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	05/06/2026

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 interview, clinical record review, and facility document review, the facility staff failed to inform the physician of a change in condition timely for one of nine residents in the survey sample, (Resident #3). The findings include:The physician was not notified of a change in condition (nausea and vomiting) timely for Resident #3 (R3). Diagnoses for R3 included congestive heart failure, end stage renal disease, chronic obstructive pulmonary disease, metabolic encephalopathy, and acute cystitis without hematuria. The most current MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 12/17/25. R3 was assessed with a cognitive score of 11 indicating moderately cognitively impaired. Review of R3's clinical record revealed the following via progress notes: A nurse practitioner note dated 3/23/26 indicated R3 was being seen for nausea and vomiting. The nurse practitioner ordered Zofran for nausea and due to history, ordered urinalysis for possible urinary tract infection (UTI). A nurses assessment note dated 3/24/26 indicated that R3 stated had complained of nausea for the past several days. Prior to the nurse practitioner note dated 3/23/26 there were no notes regarding R3 having nausea and vomiting. The last progress note prior to 3/23/26 was dated 3/18/26 and did not include any concerns with R3. On 5/4/26 at 1:00 p.m. registered nurse (RN #1, nurse that wrote the note on 3/24/26) was interviewed. RN #1 verbalized being on a four-day break and upon returning noticed that R3 was not at baseline and it was reported that by R3 of feeling nauseated and had been vomiting for the past few days. On 5/4/26 at 1:35 p.m. the facilities nurse practitioner (NP) was interviewed. NP verbalized while assessing R3's roommate, R3 had reported not feeling well over the weekend and had had some nausea and vomiting. NP said that there was a basin at R3's bedside containing a small amount of gastric emesis. NP verbalized assessing R3 and ordered an antiemetic and a urinalysis due to a history of UTI. NP said that the staff should have contacted 3rd eye (an outside company) about the change in condition or tried to contact an on-call person to let them know of the change in condition but was unaware of any concerns until speaking with R3. On 5/4/26 at 6:15 p.m. license practical nurse (LPN #1, nurse responsible for documenting a change of condition) was interviewed. LPN #1 verbalized being assigned to R3 on the night shift on 3/22/26. LPN #1 verbalized during report given by the off going 3-11 shift it was reported that R3 had been nauseated and had vomited. LPN #1 verbalized there was no documentation of the change in condition on any of the previous shifts, which prompted LPN#1 to document a change in condition report. A policy titled Notification of Changes read in part: The facility must inform [.] the physician [.] when there is a change requiring such notification. Circumstances requiring notification include: [.] Circumstances that require a need to alter treatment. On 5/5/26 at 2:30 p.m. the above finding was presented to the director of nursing and administrator. No other information was presented prior to exiting the facility on 5/5/26.

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
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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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on staff interviews, facility document review and clinical record review, the facility staff failed to follow professional standards of quality for one of nine residents in the survey sample (Resident #3). The findings include:The facility staff did not document assessments regarding a change in condition for Resident #3 (R3). Diagnoses for R3 included congestive heart failure, end stage renal disease, chronic obstructive pulmonary disease, metabolic encephalopathy, and acute cystitis without hematuria. The most current MDS (minimum data set) was an admission assessment with an ARD (assessment reference date) of 12/17/25. R3 was assessed with a cognitive score of 11 indicating moderately cognitively impaired. Review of R3's clinical record revealed the following via progress notes: A nurse practitioner note dated 3/23/26 indicated R3 was being seen for nausea and vomiting. The nurse practitioner ordered Zofran for nausea and due to history, ordered urinalysis for possible urinary tract infection (UTI). Prior to the nurse practitioner note dated 3/23/26 there were no notes regarding R3 having nausea and vomiting. The last progress note prior to 3/23/26 was dated 3/18/26 and did not include any concerns with R3. A nurses assessment note dated 3/24/26 indicated that R3 stated had complained of nausea for the past several days. On 5/4/26 at 1:00 p.m. registered nurse (RN #1, nurse that wrote the note on 3/24/26) was interviewed. RN #1 verbalized being on a four-day break and upon returning noticed that R3 was not at baseline and it was reported by R3 of feeling nauseated and had been vomiting for the past few days. On 5/4/26 at 1:35 p.m. the facilities nurse practitioner (NP) was interviewed. NP verbalized while assessing R3's roommate (the morning of 3/23/26), R3 had reported not feeling well over the weekend and had had some nausea and vomiting. NP said that there was a basin at R3's bedside containing a small amount of gastric emesis. NP verbalized assessing R3 and ordered an antiemetic and a urinalysis due to R3 having to a history of UTI. NP said that the staff should have contacted 3rd eye (an outside company) about the change in condition or tried to contact an on-call person to let them know of the change in condition but was unaware of any concerns until speaking with R3. NP said that staff seemed aware of the change in condition and were monitoring the concern, however there was no documentation to review regarding the concern. On 5/4/26 at 3:00 p.m. the director of nursing (DON) was interviewed regarding documenting in the clinical record. The DON verbalized that typically documentation (in progress notes) is not done when a resident is not skilled unless there is a concern. On 5/4/26 at 6:15 p.m. license practical nurse (LPN #1, nurse responsible for documenting a change of condition) was interviewed. LPN #1 verbalized being assigned to R3 on the night shift on 3/22/26. LPN #1 verbalized during report given by the off going 3-11 shift it was reported that R3 had been nauseated and had vomited. LPN #1 verbalized doing an assessment on R3 and monitoring throughout the night and did not have any vomiting episodes but was nauseated. LPN #1 said that there was no documentation from the previous shifts although the concern had been verbally reported from one shift to the other and was being monitored and addressed. LPN #1 said that typically there should be documentation in progress notes indicating the status of a resident that has had a change in condition. LPN #1 verbalized that due to the concerns going on with R3 and the day shift nurse (RN #1) coming back from being off, saying R3 was not at her baseline led to the documentation of a change in condition. The facility policy titled Documentation in Medical Record read in part: Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include information to provide a picture of the resident's progress through complete, accurate, and timely documentation. 1. Licensed staff and interdisciplinary team members shall document all assessments, observations, and services provided in the resident's medical record in accordance with state law and facility policy. 2. Documentation shall be completed at the time of service, but no later than the shift in which the assessment, observation, or care service occurred. On 5/5/26 at 2:30 p.m. the above finding was presented to the director of nursing and administrator. No other information was presented prior to exiting the facility on 5/5/26.