STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495377	A. Building B. Wing	07/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Charlottesville	490 Hillsdale Drive Charlottesville, VA 22901

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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 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. Based on observation, resident interview, staff interview and facility documentation, the facility staff failed to resolve a grievance in a timely manner, failed to post the identification of the grievance officer, and failed to post the grievance procedure in the facility.The findings included: The facility did not have the grievance procedure or who the officer was posted and did not respond to a grievance timely. On 7/21/25 at 2:00 p.m., a tour of the facility's nursing unit one, unit two and unit three was conducted. There was no posting for who the grievance officer was or how to file a grievance on the nursing units or in the lobby area of the facility. On 7/22/25/at 3:00 p.m., a resident council meeting was held. During the meeting questions were asked about how to file a grievance and who the grievance officer was at the facility. There were 15 residents in attendance at the meeting, and no one knew who the grievance officer was or how to file a grievance. During the meeting Resident #114 said, I guess we could tell the nurses our concerns and they could pass it on to us. Resident #82 said, We were not aware of a grievance form, and we don't know who the grievance officer is or even if we have one here. On 7/22/25 at 3:30 p.m., the activity's director was asked if she knew who the grievance officer was and she said, no. On 7/23/25 at 8:49 a.m., the social service director stated that she was not aware of who the grievance officer was at the facility. On 07/24/2025 at 8:22 a.m., an interview was conducted with the administrator. The administrator said, I am the grievance officer at this time because there has been so much turnover with the social workers. The administrator stated there was no posting about the grievance officer or procedure, but the guest could go to any staff with their concerns. On 7/24/25 at 10:00 a.m., the administrator provided a copy of their grievance log and a grievance that was filed by Resident #131's (R131) responsible person during his stay at the facility. Reviewing the grievance form R131's spouse had five concerns that were listed on the grievance form. The grievance was filed on 5/15/24 and had a resolution date of 6/4/24, which was R131's discharge date . On 7/24/25 a facility policy was reviewed. The policy titled, Care Program, read in part, . Sharing pertinent resident concerns with the IDT [interdisciplinary team] at morning meetings and establishing communication with the family. A=Action section 2. All concerns shall be discussed with the Department Managers during the morning interdisciplinary Team (IDT) meeting following the day of receipt. During the meeting the team will determine who will investigate the concern if the investigation has not been initiated. The Department manager/designee assigned has 5-7 business days following receipt of the concern to complete the investigation and document his/her conclusions. On 7/24/25 at 11:13 a.m., an end of day meeting was held with the administrator, the director of nurses, the assistant director of nurses and the regional clinical director. They were informed of the above concern. No additional information was provided prior to the exit interview.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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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 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 complete an accurate minimum data set (MDS) for one of thirty-three residents in the survey sample (Resident #132)The findings include:Resident #132 (R132) was admitted to the facility with diagnoses that included cerebrovascular accident (stroke), hemiplegia, atrial fibrillation, aphasia, cognitive communication deficit, diabetes, dysphagia with gastrostomy, dementia, hypertension, and pressure ulcer. The minimum data set (MDS) dated [DATE] assessed R132 with severely impaired cognitive skills. R132's clinical record documented an admission assessment dated [DATE] listing the resident had a stage 2 pressure ulcer on the sacrum. R132's clinical record documented physician orders entered on 2/17/24 for treatment of a sacral pressure ulcer with normal saline, medi-honey and foam dressing daily. R132's treatment administration records documented daily wound care to the sacral pressure ulcer as ordered. Section M0210 of R132's admission MDS with reference date of 2/20/24, documented the resident had no unhealed pressure ulcers/injuries. This MDS included no mention of the sacral pressure ulcer present upon admission on [DATE] with ongoing treatments. On 7/24/25 at 8:20 a.m., the registered nurse MDS coordinator (RN #1) was interviewed about the pressure ulcer not indicated on R132's admission MDS. RN #1 reviewed R132's admission assessment and stated there was a sacral pressure ulcer identified upon admission and listed on the treatment records. RN #1 stated the pressure ulcer should have been indicated on the 2/20/24 MDS as present upon admission. RN #1 stated, It was an oversight. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual (October 2024) documents on page M-5 regarding steps for assessment of unhealed pressure injuries, .Code based on the presence of any pressure ulcer/injury (regardless of stage) in the past 7 days .Code 1, yes: if the resident had any pressure ulcer/injury (Stage 1, 2, 3, 4, or unstageable) in the 7-day look-back period. Proceed to M0300, Current Number of Unhealed Pressure Ulcers/Injuries at Each Stage . (1) This finding was reviewed with the administrator, director of nursing and regional nurse consultant on 7/24/25 at 12:45 p.m. with no further information presented prior to the end of the survey. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.19.1, Centers for Medicare & Medicaid Services, Revised October 2024.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **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 follow professional standards of nurse practice for three residents (Resident #22-R22, Resident #35-R35, and Resident #132-R132) in a survey sample of thirty-three residents. The findings included: 1. For R22, the facility staff failed to administer medications timely, within the professional standard of one hour of scheduled time, which had the potential to affect the next scheduled dose and affect level of medication within the resident’s system at a given time. On 7/22/25 at 8:20 a.m., during an interview with R22, she verbalized concern about the administration of her insulin. R22 said frequently in the morning they do not give her morning insulin until 10:30-11 a.m., and about a week ago the nurse had to not administer the afternoon dose of insulin because she had just given the morning dose. R22 said, “I think the insulin is important and you can’t just put one on top of the other, you shouldn’t be taking your medications at lunch time.” On 7/23/25, a clinical record review was conducted. This review revealed R22 had multiple physician orders for insulin. The orders included: a. Basaglar Kwik pen 100UNIT/1ML insulin pen, Inject 34 unit subcutaneously two times a day for Diabetes, hold for BG [blood glucose] less than 100, Notify MD [medical doctor]. According to the medication administration record (MAR), the basaglar Kwik pen was scheduled for administration at 9 a.m., and 9 p.m., daily. b. Humalog Injection Solution (Insulin Lispro) Inject as per sliding scale: if 160-200 = 1unit inject sub Q [subcutaneous]; 201- 240 = 2 units inject sub Q; 241-280 = 3 units inject sub Q; 281-320 = 4 units; 321-360 = 5 units; 361-400 = 6units; 401+ contact Doctor for orders, subcutaneously before meals and at bedtime for diabetes. According to the MAR, the Humalog sliding scale was to be administered at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9 p.m. daily. c. Humalog Kwik Pen Subcutaneous Solution Pen injector 100 UNIT/ML (Insulin Lispro) Inject 16 unit subcutaneously three times a day for Diabetes Mellitus. According to the MAR, the 16 units of Humalog was scheduled to be given at 9 a.m., 1 p.m., and 5 p.m., respectively. d. Trulicity Subcutaneous Solution Auto-injector 0.75 MG/0.5ML (Dulaglutide) Inject 0.5 ml subcutaneously one time a day every Fri for DM2 [type 2 diabetes]. The MAR indicated the Trulicity was to be administered at 4:30 p.m. weekly on Fridays. On 7/23/25, the facility’s Director of Nursing (DON) provided the surveyor with a “Location of Administration” report which noted the administration times and administration location of insulin. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	It noted on numerous occasions insulin was not given in accordance with professional standards of practice to administer medications within an hour of the scheduled time. Some of the incidents of non-compliance included, but were not limited to: On 7/7/25, 7/11/25, 7/14/25, 7/17/25, 7/20/25, and 7/23/25, the 9 a.m., dose of Basaglar insulin was administered after 11:00 a.m. The Humalog sliding scale insulin scheduled before meals and at bedtime was not administered within an hour of being scheduled on the following instances: On 7/4/25 the 11:30 a.m., dose was given at 2:44 p.m. On 7/5/25, the 4:30 p.m. dose was administered at 6:28 p.m. On 7/14/25, the 11:30 a.m. dose was given at 1:42 p.m., which would have been after the resident had eaten. On 7/17/25 and 7/19/25, the 11:30 a.m dose was given at 1:15 p.m. and 12:56 p.m., respectively, which also would have been after the lunch meal. Regarding the 16 units of Humalog scheduled for 9 a.m., 1 p.m., and 5 p.m., daily, there were fifteen instances in July 2025 that it was administered outside of the 1-hour window of the time it was scheduled. Some of the instances were as great as two hours and thirty-eight minutes after the scheduled time. The Trulicity was given on 7/4/25 at 2:40 p.m., which was over five hours after the scheduled time. On 7/23/25, during an interview with the director of nursing, she confirmed that medications are to be given within an hour of the scheduled time. On 7/23/25 at 4:08 p.m., during an end of day meeting, the above concerns were discussed. No additional information was provided prior to the conclusion of the survey. 2. For R35, the facility staff provided the resident with medication and walked away without observing the resident swallow/ingest the medication(s). On 7/23/25, an interview was conducted with R35. During the interview she was asked about an incident where medications were lying on her bed, she had no recall of the incident. On 7/23/25 a clinical record review was conducted, and the progress notes gave no details. On 7/24/25 at 8:46 a.m., an interview was conducted with the unit manager, who was registered nurse #4 (RN #4). RN #4 confirmed that there was an incident where a licensed practical nurse #5 (LPN #5) left medications in the room. RN #4 said she heard that the family of R35 came in and medications were on the resident’s bed. RN #4 said, “the nurse said she [R35] was putting them in her mouth and she [LPN #5] walked out of the room. She was reprimanded and told she can’t walk out.” On 7/24/25 at 9:03 a.m., an interview was conducted with LPN #5. LPN #5 was asked about an incident involving R35 and medications. LPN #5 explained that the resident was taking her medications, and she walked away. When the family came in medications were on her bed. LPN #5 said, “I’m not perfect, but I’m a good nurse. I was written up for it.” (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/25, the employee file of LPN #5 was reviewed. There was an “Employee Disciplinary Record” dated 6/3/25 that was a written warning and noted, “… Medication are never to be left with a guest.” According to The Lippincott Manual of Nursing Practice 11th edition on page 15 documents regarding common departures for standards of care, . Failure to administer medications properly and in a timely fashion…” (1) On 7/23/25 at 4:08 p.m., during an end of day meeting, the above concerns were discussed. No additional information was provided prior to the conclusion of the survey. 3. Facility staff failed to document a thorough assessment of Resident #132's pressure ulcer that included size, appearance and/or description of the wound. Resident #132 (R132) was admitted to the facility with diagnoses that included cerebrovascular accident (stroke), hemiplegia, atrial fibrillation, aphasia, cognitive communication deficit, diabetes, dysphagia with gastrostomy, dementia, hypertension, and pressure ulcer. The minimum data set (MDS) dated [DATE] assessed R132 with severely impaired cognitive skills. R132's clinical record documented an admission nursing assessment dated [DATE] listing the resident was assessed with a stage 2 pressure ulcer on the sacrum. The assessment included no description of the wound's appearance indicating the size, skin color, wound bed or presence of drainage/odor. Physician orders were entered on 2/17/24 for treatment of the pressure ulcer. R132's treatment administration record (TAR) documented treatment of the pressure ulcer with normal saline, medi-honey and foam dressing daily as ordered. Clinical notes from 2/17/24 through 2/27/24 documented ongoing treatment of the ulcer with no changes in status noted but included no descriptive assessment of the wound including size or appearance of the wound bed or surrounding tissue. A wound evaluation dated 2/28/24 documented the pressure ulcer was present upon admission and listed the status as unstageable due to the presence of slough and/or eschar with measurements listed as 5.9 cm (centimeters) by 2.7 cm (length by width) with no determined depth. This assessment listed the wound bed had 30% granulation, 30% slough, 40% eschar with no signs of infection, moderate exudate, and no odor with surrounding tissue normal in color/temperature. The consultant wound nurse practitioner assessed the ulcer on 2/28/24, listing a detailed assessment and ordered treatments to continue with normal saline, medi-honey and foam dressing daily. On 7/24/25 at 8:33 a.m., the registered nurse unit manager (RN #4) that completed R132's admission assessment was interviewed about any description or assessment of the identified pressure ulcer. RN #4 stated she listed the resident had a stage 2 pressure ulcer on the sacrum but that she did not document any other details about the wound. RN #4 stated she remembered the resident, that she had a wound on the sacrum but was unable to recall what the ulcer looked like. RN #4 stated, We usually describe the wound in some fashion. RN #4 stated not all nurses were able to stage pressure ulcers but that there should have been some description of the wound's appearance. RN #4 stated the consultant wound nurse practitioner measured wounds weekly and provided detailed assessments. RN #4 stated the wound was treated and monitored during daily dressing changes but there were no descriptive assessments of the wound's status until 2/28/24 when the wound practitioner assessed the wound. RN #4 stated, I would think there should have been more of a description of the wound. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/25 at 8:42 a.m., the director of nursing (DON) was interviewed about a documented assessment of R132's pressure ulcer upon admission and during the first week of the resident's stay. The DON stated all nurses were not able to stage pressure ulcers but that nurses were expected to document what they see regarding the appearance of the wound. The DON stated the consultant wound practitioner routinely assessed wounds and provided detailed assessments but that nurses should have documented a descriptive assessment upon admission and prior to the first wound consultant visit. The DON stated, I would think there would be a descriptive assessment, especially since it was a week before the wound NP [nurse practitioner] assessed the wound. The DON stated the expectation was for nurses to document what they see, describe the wound appearance. The facility's policy titled Skin Management (revised 8/14/24) documented, .Residents with wounds and/or pressure injury and those at risk for skin compromise are identified, evaluated and provided appropriate treatment to promote prevention and healing. Ongoing monitoring and evaluation are provided to ensure optimal guest/resident outcomes .Residents admitted with any skin impairment will have: Appropriate interventions implemented to promote healing, A physician's order for treatment, and Skin impairment location, measurement and characteristics documented .Residents with pressure injury and lower extremity ulcers will be evaluated, measured and staged weekly (pressure injury and vascular ulcers only) in accordance with the practice guidelines until resolved . The Lippincott Manual of Nursing Practice 11th edition on page 15 documents regarding common departures for standards of 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 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) This finding was reviewed with the administrator, DON and regional nurse consultant during a meeting on 7/24/25 at 11:15 a.m. with no further information presented prior to the end of the survey. (1) [NAME], [NAME] M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/[NAME] & [NAME], 2019.

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, clinical record and facility documentation the facility staff failed to provide activity of daily living (ADL) assistance for three residents Resident #131 (R131), Resident #89 (R89) and Resident #35 (R35) out of a survey sample of 33 residents.The findings included: R131 was not shaved by the facility staff during his stay. R131 was no longer a resident at the facility so was unable to be interviewed. On 7/23/25 at 2:55 p.m., an interview was conducted with a certified nursing assistant, CNA#3 (CNA3). CNA3 stated that some aides were scared to shave R131. She stated she may have shaved him for an aide while he was here at the facility. CNA3 stated that she shaved him on the day of his discharge. CNA3 stated he had a lot of hair on his face and needed to be shaved. On 7/23/25 at 3:30 p.m., a clinical record review was conducted. R131's care plan was that he needed assistance with all self-care. The minimum data set (MDS) dated [DATE] coded that R131 was requiring moderate to maximum assistance from staff for his ADL's. On 7/24/25 at 10:00 a.m., the administrator provided a copy of their grievance log and a grievance that was filed by Resident #131's (R131) responsible person during his stay at the facility. Reviewing the grievance form, R131's spouse had five concerns that were listed on the grievance form and one of the concerns was about R131 not being shaved by staff. The concern read in part, .asked for him to be shaved from admission 5/9/ finally did it with him on 5/15. The grievance was filed on 5/15/24 and had a resolution date of 6/4/24, which was R131's discharge date . The resolution for the concern of being assisted with shaving was dated 6/4/25 and read in part, .staff educated that spouse preferences is us to shave him. 2. For Resident #89 (R89), the facility staff failed to set up the residents’ meals and failed to provide the necessary assistance and utensils, so the resident could feed herself. On 7/23/25 at approximately 8:30 a.m., R89 called out and motioned for the surveyor to enter her room. R89 was observed crying and very upset. When asked what was wrong, R89 explained that her breakfast had not been set-up, nor was she provide the items needed so she could eat/feed herself and had no milk for her cereal. R89 had observed to have limited range of motion in her arms and reported to the surveyor limited use of her arms and hands. R89 stated she was not able to remove the lid on the cereal and was limited in her ability to cut up her food. R89’s breakfast tray was observed to have a bowl of cold/dry cereal, that had a lid the resident was unable to remove. There was no milk for the cereal. The resident had no fork, and her egg was so hard she couldn’t cut it. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/25 at approximately 8:40 a.m., the dietary manager was asked to come to R89’s room. Upon the dietary manager’s arrival, the above items were pointed out. The dietary manager immediately began saying she didn’t know why she didn’t have a fork, nursing staff should have given her milk and opened her items. The dietary manager confirmed the egg was so hard/tough that it couldn’t be cut. On 7/23/25, a clinical record review was conducted of R89’s chart. According to R89’s most recent minimum data set assessment, which was an annual assessment and had a reference date of 6/12/25, R89 was noted with range of motion [movement] impairments of her upper extremities [shoulder, elbow, wrist, hand] on both sides. According to that same assessment, R89 was coded as having required “setup or clean-up assistance” for eating in section GG. R89’s diagnosis included, but was not limited to, impingement syndrome of right shoulder, pain in right shoulder, and polyneuropathy. According to the facility policy titled, Activities of Daily Living (ADL) Program, assistance with daily care needs was not addressed. The policy only referred to a restorative nursing program. On 7/23/25 at 4:08 p.m., the facility administrator and director of nursing were made aware of the above findings. No additional information was provided. 3. For Resident #35 (R35), the facility staff failed to help with activities of daily living, that resulted in the resident calling 911. On 7/21/25 at 3:23 p.m., during an interview with R35, she and her roommate both reported that on July 3rd or 4th, they had been sitting up in their wheelchairs all day and wanted to lay down. They reported, “we rang and rang our bell. We waited over two and a half hours, and no one came. We were hurting from sitting up all day.” R35 reported she called her son to report the issue, and he then called 911. On 7/22/25 at 10:55 a.m., during a second interview, R35 reported the incident again from July 3rd or 4th and reported after getting out of bed that morning they received no other care until late that night, despite ringing the call bell for over two and a half hours. On 7/23/25, a clinical record review was conducted of R35’s chart. According to a minimum data set (an assessment) with an assessment reference date of 6/13/25, R35 was cognitively intact with a brief interview for mental status score of 13 of 15. According to section G, R35 required extensive assistance and two-person physical assistance with bed mobility, transfers, and toilet use. According to the activities of daily living documentation, on 7/3/25, there was no indication that any assistance with daily care needs was provided on the evening shift from 3pm-11 pm, as the documentation was blank. On 7/24/25 at 8:15 a.m., an interview was conducted with a certified nursing assistant #8 (CNA#8). CNA #8 explained that all care is documented in the electronic health record. When asked what is means if it is blank, CNA #8 said, “No care was done.” (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/24/25 at 8:30 a.m., an interview was conducted with the unit manager, registered nurse #4 (RN #4). RN #4 explained that care is documented throughout the day as care is provided. When asked what it means if it is blank, RN #2 said, “I have to assume care wasn’t provided. If nothing is charted, care wasn’t provided.” RN #4 was told of R35’s allegation of not receiving care and calling her son after being up all day and calling for assistance for 2 ½ hours with no response. It was explained that on 7/3/25, no documentation was in the clinical record regarding care being provided. RN #4 said, “Yeah, you would have to agree it wasn’t done.” RN #4 went on to say, “There is no excuse for that. They informed me when I returned to work that it did occur and by the time the police got here, she had been put in bed.” When asked if a grievance was filed, RN #4 said, “Not that I am aware of.” I spoke to the staff about it; their reasoning was that they were attending to each resident as fast as they could. That group is heavy [require more care], and it takes time. ” According to the grievance log there was no record of R35’s complaint that resulted in the police responding to the facility. On 7/24/25 at 8:45 a.m., the facility’s director of nursing (DON) was asked if she had information regarding R35’s allegation regarding the lack of care on 7/3/25. The DON stated she would have to look, since the previous DON was in charge at that time. On 7/24/25 at approximately 9 a.m., an interview was conducted with the facility administrator. When the surveyor asked about her knowledge of R35’s allegation regarding the lack of care on 7/3/25, the facility administrator reported she had no knowledge. On 7/24/25 at 11:13 a.m., during a meeting with the facility administrator and director of nursing, the above concerns were discussed. On 7/24/25 at 12:30 p.m., just prior to the survey exit conference, the facility’s DON provided the survey team with a statement and stated that she had spoken to the nurse that was on duty on 6/4/25. The document was reviewed and identified to reference a date that was different from the day of the resident’s allegation. The written statement indicated there were no resident or family complaints and no police in the facility on 6/4/25. The DON also had a statement that she had spoken to the weekend supervisor who worked 6/5/25-6/6/25, which was not the dates in question/of concern previously discussed with the DON. According to the DON's interview with the weekend supervisior, the supervisor reported R35’s son was in and complained of the resident’s pain and being out of bed too long. The weekend supervisor reported she resolved all of the son’s concerns with no further complaints and indicated the unit manager (RN #4) followed up with a call on Monday to address any further concerns. On 7/24/25 at 12:30 p.m, within the documents the facility's director of nursing gave the surveyor was an email that was from R35's son. The email was dated 7/4/25 and read, I am trying to reach someone there today because my mother is in severe pain and cannot get a response from anyone. I'm sure you're probably off today, but I'm trying anything I can. I'm 6 hours away but if I need to come over there to help her, then I may need to call 911 to get her help before I can get there. I'm currently on hold waiting for someone to pick up. This is not acceptable. No additional information was provided.

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The Laurels of Charlottesville	490 Hillsdale Drive Charlottesville, VA 22901

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based upon observations, resident & staff interviews, clinical record review, and facility documentation review, the facility failed to follow physician's orders for seven of thirty-three residents in the survey sample, Resident #134 (R134), Resident #41 (R41), Resident #49 (R49), Resident #22 (R29), Resident #31 (R31), Resident #38 (R38), and Resident #43 (R43).The Findings Include: 1. Resident #134 (R134) did not receive Cefazolin (antibiotic) as ordered. R134 was admitted to the facility with diagnoses that included cellulitis, right toes amputation, congestive heart failure, MRSA, and diabetes. The most recent minimum data set (MDS) was a 5-day assessment dated [DATE], R134 was assessed as being conatively intact. Review of R134’s clinical record indicated an order for “Cefazolin sodium inject 2 grams IM three times a day.” The order was written on 3/12/25 to start 3/13/25. Review of R134’s medication Administration Record (MAR) indicated R134 did not get morning dose of antibiotic on 3/13/25 (6;00 a.m. dose), the physician was notified, and the medication was put on hold. On 7/22/25 at 1:40 p.m. the unit manager (license practical nurse, LPN #1) where R134 resided while at the facility, was interviewed. LPN #1 reviewed documentation and verbalized R134 entered the facility on 3/12/25 at 7:13 p.m. and the medication may not have been available due to the time of admission being late in the evening and would contact the nurse on duty that night to find out what happened. LPN #1 then went to automated medication dispensing storage (Omni-cell) to see if the facility keeps the medication on hand and showed the medication was not available. LPN #1 then reviewed the contents in the unit's STAT medication box and found the box contained two 1-gram vials of Cefazolin. LPN #1 said that the nurse on duty should have used the medication in the STAT box. On 7/22/2025 at 4:11 p.m. LPN #1 came back and gave information regarding medication not given. LPN #1 said the nurse on duty the day in question was unable to be contacted, but called pharmacy and said the antibiotic in question was not pulled from the stat box and could have been. The above information was presented to the administrator and director of nursing on 7/23/25. No other information was provided prior to the exit conference. 2. Resident #41 was administered 10 mg (milligrams) of the medication Bacoflen when the physician's order required a 5 mg dose. A medication pass observation was conducted on 7/22/24 at 8:44 a.m. with licensed practical nurse (LPN #5) administering medications to Resident #41 (R41). Among the medications administered to R42 was Baclofen 10 mg. R42's clinical record documented a physician's order dated 5/1/25 for Baclofen 5 mg once daily for treatment of muscle spasms. R42's medication administration record documented the Baclofen 5 mg was scheduled each day for administration at 9:00 a.m. The record also included a physician's order dated 5/1/25 for Baclofen 10 mg to be administered at each bedtime with the scheduled time listed on the administration record at 9:00 p.m. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/22/25 at 8:50 a.m., LPN #5 was interviewed about administering a 10 mg dose of Baclofen instead of the ordered 5 mg dose. LPN #5 reviewed the medication card and stated she gave the bedtime dose instead of the 5 mg dose scheduled for 9:00 a.m. LPN #5 reviewed the medicine supply cards and located R41's Baclofen 5 mg labelled for administration at 9:00 a.m. On 7/22/25 at 8:55 a.m., the registered nurse unit manager (RN #4) was interviewed about the medication error with R41's Baclofen. RN #4 reviewed and stated LPN #5 obtained the 10 mg dose from the supply card labelled for bedtime. RN #4 displayed that the supply card with the 5 mg dose was available in the medication cart. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 7/23/25 at 4:15 p.m. with no further information presented prior to the end of the survey. 3. Resident #49 did not have vital signs assessed each shift as ordered by the physician. Resident #49 (R49) was admitted to the facility with diagnoses that included tibia fracture, venous thrombosis, fractured metatarsal bones, depression, benign prostatic hyperplasia, sacrum fracture, pneumothorax, anemia, multiple rib fractures, and back contusion. The minimum data set (MDS) dated [DATE] assessed R49 as cognitively intact. R49's clinical record documented a physician's order dated 7/8/25 for vital signs every shift for 14 days. Vitals signs listed on the medication administration record (MAR)included assessment of blood pressure, temperature, pulse rate, respiration rate and oxygen saturation. R49's MAR documented no vital signs were assessed on the day shift on 7/12/25 and 7/19/25. Clinical notes documented no explanation of why vital signs were not obtained on these dates. On 7/22/25 at 3:54 p.m., the licensed practical nurse unit manager (LPN #1) was interviewed about R49's missed vital signs. LPN #1 stated she reviewed the clinical record and did not find vital signs for 7/12/25 or 7/19/25. LPN #1 stated, I don't see where they [vital signs] were done. LPN #1 stated vital signs were supposed to be documented in the clinical record as ordered. This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 7/23/25 at 4:15 p.m. with no further information presented prior to the end of the survey. 4. For Resident #22 (R22), the facility staff failed to administer insulin in accordance with physician orders and the standard of practice to administer medications within an hour of scheduled dose. On 7/22/25 at 8:20 a.m., during an interview with R22, she verbalized concern about the administration of her insulin. R22 said frequently in the morning they do not give her morning insulin until 10:30-11 a.m., and about a week ago the nurse had to not administer the afternoon dose of insulin because she had just given the morning dose. R22 said, “I think the insulin is important and you can’t just put one on top of the other, you shouldn’t be taking your medications at lunch time.” (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/23/25, a clinical record review was conducted. This review revealed R22 had multiple physician orders for insulin. The orders included an order for sliding scale insulin, which read, “Humalog Injection Solution (Insulin Lispro) Inject as per sliding scale: if 160-200 = 1unit inject sub Q [subcutaneous]; 201- 240 = 2 units inject sub Q; 241-280 = 3 units inject sub Q; 281-320 = 4 units; 321-360 = 5 units; 361-400 = 6units; 401+ contact Doctor for orders, subcutaneously before meals and at bedtime for diabetes.” According to the MAR, the Humalog sliding scale was to be administered at 6:30 a.m., 11:30 a.m., 4:30 p.m., and 9 p.m. daily. On 7/3/25, R22’s blood sugar was not checked at 11:30 a.m., and therefore, no insulin was administered. On 7/19/25 the 6:30 a.m. blood glucose check, R22’s sugar was recorded as 170 and no insulin was administered. According to the physician order 1 unit of insulin was to be given for blood sugar levels between 160-200. There was no documentation that the doctor was notified of this omission of administration. On 7/23/25, during an interview with the director of nursing, she was made aware of the insulin not being administered as ordered. According to the Institute for Safe Medication Practices (ISMP) document titled, ISMP Guidelines for Optimizing Safe Subcutaneous Insulin Use in Adults, it read in part, . Medications that are associated with the highest risk of injury when used in error are known as high-alert medications. Insulin has long been identified as belonging to this group of medications . For many years, insulin has been shown to be associated with more medication errors than any other type or class of drugs . Types and Causes of Insulin Errors: A variety of error types have been associated with insulin therapy, including administration of the wrong insulin product, improper dosing (under-dosing and overdosing), dose omissions, incorrect use of insulin delivery devices, wrong route (intramuscular versus subcutaneous), and improper patient monitoring. Many errors result in serious hypoglycemia or hyperglycemia . Hypoglycemia is often caused by a failure to adjust insulin therapy in response to a reduction in nutritional intake, or an excessive insulin dose stemming from a prescribing or dose measurement error. Other factors that contribute to serious hypoglycemia include inappropriate timing of insulin doses with food intake, creatinine clearance, body weight, changes in medications that affect blood glucose levels, poor communication during patient transfer to different care teams, and poor coordination of blood glucose testing with insulin administration at meal times . The above referenced document went on to read, .Poor coordination of insulin with meals and glucose monitoring in inpatient settings: Coordinating glucose monitoring, meal delivery, and insulin administration within the ideal time frame for rapid-acting insulin is a significant challenge often not being met in inpatient settings. Studies suggest that glucose monitoring and insulin administration occur within an acceptable range less than half of the time in hospitalized patients prescribed insulin. In two studies, less than half of patients met the goal of receiving a rapid-acting insulin within 10-15 minutes of a meal, and 35% received glucose monitoring within one hour prior to insulin administration. Timing for meals, blood glucose testing, and rapid-acting insulin administration varied significantly and was not well synchronized among the various facilities . Accessed online at: 2017 ISMP Guidelines for Optimizing Safe Subcutaneous Insulin Use in Adults On 7/23/25 at 4:08 p.m., during an end of day meeting, the above concerns were discussed. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No additional information was provided prior to the conclusion of the survey. 5. For Resident #31 (R31), who had orders for daily weights and to notify the physician of significant weight changes, the facility staff failed to notify the physician when the weight exceeded the parameters set by the doctor. On 7/21/25, R31 was visited in her room. R31 reported she had recently been readmitted to the facility following hospitalization. She reported she had been a resident of the facility prior but had gone home but was thankful they accepted her back. On 7/22/25, during a clinical record review, it was noted that R31’s diagnosis included but were not limited to: Chronic diastolic/congestive heart failure, chronic kidney disease stage 3A, and acute kidney failure. On 7/18/25, the doctor ordered, “Weight: Daily Notify MD of 3 lb. [pound] weight gain in 1 day or 5 lb. weight gain in 1 week. every day shift.” According to R31’s recorded weights, on 7/19/25 the resident weighed 215.2 pounds. On 7/20/25 and 7/21/25 the resident weighed 221.4 pounds and 221.6 pounds. There was no indication that the doctor was made aware of this weight gain of six pounds in one day. On 7/23/25 at 2 p.m., an interview was conducted with registered nurse #4 (RN #4), who was a unit manager. When asked about physician orders for daily weights, RN #4 explained that this is particularly important with residents who have congestive heart failure, impaired kidney function, or are not consuming enough of their meals. “Weight is so important,” she said. She said it is important to let the doctor of weight changes as ordered because it could mean they are retaining fluid, medications need to be adjusted, etc. On 7/23/25 at 2:13 p.m., an interview was conducted with licensed practical nurse #9 (LPN #9) who was also a unit manager and the manager on the unit where R31 was a resident. When asked about daily weights, LPN #9 said at times nursing will write it on paper and then put it in the computer/electronic health record of the resident. When R31 weight loss was discussed and according to the doctor’s order, the physician should have been notified, LPN #9 agreed. She was unable to find evidence of the provider being made aware of the significant weight change in 24 hours. 6. For Resident #38 (R38), the facility staff failed to obtain daily weights as ordered by the physician. On 7/21/25, in the afternoon, an interview was conducted with R38. R38 was observed in bed and appeared very thin and frail. On 7/22/25, a clinical record review was conducted that revealed R38 was admitted to the facility on [DATE] and diagnosis included gastric ulcer and helicobacter pylori. According to the physician orders, R38 had an order dated 7/10/25, that read, “Daily weight.” According to the recorded weights in R38’s chart, her weight was as follows: (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/11/25- 135 pounds. On 7/13/25- 136.1 pounds. On 7/17/25- 138.2 pounds. On 7/19/25- 138 pounds and on 7/21/25 R38’s weight dropped to 121.6 pounds. On 7/22/25 R38’s weight was 122.4 pounds. There were no other recorded weights in R38’s chart. According to the care plan, it indicated to notify the doctor of a change of 5% or more. On 7/23/25 at 10:18 a.m., an interview was conducted with R38’s attending physician. The doctor noted that they felt the weight change recorded was not an accurate weight. When asked about his expectation regarding weights for R38. The doctor said, if he orders daily weights, he expects it to be done and documented. On 7/23/25 at 2:13 p.m., an interview was conducted with licensed practical nurse #9 (LPN #9) who was also a unit manager and the manager on the unit where R38 was a resident. When asked about daily weights, LPN #9 said at times nursing will write it on paper and then put it in the computer/electronic health record of the resident. When it was discussed that R38’s physician had ordered daily weights, but weights were not recorded for 7/12/25, 7/14/25, 7/16/25, 7/18/25, and 7/20/25. LPN #9 reviewed the chart and paper logs and was not able to find any weights recorded for those days. On 7/23/25 at 4:08 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings. No additional information was provided. 7. For Resident #43 (R43), the facility staff failed to obtain daily weights and notify the doctor of a weight change as ordered by the physician. On 7/22/25 at 10:34 a.m., during an interview with R43 he expressed concerns about the food and reported he had lost some weight. On 7/23/25, a clinical record review was conducted of R43’s chart. R43’s diagnosis included, but were not limited to, chronic diastolic/congestive heart failure, atrioventricular block-complete, and atherosclerotic heart disease of native coronary artery. A physician order dated 5/12/25 read, “Weight: Daily every day shift Notify provider if gain 3 lbs. in 24hrs or 5 lbs. in 1 week.” According to the weights recorded in R43’s chart, there were numerous days that weights were not obtained/recorded: which included, but were not limited to: 6/19/25, 6/21/25, 6/27/25, 7/4/25, 7/10/25, 7/12/25, and 7/18/25. According to the weight record of R43, on 6/28/25 the resident weighed 186 pounds. On 6/29/25 the resident weighed 193.3, which was a 7.3-pound variance in one day. According to the physician order any weight gain of three pounds in 24 hours or five pounds in a weight was to be communicated to the doctor. There was no evidence that the weight gain from 6/28/25 or 6/29/25 was communicated to the doctor. According to the facility policy titled, “Physician’s Order,” it read in part, “… Treatment rendered to a resident must be in accordance with the specific standing, written, verbal, or telephone order of a physician…” (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	According to the facility’s “Weight Management” policy, with a revision date of 9/22/23, it read in part, “Residents will be monitored for significant weight changes on a regular basis… 7. Dietary manager, unit manager and/or RD [registered dietician] are to communicate weight changes to the IDT [interdisciplinary team], attending physician and resident’s responsible party. This is documented in the medical record…” On 7/23/25 at 4:08 p.m., during an end of day meeting, the above concerns regarding residents’ 38, 31, 43 and 22 were discussed with the facility administrator and director of nursing. No additional information was provided prior to the conclusion of the survey.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, and clinical record review the facility failed to ensure a complete and accurate record for one of thirty-three residents, Resident #134.The findings Include:The facility did not document wound care on the Treatment Administration Record (TAR) for Resident #134 (R134).R134 was admitted to the facility with diagnoses that included cellulitis, right toes amputation, congestive heart failure, MRSA, and diabetes. The most recent minimum data set (MDS) was a 5-day assessment dated [DATE], R134 was assessed as being conatively intact.Review of R134's clinical record indicated an order dated 3/12/25 to complete wound care and dressing change to R134's root foot every day and evening shift starting on 3/13/25.Review of R134's TAR indicated on 3/16/25 day shift and 3/17/25 evening shift was not signed off to indicate the dressing change was completed. On 7/22/25 at 1:40 p.m. the unit manager (license practical nurse, LPN #1) where R134 resided while at the facility, was interviewed. LPN #1 reviewed documentation and verbalized there should be no blanks on the TAR and would see who was assigned on the days in question and find out what happened.On 7/22/2025 at 4:11 p.m. LPN #1 came back and gave information regarding treatments not being documented. LPN #1 verbalized that both nurses were contacted and verbalized that R134 had refused the treatment change. LPN #1 said the nurses should have coded the refusal on the TAR and wrote a progress note about the refusal.On 07/22/2025 at 4:16 p.m. registered nurse RN #2 was interviewed regarding treatments. RN #2 said that he was assigned to R134 on 3/16/25 and R134 had refused treatment to the foot. RN #2 verbalized he had gotten busy and forgot to document the refusal. RN #2 verbalized R134 refused the dressing changes often. The above information was presented to the administrator and director of nursing on 7/23/25. No other information was provided 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 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on staff interviews and facility documentation review the facility staff failed to ensure that staff received required training related to the care of residents with cognitive impairments, including dementia, for two of five staff reviewed for training. The findings included:Two certified nursing assistants were not in compliance with the training requirements for caring for cognitive impaired residents. On 7/24/25 at 8:30 a.m. an interview was conducted with a registered nurse, RN#3 (RN3). RN3 was asked if she was over staff training and she stated she was. Five employee training records were requested, RN3 stated that it was yearly training required and completed on Relias and then she had some in-services as well.On 07/24/2025 at 9:36 a.m. The requested training records for staff was reviewed. Certified nurse assistant (CNA), CNA#4 (CNA4), CNA#5 (CNA5) CNA#6 (CNA6), licensed practical nurse (LPN), LPN#4 (LPN4) LPN#5 (LPN5) training records were reviewed. Two employees, CNA4 and CNA6 out of the five employee records reviewed, did not receive the required training for the care of residents with cognitive impairments.On 7/24/25 at 10:30 a.m. a review of facility documentation was conducted. The facility document that read, Staff development, read in part, the staff development coordinator provides training and orientation to assist staff in performing their assigned functions. The annual training schedule should include programs relating to but not limited to dementia care and quality of care problems.On 7/24/25 at 12:30 p.m. a meeting was held with the administrator, the director of nurses, the assistant director of nurses and the regional clinical director and they were informed of the above concerns. No additional information was provided prior to the exit conference.