The call bell should be within her reach to be able to call for assistance if she needs it. On 8/28/24 a clinical record review was conducted. R49's care plan was reviewed and read in part, . [name redacted] has an ADL self-care performance deficit r/t Limited Mobility. The care plan had that R49's ADL (activity of daily living) needs would be provided by staff. On 8/28/24 a clinical record review was conducted. R49's MDS (minimum data set -an assessment tool) with the ARD (assessment reference date) of 5/23/24 documented that R49 was dependent on staff for toileting, bathing, and dressing, while maximal assistance was needed with personal hygiene and oral care On 8/28/24 a facility document was provided and reviewed. The facility policy titled, Call lights: Accessibility and Timely Response, read in part, .all staff will be educated on the proper use of the resident call system, including how the system works and ensuring resident access to the call light. With each interaction in the resident's room or bathroom, staff will ensure the call light is within reach of resident and secured, as needed. On 8/28/24, during an end of day meeting, the above concerns were discussed with the DON, the administrator, and the nurse consultant. No additional information was provided.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. 41449 Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure two residents (Resident #32-R32 and Resident #249) were free from significant medication errors/omissions, in a survey sample of 31 residents. The findings included: 1. For Resident #32 (R32), the facility staff failed to ensure the resident received antibiotic medication, as ordered by the physician. On 8/26/24 at 7:16 p.m., R32 was interviewed in his room. During the interview, R32 reported that he had osteomyelitis, a serious bone infection, and had been treated for c-diff (clostridioides difficile - an infection of the colon) but had missed a lot of his antibiotic doses .because they don't have the vanc [vancomycin] frequently. On 8/27/24, a clinical record review was conducted. This review revealed a physician order dated 7/20/24 that read, Vancomycin HCl Suspension 50MG/ML Give 2.5 ml by mouth in the morning every 2 day(s) for c diff for 8 Weeks. According to the medication administration record (MAR), R32 was not provided the vancomycin on 8/9/24 and 8/21/24. On 8/9/24, there was a nursing note that indicated the vancomycin was not available, re-ordered. On 6/21/24, there was a physician order written that read, Vancomycin HCl Suspension 50 MG/ML Give 2.5 ml by mouth four times a day for c diff for 14 Days. According to the MAR, R32 missed 12 of the scheduled doses of vancomycin. There was a progress note dated 6/28/24, that indicated that this physician ordered antibiotic was on order and another that read, none available - reordered. There was no indication that the doctor had been called and made aware of the missed doses or given the opportunity to give alternate orders. 2. For Resident #249 (R249), who was an insulin dependent diabetic, the facility staff failed to administer multiple doses of insulin and the physician was not notified of the omitted doses of medication. On 8/26/24 at 6:35 p.m., R249 was interviewed in his room. The resident expressed concern that, they run out of antibiotic often. They say they have to get it through pharmacy. The resident explained that he has an artificial hip joint and is on the antibiotic for that. On 8/27/24, a clinical record review was conducted. This review revealed R249 was receiving antibiotics as ordered with no indication of missed doses. During the record review it was noted that the resident had a physician order for Basaglar Kwik Pen 100 UNIT/ML Solution pen-injector Give 10 unit by mouth in the morning for DM [diabetes mellitus]. According to the MAR, R249 was not given the Basaglar insulin on 8/7/24, 8/12/24-8/15/24. According to the nursing progress notes there was no indication why the dose on 8/7/24 was not administered. There was a nursing note entry on 8/12/24, regarding the Basaglar insulin that read, not available. There was no indication as to why the insulin was not given on 8/13/24-8/15/24. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	There was another physician order for Humalog Kwik Pen Solution Peninjector100 UNIT/ML (Insulin Lispro (Human)) Inject 8 unit subcutaneously three times a day for DMII, ordered 8/21/24. According to the MAR, R249 missed two does on 8/21/24 and 8/22/24. There was a nursing medication administration note dated 8/22/24 at 9:48 a.m., that read, awaiting arrival. There was no indication that the physician had been called and notified that the medication was not available for administration, nor that a call to the pharmacy had been placed. On 8/27/24 at 2:22 p.m., an interview was conducted with licensed practical nurse # 6 (LPN #6). LPN #6 was asked to explain what the process is if during medication administration she doesn't have a medication available. LPN #6 said, if a medication is not available, I will check the cart, check the cubex [emergency supply of medications], call the doctor to notify them and see if there is a substitution that needs to be done or if it can be held. I call the pharmacy and see when the medicine will get here in a reasonable time and put in a note about it. Following the above interview with LPN #6, the nurse took the surveyor into the medication room and observations were made of the emergency insulin supply. Within the box it was noted that the box was supposed to contain both Humalog/Lispro insulin pen and Basaglar. However, upon opening the box only aspart and levimier was present. LPN #6 said the pharmacy is supposed to restock/change out the box, but she didn't know how often that occurred. LPN #6 also provided the surveyor with a listing of the medications contained in the cubex and it was noted that vancomycin was available only in a 1 gram and 500 mg injectable dose. On 8/28/24 at 3:31 p.m., an interview was conducted with the unit manager. She was made aware of the above findings regarding insulin not being available. The unit manager said, there are times when we don't have insulin. The unit manager again accompanied the surveyor into the medication room and accessed the emergency supply of insulin which revealed only levimier and a 70/30 mix. The pharmacy doesn't change it out very often, we don't have any slips to let them know when they are being pulled, so unless you pull from the cubex or IV box, there is no record of what you are pulling, there are no insulin slips. When asked if she would expect them to check the other unit to see if the medication was available in their box and if not, to let doctor know, the unit manager said, absolutely. On 8/28/24 at 3:35 p.m., an interview was conducted with registered nurse #1 (RN #1), who was working on the other unit. RN #1 was asked to explain what is done if insulin is not available. RN #1 said, we go to refrigerator and look and if not there go to stat box we call the doctor and get a hold order and check blood sugars often. We call pharmacy and beg them to send it to us. RN #1 was asked if they had a local pharmacy they could call as a back up to deliver and she said, no, everything comes out of Maryland. The surveyor was then accompanied into the medication room on that unit and the emergency box of insulin was observed, it was noted that the following insulins were present: Aspart insulin pen, Levemir flex pen, Lispro, Humulin N Kwik pen, Lispro Kwik pen and a multi-dose vial of Humulin R. (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review was conducted of the facility policy titled, Unavailable Medications. The policy read in part, 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn [as needed], and emergency medications. 2. A STAT [emergent] supply of commonly used medications is maintained in-house for timely initiation of medications. 3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications. 4. Medications may be unavailable for a number of reasons. Staff shall take immediate action when it is known that a medication is unavailable: a. Determine reason for unavailability, length of time medication is unavailable, and what efforts have been attempted by the facility or pharmacy provider to obtain the medication. b. Notify physician of inability to obtain medication upon notification or awareness that medication is not available. Obtain alternative treatment orders and/or specific orders for monitoring resident while medication is on hold . 5. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reactions to omission of the medication. On 8/28/24, during a mid-day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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** 41449 Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to maintain a complete and accurate clinical record for four residents (resident #79-R79, resident #57-R57, resident #32-R32 and resident #93-R93), in a survey sample of 31 residents. The findings included: 1. For Resident #79, the facility staff failed to maintain an accurate clinical record with regards to the changing of oxygen tubing and nebulizer tubing and mask. During initial tour on [DATE] at approximately 6:30 p.m., R79 was visited in her room. It was observed that R79 had a nebulizer on her bedside table. The nebulizer mask was sitting in the top drawer of the bedside table and was open to air. The nebulizer mask and tubing were dated [DATE], as the date it was changed. On [DATE] at 7:09 p.m., an interview was conducted with licensed practical nurse (LPN) #4. LPN #4 was asked about oxygen and nebulizer tubing and the frequency they were changed, LPN #4 said they are to be changed weekly. On [DATE] at 8:31 a.m., R79 was observed with her oxygen tubing and nebulizer tubing stored in a bag. The nebulizer mask that was removed was observed in the trash can at R79's bedside. On [DATE] at 8:33 a.m., an interview was conducted with the unit manager. The unit manager said that oxygen tubing was to be changed weekly and said, this unit is set for Sundays. When asked where it would be documented, the unit manager said, it should be documented on the TAR (treatment administration record) on the night shift. The unit manager then accompanied the surveyor to R79's room and confirmed that the nebulizer had been changed that day [DATE]. The discarded nebulizer mask in the trash was confirmed to be dated [DATE]. On [DATE], a clinical record review was conducted of R79's chart. The physician orders read, Change O2/Nebulizer tubing, humidification bottle (label and date tubing) and bag cover every week every night shift every Thu [Thursday]. The TAR was signed off, to indicate it had been changed [DATE], [DATE], and [DATE], despite it being dated [DATE]. On [DATE] at approximately 1:30 p.m., the above findings were shared during a meeting with the facility administrator and director of nursing. The facility policy titled; Nebulizer Therapy was reviewed. The policy read in part, . 2. Care of the Equipment . h. Change nebulizer tubing once weekly . No additional information was provided. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. For R57, who was being treated by a dermatologist, the facility failed to maintain a complete and accurate clinical record to include treatment notes from the dermatologist. On [DATE] at approximately 6:50 p.m., R57 was visited in his room. R57 had a hospital gown on that left his back exposed as well as his arms and legs. It was noted that R57 had red lesions areas all over his visible body parts and some had dried blood. R57 was asked about it and reported it was scabies. On [DATE], a clinical record review was conducted. This review revealed multiple entries within the nursing notes that were written by the on-site medical provider that referenced the diagnosis of scabies and being seen by a dermatologist. The most recent entry that noted the scabies diagnosis was dated [DATE]. It read in part, Chief Complaint/Reason for this Visit: Patient who presents today for a medication review and follow-up on scabies treatment. HPI [history and physical information] Relating to this Visit: Patient was diagnosed with scabies by a dermatologist after a second skin scraping, with the first one being negative. Patient has been using permethrin cream, with one dose given last week and the second dose recently administered. They report improvement in itching and a reduction in small areas of excoriation on their arms. However, they still have some affected areas on their bilateral legs and belly. Patient is also taking hydroxyzine three times a day and clobetasol for their skin condition The various sections of the clinical record were reviewed with no information from the dermatologist found. On [DATE] in the mid-morning, the unit manager was interviewed. The unit manager confirmed that R57 had been dealing with the rash for an extended time and the scrapings they did were all negative. Dermatology was consulted and did a biopsy, which confirmed it was scabies. When advised that the surveyor was not able to find any information from the dermatologist, the unit manager reviewed R57's chart and confirmed the information was not present. She stated she would check up front to make sure it just had not been scanned into the record yet. On [DATE] in the afternoon, the unit manager provided the surveyor with notes from the dermatologist. The unit manager confirmed they did not have them at the facility, and she had called the dermatologist, and they faxed the information over. When asked if this information would have been expected to be a part of R57's clinical record she stated yes. 3. For R32, the facility staff failed to maintain a complete clinical record to include information from dialysis regarding dialysis treatment sessions. On [DATE] at approximately 8:15 am. R32 was visited in his room. When asked about communication between the facility and the dialysis center, the resident reported there was a folder that gets sent with him at times, but no one fills out anything. On [DATE] at 8:57 a.m., LPN #5 was asked how they communicate with dialysis and know what has occurred at dialysis. The nurse said there should be a book but was unable to find one. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495146	A. Building B. Wing	08/28/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ridge Rehabilitation and Nursing	94 South Avenue 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.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On [DATE] at 9:15 a.m., the unit manager was asked about communication between the facility and dialysis. She stated there is a book that they send back and forth. When asked if she could locate the book for the surveyor, she was not able to. The unit manager reviewed R32's electronic health record and confirmed that no information was within the chart with regards to dialysis visits. On [DATE] at approximately 9:20 a.m., the unit manager provided the surveyor with a dialysis communication book for R32, which she found at the nursing station on the other unit within the facility. According to R32's clinical record and census tab, R32 had been transferred to the current unit on [DATE]. When the surveyor looked at the book, it was full of blank pages, with no information filled in. R32's clinical record had no information with regards to communication between the facility and dialysis, nor any treatment details, medications given while at dialysis, pre and post dialysis weights on a routine basis or any complications encountered during dialysis sessions. On [DATE] at 9:24 a.m., an interview was conducted with the unit manager. When asked if she had looked at the dialysis communication book, she said, I didn't look at it but I'm sure it is not up to date because it was on the other unit. When asked what the purpose of the dialysis communication book is, she said, to monitor how they do while they are there, record their heavy weight and dry weight. They don't write stuff down for us. Review of the dialysis contract executed [DATE], between the facility and the dialysis center was conducted. The contract read in part, . Shared communication between both parties: the care of the resident receiving dialysis services must reflect ongoing communication, coordination and collaboration between the nursing home and the dialysis staff. The communication progress should include how the communication will occur, who is responsible for communicating, and where the communication and response will be documented in the medical record . On [DATE] at 1:30 p.m., during a meeting with the survey team and the facility administrator and director of nursing, the above findings were discussed. No additional information was provided. 4. For resident #32- R32, the facility staff failed to maintain an accurate clinical record with regards to wound treatments being performed as ordered by the physician. On [DATE] at 7:16 p.m., R32 was visited in his room. During the interview, R32 reported, I developed a foot ulcer and went on to say that the facility staff are supposed to change the bandage every other day, but often times they miss treatments. R32 reported it was last changed, day before yesterday. R32 also reported he was scheduled for amputation of a toe on his left foot on [DATE]. On [DATE], a clinical record review was conducted. This review revealed the following physician orders: cleanse left 2nd toe with NS [normal saline] or DWC [dermal wound cleanser], pat dry, apply hydrofera or derma blue and cover with fluff gauze and cleanse left heel with NS or DWC, pat dry, apply hydrofera or derma blue to wound bed, cover with dry dressing. The directions with those two orders read, Every day shift every other day. Documentation within the chart revealed the wounds were vascular in nature and not pressure wounds. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the treatment administration record (TAR), R32 had received wound treatments to the left toe and heel on [DATE], as indicated by the treatment being signed off. On [DATE] at 9:05 a.m., the surveyor visited R32 who reported, I was waiting for the wound nurse to come yesterday because it was due, but I didn't see anyone. On [DATE] at 9:35 a.m., the unit manager was accompanied by the surveyor to R32's wound to observe the wound. It was noted that the wound had drained through the bandage and onto the bed linen. The dressing on the foot was dated [DATE], which was confirmed by the unit manager. The unit manager said, this had been an ongoing problem of staff not changing his bandage as ordered. The unit manager was told by the surveyor that the resident reported this happens frequently where his dressings are not done as ordered, she said, It does, and as a wound nurse you can't be here 24 hours a day and you expect them to do what they are supposed to do. No additional information was provided. 49456 5. The facility failed to accurately document R93's code status. The nurse practitioner noted R93 as a full code and CPR was to be performed and according to the care plan and physician orders R93 was a do not resuscitate (DNR). On [DATE] a clinical record review was conducted. A DNR was in the clinical record and signed on [DATE] by R93. R93's care plan, that was revised on [DATE] had R93 as a DNR. R93 had a physician's order the code status to be a DNR and was dated [DATE]. The nurse practitioner had a progress note dated [DATE] and it read in part, .Code status, Full Code - attempt CPR {Cardiopulmonary resuscitation}. The nurse practitioner had a progress note dated [DATE] and it read in part, .Code status, Full Code - attempt CPR {Cardiopulmonary resuscitation}. On [DATE] at 2:00 p.m. an interview was conducted with the director of nursing (DON). The DON stated, she does not know why she [nurse practitioner] put that in her notes and she will speak with her. On [DATE] at the end of day meeting the above concerns were discussed with the DON, the administrator and the nurse consultant. No new information was provided.