STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Health & Rehab Center	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)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations, staff interviews, and facility document review, the facility staff failed to properly store, prepare and distribute food in the facility kitchen in a manner that would prevent foodborne illnesses.The findings included:The facility staff failed to maintain one of two kitchen freezers in proper working order, freezer #2 contained multiple food items that were not fully frozen. The facility staff had stacked wet pans nesting them while wet and a large scoop was stored inside an uncovered container of powdered thickener. There was a white cloth lying on the floor of the refrigerator and a roll of buffet ham was stored above produce, creating a risk of cross-contamination. On 04/21/2026 at 5:55 a.m., during the initial kitchen tour, the survey team observed a clear plastic container of powdered thickener without a lid, with a scoop inside. Dietary Aide #1 removed the scoop. The survey team observed numerous silver pans stacked on a metal rack with visible water droplets present on several pans. When asked about the stacking of wet pans Dietary Aide #1 stated that items are typically placed on a drying rack. Kitchen refrigerator #1 was observed with a white cloth lying on the bottom of the refrigerator beneath a storage rack. Staff were observed to remove this cloth. A roll of buffet ham was stored on the second shelf above produce. The Dietary Manager (DM) confirmed the ham should not have been stored above produce. Freezer #2's internal temperature was observed to be 16 degrees Fahrenheit, with visible water accumulation on the bottom shelf and wet cardboard boxes present. Several food items were not frozen including sherbert, bags of onions and peppers, pulled pork, broccoli florets, French toast, ribs, seafood, turkey sausage, Canadian bacon, pizza, flounder, broccoli and cheese soup, mighty shakes, chicken and beef dinner balls, turkey thighs, chicken and wild rice soup, chicken tenders, manicotti, and a mixture of corn and mixed vegetables. The staff did not access any of this food for the breakfast meal and stated that a food delivery had been received the previous day. Multiple boxes were dated 04/20/2026. On 04/21/2026 at 6:20 a.m., the DM stated the unfrozen food items would be discarded, and they had previous issues with this freezer.On 04/21/2026 at 8:50 a.m., during an interview, the Maintenance Director (MD) stated this was the first issue with the new freezer and stated the unit may have been overpacked and confirmed that a technician had been contacted to evaluate the equipment. Documentation provided by the MD indicated the freezer had been ordered on 02/27/2026 and delivered to the facility during the first week of 03/2026. On 04/21/2026 at 3:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), Assistant Director of Nursing (ADON), Regional Director of Clinical Services, and Regional [NAME] President of Operations the issues in the facility kitchen were reviewed. On 04/22/2026 at 8:20 a.m., during a follow-up observation in the facility kitchen the Administrator stated the freezer door had been left ajar, the freezer was too full of product, causing the freezer to freeze up. The freezer was observed to have been emptied. On 04/22/2026 at 9:50 a.m., during a follow-up interview with the DM and Dietary Aide #1, the Dietary Aide reported she had not worked over the weekend but noted on Friday the freezer temperature kept dropping. The DM stated that maintenance had been notified, the temperature went back to normal, and she assumed there was too much product in the freezer. The DM stated maintenance came in checked the freezer and stated the door was not fully closed. On 04/22/2026 at (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	11:15 a.m., the DON provided the survey team with a copy of a service ticket dated 04/21/2026. The service technician reported the fans had frozen in the freezer with excessive ice buildup in the evaporator. The freezer was cleaned and manager made aware. On 04/22/2026, the DM provided the surveyor with a copy of the Freezer & Refrigerator Temperatures Log. For 04/21/2026 the dietary staff recorded a temperature of 9.2 for the morning freezer temperature. Recorded temperatures from the previous day were -1 Fahrenheit (morning) and -6 Fahrenheit (evening). The facility kitchen included a second freezer with no problems being observed by the survey team.No additional information regarding this issue was provided to the survey team prior to the exit conference.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and clinical record review, the facility staff failed to accurately complete an admission minimum data set (MDS) assessment for 1 of 28 residents, Resident #84.The findings included:The facility staff failed to accurately code section A1550 (conditions related to intellectual and/or developmental disabilities [ID/DD]) on the admission MDS assessment.Resident #84 has a documented diagnosis of Coffins-Siris Syndrome, a genetic disorder characterized by developmental delays and intellectual disability. Section C (cognitive patterns) of Resident #84's admission MDS assessment with an assessment reference date (ARD) of 02/26/2026 included a brief interview for mental status (BIMS) score of 15, indicating Resident #84 was cognitively intact. Section A1550 was coded to indicate the resident had no conditions related to ID/DD.A review of Resident #84's clinical record revealed a Level I Preadmission Screening and Resident Review (PASSR), dated 02/20/2026, which referred the individual for a Level II assessment due to intellectual developmental disability (IDD) or a related condition. The Level II assessment dated [DATE], confirmed a diagnosis of Coffins-Siris Syndrome prior to age [AGE].On 04/21/2026 at 3:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), Assistant Director of Nursing, Regional Director of Clinical Services, and Regional [NAME] President of Operations the inaccurate coding of section A in Resident #84's admission MDS assessment was reviewed.On 04/22/2026, the DON provided the surveyor with an updated MDS and stated the MDS had been modified. Section A1550 was revised to reflect that Resident #84 has an organic condition related to ID/DD.No additional information regarding this issue was provided to the survey team prior to the exit conference.

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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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to develop a comprehensive care plan (CCP) for 2 of 28 residents, Resident #11 and Resident #105. The findings included:1. For Resident #11, the facility staff failed to develop a CCP for enhanced barrier precautions. Resident #11 had a percutaneous endoscopic gastrostomy (PEG) tube in place for nutritional support. Resident #11's diagnoses included malignant neoplasm of tonsils and Parkinsons disease. Section C (cognitive patterns) of Resident #11's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 04/05/2026 included a brief interview for mental status (BIMS) score of 15, indicating Resident #11 was cognitively intact. Section K (swallowing/nutritional status) was coded to indicate this resident had a PEG tube in place. During initial tour the surveyor observed an enhanced barrier precautions sign and personal protective equipment (PPE) outside of Resident #11's room. Staff were observed in this room with PPE in place. Resident #11's clinical record included a provider order dated 04/03/2026 for enteral-bolus tube feeding four times a day. A review of Resident #11's clinical record failed to identify a CCP for enhanced barrier precautions.On 04/21/2026 at 3:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), Assistant Director of Nursing/Infection Preventionist, Regional Director of Clinical Services, and Regional [NAME] President of Operations the omission of enhanced barrier precautions on Resident #11's CCP was reviewed. On 04/22/2026, the DON provided the surveyor with a copy of an updated CCP. Under the identified area of feeding tube the facility staff had added the approach enhanced barrier precautions for PEG tube (created date: 04/21/2026). The facility staff also provided a policy titled, Comprehensive Care Planning Policy last reviewed on 02/24/2026. This policy read in part, The facility will develop a comprehensive person-centered care plan for each resident.to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. On 04/23/2026 at 9:35 a.m., the Infection Preventionist confirmed that Resident #11 should have had a CCP in place for enhanced barrier precautions. No additional information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #105, the facility staff failed to develop a CCP for their gastrostomy tube (g-tube) and for enhanced barrier precautions. Resident #105 had a g-tube in place for water flushes only. Resident #105's diagnoses included Guillain-Barre syndrome and polyneuropathy. Section C (cognitive patterns) of Resident #105's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/24/2026 included a brief interview for mental status (BIMS) score of 15, indicating Resident #105 was cognitively intact. During initial tour the surveyor observed an enhanced barrier precautions sign and personal protective equipment (PPE) outside of Resident #105's room. On 04/21/2026 at 10:31 a.m., during an interview with Resident #105 this resident identified themselves as having a g-tube. Resident #105's clinical record included a provider order dated 03/31/2026 for enteral-free water flush: 60 cc of water via g-tube every shift. A review of Resident #105's CCP failed to identify a care plan for the resident's g-tube flush or for enhanced barrier precautions. On 04/21/2026 at 10:55 a.m., during an interview with the MDS nurse, this staff reviewed Resident #105's clinical record and confirmed there was not a care plan in place for their g-tube or enhanced barrier precautions. On 04/21/2026 at 3:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), Assistant Director of Nursing/Infection Preventionist, Regional Director of Clinical Services, and Regional [NAME] President of Operations the omission of Resident #105's g-tube and enhanced barrier precautions on their CCP was reviewed. On 04/22/2026 at 8:00 a.m., the DON provided an updated CCP that identified this resident as having a PEG tube that was used for routine flushes and as being on enhanced barrier precautions due to PEG tube (updated date: 04/21/2026). The facility staff also provided a policy titled, Comprehensive Care Planning Policy last reviewed on 02/24/2026. This policy read in part, The facility will develop a (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	comprehensive person-centered care plan for each resident.to meet the resident's medical, nursing, mental and psychosocial needs identified in the comprehensive assessment. On 04/23/2026 at 9:35 a.m., the Infection Preventionist confirmed that Resident #105 should have had a CCP in place for enhanced barrier precautions. No additional information regarding this issue was provided to the survey team prior to the exit conference.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on staff interview, clinical record review, and facility document review, the facility staff failed to revise the comprehensive care plan for 2 of 28 residents, Resident #58 and Resident #138. The findings included:1.For Resident #58, the facility staff failed to revise the comprehensive person-centered care plan to reflect a medical provider order for comfort care measures on 2/21/26. Resident #58's diagnosis list indicated diagnoses that included, but were not limited to, atherosclerotic heart disease of native coronary artery s/p (status-post) CABG (coronary artery bypass grafting), sequelae of cerebral infarction, vascular dementia, depression, weakness, and cognitive communication deficit. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 1/26/26, assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. A review of a medical provider order with a start date of 2/21/26 read in part, .Comfort care.no labs, no IVs, no weights, no hospitalization. A review of the current comprehensive person-centered activity care plan disclosed a focus with an initiated date of 4/2/26, which read in part, .Resident is on Comfort Care due to advanced dementia. A goal associated with the focus read in part, .Resident will receive comfort care measures to provide comfort care and emotional support. Interventions associated with the focus read in part, .comfort measures as ordered. On 4/22/26 at 2:21 PM, the Director of Nursing (DON) was interviewed and agreed comfort care was not added to the care plan at the time of the medical provider orders on 2/21/26. The DON stated an audit of the care plan was performed on 4/2/26 and the comfort care focus was added at that time. This concern was discussed at the end of day meeting on 4/22/26 at 4:00 PM with the Administrator, Director of Nursing, Regional Director of Clinical Services, Assistant Director of Nursing, and Regional [NAME] President of Operations. Requested and received a facility policy titled, Comprehensive Care Planning Policy with a reviewed date of 2/24/26, which read in part, .An interdisciplinary plan of care will be.updated as indicated.The care plan is.revised as indicated by the resident's needs.or a change in condition.If additional problem areas are identified.the care plan will be updated to reflect these area(s). Changes to the care plan due to.changes in the resident's status will be implemented as indicated. No further information was provided prior to exit on 4/23/26. 2. For Resident #138 (R138), who had behaviors that included aggressiveness with staff, the facility failed to revise the person-centered comprehensive care plan to include updated interventions that address continued and/or escalating behaviors. A Resident Face Sheet indicated that the facility admitted R138 on 3/9/22 with a most recent re-admission date of 8/8/25. According to the Resident Face Sheet the resident had a medical history that included bipolar disorder and dementia with other behavioral disturbance. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 4/8/26 demonstrated that R138 had a BIMS (Brief Interview for Mental Status) score of 3 out of 15 indicating severe cognitive impairment. A comprehensive review of the clinical record for R138 revealed a care plan for Behavioral Symptoms that was initiated on 11/5/25. Interventions include: -Encourage resident to express feelings, listen with empathy and nonjudgemental acceptance, compassion (initiated 11/5/25) -If resident is disruptive to others, remove resident from scenario and attempt to calm resident (initiated 11/5/25) -Provide physical and verbal cues to alleviate anxiety, give positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behaviors, encourage seeking out of staff member when agitated (initiated 11/5/25) The Care Plan problem statement was revised on 11/19/25, 12/17/25, 12/24/25, 12/31/25, 1/28/26, 2/4/26, 2/25/26, 3/11/26, and 3/18/26 to include the presence of continued and further behaviors including yelling/cursing at staff and being aggressive with care. No interventions were added to this care plan after the initial date of 11/5/25, and no revisions were made to the interventions initiated on 11/5/25. During an interview that was conducted with MDS (Minimum Data Set) Coordinator on 4/22/26 at 4:05 PM, the MDS Coordinator stated that interventions are not always updated, and that redirection worked best when managing R138's behaviors. When asked if the current interventions in place would be considered effective noting the documentation of continued and/or escalating behaviors, the MDS coordinator stated that they did not appear effective. The MDS Coordinator stated that additional interventions should be considered and added to R138's care plan to address the continued and/or escalating behaviors. A facility policy titled Comprehensive Care Planning Policy developed 1/27/11 and last reviewed on 2/24/26 stated that the care plan is revised as indicated by the resident's needs, wishes, or a change in condition. At a minimum, this will occur with each comprehensive and quarterly assessment. No further information was provided prior to exit.

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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, resident interview, staff interview, and clinical record review the facility staff failed to provide activities of daily living care for 1 of 28 residents, Resident #7. The findings included:Resident #7 was observed to have long, jagged fingernails. Resident #7's diagnoses included vascular dementia and major depressive disorder. Section C (cognitive patterns) of Resident #7's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/19/2026 included a brief interview for mental status (BIMS) score of 15, indicating Resident #7 was cognitively intact. Section GG (functional abilities) was coded to indicate Resident #7 required partial/moderate assistance with personal hygiene. Resident #7's comprehensive care plan identified a need for assistance with activities of daily living, dressing, grooming, toileting, feeding, and oral care. Approaches included check nail length and trim and clean as needed, per protocols (start date: 03/23/2026). On 04/21/2026 at 12:55 p.m., during an interview with Resident #7, their fingernails were observed to be long and jagged. The resident reported that someone had stated they would trim their nails but did not return. On 04/21/2026 at 3:00 p.m., this issue was reviewed during an end of the day meeting with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, and Regional [NAME] President of Operations. On 04/22/2026 at 9:16 a.m., during a follow-up observation with Resident #7 the Resident's fingernails were observed to have been trimmed. No additional information regarding this issue was provided to the survey team prior to the exit conference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on observation, staff interview, clinical record review and facility document review the facility staff failed to follow physician's orders for 3 of 28 residents, Resident #15, Resident #120 and Resident #58. The findings included:1. For Resident #15 the facility staff failed to administer GenTeal eye drops (used to treat dry eyes) and Voltaren gel (used to treat pain) per the physician's orders. Resident #15's face sheet listed diagnoses which included but not limited to other corneal scars and opacities and primary osteoarthritis, unspecified site. Resident #15's most recent quarterly minimum data set with an assessment reference date of 03/31/26 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #15's comprehensive care plan was reviewed and contained plans for Pain. Resident is at risk for pain secondary to Osteoarthritis and Visual Function. Resident has visual impairment r/t (related to) DX (diagnosis) of corneal scars and opacities. Interventions for these plans included administer medications as ordered and administer eye medication as ordered. Resident #15's clinical record contained a physician's order summary which read in part, Voltaren Arthritis Pain (diclofenac sodium) [OTC (over the counter)] gel; 1%; amt: 2 grams to both knees; topical. Twice A Day. 07:00-11:00, 19:00-23:00 and GenTeal Tears Moderate (PF {preservative free})(dextran 70-hypromellose (pf) [OTC] dropperette; 0.1-0.3%; amt: 2 drops; ophthalmic. Special Instructions: Instill 2 drops in Left eye two times a day for dry eyes. Twice A Day. AM Med Pass 07:00-11:00, PM Med Pass 19:00-23:00 [7:00 PM-11:00 PM]. Resident #15's electronic medication administration record (eMAR) for the month of April 2026 was reviewed and contained entries as above. The entry for GenTeal eye drops was coded as Not Administered: Drug/Item Unavailable on 04/09/26 evening, 04/13/26 evening, 04/14/26 evening and 04/20/26 evening. The entry for Voltaren gel was coded as Not Administered: Drug/Item Unavailable on 04/09/26 evening. Resident #15's progress notes were reviewed and contained a nurse's note which read in part, 04/21/2026 03:29. Call was placed to . (pharmacy) twice regarding resident's GenTeal Tears that is not available. Initial call was placed at 2358 (11:58 pm), at this time this RN (registered nurse) was informed that the medication was listed as 'house stock'. After validating that this medication was NOT available with the OTC medication as second call was placed at 0330 (3:30 AM) to ask for delivery of the medication. Surveyor spoke with the Director of Nursing (DON) on 04/22/26 at 3:05 pm regarding Resident #15's medication availability. DON stated the nurse administering the medications on the dates coded as unavailable was a new employee and did not know where to look for the medication. DON stated the medication was available for administration, and per the documentation it was not administered. Surveyor requested and was provided with a facility policy entitled General Dose Preparation and Medication Administration which read in part, 5.4 Administer medication within timeframes specified by facility policy or manufacturer's information. The concern of not administering Resident #15's medications per the physician's orders was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	discussed with the Administrator, DON, Assistant DON, Regional Vice-President of Operations, and Regional Director of Clinical Services on 04/22/26 at 4:50 pm. No further information was provided prior to exit. 2. For Resident #120 the facility staff failed to administer the medication methocarbamol (used to treat muscle spasms/pain) per the physician's order. Resident #120's face sheet listed diagnoses which included but not limited to other muscle spasm. Resident #120's most recent quarterly minimum data set with an assessment reference date of 04/14/26 assigned the resident a brief interview for mental status score of 13 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #120's clinical record was reviewed and contained a physician's order summary which read in part, methocarbamol tablet; 750 mg; amt: 1 tablet; oral. Twice A Day. AM Meds Pass 07:00-11:00, PM Med Pass 19:00-23:00. Resident #120's electronic medication administration record for the month of April 2026 was reviewed and contained an entry as above. This entry was coded as Not Administered: Drug/Item Unavailable on 04/10/26 AM med pass. Surveyor spoke with the Director of Nursing (DON) on 04/22/26 at 3:05 pm regarding Resident #120's medication availability. DON stated the nurse administering the medication on the date coded as unavailable was a new employee and did not know where to look for the medication. DON stated the medication was available for administration, and per the documentation it was not administered. Surveyor requested and was provided with a facility policy entitled General Dose Preparation and Medication Administration which read in part, 5.4 Administer medication within timeframes specified by facility policy or manufacturer's information. The concern of not administering Resident #120's medications per the physician's orders was discussed with the administrator, DON, Assistant DON, Regional Vice-President of Operations, and Regional Director of Clinical Services on 04/22/26 at 4:50 pm. No further information was provided prior to exit. 3. For Resident #58, the facility staff failed to follow a medical provider order to discontinue monthly weights with an order for comfort care measures. Resident #58's diagnosis list indicated diagnoses that included, but were not limited to, atherosclerotic heart disease of native coronary artery s/p (status-post) CABG (coronary artery bypass grafting), sequelae of cerebral infarction, vascular dementia, depression, weakness, and cognitive communication deficit. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 1/26/26, assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of a medical provider order with a start date of 2/21/26 read in part, .Comfort care.no weights. A review of the current comprehensive person-centered activity care plan disclosed a focus with an initiated date of 4/2/26, which read in part, .Resident is on Comfort Care. An intervention associated with the focus read in part, .No.weights. A review of Resident #58's weight records disclosed the resident's weight was obtained on 3/6/26 and 4/3/26. On 4/22/26 at 2:21 PM, the Director of Nursing (DON) was interviewed and stated the weights for Resident #58 on 3/6/26 and 4/3/26 were obtained in error. This concern was discussed at the end of day meeting on 4/22/26 at 4:00 PM with the Administrator, Director of Nursing, Regional Director of Clinical Services, Assistant Director of Nursing, and Regional [NAME] President of Operations. Requested and received a facility policy titled, Physician/Provider Orders Policy with a review date of 10/7/24 which read in part, .The Charge Nurse shall.review all physician/provider orders.The order must then be transcribed to all appropriate areas (eMAR (electronic medication administration record), eTAR (electronic treatment administration record) , etc.). No further information was provided prior to exit on 4/23/26.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. Building B. Wing	04/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Monroe Health & Rehab Center	1150 Northwest Drive Charlottesville, VA 22901

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on observation, staff interview, and clinical record review, the facility physician failed to review the total program of care including medications at each visit for 1 of 28 residents in the sample, Resident #87 (R87).The findings include: On 4/21/2026 at 7:40 AM, R87 was observed asleep in bed. A container of Beet Root Heart Gummies (a nutritional supplement) and Sea Veg (a nutritional supplement) were observed on the bedside table.During an interview with R87 that took place on 4/21/2026 at 11:08 AM, a container of Beet Root Heart Gummies and a container of Sea Veg were again observed on the bedside table. When asked about these supplements, R87 stated that he had ordered these items online and that he was taking these supplements to improve his health. An interview was conducted with Medical Director on 4/22/26 at 1:56 PM. The Medical Director stated that he became aware that R87 was taking Beet Root Heart Gummies a couple of weeks ago. The Medical Director stated that he did not check R87's MAR (Medication Administration Record) to see if the Beet Root Heart Gummies or other supplements were present on the MAR. The Medical Director stated he was aware that R87 does not self administer medications. No further information was provided prior to exit.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interview, clinical record review, and facility document review the facility failed to ensure the safe storage of biologicals for 1 of 28 residents in the sample, Resident #87 (R87).The findings include:A Resident Face Sheet indicated that R87 was admitted to the facility on [DATE] with a medical history that included hypertension (high blood pressure), heart failure, and hypothyroidism.On the most recent MDS (Minimum Data Set), a quarterly assessment with an ARD (Assessment Reference Date) of 4/15/26, R87 scored a 14 out of 15 on the Brief Interview for Mental Status indicating that R87 was cognitively intact. A comprehensive review of R87's clinical record revealed that on 1/15/25 the facility documented an assessment to determine R87s ability to self administer medications. This assessment revealed that R87 did not wish to self administer medications therefore R87 was not screened for the ability to self administer medications.R87's current medical provider orders and the April 2026 MAR (Medication Administration Record) for R87 demonstrated that R87 took Levothyroxine (a medication for low thyroid function) daily, Bumetanide (a medication used to treat heart failure and high blood pressure) daily, and Entresto (a medication used to treat heart failure and high blood pressure) twice daily. On 4/21/2026 at 7:40 AM, R87 was observed asleep in bed. A container of Beet Root Heart Gummies (a nutritional supplement) and Sea Veg (a nutritional supplement) were observed on the bedside table unsecured and within reach of R87.During an interview with R87 that took place on 4/21/2026 at 11:08 AM, a container of Beet Root Heart Gummies and a container of Sea Veg were again observed on the bedside table within reach of the resident. When asked about these supplements, R87 stated that he had ordered these items online and that he was taking these supplements to improve his health. Review of R87's current medical provider orders failed to demonstrate a medical provider order for Beet Root Heart Gummies and Sea Veg. Neither Beet Root Heart Gummies nor Sea Veg were present on the April 2026 MAR. Review of the product label on Beet Root Heart Gummies demonstrated a precaution to consult a physician prior to use when taking other medications or in the presence of medical conditions. Review of the product label on Sea Veg supplement demonstrated a precaution to consult a physician prior to use if taking thyroid medications. The DON (Director of Nursing) and Administrator were made aware of the presence of these supplements at the bedside at 3:30 PM on 4/21/2026.During an interview with LPN (Licensed Practical Nurse) #5 on 4/22/2026 at 12:02 PM, LPN #5 stated that R87 has a history of ordering things online and has them delivered in the mail to his room or the resident's sister will bring things in for the resident. LPN #5 stated that a couple of weeks ago R87 refused his medication for hypertension because he was interested in taking some sort of Beet Root supplement for high blood pressure. LPN #5 stated they educated R87 about the risks of refusing medication and encouraged R87 to speak with their physician before purchasing any supplements. When asked if LPN #5 was aware that R87 had Beet Root Heart Gummies and Sea Veg gummies at the bedside, LPN #5 stated they were not aware and would immediately remove the supplements from the bedside and address the situation with R87 and the physician. Review of the facility policy titled Storage and Expiration Dating of Medications and Biologicals effective 12/1/07 with a most recent revision date of 6/30/25 indicated that Facility should ensure all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors. Regarding bedside medication storage, the policy stated that Facility should store bedside medications or biologicals in a locked compartment within the resident's room.No further information was provided prior to exit.

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F 0810 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide special eating equipment and utensils for residents who need them and appropriate assistance. Based on observation, family interview, staff interview, clinical record review, and facility document review, the facility staff failed to utilize appropriate adaptive devices for meals for (1) one of (28) twenty-eight current sampled residents, Resident #58. The findings included:For Resident #58, the facility staff failed to utilize a plate guard and a two-handled cup with lid for the resident's meal on 4/21/26 as ordered by a medical provider. Resident #58's diagnosis list indicated diagnoses that included, but were not limited to, sequelae of cerebral infarction, vascular dementia, depression, weakness, and cognitive communication deficit. The most recent admission minimum data set (MDS) with an assessment reference date (ARD) of 1/26/26, assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 for cognitive abilities, indicating the resident was severely impaired in cognition. On 4/21/26 at 11:44 AM, Resident #58's Family Member #1 (FM#1) was interviewed via phone conversation and stated the resident has a plate guard to assist with eating meals, but facility staff fail to put it on the resident's plate. On 4/22/26 at 8:33 AM, Resident #58 was observed sitting up in bed eating from a plate of breakfast that was placed on the over-the-bed table. The lid to the plate of breakfast was observed to be sitting on the bed near the resident and a plate guard and two-handled cup with lid were observed to be sitting inside the lid. Resident #58 stated they would like to have some black coffee. On 4/22/26 at 8:35 AM, Certified Nursing Assistant #1 (CNA#1) was interviewed and CNA#1 stated she did not set-up Resident #58's meal, but she would correct it. CNA#1 was observed to place the plate guard on Resident #58's plate and was informed the resident requested some black coffee. CNA#1 stated she would put the coffee in the two-handled cup. Resident #58 agreed they could hold the coffee better when it was in the two-handled cup with lid. A review of a medical provider orders disclosed an order with a start date of 1/23/26, which read in part, .ADAPTIVE FEEDING EQUIPMENT (Plate Guard).Special Instructions: Plate Guard with meals. A review of a medical provider orders disclosed an order with a start date of 1/23/26, which read in part, .ADAPTIVE FEEDING EQUIPMENT: (Two-Handled Cup with Lid). A review of the comprehensive person-centered care plan disclosed a focus with a start date of 1/24/26 and an edited date of 3/8/26 which read in part, .on mechanically altered diet. Adaptive equipment in place (.plate guard, two-handled cup with lid. Interventions associated with the focus read in part, .provide diet per order.Adaptive equipment as.ordered. This concern was discussed on 4/22/26 at the end of day meeting with the Administrator, Director of Nursing, Assistant Director of Nursing, Regional Director of Clinical Services, and Regional [NAME] President of Operations. Requested and received a facility policy titled, Adaptive Eating Devices Policy with a revision date of 1/17/25 which read in part, .Adaptive (assistive) eating devices are provided per provider order. No further information was provided prior to exit on 4/23/26.

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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, clinical record review, and facility document review the facility staff failed to maintain an infection prevention and control program designed to provide a safe, sanitary, comfortable environment for 2 of 28 residents, Resident #72 Resident #115. The findings included: 1. For resident #72 the facility staff failed to ensure transmission-based precautions were followed for a resident with active influenza. The policy entitled, Transmission Based Precautions and Isolation Policy with an effective date of 05/19/2025 was reviewed. The document read in part, 2. Droplet Precautions- intended to prevent transmission of pathogens spread through close respiratory or mucous membrane contact with respiratory secretions. A. A single patient room is preferred but not required. Assess the various risks associated with other resident placement options. Maintain a spatial separation of greater than 3-6 feet (when space allows) and draw the curtain between resident beds. B. A mask is worn for close contact with infectious resident. C. Gloves, gown are worn adhering to Standard Precaution guidelines. The Resident Face Sheet revealed the facility admitted resident #72 on 02/25/2025. According to the Resident Face Sheet the resident had a medical history that included diagnoses of quadriplegia, chronic obstructive pulmonary disease, congestive heart failure and cough. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/17/2026 assigned the resident a brief interview for mental status (BIMS) score of 14 which indicated intact cognition. Resident #72's comprehensive person-centered care plan included a focus that read, Infection: Resident has a respiratory infection related to influenza with antiviral medication. The last approach listed read, Staff will follow droplet precautions/isolation as ordered, including PPE (personal protective equipment) and proper hand hygiene. Keep door to room closed. The clinical record included a medical provider order dated 04/13/2026 that read, Isolation/Transmission Based Precautions: Combined droplet/contact precautions/isolation related to Influenza B. During an observation of medication pass on 04/22/2026 at 8:55 AM resident #72's door was noted to be closed. A sign that read, STOP- DROPLET-CONTACT PRECAUTIONS; Perform hand hygiene, Wear mask before entering room, Gown before entering room, Gloves before entering room, Eye protection before entering room was noted on the door. The Activities Assistant approached the door, read the sign, opened each drawer of the bin that stored the PPE, applied a mask and entered the room. The Activities Assistant, who was wearing eyeglasses, did not apply gown or gloves. Certified Nursing Assistant (CNA) #1 entered the room directly after the Activities Assistant and did not apply any PPE. CNA #1 exited the room at 9:02 AM. When asked if they were aware that resident #72 was on droplet precautions she stated No, I wasn't, I didn't see the sign, and I don't usually work with him. The Activities Assistant was interviewed on 04/22/2026 at 10:46 AM and stated, I know, I should have put a gown and everything on. I don't know what I was thinking. I read the sign. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/22/2025 at 4:51 PM the survey team met with the Administrator, Director of Nursing (DON), Assistant Director of Nursing, and the Regional Director of Clinical Services. This concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference. 2. For resident #115 the facility staff failed to follow infection control standards of practice to reduce cross contamination during the administration of eye drops. The facility policy entitled Omnicare Medication Administered Through Certain Routes with a revision date of 11/15/2024 stated: 7.7 Wipe off tears or excess solution with a clean tissue. Two different tissues should be used, one for each eye, to prevent cross contamination. The Resident Face Sheet for resident #115 revealed the facility admitted the resident on 01/15/2025. According to the Resident Face Sheet, resident #115 had a medical history that included the diagnosis of dry eye syndrome of both lacrimal glands (glands in the upper, outer corner of each eye that produce tears to lubricate and protect the surface of the eye). A quarterly Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 04/15/2026 assigned the resident a brief interview of mental status (BIMS) score of 03 indicating severe cognitive impairment. The medication administration record (MAR) for resident #115 was reviewed. The MAR included an order that read, Refresh Classic (PF) (polyvinyl alcohol-povidon(pf)) [OTC] dropperette; 1.4-0.6 %; Amount to Administer: 2 drops in both eyes; ophthalmic (eye). On 4/22/2026 at 8:54 AM during observation of a medication pass for resident #115, Licensed Practical Nurse (LPN) #2 was observed administering eye drops to resident #115. During observation, LPN #2 administered 2 drops of refresh solution into each eye. LPN #2 then used a tissue to wipe from the inner corner of the right eye to the outer corner, then used the same tissue to wipe the left eye in the same manner. 4/22/2026 at 11:24 AM The Director of Nursing (DON) was informed of the above concern and provided the policy referenced above. On 04/22/2025 at 4:51 PM the survey team met with the Administrator, DON, Assistant Director of Nursing, and the Regional Director of Clinical Services. This concern was discussed with them at that time. No further information was provided to the survey team prior to the exit conference.