STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495306	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ridge Therapy Connection	105 Landmark Drive Stuart, VA 24171

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record, and facility document review, the facility staff failed to develop a comprehensive care plan for 6 of 33 current residents, Residents #1, #6, #126, #2, #12, and #17. The findings include. 1. For Resident (R) #1, the facility staff failed to develop a comprehensive care plan (CCP) that included their current code status. R1's clinical record included the diagnoses of toxic encephalopathy, unspecified abnormalities of gait and mobility, and muscle weakness. Section C (cognitive patterns) of R1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of [DATE] included a brief interview for mental status (BIMS) score of 11 out of a possible 15 points. Per the MDS manual an 11=moderately impaired in cognitive skills for daily decision making. R1's clinical record included a Do Not Resuscitate (DNR) order dated [DATE]. During a review of the clinical record the surveyor was unable to find information regarding R1's current code status included on the CCP. On [DATE] at 1:40 p.m., MDS nurse #1 was asked for information related to the care planning of R1's code status. On [DATE] at 2:35 p.m., MDS nurse #1 provided the surveyor with a copy of an updated CCP that now included R1's current code status. On [DATE] at 5:15 p.m. and again on [DATE] at 1:25 p.m., during meetings with the Administrator, Director of Nursing, Quality Assurance Nurse, Nurse Consultant #1 and #2, Assistant Director of Nursing, and Infection Preventionist the issue with the CCP not including information regarding this individual's code status was reviewed. The administrative staff provided the survey team with a copy of their policy titled, Care Planning-Comprehensive Person-Centered. This policy read in part, .The facility will develop and implement a comprehensive person-centered care plan for each resident. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident (R) #6, the facility staff failed to develop a comprehensive care plan (CCP) that (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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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	included their current code status. R6's diagnoses included cognitive communication deficit, dysphagia, history of falling, and diabetes. Section C (cognitive patterns) of R6's significant change in status minimum data set (MDS) assessment with an assessment reference date (ARD) of [DATE] was coded [DATE] indicating R6 had problems with long- and short-term memory and was severely impaired in cognitive skills for daily decision making. R6's clinical record included a Do Not Resuscitate (DNR) order dated [DATE]. During a review of the clinical record the surveyor was unable to find information regarding R6's current code status included on the CCP. On [DATE] at 2:35 p.m., MDS nurse #1 provided the surveyor with a copy of an updated CCP that now included R6's current code status. On [DATE] at 5:15 p.m. and again on [DATE] at 1:25 p.m., during meetings with the Administrator, Director of Nursing, Quality Assurance Nurse, Nurse Consultant #1 and #2, Assistant Director of Nursing, and Infection Preventionist the issue with the CCP not including information regarding this individual's code status was reviewed. The administrative staff provided the survey team with a copy of their policy titled, Care Planning-Comprehensive Person-Centered. This policy read in part, .The facility will develop and implement a comprehensive person-centered care plan for each resident. No further information regarding this issue was provided to the survey team prior to the exit conference. 3. For Resident (R) #126, the facility staff failed to develop a comprehensive care plan (CCP) that included their current code status. R126's diagnoses included hemiplegia and hemiparesis following cerebral infarction, gastro esophageal reflux disease, and chronic respiratory failure. Section C (cognitive patterns) of R126's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of [DATE] was coded [DATE] to indicate this resident had problems with long- and short-term memory and was severely impaired in cognitive skills for daily decision making. R126's clinical record included a Do Not Resuscitate (DNR) order dated [DATE]. During a review of the clinical record the surveyor was unable to find information regarding R6's current code status included on the CCP. On [DATE] at 2:35 p.m., MDS nurse #1 provided the surveyor with a copy of an updated CCP that had been updated to include R126's current code status. On [DATE] at 5:15 p.m. and again on [DATE] at 1:25 p.m., during meetings with the Administrator, (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Director of Nursing, Quality Assurance Nurse, Nurse Consultant #1 and #2, Assistant Director of Nursing, and Infection Preventionist the issue with the CCP not including information regarding this individual's code status was reviewed. The administrative staff provided the survey team with a copy of their policy titled, Care Planning-Comprehensive Person-Centered. This policy read in part, .The facility will develop and implement a comprehensive person-centered care plan for each resident. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #2 the facility staff failed to develop and implement a comprehensive person-centered care plan to address trauma informed care related to a diagnosis of PTSD (post-traumatic stress disorder) and the facility staff failed to develop and implement a comprehensive person-centered care plan to address the resident's end-of-life care decisions and/or advance directive for DNR (do not resuscitate). Resident #2's diagnosis list indicated diagnoses that included but were not limited to Weakness, Rupture of Artery, Gastrointestinal Hemorrhage, Ruptured Infrarenal Abdominal Aortic Aneurysm, Post-Traumatic Stress Disorder, Malignant Neoplasm of Prostate, Depression, Atrial Fibrillation, Peripheral Vascular Disease, Chronic Kidney Disease-Stage 2, and Anxiety Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of [DATE], assigned the resident a brief interview for mental status (BIMS) summary score of 13 out of 15 for cognitive abilities, indicating the resident was cognitively intact. On [DATE] at 12:47 PM, surveyor spoke with Resident #2 and he informed surveyor he had served in the United States Army and had PTSD and has been seeing a therapist for years. A review of the person-centered comprehensive care plan did not reveal a focus, goal, and/or interventions for trauma informed care related to Resident #2's diagnosis of PTSD. On [DATE] at 2:03 PM, surveyor spoke with other staff #2 (OS#2) and he informed surveyor when residents are admitted he performs trauma screens and asks the residents about triggers and it should be care planned. Surveyor and OS#2 reviewed Resident #2's care plan and he agreed a PTSD (trauma-informed) care plan focus could not be located for the resident. A medical provider orders with a start date of [DATE] read in part, .Code Status: DNR. A review of a Durable Do Not Resuscitate Order dated [DATE] disclosed Resident #2's informed decision to have life-prolonging procedures withheld or withdrawn in the event of cardiac or respiratory arrest. A review of the person-centered comprehensive care plan did not reveal a focus, goal, and/or interventions to address Resident #2's end of life care decisions and/or advance directive for DNR. These concerns were discussed on [DATE] at 5:16 PM at the end of day meeting with the administrator, director of nursing, assistant director of nursing, regional nurse consultant, infection preventionist, and quality assurance nurse. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor was provided with a care plan focus dated [DATE] which read in part, .The resident has advance directives in place. An intervention dated [DATE] read in part, .The resident has a DNR on file. Surveyor requested and received a facility policy titled, Care Planning-Comprehensive Person-Centered, which read in part, .2. The facility will develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs as identified.13. The comprehensive care plan will.d. Be culturally competent and trauma informed as applicable.J. Reflect currently recognized standards of practice for problem areas and conditions. Surveyor requested and received a facility policy titled, Advance Directives which read in part, .10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive.The plan of care will be reviewed periodically to ensure consistency with the resident's choice regarding Advanced {sic} Directive decisions. No further information regarding this issue was provided to the survey team prior to the exit on [DATE]. 5. For Resident #12 the facility staff failed to develop and implement a comprehensive person-centered care plan to address the resident's end of life care decisions and/or advance directive for DNR (do not resuscitate). Resident #12's diagnosis list indicated diagnoses that included, but were not limited to, PTSD (post-traumatic stress disorder), Anxiety Disorder, Schizoaffective Disorder-Bipolar Type, Parkinson's Disease, Depression, Mild Cognitive Impairment, Weakness, and Diabetes Mellitus Type 2. The most recent minimum data set (MDS) with an assessment reference date (ARD) of [DATE], assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A medical provider orders with a start date of [DATE] read in part, .Code Status: DNR. A review of a Durable Do Not Resuscitate Order dated [DATE] disclosed Resident #12's informed decision to have life-prolonging procedures withheld or withdrawn in the event of cardiac or respiratory arrest. A review of the person-centered comprehensive care plan did not reveal a focus, goal, and/or interventions to address Resident #12's end of life care decisions and/or advance directive for DNR. These concerns were discussed on [DATE] at 5:16 PM at the end of day meeting with the administrator, director of nursing, assistant director of nursing, regional nurse consultant, infection preventionist, and quality assurance nurse. Surveyor requested and received a facility policy titled, Advance Directives which read in part, .10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive.The plan of care will be reviewed periodically to ensure consistency with the resident's choice regarding Advanced {sic} Directive decisions. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information regarding this issue was provided to the survey team prior to the exit on [DATE]. 6. For Resident #17 the facility staff failed to develop and implement a comprehensive person-centered care plan to address the resident's end of life care decisions and/or advance directive for Full Code (medical definition means that in the event of a cardiac or respiratory arrest, healthcare providers will use all possible life-saving measures, including cardiopulmonary resuscitation (CPR), intubation, defibrillation, and other indicated interventions, without any limitations). Resident #17's diagnosis list indicated diagnoses that included, but were not limited to, Bipolar Disorder, Anxiety Disorder, Panic Disorder, Tremor, Legal Blindness, Heart Failure, Dermatitis, Chronic Pain Syndrome, Chronic Obstructive Pulmonary Disease, Depression, Schizoaffective Disorder, Epilepsy, and Torticollis. The most recent minimum data set (MDS) with an assessment reference date (ARD) of [DATE], assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A medical provider orders with a start date of [DATE] read in part, .Full Code. A review of a Preferred Intensity of Care dated [DATE] disclosed Resident #17's informed decision to have life-prolonging procedures (CPR) to restore cardiovascular and respiratory functions in the event of cardiac or respiratory arrest. A review of the person-centered comprehensive care plan did not reveal a focus, goal, and/or interventions to address Resident #17's end of life care decisions and/or advance directive for CPR (full code). These concerns were discussed on [DATE] at 5:16 PM at the end of day meeting with the administrator, director of nursing, assistant director of nursing, regional nurse consultant, infection preventionist, and quality assurance nurse. Surveyor requested and received a facility policy titled, Advance Directives which read in part, .10. The plan of care for each resident will be consistent with his or her documented treatment preferences and/or advance directive.The plan of care will be reviewed periodically to ensure consistency with the resident's choice regarding Advanced {sic} Directive decisions. No further information regarding this issue was provided to the survey team prior to the exit on [DATE].

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to treat each resident with respect and dignity for one of 33 current residents in the survey sample, resident # 155 (R155).The findings included: R155's diagnoses included but were not limited to unspecified dementia without behavioral disturbance, major depressive disorder, anxiety disorder, heart failure, hypertension, and generalized weakness. The minimum data set (MDS) assessment with an assessment reference date of 7/22/2025 indicated that R155 has impaired short- and long-term memory as well as impaired decision-making capabilities and is dependent on staff for all activities of daily living (ADL) care. On 9/24/2025 at approximately 8:30 AM this surveyor was walking down the second-floor corridor toward the dining room and witnessed an Activity Assistant approach R155, who was sitting in a wheelchair by the door of their room. The Activity Assistant began to push R155 toward the dining room where staff were serving breakfast. This surveyor witnessed certified nursing assistant (CNA) # 4 yell out to the Activity Assistant, She's a feeder and you can't bring her in here right now! The Activity Assistant hesitated and asked, what? CNA #4 repeated, She's a feeder, don't bring her in here! The Activity Assistant parked R155 in the hall. This surveyor proceeded to the dining room and noted 5 staff members not including CNA #4 and approximately 20 residents in the room, all who witnessed this interaction. On 9/24/25 at 8:40 AM this surveyor interviewed CNA #4. When asked to repeat what was said regarding R155, they stated, I was telling her not to bring (R155 name omitted) in here because she is a feeder and we are ready for the feeders yet. This surveyor asked CNA #4 if they have ever had training on dignity and resident rights and they stated that they get monthly in-services that do include those topics both in person and on the computer. They stated, I guess that wasn't the right thing to say, was it? This surveyor requested and received a copy of the policy entitled, Dignity that read in part, Each resident shall be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. The policy defined dignity as, Dignity is the right of a person to be valued and respected for their own sake, and to be treated ethically. Under number the heading, Specific Procedures the document read in part, When assisting with care, residents are supported in exercising their rights. For example, residents are e. Provided with a dignified dining experience .8. Staff speak respectfully to residents at all times, including addressing the resident by his or her name of choice and not labelling or referring to the resident by his or her room number, diagnosis, or care needs . 10. Staff protect confidential clinical information. Examples include the following: a. Verbal staff to staff communication (e.g., change of shift reports) are conducted outside the hearing range of residents and the public. On 9/25/25 at 1:25 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse, Infection Preventionist and two regional consultants. This concern was discussed with them at this time. No further information was provided to the survey team prior to the exit conference.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on staff interview, clinical record review, and facility document review the facility staff failed to complete a Level II Preadmission Screening and Resident Review (PASARR) for 1 of 33 current sampled residents. (Resident #12)The findings included:For Resident #12, the facility staff failed to complete a level II PASARR (pre-admission screening and resident review). A PASARR is a federal requirement to help ensure that individuals are not inappropriately placed in nursing homes for long term care. Resident #12's diagnosis list indicated diagnoses that included, but were not limited to, PTSD (post-traumatic stress disorder), Anxiety Disorder, Schizoaffective Disorder-Bipolar Type, Parkinson's Disease, Depression, Mild Cognitive Impairment, Weakness, and Diabetes Mellitus Type 2. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 6/18/25, assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 for cognitive abilities, indicating the resident was cognitively intact. A review of the clinical record revealed that Resident #12 had short term approval for a level II PASARR through 7/20/25. This concern was discussed on 9/24/25 at 5:16 PM at the end of day meeting with the administrator, director of nursing, assistant director of nursing, regional nurse consultant, infection preventionist, and quality assurance nurse. On 9/25/25 at 8:57 AM, the facility administrator informed this surveyor that a level II PASARR was not completed and she provided surveyor with a fax cover sheet indicating the request for a new level II PASARR was initiated on 9/24/25. Surveyor requested and received a facility policy titled, Long-Term Services and Supports (LTSS) Screening, Preadmission Screening and Resident Review (PASARR) which read in part, .4. Annual Review a. The state designated authority will review residents of the facility who have had a Level II evaluation at least once a year. No further information regarding this issue was provided to the survey team prior to the exit on 9/25/25.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility document review, the facility staff failed to provide the resident or resident representative with a copy of the baseline care plan for one of 37 residents in the survey sample, resident #28 (R28). The findings included:For R28 the facility staff were unable to provide evidence that the baseline care plan had been provided to the resident, or the residents authorized representative.R28's diagnoses included but were not limited to cirrhosis of the liver, dementia, chronic obstructive pulmonary disease, chronic atrial fibrillation, chronic diastolic heart failure, anxiety, depression and panic disorder.The minimum data set (MDS) assessment with an assessment reference date of 9/7/25 stated that R28 is cognitively impaired with both short and long-term memory impairment and severely impaired decision-making ability.The demographic sheet listed multiple family members along with contact information for each.During a review of the clinical record, this surveyor was unable to locate evidence that a base line care plan had been provided to the resident, who was listed on the demographic sheet as their own responsible party, or to any family members. On 9/24/25 at 2:11 PM this surveyor interviewed the Director of Nursing (DON) and asked where the information regarding the baseline care plan be found. The DON stated, It should be on the admission Assessment but if it isn't, there should be a progress note about it. The admission assessment dated [DATE] was reviewed. Section I on page 16 of 16, was entitled, Baseline Care Plan and read in part, A. Baseline Care Plan Initiation of Baseline Care Plan 1. I have completed the care plan items included in this assessment that initiates the resident's baseline care plan. 2. Baseline care plan has been reviewed with resident and/or responsible party. 3. Copy of baseline care plan and copy of medications have been given to the resident and/or responsible party. The only box checked was number 1 stating the baseline care plan had been completed. Items number 2 and 3 had not been checked as done. The DON stated they checked the progress notes but was unable to locate a note to indicate the baseline care plan had been reviewed and/or printed for the resident or the family.The policy entitled Baseline Care Plans was reviewed and read in part, A baseline plan of care to meet the resident's immediate needs shall be developed within forty-eight (48) hours of admission. Under the heading, Specific Procedures/Guidance the document read in part, 4. The resident and their representative will be provided a summary of the baseline care plan that includes but is not limited to a. The initial goals of the resident; b. A summary of the resident's medications and dietary instructions; c. Any services and treatments to be administered by the facility and personnel acting on behalf of the facility; and d. Any updated information based on the details of the comprehensive care plan, as necessary.The survey team met with the Administrator, DON, Assistant DON, Quality Assurance Nurse, Infection Preventionist and two regional consultants on 9/25/25 at 2:11 PM. This concern was discussed with them at that time.No further information was provided to the survey team prior to the exit conference.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to ensure a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene for one of 33 current residents in the survey sample, resident # 155 (R155). The findings included:For R155, the facility staff failed to perform fingernail care.Diagnoses for R155 included but were not limited to unspecified dementia without behavioral disturbance, major depressive disorder, anxiety disorder, heart failure, hypertension, and generalized weakness.The minimum data set (MDS) assessment with an assessment reference date of 7/22/2025 indicated that R155 has impaired short- and long-term memory as well as impaired decision-making capabilities and is dependent on staff for all activities of daily living (ADL) care. On 9/23/25 at 1:10 PM during the initial tour of the facility, this surveyor observed R155 in their room. R155's fingernails were noted to be excessively long, jagged and there was a dark brown material noted under all fingernails of both hands. The resident was unable to answer the surveyor's questions. R155's care plan included a focus that read, Maintenance: (name omitted) is a long-term care resident and requires assistance with their ADL's related to advanced age, cognitive impairment, dementia. The goal read, Resident will have all ADL needs met through the review date. On 9/24/25 at approximately 8:30 AM this surveyor observed R155 on the unit. Resident was up and seated in a wheelchair. Fingernails were noted to be long, jagged and with dark brown material underneath each one. On 9/24/25 at 8:45 AM this surveyor interviewed certified nursing assistant (CNA) #4. When asked if they were familiar with R155, they stated they were. When asked if R155 was cooperative with care such as personal hygiene, and bathing they stated, Yes, I've never had a problem with her and haven't heard that anyone else has. On 9/24/25 at 8:55 AM this surveyor interviewed CNA # 1. When asked if they were familiar with R155 they stated they were. This surveyor asked if R155 was typically cooperative with ADL care such as bathing and personal hygiene. CNA #1 stated, Yes, she is. She has really had a decline and is on hospice now. This surveyor asked if the staff or hospice was providing daily care and they stated, It depends on the day, hospice comes sometimes and they bathe her, but on the days they don't come, we do all of her care. On 9/24/25 at 5:15 PM the survey team met with the Administrator, Director of Nursing, Assistant Director of Nursing, Quality Assurance nurse and two regional consultants. This concern was discussed with them at that time. This surveyor asked if R155 tended to be combative or refused care and the DON indicated that that the resident did not typically refuse care, but they would check for any notes regarding nail care. On 9/26/25 at 8:20 AM this surveyor observed resident and noted that nails were trimmed, clean and neat. The policy entitled, Fingernails/Toenails was provided and read in part, The purpose of this procedure are to clean the nail bed, to keep nails trimmed, and to prevent infections. Under the heading entitled General Guidelines the document read in part, 1. Routine nail care may be performed by nursing staff and/or qualified activity team members . 2.a. If the resident refuses nail care or desires to have nails maintained in a manner that may impair skin integrity or injury, the risk may be addressed in the resident's plan of care. 3. Nail care includes daily cleaning and regular trimming . Under the heading entitled, Documentation the document read in part, The following information should be included in the resident's medical record: 1. The date and time that nail care was given. 2. The name and title of the individual who administered the nail care. 3. The condition of the resident's nails and nail bed . 4. Any difficulties cutting the resident's nails. 5. Any problems or complaints made by the resident with his/her hands or feet related to the procedure. 6. If the resident refuses the treatment, the reason(s) why and the intervention taken. 7. the signature and title of the person recording the data. Under the heading entitled, Reporting the document read in part, 2. Notify the licensed (there was a word omitted here in the policy that this surveyor is assuming was nurse if the resident refuses the care. No further information was provided to the survey team prior to the exit conference.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure a complete and accurate clinical record for 1 of 37 residents, Resident (R) #1.The findings include. The facility staff failed to ensure R1's allergy list was up to date. Tylenol was listed as an allergy in R1's clinical record. R1 had current orders for Tylenol.R1's clinical record included the diagnoses of toxic encephalopathy, unspecified abnormalities of gait and mobility, and muscle weakness.Section C (cognitive patterns) of R1's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 08/19/25 included a brief interview for mental status (BIMS) score of 11 out of a possible 15 points. Per the MDS manual an 11=moderately impaired in cognitive skills for daily decision making.R1's care plan included the focus area of pain related to lower back pain.R1's allergy list included Tylenol their clinical record included 3 separate orders for Tylenol (acetaminophen).Acetaminophen 325 mg give 2 tablets by mouth every 4 hours as needed for pain. Order date 05/16/25.Tylenol 325 mg give 2 tablets by mouth every 4 hours as needed for temperature of 99.5 or greater. Order date 05/16/25.Tylenol 325 mg give 2 tablets by mouth two times a day for lower back pain. Order date 05/23/25.A review of R1's current medication administration records (September 2025) revealed R1 was currently receiving Tylenol twice a day at 9:00 a.m. and 5:00 p.m. There was no documentation to indicate R1 had received Tylenol per the as needed orders for pain and/or fever.On 09/24/2025 at approximately 9:00 a.m., the Director of Nursing (DON) and Quality Assurance (QA) Nurse were made aware that R1's was receiving Tylenol, and the clinical record included a current allergy to this medication.On 09/24/25, the administrative staff provided the surveyor with evidence that indicated the Family Nurse Practitioner had spoken with this resident on 08/28/25 and 06/16/25 regarding Tylenol and pain control.On 09/24/25 at 5:15 p.m., during an end of the day meeting with the Administrator, DON, QA Nurse, Nurse Consultant #1 and #2, Assistant Director of Nursing, and the Infection Preventionist the issue with R1 having current orders for Tylenol and it being listed as an allergy in the clinical record was reviewed.Licensed Practical Nurse (LPN) #2 documented on 09/24/25 that they had spoken with R1and their daughter regarding any allergy to Tylenol. LPN #2 documented R1 and the daughter both wished for the Tylenol to continue. On 09/25/25 at 9:30 a.m., the DON provided the survey team with a copy of their policy titled, Charting and Documentation. This policy read in part, .Documentation in the medical record will be.complete, and accurate.On 09/25/2025 at10:05 a.m., during an interview with R1 this resident stated they took Tylenol, they had not had any issues, and it helped with their pain. No further information regarding this issue was provided to the survey team prior to the exit conference on 09/25/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495306	A. Building B. Wing	09/25/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Blue Ridge Therapy Connection	105 Landmark Drive Stuart, VA 24171

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, staff interview, and facility document review, the facility staff failed to maintain an infection prevention and control program to provide a safe, sanitary environment and to help prevent the development and transmission of communicable diseases and infections for 1 of 33 current sampled residents, Resident #110. The findings included:For Resident #110, the facility staff failed to store the resident's nebulizer mask in a manner to prevent contamination. Resident #110's diagnosis list indicated diagnoses, which included, but not limited to chronic kidney disease and dementia. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 7/26/25 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. Resident #110's current medical provider orders included an order dated 9/08/25 for Ipratropium-Albuterol Solution 0.5-2.5mg/3ml inhale orally via nebulizer every six (6) hours for congestion. On 9/23/25 at 2:10 PM, 9/24/25 at 11:18 AM, and 9/25/25 at 8:10 AM, surveyor observed Resident #110's nebulizer mask lying uncovered, directly on bedside table. Surveyor requested and received the facility policy titled Medicated Nebulizer Treatment with a revised date of 4/22/14 which read in part .16. Place Nebulizer mask or mouthpiece in a plastic ziplock bag when not in use.On 9/25/25 at 10:10 AM, surveyor spoke with the Infection Preventionist (IP) who stated after nebulizer use, the mask should be rinsed out, dried, and put back in a clean plastic bag and changed out weekly. On 9/25/25 at 1:25 PM, the survey team met with the facility administrative team including the administrator and discussed the concern of Resident #110's nebulizer mask observed uncovered. No further information regarding this concern was presented to the survey team prior to the exit conference on 9/25/25.