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	02/19/2025

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 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. Based on staff interviews, clinical record review, and facility documentation review the facility staff failed to provide notification to the family of a change in condition for one resident (Resident #2, R2) out of a survey sample of 11 residents. The findings included: The facility staff failed to notify the family that R2 was sent to the emergency room. On 2/19/25 at 9:45 a.m. an interview was conducted with licensed practical nurse, LPN#5 (LPN5), unit manager on the A wing. LPN5 stated that it was only one appointment she was aware of that R2 had missed. LPN5 stated that when dialysis sent R2 to the emergency room (ER), they did not let the son know and when the transport company came back to the facility to pick up someone the transport driver let the facility know R2 was transported to the ER from dialysis. LPN5 said, we didn't notify the son when we found out, no one notified the son she was at the emergency room. He found out when he came to take her to an appointment the next day. LPN5 stated that someone from the facility was supposed to notify the son when we found out R2 was at the emergency room. On 2/19/25 at 10:15 a.m. a clinical record review was conducted. A progress note was reviewed that was written on 10/15/25. The progress notes in R2's chart read, [hospital name redacted] called for patient status. Notified that patient has been admitted . On 2/19/25 at 10:45 a.m. a review of the facility documentation was conducted. The facility document titled, Notification of changes, read in part, .The purpose of this policy is to ensure the facility promptly informs the resident, consults the resident's physician; and notifies, consistent with his or her authority, resident's representative when there is a change requiring notification. On 2/19/25 at 11:45 a.m. an end of day meeting was conducted with the administrator and director of nursing, and the above concerns were discussed. No further information was provided prior to the conclusion of the survey.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, clinical record review, staff interview and facility documentation review the facility staff failed to administer oxygen according to physician orders for two residents (Resident#3, R3 and Resident #4, R4) out of a survey sample of 11 residents. The findings included: 1. The facility staff failed to have R3's oxygen concentrator providing the correct number of liters per minute according to the physician's order. On 2/18/25 at 2:50 pm an observation was conducted of R3's oxygen concentrator. The oxygen was set on three liters per minute. On 2/18/25 at 3:00 p.m. a clinical record review was conducted. The physician orders were reviewed. The oxygen order read, Oxygen continuous 2LPM [liters per minute] via NC [nasal cannula]. The treatment administration record was signed off by the registered nurse, RN# 1 (RN1) on 2/18/25. RN1 signed that R3 was receiving oxygen at 2LPM. On 2/18/25 at 3:15 p.m. an interview was conducted with RN1. RN1 was in R3's room and was asked to look at the oxygen concentrator setting. R1 said, It's on 3LPM and should be on 2LPM. R1 adjusted the oxygen concentrator setting to 2LPM. 2. The facility staff failed to have R4's oxygen concentrator providing the correct number of liters per minute according to the physician's order. On 2/18/25 at 2:55 pm an observation was conducted of R4's oxygen concentrator. The oxygen was set on two and half liters per minute. On 2/18/25 at 3:00 p.m. a clinical record review was conducted. The physician orders were reviewed. The oxygen order read in part, .supplemental O2 [oxygen] 2L, if < 92% on 2L may increase to 3L. On 2/18/25 at 3:15 p.m. an interview was conducted with RN1. RN1 was in R4's room and was asked to look at the oxygen concentrator setting. R1 said, It's on 2.5LPM and should be on 2LPM and can have 3 liters if oxygen saturations are less than 92%. R1 adjusted the oxygen concentrator setting to 2LPM. On 2/19/25 at 11:15 a.m., a review of facility documentation was completed. The facility document titled, Oxygen Administration, read in part, .oxygen is administered under orders of a physician. On 2/19/25 at 11:45 a.m., an end of day meeting was conducted with the administrator and director of nursing, and the above concerns were discussed. No further information was provided prior to the conclusion of the survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495146	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/19/2025
NAME OF PROVIDER OR SUPPLIER: Blue Ridge Rehabilitation and Nursing		STREET ADDRESS, CITY, STATE, ZIP CODE: 94 South Avenue Harrisonburg, VA 22801	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to honor resident's food preferences for two residents (Resident #5, R5 and Resident #6, R6) out of a survey sample of 11 residents. The findings included: 1. The facility staff served R5 foods that were listed on the meal ticket as food dislikes. On 12/18/25 at 12:15 p.m., an observation was conducted of the lunch meal. During the observation, the surveyor observed R5's meal ticket. R5 was served carrots, broccoli and cauliflower, and all three of these foods were listed under her food dislikes list on her meal ticket. On 12/18/25 at 12:30 p.m., an interview was conducted with R5. R5 said, I get food I don't like often, and I just leave it on my plate. On 12/19/25 at 9:05 a.m., an interview was conducted with the dietary manager. The dietary manager stated the purpose for the food dislikes on the meal ticket was for dietary to know the resident's preferences and what the resident does not like to eat. The dietary manager said, If food dislikes were carrots, broccoli and cauliflower, they should not have been served and should have been substituted with another vegetable. The servers should go by their meal tickets. 2. The facility staff served R6 foods that was listed on the meal ticket as food dislikes. On 12/18/25 at 12:15 p.m. an observation was conducted of the lunch meal. During the observation, the surveyor observed R6's meal ticket. R6 was served carrots, and this food was listed on her food dislikes list on her meal ticket. On 12/18/25 at 12:35 p.m. an interview was conducted with R6. R6 said, It doesn't matter, nothing will be done about this. On 12/19/25 at 9:05 a.m. an interview was conducted with the dietary manager. The dietary manager stated the purpose for the food dislikes on the meal ticket was for dietary to know the resident's preferences and what the resident does not like to eat. The dietary manager said, I f food dislikes was carrots, they should not have been served the melody and should have been substituted with another vegetable. The servers should go by their meal tickets. On 2/19/25 at 11:00 a.m. a facility documentation review was conducted. The policy titled, Food Preparation Guidelines, read in part, honoring resident preferences, as possible, regarding food and drinks. On 2/19/25 at 11:45 a.m. an end of day meeting was conducted with the administrator and director of nursing. The administrator handed the surveyor an updated preference assessment completed today by the dietary manager for R5 and an education sign in sheet for the dietary department on food preferences completed today. (continued on next page)

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to the conclusion of the survey.