

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495302	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 09/13/2025
NAME OF PROVIDER OR SUPPLIER Forest Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 2406 Atherholt Road Lynchburg, VA 24501	

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 0602 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from the wrongful use of the resident's belongings or money. (continued on next page)

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 0602</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, document review, and facility policy review, the facility failed to protect a resident's right to be free from misappropriation of resident property for 1 (Resident #98) of 4 sampled residents reviewed for abuse. Specifically, Licensed Practical Nurse (LPN) #18 misappropriated Resident #98's oxycodone pain medication without the resident's permission on 04/11/2025. Findings included: A facility policy titled, Virginia Resident Abuse Policy revised 07/11/2024, indicated, POLICY: The facility will not tolerate the abuse, neglect, mistreatment, exploitation of residents, or misappropriation of resident property by anyone. The policy specified, Misappropriation - the deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent. A Resident Face Sheet revealed the facility admitted Resident #98 on 03/18/2025. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of pain, osteoarthritis, and low back pain. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/19/2025, revealed Resident #98 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated the resident had moderate cognitive impairment. The MDS revealed the resident had frequently, almost constant pain received a scheduled pain medication regimen and as needed pain medication. Resident #98's Care Plan included a problem statement initiated 04/03/2025, that indicated the resident had a potential for pain related to a sacral wound, gastroenteritis and colitis, pain, cramp and spasm, low back pain, and osteoarthritis of the hip. Interventions directed staff to administer medications for pain prior to therapy sessions, dressing changes as needed, or per specific orders (initiated 04/09/2025). Resident #98's Order History for the timeframe 03/01/2025 to 09/09/2025, revealed an order dated 03/28/2025, for oxycodone 5 milligrams, one tablet every four hours as needed. The Facility Reported Incident Investigation indicated on 04/14/2025, the Social Services Director (SSD) notified the Director of Nursing (DON) that Resident #98's family member (FM) that the resident had not been given their as needed pain medication as requested on 04/11/2025. Per the Facility Reported Incident Investigation, upon review of the narcotic control count log sheet for oxycodone, three tablets were removed on 04/11/2025 by Licensed Practical Nurse (LPN) #18 and the resident declined receiving the prescribed narcotic pain medication. The Facility Reported Incident Investigation revealed Conclusion Upon a complete and thorough investigation, the facility is able to substantiate medication diversion. This is evidenced by resident statements and narcotic count review on 4/14/25. [Name] Pharmacy, the local police dept [department] and the provider have been notified of this. There has not been any identified negative outcome as a result of the diversion of medications. All residents including [Resident #98] remain safe in the facility at this time. Telephone calls were made to LPN #18 on 09/11/2025 at 2:35 PM and 09/12/2025 at 9:00 AM. There was no answer and the voicemail had not been set up. The DON was interviewed on 09/10/2025 at 12:50 PM and stated LPN #18 was terminated and reported to the state's Board of Nursing. The Assistant Director of Nursing (ADON) was interviewed on 09/12/2025 at 10:04 AM and stated when she was notified of the incident, she spoke with Resident #98, who stated LPN #18 informed them that the oxycodone was not available, yet it had been signed out as given by LPN #18. The ADON stated that after the incident all licensed nurses were required to receive education about drug diversion. She stated that all narcotic cards for residents cared for by LPN #18 were pulled, and interviews were completed with the residents she cared for to determine if other issues existed. The DON was interviewed on 09/12/2025 at 4:24 PM and stated when she notified of the incident, she began an investigation to include a review of the narcotic count log sheets, a count of the narcotics in the medication cart, interview and assessment of the resident, and interview with LPN #18. The DON stated that during the narcotic count, missing medications were identified and LPN #18 told her that she could not remember what happened, but that she had given the resident the medication. When narcotic count was completed, the DON stated she removed the keys to the medication cart from LPN #18, took LPN #18 to her office, and asked LPN #18 to write a statement. The DON stated a urine drug screen was obtained but was not valid due to the temperature of the urine and suspicion that the specimen was not urine. The DON stated LPN #18 was asked to submit another urine specimen for a drug screen but declined and exited the facility. The DON stated LPN #18 had not returned to the facility after 04/14/2025. The DON stated all narcotic logs were pulled in the entire facility, both west and east wings and no other discrepancies were found other than what LPN #18 had been involved with. Per the DON for 12 weeks, each cart was audited to make sure narcotics</p>		