

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Monroe Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 Northwest Drive Charlottesville, VA 22901	

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)
<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>Based on observations, resident interview, staff interview, clinical record review, and facility documentation review the facility staff failed to assess a resident's ability to safely self-administer medications for one resident, Resident #9 (R9) out of a survey sample of 18 residents. The findings included: Facility staff allowed R9 to keep medication at the bedside for self-administration without completing a self-administration assessment. On 8/19/25 at 11:10 a.m., an observation was conducted of medications at R9's bedside. At that time, an inhaler, CBD pain ointment, menthol pain ointment, and vitamin D3 were observed in a basket. On 8/19/25 at 11:15 a.m., an interview was conducted with R9 regarding the medications observed. R9 stated that she keeps the pain ointments in her room because she was undergoing chemotherapy and uses them for pain relief. R9 then said, I take my inhaler twice a day and the nurse brings it in here in the morning and leaves it with me to take it in the morning and at bedtime. On 8/19/25 at 11:40 a.m., an interview was conducted with a licensed practical nurse, LPN#1 (LPN1). LPN1 stated that there was a form completed for residents to be approved to self-administer medications. She further stated, skilled residents sometimes bring in their own medications and we don't know anything about it. If I was to see the medications, I would remove the medicine and explain why we were not allowed to leave medicine at the bedside. On 8/19/25 at 12:45 p.m., an interview was conducted with unit manager on unit one, LPN#2 (LPN2). LPN2 stated that she thought R9 had a self-administer assessment completed and was not aware that one had not been done. She explained that medicines found in the room that morning severed as a prompt to complete an assessment. She reported she was under the impression an assessment had already been completed due to R9's pain needs. LPN2 stated that she told R9 she was going to speak with the physician about having the medications at bedside, and then she completed a self-administration assessment. On 8/19/25 at 1:00 p.m., a follow-up observation was conducted in R9's room. The inhaler remained in the basket at the bedside. The self-administration form had been completed by LPN2; however, no locked compartment was observed for the medication storage. A review of R9's clinical record revealed there was no self-administration assessment completed prior to medications being left at bedside. R9's care plan had not addressed self-administration of medications for pain or inhaler use. The Minimum Data Set did not reflect that R9 was independent with medications. A review of facility documentation was conducted. The facility policy titled, Self-Administration of Medications, read in part, .3. To ensure safe and appropriate self-administration, facility should educate residents to ensure that a resident is able to: 3.1 state the name, dose, strength, frequency and purpose for use of their medications. 3.2 Understand the possible medication side effects and that they should notify facility staff if they experience any such side effects. 3.3 correctly administer, inject, or apply all prescribed medications. 3.4 correctly store their medications in a locked compartment. On 8/20/25 at approximately 4:00 p.m., an end of day meeting was held with the Regional Director of Clinical Services, [NAME] President of Operations and Director of Nursing. They were made aware of the concerns above. No additional information was provided.</p>

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 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>Based on staff interviews and clinical record review the facility failed to ensure reasonable care for the protection of personal property for one of eighteen residents, Resident #3 (R3). R3 did not have a personal property invoice completed upon admission to help track valuables. The Findings Include:Diagnoses for R3 included contusion of left lower leg, status post left knee surgery, obesity, depression, kidney disease, and deep vein thrombosis. The most current MDS (minimum data set) was a discharge assessment with an ARD (assessment reference date) of 08/1/2024. R3 was assessed with a cognitive score of 15 indicating cognitively intact.R3 was reviewed due to a report of possible missing medication (Ozempic brought from home to the facility) and two gift cards.Review of R3's clinical record did not evidence an inventory form had been filled out upon admission or at any time during R3's stay at the facility.On 8/19/25 at 2:30 p.m. license practical nurse (LPN #7) was interviewed regarding documentation of resident's inventory list. LPN #7 explained when a resident is admitted an inventory form is filled out. Review of the facilities grievance logs indicated that R3 had reported missing gift cards on 7/22/24 and indicated the concern was being investigated by license practical nurse (LPN #2, unit manager).On 8/19/25 at 3:00 p.m. the director of nursing (DON) was interviewed regarding R3's missing inventory list. The DON said that she would look for it. On 8/20/25 at 10:30 a.m. the DON verbalized R3 inventory list could not be found. The DON stated that she would not list medications on a personal property list but would put the medication in the refrigerator with the resident's name on it. On 8/20/25 at 11:50 a.m. The DON was able to evidence through pharmacy records that R3's personal Ozempic was used by the facility and then was being filled by the pharmacy. On 8/20/25 at 12:00 p.m. LPN #2 (who investigated the missing gift cards) was interviewed. LPN #2 was able to evidence via Concern Form that R3's gift cards were replaced by the facility. The DON presented a personal property policy that read in part The facility will take reasonable care to prevent loss, or theft of, resident's personal property while residing at facility [.]. No other information was presented prior to the exit conference on 8/21/25.</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of care regarding assessment documentation for two of eighteen residents in the survey sample (Residents #3 and #17).The findings include:1. For Resident #3, nursing staff failed to document a descriptive assessment and immediate care interventions implemented for a skin tear.</p> <p>Resident #3 (R3) was admitted to the facility with diagnoses that included iron deficiency anemia, human immunodeficiency virus, gout, obesity, depression, hypertension, chronic kidney disease, anxiety, cryptococcosis, and deep vein thrombosis. The minimum data set (MDS) dated [DATE] assessed R3 as cognitively intact.</p> <p>R3's clinical record documented a Focused Head to Toe Observation form dated 6/28/24. This observation form documented, res [resident] unbuckled seatbelt in transportation van and fell onto floor recving [receiving] skin tear. This form documented an assessment of the resident that included skin tear to LLE [left lower extremity] with trace amount of swelling of left lower leg and intermittent pain rated at 3 (on scale of 0 = no pain, 10 = worst pain).</p> <p>The observation form dated 6/28/24 documented no description of the skin tear other than the location on the left lower leg. There was no documented size/length of the tear or any description of the skin injury's appearance, bleeding status or condition of surrounding tissue. Nursing listed notification to the physician about the injury/incident but there was no documentation regarding care orders or response from the physician. There was nothing documented regarding immediate care provided for the skin tear such as pressure, cleansing or dressing application.</p> <p>R3's clinical/nursing notes had no entries on 6/28/24 referring to the incident or injury.</p> <p>On 8/20/25 at 1:05 p.m., the director of nursing (DON) was interviewed about a descriptive assessment and care implemented for R3's skin tear on 6/28/24. The DON stated first aid was provided and that nurses were not required to get an order for first aid. The DON stated the nurse cleaned and dressed the skin tear.</p> <p>On 8/20/25 at 1:15 p.m., licensed practical nurse (LPN #5) caring for R3 at the time of the 6/28/24 injury was interviewed. LPN #5 stated R3 obtained a skin tear after falling in the transportation van coming back from an appointment. LPN #5 stated R3's skin tear was a small place and that he cleaned the tear and applied a 1 x 1 Band-aid. LPN #5 stated he texted the physician but did not recall the physician's response or if an order was given for care. When asked why he did not enter a nursing note or document a description of the injury, LPN #5 stated the skin tear was superficial and nothing I would have been alarmed over. LPN #5 stated the observation form was completed and included a head-to-toe assessment in addition to pain and neurological checks. LPN #5 stated he did not remember if vital signs were obtained and that the only actions he remembered were cleansing the wound and applying a Band-aid. LPN #5 stated he did not know why a nursing note was not entered and he recalled only that he completed the observation form.</p> <p>On 8/21/25 at 8:00 a.m., the DON provided a copy of the facility's wound/incident policies the described required documentation regarding wound assessment.</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The facility's policy titled Incident/Accident Policy (revised 10/1/24) documented, . Documentation/assessment post-incident will be completed, including neurological assessment when indicated [indicated]. Further assessments will be conducted as ordered by the provider or as indicated by nursing judgement .</p> <p>The facility's policy titled Pressure Injury Prevention and Treatment Policy - Skin and Wound Care (revised 9/18/23) documented, .Pressure injuries identified will be assessed initially and at least weekly thereafter, until closed. Other wound types will be assessed every shift to determine presence of ordered dressing and wound characteristics if observable .All assessments will include the following elements .Location .Size . Exudate .Pain .Wound bed .Color and type of tissue .Appearance of surrounding tissue .Any evidence of infection .</p> <p>The Lippincott Manual of Nursing Practice 11th edition on page 15 documents regarding common departures from the standards of nursing care, .A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events . (1)</p> <p>This finding was reviewed with the director of nursing, regional nurse consultant and director of operations during a meeting on 8/20/25 at 4:00 p.m. with no further information provided prior to the end of the survey.</p> <p>(1) [NAME], [NAME] M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/[NAME] & [NAME], 2019.</p> <p>2. For Resident #17 (R17), the facility staff failed to document a detailed assessment of a skin tear/abrasion sustained on two occassions and the immediate nursing interventions/care provided.</p> <p>On 8/19/25-8/20/25, attempts were made to visit with and interview R17 but were not successful since R17 was out of the facility due to a medical procedure.</p> <p>On the evening of 8/20/25, a clinical record review was conducted of R17's chart. According to a progress note dated 10/7/24, the entry read, &ldquo;The CNA [certified nursing assistant] reported to this nurse that the resident was bleeding from his R. [right] leg. Upon assessment, the back of the right leg had a cut he had sustained while being transferred to bed using a Hoyer lift. The resident stated that his leg was caught on the wheelchair's footrest. This nurse had to apply pressure to the area to stop bleeding. NP was notified and will see the resident.&rdquo; There was no documentation with regard to the cut, to include an assessment of the area, what it looked like, treatment applied, other than pressure to stop the bleeding.</p> <p>According to a skin observation dated 10/8/24, it noted that R17 had a new skin issue, the site and description read, &ldquo;Laceration to outer right calf area with dressing in place.&rdquo; There were no details of the laceration, measurements, how it appeared, what was being done, etc.</p> <p>According to physician orders and treatment administration records, on 10/8/24-10/9/24, the order was &ldquo;clean laceration to right rear leg with NC [sic] [normal saline], pat dry, apply dry dressing.&rdquo;</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>The first instance of documentation regarding details of the wound/injury was on 10/9/24, as noted below.</p> <p>According to a wound management detail report, there was an entry dated 10/9/24 that noted, &ldquo;wound type: other-traumatic injury, wound location: right calf lateral calf, Date/time identified: 10/9/24 at 2:48 p.m. &rdquo;. The details were as follows: Length 8 cm, width 5.6 cm, healing status: improving, comments: monitor area for s/s [signs and symptoms] of infection, follow current tx [treatment] plan. Keep clean, dry and covered.&rdquo;</p> <p>On 10/9/24, R17 was seen by the wound specialist, who noted, &ldquo;Staff report patient new injury occurring from use with the &lsquo;sit to stand&rsquo; mechanical lift. Pt [patient] reports his right lower leg caught the edge of &lsquo;hoyer&rsquo; lift, causing a painful laceration. Pt rates current pain to RLE [right lower extremity] an 8 on 0 to 10 pain scale with relief from medication&hellip; Right lateral calf (+) full thickness ulceration that measures 8.0 x 6.0 x 0.8 cm [length, width, depth]. Wound base 100% granular. Edges adherent to wound base, moderate non-odorous serious drainage, periwound without erythema, no induration or cellulitis. Patient does not demonstrate evidence of pain when area is palpated&hellip; Plan: Wound care to right lateral calf as follows: cleanse with NS [normal saline] or wound cleanser, pat dry. Pack with &frac14; strength Dakin&rsquo;s moistened gauze. Cover with gauze and kerlix dressing. (tx [treatment] for moist wound healing and/or autolytic debridement), change dressing QD [every day] and as needed for saturation or soilage&hellip;&rdquo;</p> <p>According to R17&rsquo;s progress notes dated 7/29/25, which read, &ldquo;Resident rolled off of bed onto floor during ADL care. Observed skin tear to right flank area. Left thigh/knee area with edema. Resident denies pain r/t [related to] fall. Resident states that he did not hit head. MD/RP aware.&rdquo;</p> <p>There was no description of the skin tear other than the location. There was no documented size/length of the tear or any description of the skin injury's appearance, bleeding status or condition of surrounding tissue. Nursing listed notification to the physician about the injury/incident.</p> <p>According to physician orders dated 7/30/25, which read, &ldquo;cleanse skin tear to right flank area with wound cleanser, pat dry, apply xeroform and dressing QD.&rdquo; On 7/31/25, that order was discontinued and a new order was written that read, &ldquo;Apply skin prep to skin tear/right flank QD x 7/days.&rdquo;</p> <p>On 8/21/25 at 8:10 a.m., R17 was visited in his room. R17 was asked about the two incidents documented above. R17 reported that the incident in Oct. 2024 was when the CNA was getting him up from the chair with the hoyer lift and the leg rests were still on the wheelchair. &ldquo;When he started to raise me on the lift, the lift came up and the pedal on the right leg got jammed into my leg, it continued to come up and caused it to be cut.&rdquo;</p> <p>(continued on next page)</p>		

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<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>R17 explained the incident on 7/29/25 and reported, "I have to use the bed pan and the aide was trying to clean me up. She was having difficulty getting the feces out of my [NAME]. When I turned she pushed and I was on my side and went off the bed, my legs hit and got tangled up in this thing [pointing to the over bed table]." When asked if he was injured, he said, "Yes. It didn't manifest until later that day, there were no visible cuts, but bruised the heck out of my left thigh. It started to swell later in the day and [the nurse practitioner's name redacted] came and looked at it and he said to keep an eye on it. About 4 p.m., he came back and said it had gotten bigger and thought I needed to go to the ER, they sent me to [hospital name redacted]. They [the hospital] didn't even do an x-ray which I thought was odd, they put two big ace bandages on it and when I got back they [the facility staff] decided I needed to go back and I was sent to [different hospital name redacted], they confirmed it was a hematoma and also found other issues that were not related to the fall and kept me for several days."</p> <p>On 8/21/25, in the morning, an interview was conducted with the director of nursing. She reported that the skin tear was "superficial" and therefore no detailed documentation was made into the clinical record other than the treatment orders noted above.</p> <p>The facility's policy titled Incident/Accident Policy (revised 10/1/24) documented, "Documentation/assessment post-incident will be completed, including neurological assessment when indicated [indicated]. Further assessments will be conducted as ordered by the provider or as indicated by nursing judgement."</p> <p>The facility's policy titled Pressure Injury Prevention and Treatment Policy - Skin and Wound Care (revised 9/18/23) documented, "Pressure injuries identified will be assessed initially and at least weekly thereafter, until closed. Other wound types will be assessed every shift to determine presence of ordered dressing and wound characteristics if observable. All assessments will include the following elements. Location. Size. Exudate. Pain. Wound bed. Color and type of tissue. Appearance of surrounding tissue. Any evidence of infection."</p> <p>The Lippincott Manual of Nursing Practice 11th edition on page 15 documents regarding common departures from the standards of nursing care, "A deviation from the protocol should be documented in the patient's chart with clear, concise statements of the nurse's decisions, actions, and reasons for the care provided, including any apparent deviation. This should be done at the time the care is rendered because passage of time may lead to a less than accurate recollection of the specific events."</p> <p>On 8/21/25, during a meeting with the facility administrator, director of nursing, medical director, and corporate staff, the above concerns were discussed.</p> <p>No additional information was provided.</p> <p>(1) [NAME], [NAME] M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/[NAME] & [NAME], 2019.</p>		

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<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interview, staff interview, clinical record review, and facility documentation review the facility staff failed to follow physician orders for two residents, Resident #10 (R10) and Resident #16 (R16) out of a survey sample of 18 residents. The findings included: Staff failed to transcribe physician orders for compression bandages, ace wraps, and discontinuation of furosemide 20 mg daily for R10. On 8/19/25 at 11:10 a.m., during an observation of R10's room, her spouse expressed concerns that lower extremity treatments were not being done. The spouse stated the last treatment occurred on the Wednesday before R10's admission on [DATE]. On 8/20/25 at 9:50 a.m., an interview was conducted with the unit manager on unit one, licensed practical nurse, LPN#2 (LPN2). LPN2 stated that the resident R10 was admitted around 5 p.m. on 8/8/25, and that she had orders for, Pro-fore that was never carried over. It was missed on admission. The resident wanted to use the Pro-fore wraps for her edema, and only three wraps came with her, so they used those, and when that was completed, they went to the ACE wraps per the physician's order at the facility. She felt that the doctor here had talked to the wound nurse about the ACE wrap order, but she didn't see a note, so that was missed. On 8/20/25 at 10:50 a.m., an interview was conducted with the facility physician regarding missed orders. He was informed that compression bandages, ACE wraps, and furosemide discontinuation were not transcribed. The physician stated that on R10's admission day (8/8/25), he observed compression wraps but did not remove them, as he could not reapply them. He prefers not to use Pro-fore wraps because they prevent daily skin inspection and potential breakdown, so he ordered ace wraps to allow daily evaluation. He referred to R10 for a wound assessment by the wound nurse scheduled the following week and monitored her over the weekend. On 8/12/25, when the wraps were removed, he noted decreased edema, wrinkle-like skin, and no breakdown. At that time, he ordered daily ace wraps and discontinued furosemide 20 mg daily. The physician had written this in his progress notes and stated that the nurses put his orders in the system. On 8/20/25 at 11:10 a.m., LPN #3 (LPN3, wound nurse) stated that she removed the Pro-fore wraps and assessed R10's lower extremities. The legs showed improvement with no skin breakdown. The physician then ordered ace wraps to be applied in the morning and removed in the evening. LPN3 noted that verbal order was given to floor nurses or unit manager to enter it in the system. LPN3 stated that the verbal order was not given to her or entered by her. On 8/20/25, a clinical record review revealed that R-10's hospital discharge summary included an order for compression bandages that was not transcribed at admission. A facility physician's progress notes on 8/12/25 indicated discontinuation of furosemide 20 mg daily and a verbal order for ace wraps to be applied in the morning and removed in the evening, which was also not transcribed in the clinical record. On 8/20/25 at approximately 4:00 p.m., an end of day meeting was held with the Regional Director of Clinical Services, [NAME] President of Operations and Director of Nursing. They were made aware of the concerns above. On 8/21/25, a review of the facility document titled, Physician/Provider Orders, stated that the charge nurse shall transcribe and review all physician/provider orders. It further directed that telephone orders must be repeated back for verbal confirmation, recorded exactly as dictated. On admission the orders were to be transcribed from the transfer form to the Facility admission Physician Order Form. admission orders must include all information reviewed from the referring facility or agency. On 8/21/25 at 9:50 a.m., the Director of Nursing (DON) sought clarification regarding the Pro-fore order from the hospital. She was informed the order was written as compression bandages, but facility staff referred to Pro-fore because that was what had been removed from R10's lower extremities. The DON was satisfied with this clarification. When asked about providers entering orders into the clinical record, she stated that providers do not enter orders; nurses enter them. No additional information was provided.</p>		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to provide care in a manner to minimize/prevent accidents/injury for one resident (Resident #17-R17) in a survey sample of eighteen residents, which resulted in harm for R17. The findings included:1. For R17, the facility staff failed to transfer the resident with a mechanical lift in a manner to prevent accidents and injury, which resulted in a significant injury, which was harm. The facility self-identified the deficient practice and achieved past non-compliance on 10/9/24. On 8/19/25-8/20/25, attempts were made to visit with and interview R17 but were not successful since R17 was out of the facility due to a medical procedure. On the evening of 8/20/25, a clinical record review was conducted of R17's chart. According to a progress note dated 10/7/24, the entry read, The CNA [certified nursing assistant] reported to this nurse that the resident was bleeding from his R. [right] leg. Upon assessment, the back of the right leg had a cut he had sustained while being transferred to bed using a Hoyer lift. The resident stated that his leg was caught on the wheelchair's footrest. This nurse had to apply pressure to the area to stop bleeding. NP was notified and will see the resident. There was no documentation with regard to the cut, to include an assessment of the area, what it looked like, treatment applied, other than pressure to stop the bleeding. According to a skin observation dated 10/8/24, it noted that R17 had a new skin issue, the site and description read, Laceration to outer right calf area with dressing in place. There were no details of the laceration, measurements, how it appeared, what was being done, etc. According to physician orders and treatment administration records, on 10/8/24-10/9/24, the order was clean laceration to right rear leg with NC [sic] [normal saline], pat dry, apply dry dressing. On 10/9/24, a wound management detail report was completed that read in part, wound type: other-traumatic injury, wound location: right calf lateral calf, Date/time identified: 10/9/24 at 2:48 p.m. The details were as follows: Length 8 cm, width 5.6 cm, healing status: improving, comments: monitor area for s/s [signs and symptoms] of infection, follow current tx [treatment] plan. Keep clean, dry and covered. On 10/9/24, R17 was seen by the wound specialist, who noted, Staff report patient new injury occurring from use with the 'sit to stand' mechanical lift. Pt [patient] reports his right lower leg caught the edge of 'hoyer' lift, causing a painful laceration. Pt rates current pain to RLE [right lower extremity] an 8 on 0 to 10 pain scale with relief from medication. Right lateral calf (+) full thickness ulceration that measures 8.0 x 6.0 x 0.8 cm [length, width, depth]. Wound base 100% granular. Edges adherent to wound base, moderate non-odororous serious drainage, periwound without erythema, no induration or cellulitis. Patient does not demonstrate evidence of pain when area is palpated. Plan: Wound care to right lateral calf as follows: cleanse with NS [normal saline] or wound cleanser, pat dry. Pack with 1/4 strength Dakin's moistened gauze. Cover with gauze and kerlix dressing. (tx [treatment] for moist wound healing and/or autolytic debridement), change dressing QD [every day] and as needed for saturation or soilage. According to the wound care provider notes dated 10/16/24, the injury to R17's right lateral calf was noted with . full thickness ulceration that measured 8. 0 x 5.6 x 0.6 cm. Wound base 25% slough, 75% granular prior to debridement. According to the facility's wound management detail report, R17 traumatic injury to the right lateral calf continued to receive treatment and was not healed until five months later on 3/12/25. On 8/21/25, during another clinical record review, according to R17's activities of daily living (ADL) records for October 2024, the resident was noted to have been totally dependent on facility staff for transfers from bed to chair and chair to bed. According to R17's care plan with a start date of 5/1/24, it read, resident is limited in ability to transfer self, related to impaired mobility and requires the use of Hoyer lift to complete transfers. Associated interventions included, but were not limited to: Minimize hazards and risks while completing transfer with lift, provide Hoyer lift assistant for transferring w/ [with] assist of 2 . On 8/21/25 at 8:10 a.m., an interview was conducted with R17. When asked about the incident in October 2024, the resident said, What happened was, it was night and he was getting me up, the leg rests were still on the chair. When he started to raise me in the lift the lift came up and the pedal on the right side got jammed in my leg, it [the lift] continued to come up and it caused it to be cut. R17 identified that certified nursing assistant #4 (CNA #4) was the one assisting the resident at the time of the incident and was using the mechanical lift/Hoyer lift without assistance of another staff member. On 8/21/25 at 9:10 a.m., an interview was conducted with the unit manager, licensed practical nurse #2 (LPN #2), where R17 resided. LPN #2 stated she was not a unit manager at the time of R17's incident that occurred in October 2024. When asked about transfers with a Hoyer lift she said, Two people with the Hoyer at all</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495326	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/21/2025
NAME OF PROVIDER OR SUPPLIER Monroe Health & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1150 Northwest Drive Charlottesville, VA 22901	
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)		
<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>Based on observations, resident interview, staff interview, clinical record review, and facility documentation review the facility staff failed to administer oxygen per physician's orders, and to date and label oxygen tubing and humidifier bottle for one resident, Resident #10 (R10) out of a survey sample of 18 residents. The findings included: R10 was not being administered her ordered oxygen, and the oxygen tubing and humidifier bottle were not labeled with a date of placement. On 8/19/25 at 11:10 a.m., an observation of R10 revealed that oxygen was not being administered as ordered. The oxygen concentrator was observed in the resident's room with the humidifier bottle sitting on the floor. There was no oxygen tubing connected to the concentrator. During the observation, R10's spouse was present in the room, stated that the resident had not had the oxygen on since the previous day when it was removed and the oxygen tubing was taken out of the room. A subsequent observation of R10 on 8/19/25 at 2:45 p.m., again revealed that oxygen was not being administered per the physician's order. On 8/19/25 at 2:45 p.m., an interview was conducted with the unit one manager, licensed practical nurse, LPN#2 (LPN2). LPN2 was asked to review R10's oxygen order and stated that the order was for two liters per nasal cannula, continuous. LPN2 then entered R10's room and was observed looking at the oxygen concentrator. The concentrator had tubing and humidifier bottle present; however, the tubing was stored in a bag and there were no dates or labels on the tubing or the humidifier bottle. At the time of the observation, R10 was still not receiving oxygen as ordered. During this observation with LPN2 on 8/19/25 at 2:45 p.m., R10's spouse, who was in the room, told LPN2 that the tubing from the oxygen concentrator had been removed the previous day. He further stated that they were planning to keep a check on the resident's oxygen levels, and that no staff had come in to check since he had been present that morning. R10 was still not receiving oxygen per order. On 8/19/25 at 4:00 p.m., another observation showed R10 still was not receiving oxygen. At that time, LPN1 was observed checking R10's oxygen saturation, which measured 94%. Earlier that morning, the oxygen saturation had been documented at 98%. On 8/19/25, a review of R10's clinical record revealed a physician's order for oxygen to be administered via nasal cannula continuously at two liters. Documentation showed the order had been signed off that morning as having been administered. Review of R10's care plan reflected the same instructions for continuous oxygen at two liters via nasal cannula. On 8/20/25, a facility document was reviewed. The facility documentation titled, Oxygen Administration (all routes) Policy, read in part, ".licensed clinicians with demonstrated competence will administer oxygen via the specified route as ordered by a provider. On 8/20/25 at approximately 4:00 p.m., an end of the day meeting was held with the regional director of clinical services, vice president of operations and director of nursing. They were made aware of the concerns above. No additional information was provided.</p>		

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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0842</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 resident interview, staff interviews, and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for one resident (Resident #17- R17) in a survey sample of eighteen residents. The findings included:For R17, who was hospitalized following an incident of rolling out of bed and sustained a hematoma, the facility staff failed to have the hospital report/records available in R17's clinical record. On the evening of 8/20/25, a clinical record review was conducted of R17's chart. According to R17's progress notes dated 7/29/25, which read, Resident rolled off of bed onto floor during ADL care. Observed skin tear to right flank area. Left thigh/knee area with edema. Resident denies pain r/t [related to] fall. Resident states that he did not hit head. MD/RP [medical doctor/responsible party] aware. On 8/21/25 at 8:10 a.m., an interview was conducted with R17. R17 explained the incident on 7/29/25 and reported, I have to use the bed pan and the aide was trying to clean me up. She was having difficulty getting the feces out of my [NAME]. When I turned, she pushed and I was on my side and went off the bed, my legs hit and got tangled up in this thing [pointing to the over bed table]. When asked if he was injured, he said, Yes. It didn't manifest until later that day, there were no visible cuts, but bruised the heck out of my left thigh. It started to swell later in the day and [the nurse practitioner's name redacted] came and looked at it and he said to keep an eye on it. About 4 p.m., he came back and said it had gotten bigger and thought I needed to go to the ER, they sent me to [hospital name redacted]. They [the hospital] didn't even do an x-ray which I thought was odd, they put two big ace bandages on it and when I got back they [the facility staff] decided I needed to go back and I was sent to [different hospital name redacted], they confirmed it was a hematoma and also found other issues that were not related to the fall and kept me for several days. The resident reported he felt like he was too far to the side of the bed when he turned, and the aide pushed him; it caused him to fall off the bed. On 8/21/25 at 8:40 a.m., R17's clinical record was reviewed again and hospital records from 7/29/25 were not able to be located within the chart.On 8/21/25 at 8:45 a.m., the DON was asked to provide hospital records from R17's hospital visits. On 8/21/25 at 9 a.m., an interview was conducted with certified nursing assistant #2 (CNA #2). CNA #2 confirmed she had been providing care to R17 on 7/29/25, when he rolled out of bed. CNA #2 reported, I had him and was cleaning him. He was turned facing the window and his legs fell off the bed which threw the rest of him out of the bed. Now if we turn him, we have to have two people. It happened so fast, I couldn't catch him. He had a small skin tear on his back, when he fell somehow this part of his leg [pointing to her left thigh] swelled. The nurse assessed him and later that day he went to the hospital. I felt so bad. On 8/21/25 at 9:10 a.m., an interview was conducted with licensed practical nurse #2 (LPN #2), who was the unit manager. LPN #2 stated, I got report that she was doing ADL care and was cleaning him alone. When she turned him, he was too close to the edge of the mattress and when he turned, he rolled to the right side of the bed. We offered him a lip mattress [mattress with a raised edge] but he declined, said it wasn't the mattress that he wasn't properly positioned during ADL care. He got an abrasion to his left buttock; he went to the hospital two days later. We did an x-ray here and it was no injuries. They kept him at the hospital for abnormal lab values; this was all per his wife. While in the hospital his wife would come to get items out of his room and she would give us bits and pieces of information, we never got any documentation from the hospital. The DON provided the surveyor with a progress note from the nurse practitioner dated 7/29/25 that indicated R17 had been sent to the hospital, the read in part, I saw and examined the patient per nursing request s/p [status post] a fall from his bed. Nursing reported to me that the patient rolled off his bed and onto the floor as personal care was being performed around 12:00 s/p having had a bowel movement. He reportedly fell onto the floor landing on his left lower extremity; he apparently did not hit his head. I did notice swelling on the lateral distal left thigh/knee area which appeared to be a hematoma.I marked the affected area with a pen establishing an area of 19 cm along the distal lateral femur and 14 cm wide transverse to the leg on my initial visit. I discussed the value of XR [x-ray] imaging to rule out any type of fracture. The patient refused having the leg imaged at this time. I spoke with nursing and ordered to keep the leg elevated, and to apply an ice pack. I promised to return in about an hour to re-evaluate the hematoma and developing situation. I re-examined the patient at 15:30. The patient was in no acute distress, but clearly uncomfortable and appeared frustrated. My examination revealed expansion of the hematoma now to 21 cm long x 18 cm wide. Given my concern r/t [related to] his chronic anticoagulation and hematoma development, and subsequent blood loss. I strongly encouraged the patient to consider being sent out via EMS [emergency</p>		

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<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>Make sure there is a pest control program to prevent/deal with mice, insects, or other pests.</p> <p>(continued on next page)</p>

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0925</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Many</p>	<p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to maintain an effective pest control program on three of three resident units and in the main kitchen and common areas of the facility. The findings included: On 8/19/25 at 1:55 p.m., a review of resident council minutes revealed that on 7/7/25, the resident council reported that Residents are seeing gnats and roaches. Both residents listed on the grievance lived on the 200 South unit. During the resident council meeting held Dec. 18, 2024, it noted . The group all mentioned an increase in cockroach sightings. In the September 2024 meeting it noted, . Resident [name redacted] stated he spotted a cockroach in his room by his bed recently. During the August 2024 resident council meeting, notes included, . Cockroaches have recently been spotted in [three resident's names redacted] and in the phone booth. Group stated that all has already been reported. On March 20, 2024, during the resident council meeting another resident mentioned seeing roaches in her bathroom last week. On 8/19/25, a review of pest control logs was conducted. It revealed the monthly pest service was being performed by an outside contractor. The reports included ongoing sightings and evidence of pest activity that included roaches. Each of the reports from January 2024-July 2025, there were recommendations to the facility each month that were not resolved. The pest control company indicated that the identified areas could be contributing to pest access/entry. The same areas of concern were noted month after month, dating as far back as [DATE], without facility resolution. On 8/19/25 at 2:40 p.m., another tour was conducted of the second-floor unit. During the tour, Resident #20's (R20) room was noted to have a glue trap under the heating/air conditioning unit. The surveyor entered the room and interviewed R20. R20 was asked about pests and reported seeing roaches, every morning and every night ever since I've been here a year. They crawl up the wall, on the bed. R20 went on to report that he requested the glue traps and they have put them in the ceiling, but he continues to see them. There were four glue traps observed in the room and two of the four had a copious number of roaches in the trap and a third had a few roaches present. On 8/19/25 at 2:53 p.m., an interview was conducted with a housekeeper, (Other Staff #7- OS7). OS7 reported she had worked at the facility for three years and sees roaches throughout the unit routinely. When asked about pest control services, OS7 reported they come and spray and usually following the pest control visit she observes an increase in the roaches. On 8/19/25 at 3:02 p.m., an interview was conducted with the environmental services director (EVSD) (other staff #6- OS6). The EVSD reported that a pest control company is contracted and comes monthly. He confirmed they have had on-going issues with roaches and said, they bait areas and spray problem areas. When asked what the pest control company has reported regarding the roach problem, the EVSD said, They think it is from different avenues like residents bringing in items from outside. When asked about R20's room, the EVSD stated he was not aware of that being a problem area. The EVSD reported that the glue traps are changed monthly unless he notes they are dirty, he will change them in between the monthly pest control visits. He was made aware of the glue traps in R20's room having a heavy number of roaches in them. During the above interview with the EVSD he was asked about the problem areas identified in the pest control report from the contractor and that the same areas are noted month after month, indicating the facility is not taking action to resolve the matter. The EVSD reported he has been working to resolve the issues, but it is not always effective. The surveyor asked to tour with the EVSD to look at some of the areas identified in the pest control report. The pest control reports noted that high severity area of concerns on reports dating back to 1/17/2023, was the lobby: gap between double doors lobby allowing pest access. Please repair to prevent pest entry. During the tour it was noted that there were two sets of double doors for entry into the lobby and both had visible gaps which would allow pests to enter. The EVSD reported he has put weather stripping on the doors to seal the gaps, but wheelchairs tend to knock it off. On 8/19/25 at 3:20 p.m., a tour of was conducted of the kitchen with the EVSD. According to the pest control reports it noted cracks or damage to wall behind dishwasher allowing pest access, was a high area of concern since April 15, 2025. Also noted in the pest control report dated 7/16/25, it read, wall around the dishwasher machine needs to be removed and clean all the food and standing water from inside the wall, also sealed opening around pipes, wall and floor, we recommend this so many time [sic]! During the tour of the kitchen, it was noted that in the dish room there was still openings around the pipes under the dish machine, broken tiles, standing water, and many of the areas identified on the pest control reports were still present. The EVSD reported that he had caulked some holes in the kitchen</p>		