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 0572 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Give residents a notice of rights, rules, services and charges. Based on observations, resident and staff interviews, and facility documentation, the facility staff failed to appropriately inform residents-both orally and in writing-of their rights and all rules and regulations governing resident conduct and responsibilities during their stay, as required. Additionally, the facility did not have resident rights visibly posted for easy access by all residents.The findings included: The facility staff failed to provide residents with a review of resident rights, facility rules yearly and failed to have resident rights posted where residents can read their rights. On 7/21/25 at 2:00 p.m., a tour of the facility's nursing unit one, two and three was conducted. During the tour, it was observed that resident rights were posted on unit two, above the water fountain, at a level that was not accessible to wheelchair bound residents. Observations noted that unit one and unit three had no resident rights posted on their units. It was also observed that the resident rights were not posted in common areas or the lobby area. On 7/22/25 at 3:30 p.m., During the resident council meeting it was stated by the residents that no one reviews the resident right yearly. The resident stated that they were not aware of where the resident rights was posted. The activity director stated that she doesn't go over resident rights in the resident council meetings and does not do a yearly review with the residents. She said, I will address a resident right if asked a specific question by a guest. On 7/22/25 at 3:40 p.m., an interview was conducted about the location of the resident rights. Resident #82 said, They were posted on unit two but in a wheelchair, you cannot see it well enough to read it. It is posted too high. It's above the water fountain. On 7/23/25 at 8:49 a.m., an interview was conducted with the social services director. She stated that she was not going over resident rights yearly and that the resident rights were reviewed with residents on admission by the admissions director. On 7/23/25 at 2:00 p.m. The activity director provided documents titled, Services and Payment Sources, for five residents, Resident #82, Resident #88, Resident #89, Resident #113 and Resident #114, all dated within this year, but only Resident #82's form had the activity director's signature, indicating completion. On 07/24/2025 8:56 a.m., an interview was conducted with four out of the five residents, about the resident rights review this year and they were shown the facility document that was provided. Resident #82 at 8:50 a.m., said, that no one has reviewed them with me. Resident #88 at 8:55 a.m. said, they have not gone over these rights with me this year I know some of them, but no one has reviewed with me. Resident #114 said, No these were not reviewed with me on 5/22/25. At 8:41 a.m. Resident #89 said, I know for sure they didn't review this with me in March [3/20/25)]. On 7/24/25 at 11:00 a.m., the administrator provided admission agreements for five residents. This documentation indicated that Resident #89 was given the rules for the facility on 9/13/23 and Resident #113 was given the rules on 8/28/24. On 7/24/25 at 11:30 a.m., a review of facility documentation was conducted. The facility policy titled, Guest/Resident Council, read in part, during each Guest/Resident council meeting it is recommended to review 2 resident rights. The use of resources to enhance the guest's/resident's understanding of facility functions and/or issues that affect them will be facilitated. On 7/24/25 at 11:15 a.m., an end of day meeting was conducted with the administrator, director of nurses, assistant director of nurses and the regional clinical director. They were informed of the above concerns. No additional information was provided prior to the exit conference.

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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(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.

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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 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview, facility document review, employee record review and clinical record review, the facility staff failed to follow abuse prevention policies for pre-employment screening for thirteen of twenty-five employee records reviewed and failed to identify abuse as defined in the abuse policy following an investigation for one of thirty-three residents in the survey sampled (Resident #43).The findings include:On 7/24/25, twenty-five employee records were reviewed for compliance with the facility's abuse prevention policies for criminal background checks and pre-employment screenings. Of the twenty-five records reviewed, twelve records had no reference checks, two nursing licenses had not been verified prior to employment and two records had no criminal background checks performed prior to or within 30 days of hire. The list of employee records with missing information identified was provided to the facility's human resource (HR) manager (other staff #7) on 7/24/25. On 7/24/25 at 10:38 a.m., the current HR manager (other staff #7) and the HR manager-in-training (other staff #6) were interviewed about the missing background checks, references and license verifications. The HR manager-in- training stated that reference checks were required for all new hires along with criminal background checks and license verification if applicable. The HR manager-in-training stated she was unable to locate reference checks for the employees identified with missing information. The current HR manager stated he was unable to locate the missing documentation for the identified employees. The current HR manager stated he had been obtaining the required documentation since January (2025) but was not sure about missing information prior to this date. The current HR manager and HR manager-in-training reviewed employee files and were unable to find/present the identified missing documents. The facility's policy titled Abuse Prohibition Policy (revised 9/9/22) documented regarding screening of employees, .The facility will screen potential new employees for history of abuse, neglect, exploitation, misappropriation of property or mistreatment by a court of law (This includes attempting to obtain information from previous employers and/or current employers, and checking with the appropriate licensing boards and registries and background checks per state guidelines). The facility will not hire anyone with disciplinary action in effect against a professional license by a state or licensing board .Without exception, all potential licensed and certified candidates must have their status confirmed with the appropriate boards to verify license/certification and to determine if any action has been taken against the license or certifications .The facility will screen for potentially abusive individuals involved with the guest/resident who are not providing a professional service . This finding was reviewed with the administrator, director of nursing and regional nurse consultant during a meeting on 7/24/25 at 11:15 a.m. with no further information provided prior to the end of the survey. 2. For Resident #43 (R43), the facility staff failed to identify abuse during an investigation into an allegation of abuse that was witnessed. On 7/22/2025 at 2:06 p.m., during an interview with R43, he reported that a staff member, he identified as a certified nursing assistant (CNA #7), came in one morning to get me up and she cussed me, I told her to not be cussing me, I don't cuss at y'all. She left and I rang the bell; I needed help pulling cover up. She came in and said, What the hell do you want now. I told her I was going to tell on her. R43 stated that he had talked to the administrator, and said, two or three of them talked to me about it and I talked to the police. She never took care of me again. She had done it before, one (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	morning she was turning me over and my head hit the railing, I should have reported that but didn't. I thought she may have had a rough night and may have been tired. R43 also reported that the residents across the hall heard the event. On 07/22/2025 at 2:40 p.m., the two residents across the hall were identified as Resident #22 (R22) and Resident #121 (R121). On 7/22/25 at 3:39 p.m., an interview was conducted with R22. When asked about an incident involving R43 and if she heard anything, R22 said, We definitely did, it would wake the dead, it was about 4 in the morning, I was in a dead sleep! I don't know what precipitated it, he was very quietly trying to talk to her about whatever the incident was over, and I heard him say, why are you cursing me, I'm not cursing or screaming at you. She [CNA #7] said shut up and just get back in the damn bed, I don't want to hear any more out of you. Just stop talking and get in the damn bed and I'm not going to come back in here anymore! She slammed the door. R22 reported, it scared us [her and her roommate] terrible, I was in a dead sleep. We were shocked because she had been the aide over here a couple of times, she was a new employee, had been very pleasant with us. When I realized the voice and who it was, I was shocked. The man from APS [adult protective services] came and talked to my roommate and the unit manager came and talked to me as well. I told them it would have woken up a dead person. I've never heard anyone curse the residents like she did. I can't imagine what he did. When asked, how did it make you feel? R22 stated, It was frightening, if she would scream and curse him like that she would scream and curse me too. R22 reported she and her roommate were not able to go back to sleep and said, oh no, she [her roommate-R121] couldn't go back to sleep either, we laid here and talked until time to get up. On 7/22/25, the facility's incident summary, investigation and the facility synopsis of the incident was reviewed. Included was a statement from R43 that reported CNA #7 entered his room and stated, what the hell do you want now? . You are acting like a child and a damn fool. you need to shut the hell up. R43 reported in his statement, She told me to shut up multiple times. When I told her I was going to report her, she said, 'go ahead, tell the whole world.' According to a statement from R22, she reported hearing CNA #7 say to R22, What the hell do you want, I've done everything you need, you need to shut up. He [R22] said I don't talk to you like that, why are you talking to me like that. CNA #7 [name redacted] stated because you're acting like a damn fool, like a child. He stated he was going to report her, and she stated go ahead and report it to whoever you want. Then she told him to shut the hell up, shut the door and went out. According to a statement by R121 she reported, I got woken up by CNA #7 [name redacted] around 4 a.m. [R22's name redacted] was yelling help and CNA #7 said, what do you want now, what the hell do you want? He said you are too rough, is it because I'm black? I'm going to report you. CNA stated you can report it to whoever you want. It was very bad. CNA kept cursing at resident. According to the facility's synopsis of the incident it read in part, . In conclusion, based on investigation and interviews, the facility is unable to substantiate the allegations of abuse, however, the decision was made to not continue [CNA #7's name redacted] employment, as she is not in alignment with the facility's standards of high quality of care and customer service. On 7/23/2025 at 10:30 a.m., an interview was conducted with the facility administrator, who confirmed she is the facility's abuse coordinator. The administrator was asked to define abuse. She (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	defined abuse as being verbal, physical, mental, or anything that could or causes anguish. When asked if abuse has to cause anguish to be considered abuse, the administrator said, no, if it has the potential. When asked to discuss R43's allegation of abuse involving CNA #7, the administrator stated, she was suspended pending an investigation. We reported her to the board, we called the police, they came, and we terminated her. When asked to explain the conclusion of abuse not being substantiated, when two other residents in addition to R43 reported hearing the CNA yelling and cursing the resident. The administrator said, when we interviewed [R43's name redacted] he didn't feel like he was being abused, she was rough with him, we monitored him for any signs of distress due to this incident. The administrator stated she wanted to get with the nurse consultant and Director of Nursing (DON), who had assisted with the investigation. On 7/23/2025 at 10:47 a.m., an interview was conducted with the nurse consultant. The nurse consultant was told of the incident and had no recall of the incident. She was shown the facility's incident summary and facility synopsis and said she didn't remember it but would check her log she keeps. The nurse consultant reviewed her log and said she received the facility synopsis but was not involved in the investigation or conclusion, as she had taken some time off and it may have occurred while she was out of work. On 7/23/2025 at 10:53 a.m., an interview was conducted with the DON. The [NAME] reported she had talked to R43 and he said she was verbally aggressive with him. We collected statements from staff, adjacent residents with BIMs [brief interview for mental status score] of 12 or above [which indicated they were cognitively intact]. No other residents had any concerns. These were the only other 2 staff here. When asked about the facility's conclusion that abuse had not occurred, the DON said, We determined she was a new hire, had been here less than 90 days and the fact that we got statements from other residents that heard her yelling, talking to the resident in a non-professional way, the residents said she was unprofessional and she was terminated. We felt it was a customer service issue. The statements from R22 and R121 was read outload, along with R43's statement. The nurse consultant agreed that this was abusive and neglectful. On 7/23/25 at 1:13 p.m., the facility administrator provided the survey team with a document from adult protective services indicated that an allegation of neglect involving R43 had been conducted and unfounded. It did not speak to the allegations of abuse. According to the facility's abuse policy titled, Abuse Prohibition Policy with a revision date of 9/9/22, it read, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse. The policy defined verbal abuse as the use of verbal or nonverbal conduct which causes or has the potential to cause the guest/resident to experience humiliation, intimidation, fear, shame, or degradation regardless of their age, ability to comprehend or disability. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to guests/residents within hearing distance, regardless of age, ability to comprehend, or disability. On 7/23/25 at 3 p.m., a follow-up interview was conducted with R43. R43 reported it made him feel real cheap. I didn't like it; it hurt my feelings. Made me feel like a fool, you know how you feel if (continued on next page)

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	someone does something to you. She was disrespecting me. That wasn't the first time she did something to me, she was turning me over and hit my head against the railing on the bed and I should have reported her then. When asked if he had reported this when he talked to the administrator, he said yes. When asked if he feels she was abusive to him, R43 said, yeah. On 7/23/25 at 4:08 p.m., during an end of day meeting with the facility administrator and director of nursing the above concerns were discussed. No additional information was provided.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility failed to review and revise comprehensive care plans for four of thirty-three residents in the survey sample. Resident numbers: 1, 9, 17, and 43. The Findings Include: 1. Resident 1's (R1) care plan was not revised to reflect the residents' inability to self- position in bed. R1 was admitted to the facility with diagnoses that included bilateral above knee amputation, acute respiratory failure, peripheral vascular disease, and diabetes. The most recent minimum data set (MDS) was a significant change assessment dated [DATE] and assessed R1as being moderately conatively impaired. Section GG of the MDS indicated R1 was dependent for bed mobility indicating R1unable to self-position in bed. Observations of R1 were made throughout the survey of staff aides assisting to turn R1 in bed and being assisted by the wound care nurse (license practical nurse, LPN #2) to turn R1 to be able to complete wound care. Review of R1's Activity of Daily Living (ADL) care plan indicated supervision and partial assistance for bed mobility. On 7/23/2025 at 10:49 a.m. registered nurse (RN #1, MDS coordinator) was interviewed. RN #1 reviewed the documentation and verbalized someone should have caught that resident was dependent on bed mobility and revised care plan. On 7/23/25 the above finding was presented to the administrator and director of nursing during an end-of-day staff meeting. No other information was presented prior to exit conference. 2. Resident 9's (R9) care plan was not revised to reflect the residents' inability to use a call bell. R9 was admitted to the facility with diagnoses that included end stage Alzheimer's disease, dementia, neurocognitive disorder, and adult failure to thrive. The most recent minimum data set (MDS) was a 5-day assessment dated [DATE] and assessed R9 as being severely cognitively impaired. Section GG of the MDS indicated R9's range of motion is impaired in all extremities and is dependent on all activities of daily living (ADL's) and mobility. On 7/21/2025 at 11:12 a.m. during the initial tour of the facility, R9 was observed in bed with a call bell within reach. R9 was nonverbal towards the surveyor, right hand appeared to be contracted and was not moving about the bed. During a family interview conducted on 7/21/25 at 2:30 p.m. with R9's responsible party (RP) via telephone, the RP mentioned concerns regarding R9's inability to use the call bell. On 7/22/25 at 11:00 a.m. R9 was observed in bed with a call bell lying on the bed. R9 was asked if he could use the call bell several times. R9 was nonverbal towards the surveyor and did not attempt to reach for the call bell. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/23/2025 at 2:44 p.m. occupational therapist (other staff, OS #2) was interviewed regarding the ability to use the call bell provided to R9. OS #2 verbalized R9 had end stage dementia, was not able to follow direction, and doesn't feel R9 can use the call bell provided. On 7/23/2025 at 2:51 p.m. R9 was observed while certified nursing assistant (CNA #1) was providing care. CAN #1 verbalized R9 is a total care resident and feels that R9 is unable to use the call bell and is continuously monitored because of the care needed. Review of R9's ADL care plan interventions indicated to Encourage resident to use bell/call light to call for assistance. On 7/23/2025 at 3:42 p.m. RN #1 (MDS coordinator) was interviewed regarding use of call bells. RN #1 said that R9 was a recent admission to the facility and when the care plan is being created, intervention automatically populates into the system and should be revised more information is gathered about a resident. RN #1 said that the concern should have been brought to her attention and the care plan would then been updated. On 7/23/25 the above finding was presented to the administrator and director of nursing during an end-of-day staff meeting. No other information was presented prior to exit conference. 3. R17's care plan had a diagnosis of dementia, which was not listed among her diagnoses. On 07/23/2025 8:32 a.m., a review of R17's care plan was conducted. The care plan has several references to the diagnosis of dementia and R17 does not have that diagnosis. A review of R17's diagnosis, minimum data set (MDS) and physician progress notes were conducted. The diagnosis for dementia was not in the progress notes or on the MDS. The MDS had R17 coded with a BIMS (brief interview for mental status) score of 13. R17's BIMS scored her with no cognitive impairment. On 07/24/2025 8:19 a.m., an interview was conducted with the MDS coordinator, and she stated that dementia should not be on the care plan. The MDS coordinator reviewed R17's diagnosis and was unable to find the diagnosis of dementia. The MDS coordinator stated she was going to get the care plan corrected. 4. For Resident #43 (R43), the care plan was not revised to reflect the daily weights and still listed a nutritional supplement that was discontinued over a year ago. On 7/23/25, a clinical record review was conducted of R43's chart. R43 had a physician order dated 5/12/25 that read, Weight: Daily every day shift Notify provider if gain 3 lbs in 24hrs or 5 lbs in 1 week. According to physician orders, the order for Magic Cups one time a day 4 oz at dinner was ordered 9/28/2023 and discontinued on 4/19/2024. According to R43's care plan, R43 was identified at nutritional and dehydration risk related to diagnosis of diabetes, therapeutic diet, CHF [congestive heart failure], fluctuating weights r/t [related to] CHF and diuretic use, infection, Ogilvie syndrome, depression. There were thirteen associated interventions with this focus area. Nine of the interventions were last revised on 5/29/19, one was revised on 2/3/23, and the other three were most recently revised on 6/8/23. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Included in the interventions was one that read, Provide supplements as ordered 6/8/23 magic cup with supper. This intervention was not reviewed, revised, or discontinued when the order was discontinued on 4/19/24. Another intervention dated 5/29/19 read, Obtain weight at a minimum of monthly. Report significant weight changes of 5% x 1 month, 7.5% x 3 months or 10% x 6 months to the physician and dietitian. There was no indication that the care plan had been revised or updated to include the physician order with regards to the daily weights ordered 5/12/25, and to notify the physician of a three-pound change in 24 hours or five-pound change in one week. On 7/23/25 at 2 p.m., an interview was conducted with a registered nurse (RN #1), who was the facility's care plan coordinator. She stated that the care plan is reviewed at a minimum of quarterly and is used by all staff to care for the patients. RN #1 went on to state that it is important for the care plan to be accurate to reflect their care and it drives care and treatment for residents. When asked to access R43's care plan, she did and confirmed that the daily weights were not listed and it noted a supplement that had been discontinued over a year prior. RN #1 stated, I missed taking that out [referring to the magic cups that was discontinued] and I thought we were to be less specific in the care plan. 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.

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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 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.” 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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: 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 (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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…” 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…” (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 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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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are free from significant medication errors. Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to ensure residents are free from significant medication errors for one resident (Resident #22-R22) in a survey sample of thirty-three residents. The findings included: For R22, the facility staff failed to administer insulin timely on numerous occassions, which had the potential to affect the next scheduled dose and the resident's blood glucose levels, which was a significant medication error. On 7/22/25 at 8:20 a.m., during an interview with R22, the resident 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 reported about a week ago the nurse had to hold 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. 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 and had no explination why R22's insulin was not administered within the standard of practice of within one hour. 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. 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 (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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 regarding R22's insulin administration not being timely was discussed. No additional information was provided prior to the conclusion of the survey.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to properly label and store medications on two of three units (unit 1 and unit 2) and for one of thirty-three residents in the survey sample (Resident #31). The findings include: 1. An opened insulin pen was stored in the medication cart on unit 2 with no indication of the date opened. An unopened vial of Admelog insulin was stored in the unit 2 medication cart when the label indicated to refrigerate until opened. On 7/22/25 at 1:26 p.m., accompanied by licensed practical nurse (LPN) #7, a medication cart on unit 2 was inspected. Stored in the cart was a glargine insulin pen for a current resident. The pen had been opened/used and had no date of when the pen was opened. A vial of Admelog insulin for a current resident was also stored in this cart. The vial was sealed/unopened and had a label stating to refrigerate until opened. LPN #7 was interviewed at this time about the undated insulin and the unopened insulin stored on the cart. LPN #7 stated insulin pens were supposed to be dated when opened. LPN #7 stated she was not sure why the unopened vial of insulin was in the cart and not in the refrigerator. On 7/22/25 at 1:50 p.m., the registered nurse unit manager (RN #4) was interviewed about the improperly stored drugs on the unit 2 cart. RN #4 stated unopened insulin should have been refrigerated and not placed in the cart until opened/used. RN #4 stated all insulin pens/vials were supposed to be dated when opened so that they were discarded appropriately. The facility's pharmacy document titled Insulin Storage Recommendations (2021) documented that opened pens/vials of Admelog insulin could be stored at room temperature up to 28 days. This document listed glargine (Lantus) insulin could be used up to 28 days after opening. 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. 2. The facility failed to ensure an open date on a multi dose Tuberculin found in the medication storage refrigerator on unit one. The findings include: On 7/22/25 at 1:19 p.m., accompanied by licensed practical nurse (LPN) 3, medications stored in the refrigerator on unit one was inspected. In the medication refrigerator there was an opened multi dose vial of Tuberculin with no open date. There was a label on the vail that read discard after 28 days. The Tuberculin had no data written on the label indicating when the vial was opened. LPN #3 was interviewed at this time about the storage of opened Tuberculin. LPN #3 stated the Tuberculin should have an open date on the bottle or package. On 7/22/25 at 3:30 p.m. the administrator was made aware of the above finding. Policy was presented titled Medication Storage Guidance that read in part Tuberculin Tests: Store in refrigerator [.] Date when opened and discard unused portion after 30 days. (continued on next page)

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The Laurels of Charlottesville	490 Hillsdale Drive Charlottesville, VA 22901

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No other information was presented prior to the exit conference on 5/24/25. 3. For Resident #31- R31, the facility staff permitted the resident to store medications at the bedside that were not secured and accessible. On 7/21/25 at 1:30 p.m., during a facility tour, R31 was observed sitting in a wheelchair at the bedside. On the bedside table were two prescription bottles. When asked about the medications, R31 reported it was eye drops she had been given by the nurse. R31 reported that the facility is using her drops from home and the nurse had given her these to keep. The resident agreed to the surveyor looking at them, both had a label with the resident's name and indicated they had been dispensed by the facility's contracted pharmacy. The medications were Brimonidine Tartrate Ophthalmic Solution 0.2 % and Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2 0.5 %. On 7/21/25 at 3:05 p.m., an additional observation was conducted of R31's room and the drops remained on the bedside table. On 7/21/2025 at 3:10 p.m., an interview was conducted with a licensed practical nurse (LPN #8) who was R31's assigned nurse. LPN #8 stated that all medications are kept in the medication cart and residents are not permitted to keep them in their room. When asked if residents can self-administer medications, LPN #8 explained that they can but there is an assessment that has to be done. LPN #8 was asked about R31's eye drops, and she said they were using the resident's personal supply of eye drops which was stored in the medication cart. LPN #8 retrieved the drops and permitted the surveyor to see them. When advised that R31 had eye drops at the bedside that had a label from the facility's pharmacy, LPN #8 said, No wonder I couldn't find them. LPN #8 accompanied the surveyor to R31's room, confirmed the observation of the two bottles of eye drops on the bedside table. R31 explained that registered nurse #2 (RN #2) had given them to her. LPN #8 obtained R31's permission to remove them from the room so they could be secured in the medication cart. On 7/21/2025 at 3:37 p.m., an interview was conducted with RN #2. RN #2 explained that R31 had provided her own personal supply of eye drops to the facility for use since she was a new admission. RN #2 explained that the resident had requested eye drops from the pharmacy be given to her since they were using her personal supply and when they came in he gave them to the resident. RN #2 said, it seemed like a valid point, but I didn't know she was going to leave them sitting out. Was I not supposed to do that? RN #2 confirmed that medications are to be stored in a secure location so that no one can access them. On 7/22/25 a review of R31's clinical record. According to the physician orders, R31 had orders for both eye drops, Brimonidine Tartrate Ophthalmic Solution 0.2 % (Brimonidine Tartrate) and Dorzolamide HCl-Timolol Mal Ophthalmic Solution 2 0.5 % (Dorzolamide HCl-Timolol Maleate). The resident was to receive one drop in both eyes two times a day for each of the drops and the indication was for Glaucoma. On 7/22/2025 at 4:03 p.m., an interview was conducted with licensed practical nurse #9 (LPN #9), who was the unit manager. When asked about medication storage, LPN #9 stated that when medications are delivered from the pharmacy, they are placed in the cart and all medications are stored in the medication cart. When asked why medications cannot be kept at the resident's bedside, she said, you are putting the residents at risk they could come by and pick it up and it has the resident's information. The unit manager was made aware of the findings/observations from 7/21/25, regarding R31's eye drops. LPN #9 stated she was aware of it and had spoken to the nurse (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	responsible. According to the facility provided document titled, Medication Storage Guidance, it noted that ophthalmic products are to be dated when opened and discarded after 28 days. Storage in an upright position may be warranted- refer to manufacturer's recommendations. 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 of medications being stored at R31's bedside. No additional information was provided.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. Based on observation, staff interviews, resident interviews and facility documentation reviews the facility staff failed to provide meals that were palatable and at appetizing temperatures for one of three units.The findings included: The test tray that was served was not palatable and was not served at appetizing temperatures. On 7/23/25 at 8:30 a.m. a test tray was conducted with the dietary manager. The test tray served was the breakfast meal on nursing unit two. The meal arrived at the unit at 8:09 a.m. and was served at 8:19 a.m. in a Styrofoam container. The eggs were bland and lukewarm, and the temperature was 130, the sausage links temperature was 121 and lukewarm, the cinnamon bun temperature was 105, lukewarm, hard on the edges and had a bland taste and the coffee was lukewarm, and the temperature was 125. On 7/23/25 at 8:45 a.m. the dietary manager was interviewed about the test tray that was conducted. The dietary manager stated the food could be warmer and the eggs were lukewarm and bland tasting. On 7/23/25 at 10:30 a.m. several interviews were conducted with residents on unit two about their food that was served for breakfast this morning. Majority of the residents on the unit stated that it was like most meals that were served, cold and had no taste. On 7/23/25 at 11:00 a.m. a review of the resident council minutes was reviewed. The 2025 minutes were reviewed and for several months there were complaints about the food being served cold even when the residents were served in the dining room. There were complaints about the vegetables being cooked too long, the meat being cooked too long and sometimes burnt. The resident council meeting that was held on 7/22/25 had 15 residents in attendance, and they all complained about the food. The residents said their food concerns were, that we get very few hot meals or even warm, they give us the hot plates, but was not even warm, soups and eggs was served cold. We don't understand when outback brings food in its hot, but you cannot get food hot here. On 7/23/25 at 2:30 p.m. a review of the facility documentation was conducted. The facility document titled, Food Temperatures, read in part, .foods will be maintained at proper temperature to ensure food safety. The temperature of holding hot foods at point of service will be greater than 135 [degrees Fahrenheit]. On 7/23/25 at 4:30 p.m. an end of day meeting was held with the administrator, director of nurses, assistant director of nurses and the regional clinical director. They were made aware of the above concerns. No additional information was provided prior to the exit conference. 2. For Resident #22 (R22), the facility staff failed to serve food at an appetizing temperature. On 7/22/2025 at 8:28 a.m., during an interview with R22, the resident stated, The food is always cold. On Tuesdays they give you a menu to select menu choices for the next week, but it is pointless, they always say they are out of things. I rarely get butter, I save what I do get, so that I have it when I need it. I don't know what has happened to the kitchen, it is getting worse and worse. We have gotten a plain hamburger with tartar sauce with no other condiments, I got one of those deals a few days (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	ago, just slapped up on the plate and they don't pay any attention to what they are doing. On 7/23/2025 at 8:27 a.m., R22 was observed in bed and was served her breakfast. The resident reported that all her food was cold. The surveyor stepped out of the room and asked the dietary manager to accompany her to the room of R22. Upon entry, R22 reported to the dietary manager that all her food was cold. The dietary manager agreed to prepare a new plate of food for R22. On 7/23/25 at 4:30 p.m., during an end of day meeting, the facility administrator and director of nursing were made aware of the above findings.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews the facility staff failed to store, label and distribute food in a sanitary manner in the main kitchen. The findings included: The facility failed to label open items stored in the refrigerator, wear hairnets and beard guards in the kitchen, stored dirty dishes in the clean bowl holder and had a resident's personal food stored in the reach in refrigerator. On 7/21/25 at 10:40 a.m., During a tour of the main kitchen with the Dietary Manager, the following was observed: in the walk-in refrigerator, whole hot dogs were stored in a metal container covered with plastic wrap, with no label indicating the date or time when opened. Red onions were stored in plastic containers covered with plastic wrap, with no label indicating the date or time when opened. A plastic container of tuna had a use by date of 07/16/2025. In the reach-in refrigerator, a ham salad sandwich was covered with plastic wrap labeled 07/17/2025. The Dietary Manager removed the sandwich from the refrigerator and stated it was to be discarded. The sandwich was placed on the kitchen steel table for disposal. 07/21/2025 10:40 a.m., Upon entering the kitchen area for the tour, the dietary manager was observed inside the walk-in freezer, removing food items for discarding. It was observed that she was not wearing the required hair nets. The dietary aide with visible facial hair that hung below his chin was observed walking around in the kitchen area without wearing a beard guard, although a supply of beard guards was available for use. Several bowls were observed in the clean bowl holder, ready for use. When questioned, the dietary manager stated that they were supposed to be clean bowls. The stack appeared to be holding 15 bowls. The dietary manager removed nine bowls from the bowl holder that were clearly wet and contained dried food particles on the surface of the bowls. It was also observed during the tour that the dishwasher was leaking. The dietary manager reported that it went down on Saturday, two days earlier, adding that the disposable food containers and plastic utensils were being used to serve food. The dietary manager stated that the repair service had been called this morning and that they were coming out to repair the dishwasher. During the tour, it was observed that the reach in the freezer was not registering a temperature on the outside freezer thermometer reader. When inspecting inside, it was found that the supply of ice cream stored in the freezer had thawed and was soft. The dietary cook stated that he had checked the freezer temperature that morning when he arrived at work at 5:00 a.m. Reviewing the temperature log revealed that an evening shift temperature had been recorded as -6 degrees at 10:45 a.m. After reviewing the log, the dietary manager stated that it was recorded before the staff member left for the day. The dietary manager then marked that temperature out on the temperature log and stated that it was not accurate because they documented it too early in the day. The kitchen staff had not been aware that the reach in the freezer's thermometer was not operating until it was identified during the tour of the main kitchen. Prior to leaving the area, the kitchen staff was observed moving all the cases of ice cream from the reach in the freezer to the walk-in freezer. On 7/22/25 at approximately 2:00 p.m., the dietary manager stated that the walk-in freezer was now working, and that a breaker had been thrown. 07/23/2025 10:50 AM a tour of the nourishment rooms on all three nursing units was conducted. On Unit two there were four med pass containers that were opened and not labeled with a date and time. 07/23/2025 at 10:50 AM a licensed practical nurse (LPN), LPN#5 (LPN5) was asked to come in the nourishment room to observe the findings of the med pass not being labeled with a date and time. LPN5 said, these should be dated, and they are only good for four hours on the med cart and have to be thrown away. So, the date and time should be on them when opened. 07/23/2025 at 11:00 AM a tour of the nourishment room was conducted on unit three. On Unit three there were three med pass nourishment containers not labeled with a date or time. There was one med pass container that was labeled with an open date of 5/26/25. 07/23/25 at 11:00 A.M. an interview was conducted with an LPN. LPN#4 said, I will throw these away they should have a date and the one with 5/26/25 date I will throw this away it has been opened awhile. 07/23/25 at 3:00 P.M. a review of the facility (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	documentation was conducted. The document titled, Food purchasing and storage, read in part, .leftover foods should be put in the refrigerator in shallow pans (2-4 inches deep) so the interior temperature of the food chills quickly to <41 [degrees Fahrenheit]. They will be covered, dated and labeled. All food items in refrigerators will be properly dated, labeled, and placed in containers with lids, will be wrapped, or stored in sealed food storage bags. 07/23/25 at 3:00 P.M The facility document titled, Food Safety, read in part, .b. Food storage: Refrigerator units must be maintained at <41 [degrees Fahrenheit] and freezers <0 [degrees Fahrenheit] or at a temperature to keep frozen foods solid. 07/23/25 at 3:00 P.M The facility document titled, Food from Outside Sources, read in part, .It is the policy of this facility not to accept foods through the Dietary department from any source not approved by the Dietitian. Individual family members may bring food into the facility for a specific guest/resident but must notify the Nurse these foods are being provided. 7. Food brought in from family will not be stored in the Dietary department. 07/23/25 at 3:00 P.M The facility document titled, Three Compartment Sink, read in part, .10. remove pots and pans, place upside down and allow to air dry. 12. Inspect the dishware to ensure items are clean and grease free for storing. On 7/23/25 an end of day meeting was held with the administrator, director of nurses, assistant director of nurses and the regional clinical director. They were made aware of the above concerns. On 7/24/25, it was observed that the dishwasher had been repaired, and use of the usual dishware and utensils had been resumed. No additional information was provided prior to the exit summary

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide education and offer the COVID-19 vaccines to four of five residents reviewed for immunizations (Resident #17-R17, Resident #13-R13, Resident #2-R2, and Resident #14-R14). The findings included:On 7/22/2025 at 2:21 p.m., a sample of five residents was selected for review of immunizations. Clinical record reviews were conducted. For R17, according to the clinical record, the resident was admitted on [DATE]. According to the immunization tab of the clinical record, R17's most recent dose of the COVID vaccine was given prior to admission on [DATE]. There was no indication within the clinical record that R17 had been educated regarding the immunizations and what she was eligible for, nor offered the COVID booster. For R13, who was admitted to the facility on [DATE], the resident's most recent COVID immunization was administered on 2/26/21. According to a consent form dated 10/14/24, the resident's representative gave consent for the resident to receive the COVID booster. There was no evidence that this had been provided/administered.Resident #2 was admitted to the facility on [DATE]. According to the immunization tab of the clinical record, R2 was not up to date on COVID immunizations. R2's most recent COVID immunizations was administered 4/24/21. There was no evidence of R2 having received any education or being offered the COVID vaccine.R14 was admitted to the facility on [DATE] and was not up to date with the COVID vaccine. There was a signed consent form dated 10/14/24 which noted the resident wanted the booster vaccine. There was no indication that the resident had received the 2024-2025 COVID booster, despite having consented. R14's most recent COVID vaccine was 10/25/23. On 7/24/2025 at 9:50 a.m., an interview was conducted with the facility's infection preventionist (IP), who was a registered nurse and the assistant director of nursing. The IP accessed each of the residents' charts and confirmed the above findings. The IP explained that without immunizations being current, residents are at risk for catching COVID and being sick. The IP also stated, It helps keep them protected and decreases our infection control [infection rates], in the winter we see a lot of respiratory infections and it is important to keep them up to date and protected so we don't spread it. The IP explained that she has access to the Virginia Immunization Information System and looks at each resident's immunizations. They offer pneumonia and COVID vaccines. She explained that as a company they just had a call on July 15, 2025, to explain that they are contracting with a third-party vendor who will come on-site to provide vaccines. The IP provided the surveyor with a copy of the information she received which dated the third-party vendor, [company name redacted], to assist with administration of vaccines for the 2025/2026 respiratory season. Many facilities have residents eligible for the second dose of the 2024/2025 COVID vaccine. If you have residents that are eligible for the second dose and want it, please reach out to me as soon as possible before ordering the vaccine from the pharmacy and I will try to get a vaccine clinic set up with [third-party vendor name redacted] to assist in the administration of the vaccine. The IP confirmed that she has residents who want the vaccine but has not moved forward with uploading the information to move forward with that process to get a clinic scheduled. The IP stated prior to the information being shared on 7/15/25, about a third-party vendor they would just order the vaccines from their pharmacy and administer them, but the four residents reviewed above, had not received the immunizations. The facility policy titled, Resident COVID-19 Vaccination with a revision date of 11/4/24, was received and reviewed. The policy read in part, To prevent the spread of infectious disease and to decrease the morbidity and mortality associated with the SARS-CoV-2 virus, commonly known as COVID-19. Residents and/or resident representatives will be provided with education by physician or licensed nurse regarding COVID-19 immunization using the Emergency Authorization Use (EAU) Fact Sheet. Any new vaccine information will be dispersed as (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	they become available. 3. All new residents and resident representative will be provided with education COVID-19 vaccination utilizing the approved Food and Drug Administration EAU or VIS [vaccine information sheet] Fact Sheet. 4. The facility will obtain a signed consent form for the administration of the COVID-19 vaccine from the resident or the resident's designated health care representative(s). A declination will be signed if consent is not given. 5. A copy of the consent form will be provide [sic] to the pharmacy, if required. According to the Centers for Disease Control and Prevention (CDC) document titled, Staying Up to Date with COVID-19 Vaccines it read in part, . What to know: CDC recommends a 2024-2025 COVID-19 vaccine for most adults ages 18 and older. Parents of children ages 6 months to 17 years should discuss the benefits of vaccination with a healthcare provider. The COVID-19 vaccine helps protect you from severe illness, hospitalization, and death. It is especially important to get your 2024-2025 COVID-19 vaccine if you are ages 65 and older, are at high risk for severe COVID-19, or have never received a COVID-19 vaccine. Vaccine protection decreases over time, so it is important to get your 2024-2025 COVID-19 vaccine. Who needs a COVID-19 vaccine: Reminder. CDC recommends a 2024-2025 COVID-19 vaccine for most adults ages 18 years and older. This includes people who have received a COVID-19 vaccine, people who have had COVID-19, and people with long COVID. Importance of staying up to date: Getting the 2024-2025 COVID-19 vaccine is important because: Protection from the COVID-19 vaccine decreases with time. Immunity after COVID-19 infection decreases with time. COVID-19 vaccines are updated to give you the best protection from the currently circulating strains. Getting the 2024-2025 COVID-19 vaccine is especially important if you: Never received a COVID-19 vaccine, Are ages 65 years and older, Are at high risk for severe COVID-19, Are living in a long-term care facility. Want to lower your risk of getting Long COVID . Accessed online at: https://www.cdc.gov/covid/vaccines/stay-up-to-date.html On 7/24/25 at 11:13 a.m., the above findings were reviewed with the facility administrator and director of nursing. No additional information was provided.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation, resident and staff interviews, the facility staff failed to uphold resident rights and knock before entering residents rooms on one of three resident care units (200 unit).The findings included: 1. On the 200 unit, the nursing staff were observed to enter residents' rooms without knocking and requesting permission to enter.On 7/22/2025 at 8:37 a.m., a certified nursing assistant (CAN #5) was observed to enter rooms 201, 203 and 206 without knocking or requesting permission to enter, before entering the residents' rooms. When questioned CNA #5 aid, Yes I should knock when I enter a resident's room. When the observations were discussed and she was asked why she had not knocked, CNA #5 said, No reason that I didn't knock, just busy I guess, I usually do knock on the doors. On 7/22/25 at 3:00 p.m., during a resident council meeting, the residents reported that some staff knock before entering and some do not. 2. The facility staff failed to knock prior to entering Resident #22's (R22) room.On 7/22/25 at 3:39 p.m., while the surveyor was conducting an interview with R22, a certified nursing assistant (CNA #6) entered the room three times, each time without knocking to gain permission to enter.On 7/22/25 at 3:45 p.m., following CNA #6's third entry to the room without knocking, the surveyor questioned the staff member. CNA #6 stated that she was passing ice. When asked if she doesn't knock when she is distributing ice, the CNA said she normally does. CNA #6 said she is always to knock before entering a resident's room.On 7/23/25, 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.

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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 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, clinical record review and facility documentation review, the facility staff failed to provide written notice for a room change prior to the move, affecting two residents, Resident #17 (R17) and Resident #38 (R38) out of a survey sample of 33 residents. The findings included: R17 had to change rooms from one unit to another unit and was not notified in writing by facility staff prior to the room change. On 7/22/25 at 8:44 a.m., an interview was conducted with R17. She had a concern about changing rooms from one unit to another unit to remain long term care (LTC) and was not notified by the staff at the facility prior to the room change. On 07/24/2025 at 8:20 a.m., an interview was conducted with the social service director. She stated that the process for a room change for a resident was they had to be notified in writing about the room change prior to changing rooms. She stated she was not employed here when R17's room change occurred but R17 is her own responsible person, and she should have been notified. Evidence of written notice given to R17 about the room change and remaining here for LTC was requested and no additional information was provided. On 7/24/25 at 8:30 a.m. a clinical record review was conducted. There was a progress note written by the social worker on 11/7/2024 that read, SW [social worker] contacted guest's mother that guest mother to notify of guest's room change. SW informed that guest will be moved to [R17's room number redacted], which would her LTC bed placement (sic). The care plan was reviewed, and it read in part, . [R17's name redacted] requires 24-hour care/LTC placement at this time related to dementia. Family/legal decision maker has verbalized acceptance of plan for her to remain in the facility. 2. For Resident #38 (R38), the facility staff failed to notify the residents of the room change in writing prior to being moved. On 7/21/25 at 2:43 p.m., during an interview with R38, the resident expressed concern that the facility had changed her room and was unsure why. When asked if she was given anything in writing to notify her of the change, R38 said No. On 7/22/25, a clinical record review was conducted. According to R38's census tab, the resident was admitted on [DATE] and placed in a private room. The room change was conducted on 7/14/25, moving R38 to a semi-private room. During the survey, R38's room was not occupied by another resident. According to the progress notes, an entry dated 7/14/25 read, Resident is on contact isolation and is in a private room. All care/activities delivered in the room. According to a progress note written 7/14/25, by the attending physician, the note read in part, . Patient found with a bedbug in her bedding. No other bugs noted. Patient to be moved and isolated. Recent test. There were no other notes regarding the room change. According to the assessment tab, a Notice of Room Change form was completed 7/22/25 by the social worker. (continued on next page)

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F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 7/23/25 at 8:49 a.m., an interview was conducted with the social worker (SW). When asked about the room change process, she explained that during the daily morning meeting, new admissions and room changes are discussed. The SW went on to state that they talk to the residents and call the resident's responsible party, complete a notice of room change and make a progress note entry. When asked about R38's room change, the social worker said, I didn't know about any of that. The social worker stated that residents are to receive written notice of room changes and she completed the room change notice form on 7/22/25, when she became aware that R38 had a room change the week prior. The facility policy titled, Room & Roommate Assignment with a revision date of 9/7/23, was reviewed. According to the policy, it read in part, . 5. When a resident is being moved at the request of facility staff, the resident, family, and/or resident representative may receive an explanation in writing, upon request, explaining the reason for the move. The resident should be provided the opportunity to see the new location, meet the roommate, and ask questions about the move. 6. A notice of room change evaluation will be documented in the medical record. A copy of this evaluation can be provided to the resident or resident representative, if requested. 7. The facility may make an emergency change in room or roommate assignment should it become necessary for the safety and well-being of the resident or for medical reasons, e.g., transfer to isolation due to infectious disease. The resident's representative will be notified of such changes as soon as possible. The notification of the move will be documented in the medical record. According to the facility document titled, Federal Resident Rights & Facility Responsibilities which read in part, (e) Respect and dignity. The resident has a right to be treated with respect and dignity, including: . (6) Written notice of room/roommate change. The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. 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 concerns. No additional information was provided prior to conclusion of the survey.

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on observation, resident interview and facility documentation the facility staff failed to provide a private area without staff interference for the Resident council meeting.The findings included:On 7/22/25 at 3:00 p.m., a resident council meeting was held in the dining room area. A sign was posted outside the door that it was a resident council meeting being held, dietary staff were asked to keep the kitchen doors closed and staff were asked not to enter the dining room until the resident council meeting was completed. During the meeting it was observed that three staff members entered the dining room and stood in the back of the dining room area talking with staff in the kitchen. When the staff entered, it was observed that the meeting was paused until the staff exited the room.On 7/22/25 at 3:30 p.m., an interview with Resident #82 (R82) was conducted. Identified as the resident council president, R82 said, When we hold the meetings in the dining room area for more space, staff comes in and out as they want.On 7/23/25 at 4:00 p.m., a review of facility documentation was conducted. The policy titled, Guest/Resident Council, read in part, .the facility must allow guest/residents to organize into a council group without interference. The facility must provide the group with space, privacy for meetings, and staff support, if requested. 8. A private space with sufficient room for all who wish to attend will be provided, if possible, that affords the group full auditory and visual privacy and is free from interruptions.On 7/23/25 at 4:08 p.m., an end of day meeting was held with the administrator, director of nurses, assistant director of nurses and the regional clinical director. They were informed of the above concerns.No additional information was provided prior to the exit conference.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. Based on resident interview, staff interview, clinical record review, and facility documentation review, the facility failed to protect the resident's right to be free from verbal abuse by staff for one resident (Resident #43- R43) in a survey sample of 33 residents. The findings included: On 7/22/2025 at 2:06 p.m., during an interview with R43, he reported that a staff member, he identified as a certified nursing assistant (CNA #7), came in one morning to get me up and she cussed me, I told her to not be cussing me, I don't cuss at y'all. She left and I rang the bell; I needed help pulling cover up. She came in and said, What the hell do you want now. I told her I was going to tell on her. R43 stated that he had talked to the administrator, and said, two or three of them talked to me about it and I talked to the police. She never took care of me again. She had done it before, one morning she was turning me over and my head hit the railing, I should have reported that but didn't. I thought she may have had a rough night and may have been tired. R43 also reported that the residents across the hall heard the event. On 07/22/2025 at 2:40 p.m., the two residents across the hall were identified as Resident #22 (R22) and Resident #121 (R121). On 7/22/25 at 3:39 p.m., an interview was conducted with R22. When asked about an incident involving R43 and if she heard anything, R22 said, We definitely did, it would wake the dead, it was about 4 in the morning, I was in a dead sleep! I don't know what precipitated it, he was very quietly trying to talk to her about whatever the incident was over, and I heard him say, why are you cursing me, I'm not cursing or screaming at you. She [CNA #7] said 'shut up and just get back in the damn bed, I don't want to hear any more out of you. Just stop talking and get in the damn bed and I'm not going to come back in here anymore!' She slammed the door. R22 reported, it scared us [her and her roommate] terrible, I was in a dead sleep. We were shocked because she had been the aide over here a couple of times, she was a new employee, had been very pleasant with us. When I realized the voice and who it was, I was shocked. The man from APS [adult protective services] came and talked to my roommate and the unit manager came and talked to me as well. I told them it would have woken up a dead person. I've never heard anyone curse the residents like she did. I can't imagine what he did. When asked, how it made her feel? R22 stated, It was frightening, if she would scream and curse him like that she would scream and curse me too. R22 reported she and her roommate were not able to go back to sleep and said, oh no, she [her roommate-R121] couldn't go back to sleep either, we laid here and talked until time to get up. On 7/22/25, the facility's incident summary, investigation and the facility synopsis of the incident was reviewed. Included was a statement from R43 that reported CNA #7 entered his room and stated, what the hell do you want now? . You are acting like a child and a damn fool. you need to shut the hell up. R43 reported in his statement, She told me to shut up multiple times. When I told her I was going to report her, she said, ?go ahead, tell the whole world.' According to a statement from R22, she reported hearing CNA #7 say to R22, What the hell do you want, I've done everything you need, you need to shut up. He [R22] said I don't talk to you like that, why are you talking to me like that. CNA #7 [name redacted] stated because you're acting like a damn fool, like a child. He stated he was going to report her, and she stated go ahead and report it to whoever you want. Then she told him to shut the hell up, shut the door and went out. According to a statement by R121 she reported, I got woken up by CNA #7 [name redacted] around 4 a.m. [R22's name redacted] was yelling help and CNA #7 said, what do you want now, what the hell do you want? He said you are too rough, is it because I'm black? I'm going to report you. CNA stated you can report it to whoever you want. It was very bad. CNA kept cursing at resident. According to the facility's synopsis of the incident it read in part, . In conclusion, based on investigation and interviews, the facility is unable to substantiate the allegations of abuse, however, the decision was made to not continue [CNA #7's name redacted] employment, as she is not in alignment with the facility's standards of high quality of care and customer service. On 7/23/2025 at 10:30 a.m., an interview was conducted with the facility administrator, who confirmed she is the (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	facility's abuse coordinator. The administrator was asked to define abuse. She defined abuse as being verbal, physical, mental, or anything that could or causes anguish. When asked if abuse has to cause anguish to be considered abuse, the administrator said, no, if it has the potential. When asked to discuss R43's allegation of abuse involving CAN #7, the administrator stated, she was suspended pending an investigation. We reported her to the board, we called the police, they came, and we terminated her. When asked to explain the conclusion of abuse not being substantiated, when two other residents in addition to R43 reported hearing the CAN yelling and cursing the resident. The administrator said, when we interviewed [R43's name redacted] he didn't feel like he was being abused, she was rough with him, we monitored him for any signs of distress due to this incident. The administrator stated she wanted to get with the nurse consultant and Director of Nursing (DON), who had assisted with the investigation. On 7/23/2025 at 10:47 a.m., an interview was conducted with the nurse consultant. The nurse consultant was told of the incident and had no recall of the incident. She was shown the facility's incident summary and facility synopsis and said she didn't remember it but would check her log she keeps. The nurse consultant reviewed her log and said she received the facility synopsis but was not involved in the investigation or conclusion, as she had taken some time off and it may have occurred while she was out of work. On 7/23/2025 at 10:53 a.m., an interview was conducted with the DON. The [NAME] reported she had talked to R43 and he said she was verbally aggressive with him. We collected statements from staff, adjacent residents with BIMs [brief interview for mental status score] of 12 or above [which indicated they were cognitively intact]. No other residents had any concerns. These were the only other 2 staff here. When asked about the facility's conclusion that abuse had not occurred, the DON said, We determined she was a new hire, had been here less than 90 days and the fact that we got statements from other residents that heard her yelling, talking to the resident in a non-professional way, the residents said she was unprofessional and she was terminated. We felt it was a customer service issue. The statements from R22 and R121 was read outload, along with R43's statement. The nurse consultant agreed that this was abusive and neglectful. On 7/23/25 at 1:13 p.m., the facility administrator provided the survey team with a document from adult protective services indicated that an allegation of neglect involving R43 had been conducted and unfounded. It did not speak to the allegations of abuse. According to the facility's abuse policy titled, Abuse Prohibition Policy with a revision date of 9/9/22, it read, Each guest/resident shall be free from abuse, neglect, mistreatment, exploitation, and misappropriation of property. Abuse shall include freedom from verbal, mental, sexual, physical abuse. The policy defined verbal abuse as the use of verbal or nonverbal conduct which causes or has the potential to cause the guest/resident to experience humiliation, intimidation, fear, shame, or degradation regardless of their age, ability to comprehend or disability. Verbal abuse may be considered to be a type of mental abuse. Verbal abuse includes the use of oral, written, or gestured communication, or sounds, to guests/residents within hearing distance, regardless of age, ability to comprehend, or disability.On 7/23/25 at 3 p.m., a follow-up interview was conducted with R43. R43 reported it made him feel real cheap. I didn't like it; it hurt my feelings. Made me feel like a fool, you know how you feel if someone does something to you. She was disrespecting me. That wasn't the first time she did something to me, she was turning me over and hit my head against the railing on the bed and I should have reported her then. When asked if he had reported this when he talked to the administrator, he said yes. When asked if he feels she was abusive to him, R43 said, yeah. R43 denied being afraid and reported the employee no longer works at the facility and he feels safe. On 7/23/25 at 4:08 p.m., during an end of day meeting with the facility administrator and director of nursing, they were made aware that the facility had failed to ensure R43's right to be free from abuse was upheld.No additional information was provided.

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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 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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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, and clinical record review, the facility staff failed to develop a baseline care plan within 48 hours of admission for one resident (Resident #31-R31) in a survey sample of thirty-three residents.The findings included:For R31, the facility staff failed to develop a baseline care plan within 48 hours of admission that included instructions needed to provide resident-centered care. On 7/21/25, R31 was interviewed in her room. R31 reported she had come in recently from the hospital. On 7/23/25, a clinical record review was conducted of R31's electronic health records. The following was noted:R31 was admitted to the facility on [DATE]. R31's diagnosis included, but were not limited to: acute on chronic diastolic heart failure, muscle weakness, paroxysmal atrial fibrillation, chronic kidney disease- stage 3A, acute kidney failure, and osteoarthritis of knee. According to R31's care plan, each of the focus areas and interventions were dated 7/21/25, which was outside of the 48-hour requirement for development and implementation of a baseline care plan. On 7/23/25 at 2 p.m., an interview was conducted with a registered nurse (RN #1), who was the facility's care plan coordinator. RN #1 explained that when resident's diagnosis are entered, it generates the baseline care plan. She said, We go in and personalize it. The care plan coordinator explained that the care plan is important because it drives the care for the patient and is the plan for the care of the patient. When R31's delay in developing a baseline care plan was discussed, RN #1 had no explination. On 7/23/25 at 4:08 p.m., during an end of day meeting, concerns regarding care plans were discussed with the facility's administrator and director of nursing. No additional information was provided.

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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. 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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.” 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) (continued on next page)

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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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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. (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, 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.” 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 (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review, and facility documentation review, the facility staff failed to administer oxygen at the physician ordered rate for one resident (Resident #35-R25) and failed to store respiratory equipment in a manner to prevent contamination for one resident (Resident #22-R22) in a survey sample of thirty-three residents. The findings included:1. For Resident #35, the facility staff failed to administer oxygen at the physician ordered rate of 2 liters.On 7/21/25 at 3:23 p.m., during an interview with R35, it was observed that an oxygen concentrator at the bedside was running, and the cannula was on the floor. When asked, R35 reported she wears the oxygen daily but was unsure at what rate/volume it was to be at. The concentrator was observed to be set just above 3 liters. On 7/22/25, a clinical record review was conducted. This review revealed that R35 had an order dated 5/28/25, that remained an active order and read, Oxygen: Oxygen at 2 liters via nasal cannula as needed for SOB [shortness of breath] or pox [pulse-oxygen] less than 90%. R35's diagnosis included, dependence on supplemental oxygen. According to R35's care plan, it noted, [R35's name redacted] has a potential for difficulty breathing and risk for respiratory complications r/t [related to]: COPD [chronic obstructive pulmonary disease], dysphagia, CKD3b [chronic kidney disease stage 3b], Afib [atrial fibrillation], . use of oxygen. Interventions included, but were not limited to, Oxygen use. On 7/22/25 at 11:04 a.m., during a follow-up interview with R35 she was observed wearing oxygen and the concentrator was running at above 3 liters. On 7/22/25 at 11:30 a.m., an interview was conducted with licensed practical nurse #5 (LPN #5). LPN #5 stated that oxygen is administered at the rate ordered because at a higher rate the resident can become dependent on more oxygen than is needed. LPN #5 accessed R35's clinical record and confirmed that the physician order was for oxygen at 2 liters. LPN #5 then accompanied the surveyor to the resident's room and confirmed that R35's oxygen was running at a rate of just above 3 liters. LPN #5 immediately adjusted the concentrator [NAME] to lower the oxygen flow rate to 2 liters. 2. For Resident #22, the nebulizer mask was left sitting open to air and not stored in a manner to prevent contamination that could cause respiratory infections. On 7/22/25 at 8:27 a.m., during an interview with R22, a nebulizer was observed on the bedside table and the mask was lying open to air. When asked, R22 reported that she uses the nebulizer twice daily. R22 went on to report that she has had a cough for a while and the doctor had ordered a chest x-ray and echocardiogram because he wasn't sure if it was my lungs or heart. On 7/22/25 at 8:30 a.m., licensed practical nurse #5 (LPN #5) entered the room to administer medication to R22. When asked about the nebulizer, LPN #5 confirmed that the resident uses it daily and when not in use it should be stored in a bag. When asked why it is stored that way, LPN #5 said, For infection control. LPN #5 also observed R22's nebulizer mask not stored in a bag and left open to air. LPN #5 stated she had not administered the nebulizer, and it was left from the day before by someone else. According to R22's clinical record, a physician order dated 4/15/25, which remained active, read, Ipratropium-Albuterol Inhalation Solution 0.5-2.5 (3) MG/3ML (Ipratropium-Albuterol) 3 ml inhale orally two times a day for SOB./Wheezing. According to R22's care plan, a focus area noted, [R22's name redacted] has a potential for difficulty breathing and risk for respiratory complications R/T: COPD, bilateral PE [pulmonary edema], morbid obesity, anxiety, cough. Interventions included, Administer medication & treatments per physician orders. The facility policy, titled Use of Oxygen, read in part, .III. The O2 cannula or mask, when not in use, should be stored in a clean bag. Bag should be changed weekly. The policy did not address the importance of oxygen being administered in accordance with physician orders. 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.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. Based on observation, resident and staff interviews, clinical record review, and facility documentation review, the facility staff failed to serve meals in accordance with resident preference for one resident (Resident #22-R22) in a survey sample of thirty-three residents. The findings included:For Resident #22 (R22), the facility staff failed to provide double meat portions as requested by the resident. On 7/22/2025 at 8:28 a.m., during an interview with R22, the resident had multiple complaints of the food and reported, .On Tuesdays they give you a menu to select menu choices for the next week, but it is pointless, they always say they are out of things. They don't pay any attention to what they are doing. On 7/23/2025 at 8:27 a.m., R22 was observed in bed and was served her breakfast. The resident received a small portion of eggs, two slices of bacon, and a cinnamon roll. The resident reported that all her food was cold. According to the resident's meal ticket it read, special diets: Double Meat Portions, Double Vegetables. Handwritten on the ticket was, Egg, 2x Bacon, Cinnamon Roll. The surveyor stepped out of the room and conducted an interview with the dietary manager. The dietary manager confirmed that double portion bacon would be four slices. The dietary manager accompanied the surveyor back into R22's room. The dietary manager confirmed that the resident did not receive the double portion of bacon as requested and agreed to prepare the resident a new plate. According to R22's clinical record, a document titled, Nutritional Evaluation, was dated 4/22/25, was completed by the registered dietician. The document read in part, .33. Current Nutrition Prescription: CCD diet, regular texture, thin liquid consistency. Desires double meat and Double vegetables portions Would like to fill out menus' requests, spoke with diet manager. 40. Summary: Nutrition Plan/Goals. Honor food preferences. According to the facility policy titled, Food Preferences, which read in part, . 8. Food preferences will be identified on tray tickets to ensure residents are provided with approprite food items. On 7/23/25 at 4:30 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.

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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 0808 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure therapeutic diets are prescribed by the attending physician and may be delegated to a registered or licensed dietitian, to the extent allowed by State law. Based on observations, staff interview, clinical record review and facility documentation review the facility staff failed to provide a therapeutic diet per physician orders.The findings included:Resident #59 (R59) was not served fortified foods at the lunchtime meal.On 7/21/25 at 12:00 p.m. an observation of the lunchtime meal was made by the residents in the dining room. During the meal it was observed that R59 was served a peanut butter and jelly sandwich, piece of chocolate cake and tea to drink. R59's meal ticket was read, and she should have had fortified foods with her meal. On 7/22/25 at 12:15 p.m. a second observation of R59's lunchtime meal was conducted. R59 had a peanut butter and jelly sandwich, apple crisp and juice to drink. R59 was not served any fortified food with her meal. During the observation of the kitchen serving the lunchtime meal mashed potatoes and ice cream were available to be served as the fortified foods. On 7/22/25 at 12:25 p.m. an interview was conducted with the dietary manager, and she stated fortified foods were foods like ice cream, mashed potatoes and puddings. On 7/23/25 at 1:30 p.m. a review of R59's clinical record was conducted. R59 had a physician's order for fortified foods due to weight loss. The fortified food was also on R59's meal ticket that the kitchen prints out daily.On 7/23/25 at 3:00 p.m. a review of facility documents was conducted. The facility documentation titled, Diet Orders, read in part, .the facility will adhere to therapeutic diet parameters during food preparation and when dispensing condiments.On 7/23/25 at 4:30 p.m. an end-of-day meeting was conducted with the administrator, director of nurses, assistant director of nurses and the regional clinical director and the above concerns were discussed.No additional information was provided prior to the exit conference.

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	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 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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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 observations, staff interview, clinical record review and facility documentation review the facility staff failed to implement their infection prevention and control program for one resident out of a survey sample of 33 residents.The findings included:Resident #2 (R2) was on contact isolation and the facility staff had enhance barrier precautions posted outside the door.On 7/21/25 a tour of nursing unit two was conducted. During the tour it was observed that R2 signage on the outside of his door was for enhanced barrier precautions. Review of the facility matrix R2 was on transmission based precautions. Reviewing the clinical record there was a physician order for R2 to be on contact isolation due to c-difficile (c-diff) infection. A second observation was conducted and enhanced barrier precautions signage was posted outside R2's door.On 07/23/2025 at 11:20 a.m., an interview was conducted with the infection preventionist registered nurse RN#3 (RN3). RN3 stated that R2 should not be on contact precautions that order was supposed to be discontinued. RN3 stated that R2 was not being treated for an active case of c-difficile and the antibiotic was preventive care. RN3 was asked about the loose stools being charted in the clinical record, and RN3 said, I was not aware of loose stools being charted in the clinical record. I am going to put up contact precautions and talk with the doctor.On 7/23/25 a clinical record review was conducted. There was an active order in the clinical record for contact precautions related to c-diff written on 6/12/25. There was an active order written on 7/15/25 that read in part, Vancomycin HCl Oral Capsule 125MG (Vancomycin HCl) Give 1 capsule by mouth two times a day for c. diff, taper until 07/22/2025 23:59 AND Give 1 capsule by mouth onetime a day for c diff, taper until 07/30/2025 23:59.On 7/23/25 at 4:30 p.m., there was an end of day meeting held with the administrator, director of nurses, assistant director of nurses and the regional clinical director and they were made aware of the above concerns.No additional information was provided prior to the exit conference.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, and facility documentation review, the facility staff failed to provide education and offer the flu and pnuemococcal vaccines to two of five residents reviewed for immunizations (Resident #17-R17 and Resident #110-R110). The findings included:On 7/22/2025 at 2:21 p.m., a sample of five residents was selected for review of immunizations. Clinical record reviews were conducted. For R17, according to the clinical record, the resident was admitted on [DATE] and was a resident of the facility during the 2024/2025 flu season. According to the immunization tab of the clinical record, R17's most recent dose of the influenza vaccine was 3/8/23. There was no indication that the facility provided R17 any education nor offered the flu vaccine. R17's chart had no evidence of a consent or declination of the flu vaccine for the 2024/2025 flu season. For R110, whose most recent readmission following hospitalization was 12/26/24. According to the immunization tab of the clinical record, R110 had refused the pneumococcal vaccine on 7/12/23. The record indicated R110 only had received the PPSV23 on 10/20/2014. There was a consent form that had been marked declined, but that selection was errored and initialed and the consent box was checked. The form was dated 6/28/23 but was entered into the immunization tab as a refusal, which was dated 7/12/23. On 7/24/2025 at 9:50 a.m., an interview was conducted with the facility's infection preventionist (IP), who was a registered nurse and the assistant director of nursing. The IP accessed each of the residents' charts and confirmed the above findings. The IP confirmed that R17 would have been eligible for the flu vaccine since she was a resident of the facility during the flu season and that documentation/evidence of the resident being offered the flu vaccine was not present. The IP also confirmed that R110's pneumonia immunizations were not up to date and the consent form appeared to indicate they wanted the vaccine but had been inaccurately recorded as a refusal. The IP explained the importance of immunizations being current, and said, It helps keep them protected and decreases our infection control [infection rates], in the winter we see a lot of respiratory infections and it is important to keep them up to date and protected so we don't spread it. The facility policy titled, Immunizations: Influenza (Flu) Vaccination of Residents with a revision date of 4/17/25, was received and reviewed. The policy read in part, It is the policy of this facility that, annually, residents will be offered immunization against influenza. 1. The vaccine program runs from early October through March 31st but is flexible depending upon recommendations from the Health Department and CDC for each vaccine year. Nursing Procedure: 1. Beginning in October, when notified to begin Influenza vaccination by Infection Control, review the Standing Protocol for Influenza Vaccine. 9. Document resident refusal and education of risk vs. benefit. The facility policy titled, Immunizations: Pneumococcal Vaccination (PPV) of Residents, was received and reviewed. The policy read in part, Guideline: . 3. Every year, a log will be maintained documenting the number of residents who received the vaccine, as well as the number who refused or did not get vaccinated. II. Administration Procedure: . Pneumococcal Vaccine Timing for Adults. indicated that if a resident had only PPSV23 only they were eligible for PCV20 or PCV21. An option B was also available which gave an option for PCV15 to be administered which would complete their vaccination series for pneumonia. According to the Centers for Disease Control and Prevention (CDC), a document titled, Adult Immunization Standards was reviewed. The document read in part, The National Vaccine Advisory Committee developed the Standards for Adult Immunization Practice to reflect the critical need for all health care professionals - whether they provide immunization services or not - to take steps to ensure that adult patients get the vaccines they need. These standards are important because: Adult vaccination coverage is low. Many adults are not aware that they need vaccines. A health care professional's recommendation is the strongest predictor of whether a patient gets vaccinated. There are often missed opportunities for vaccination because many health care professionals are not assessing vaccination status. CDC encourages all health care professionals to implement these (continued on next page)

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	standards into their practice. 1. Assess the immunization status of all your patients at every clinical encounter . Stay informed. Get the latest CDC recommendations for adult immunization. Evaluate how your practice is doing. Review a sample of patients' charts or analyze electronic health record data for your practice to see whether your patients are receiving needed vaccines.Use reminders to help your practice stay on top of needed vaccines. Generate reminders using a computer system (electronic health record) or immunization registries or make a note of needed vaccines on a patient's chart. 2. Make clear recommendations for vaccines that patients need. For some patients, a recommendation may not be enough. Share important information to help patients make informed decisions about vaccinations . 3. Administer vaccines or refer your patients to a vaccination provider. Recommend and offer vaccines at the same visit. Research shows that when patients receive a vaccine recommendation and are offered the vaccine at the same time, they are more likely to be vaccinated. Implement standing orders or protocols.Ensure patients' vaccine needs are routinely reviewed, and patients get reminders about vaccines they need . 4. Document vaccines received by your patients in their medical records and in immunization information systems (IIS) . Accessed online at: https://www.cdc.gov/vaccines-adults/hcp/imz-standards/index.html On 7/24/25 at 11:13 a.m., the above findings were reviewed with the facility administrator and director of nursing. No additional information was provided.

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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.