STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495420	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Albemarle Health & Rehabilitation Center	1540 Founders Place Charlottesville, VA 22902

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff allowed self-administration of medications without a prior assessment or physician's order for two of eight residents in the survey sample (Residents #5 and #6). The findings include: Resident #5 (R5) was admitted to the facility with diagnoses that included diabetes, asthma, atrial fibrillation, anorexia, depression, neuropathy, chronic kidney disease, anxiety and insomnia. The minimum data set (MDS) dated [DATE] assessed R5 as cognitively intact. Resident #6 (R6) was admitted to the facility with diagnoses that included spinal stenosis, osteoporosis, peripheral vascular disease, gastroesophageal reflux disease, insomnia, depression, anxiety and hypertension. The MDS dated [DATE] assessed R6 as cognitively intact. 1. Oral medications were prepared and left at the bedside on 2/22/25 for R5 and R6 to self-administer when the residents had no prior assessment or physician's order to self-administer medications. Clinical records for R5 and R6 included no physician's order or assessments indicating the residents were deemed safe to self-administer medications. On 6/10/25 at 12:10 p.m., licensed practical nurse (LPN #1) caring for R5 and R6 on the evening of 2/22/25, was interviewed about an allegation that medications had been left at the bedside. LPN #1 stated R5 and R6 liked to be the first residents to get their evening medicines. LPN #1 stated on 2/22/25 around 5:30 or 6:00 p. m., R5 and R6 were in the dining room. LPN #1 stated she told R5 and R6 that she had prepared their bedtime medicines and had put the medicines on their bedside tables for them to take when they returned to their rooms. LPN #1 stated she was in hallway the entire evening passing medications to other residents and R5 and R6 returned to their rooms after dinner. LPN #1 stated R5 reported that she took her medications after she got back to the room, but she did not witness R5 take the medicines. LPN #1 stated later in the evening, R6 asked about her medications, she then accompanied R6 to the room and found the medicines still on the bedside table. LPN #1 stated she witnessed R6 take the prepared medications. LPN #1 stated the medications left for the residents were medicines scheduled for 9:00 p.m. When asked why she left the medications unsecured/unattended, LPN #1 stated she was trying to get them [medications] out of the way and get ahead. (continued on next page)

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 3:09 a.m., the director of nursing (DON) and registered nurse staff development coordinator (RN #1) were interviewed about LPN #1 preparing and leaving medicines for R5 and R6 to self-administer. RN #1 stated R5 and R6 had not been assessed for self-administration of medications. The DON stated nurses were not expected to leave medications at the bedside unattended. The DON stated residents desiring to self-administer medicines required a physician's order to do so and an assessment by the interdisciplinary team indicating the resident was safe to self-administer. The DON stated residents assessed as safe to self-administer medicines were provided a lock box for medication storage in the room. R5's clinical record documented the medications prepared and left for self-administration on 2/22/25 at 9:00 p.m. included montelukast sodium 10 mg (milligrams) and sodium bicarbonate 650 mg. R6's clinical record documented medications administered to R6 on 2/22/25 at 9:00 p.m. included atorvastatin 20 mg, gabapentin 300 mg (2 capsules), melatonin 6 mg, trazodone 400 mg, Tylenol 500 mg (2 tablets) and Cymbalta 30 mg. 2. R5 had the medication Trelegy Ellipta inhaler at the bedside without a prior physician's order or assessment to safely self-administer medications. On 6/10/25 at 10:45 a.m., R5 was observed in her room with a Trelegy Ellipta inhaler device located on the bedside table. R5 was interviewed at this time about the Trelegy Ellipta. R5 stated she was able to self-administer the Trelegy Ellipta and that she took the Trelegy Ellipta once per day. R5 stated she thought a nurse had left the Trelegy Ellipta inhaler in the room, but she did not recall when that occurred or how long the Trelegy Ellipta inhaler had been in her room. R5's clinical record documented a physician's order dated 6/27/24 for Trelegy Ellipta inhalation aerosol powder breath activated 100-62.5-25 micrograms/actuation with instructions to inhale one puff orally once per day with mouth rinse after for treatment of asthma. R5's clinical record documented no physician's order for self-administration and no assessment indicating the resident was deemed safe to self-administer medications. On 6/10/25 at 11:50 a.m., the licensed practical nurse (LPN #2) caring for R5 was interviewed about the Trelegy Ellipta inhaler. LPN #2 stated R5 had not been assessed to self-administer medications and that the Trelegy Ellipta inhaler should not be at the resident's bedside. Accompanied by LPN #2, the Trelegy Ellipta inhaler was observed on the resident's bedside table. LPN #2 stated four doses had been activated from the device. LPN #2 stated she was not aware the device was at the bedside. LPN #2 stated, A nurse must have left it in the room. On 6/10/25 at 3:09 a.m., the director of nursing (DON) and registered nurse staff development coordinator (RN #1) were interviewed about R5 having the Trelegy Ellipta inhaler at the bedside. RN #1 stated R5 had not been assessed for self-administration of medications. The DON stated nurses were not expected to leave medications at the bedside unattended. The DON stated residents desiring to self-administer medicines required a physician's order to do so and an assessment by the interdisciplinary team indicating the resident as safe to self-administer. The DON stated residents assessed as safe to self-administer medicines were provided a lock box for medication storage in the room. (continued on next page)

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Albemarle Health & Rehabilitation Center	1540 Founders Place Charlottesville, VA 22902

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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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled Self-Administration of Medication at Bedside (effective 1/29/24) documented, .A licensed nurse will assess patient's ability to self-administer medication .Complete Medication Self-Administration Safety Screen assessment .The Interdisciplinary Team will review the assessment and together, use clinical judgement to determine if the patient is eligible .If eligible, medications that are ordered by a provider to be self-administered will be identified in the medical record .The Medication Self-Administration Safety Screen assessment will be reviewed quarterly by the Interdisciplinary Team . These findings were reviewed with the administrator and regional nurse consultant during a meeting on 6/11/25 at 10:30 a.m. with no further information presented prior to the end of the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 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 staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of quality during medication administration for two of eight residents in the survey sample (Residents #5 and #6). The findings include: On 2/22/25, oral medications were prepared ahead of the scheduled administration time and left unattended/unsecured at the bedside for two residents (Residents #5 and #6). The nurse failed to observe R5 take the prepared medications. Resident #5 (R5) was admitted to the facility with diagnoses that included diabetes, asthma, atrial fibrillation, anorexia, depression, neuropathy, chronic kidney disease, anxiety and insomnia. The minimum data set (MDS) dated [DATE] assessed R5 as cognitively intact. Resident #6 (R6) was admitted to the facility with diagnoses that included spinal stenosis, osteoporosis, peripheral vascular disease, gastroesophageal reflux disease, insomnia, depression, anxiety and hypertension. The MDS dated [DATE] assessed R6 as cognitively intact. On 6/10/25, R5, R6 and LPN #1 were interviewed regarding an allegation that medications were prepared ahead and left unattended in the residents' rooms on the evening of 2/22/25. On 6/10/25 at 10:45 a.m., R5 stated she did not remember a nurse leaving medications in her room during February (2025). On 6/10/25 at 10:50 a.m., R6 stated she did not remember a nurse leaving medications in her room during February (2025). On 6/10/25 at 12:10 p.m., licensed practical nurse (LPN #1) that cared for R5 and R6 on the evening of 2/22/25 was interviewed about an allegation that medications had been left at the bedside. LPN #1 stated R5 and R6 liked to be the first residents to get their evening medicines. LPN #1 stated on 2/22/25 around 5:30 or 6:00 p.m., R5 and R6 were in the dining room. LPN #1 stated she told R5 and R6 that she had prepared their bedtime medicines and had put the medicines on their bedside tables for them to take when they returned to their rooms. LPN #1 stated she was in hallway the entire evening passing medications to other residents. LPN #1 stated after dinner, R5 returned to her room. LPN #1 stated that R5 reported that she took the prepared medications but that she did not witness R5 take the medicines. LPN #1 stated later in the evening, R6 asked about her bedtime medications, that she then accompanied R6 to the room and found the medicines still on the bedside table. LPN #1 stated she witnessed R6 take the prepared medications. LPN #1 stated the medications prepared and left for the residents were medicines scheduled for 9:00 p.m. that evening. LPN #1 stated she was aware that she was not supposed to leave medicines unattended. When asked why she prepared the medicines ahead and left them unattended, LPN #1 stated she was trying to get them [medications] out of the way and get ahead. LPN #1 stated medications were supposed to be administered within an hour before or after the scheduled administration time. (continued on next page)

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Albemarle Health & Rehabilitation Center	1540 Founders Place Charlottesville, VA 22902

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/10/25 at 3:09 a.m., the director of nursing (DON) and registered nurse staff development coordinator (RN #1) were interviewed about LPN #1 preparing and leaving medicines for R5 and R6 to self-administer. RN #1 stated R5 and R6 had not been assessed for self-administration of medications. The DON stated nurses were not expected to leave medications at the bedside unattended or unsecured. The DON stated residents desiring to self-administer medicines required a physician's order to do so and an assessment by the interdisciplinary team indicating the resident as safe to self-administer medicines. RN #1 stated nurses were expected to observed residents taking medications to ensure proper administration. R5's clinical record documented the medications administered on 2/22/25 at 9:00 p.m. included montelukast sodium 10 mg (milligrams) and sodium bicarbonate 650 mg. R6's clinical record documented medications administered to R6 on 2/22/25 at 9:00 p.m. included atorvastatin 20 mg, gabapentin 300 mg (2 capsules), melatonin 6 mg, trazodone 400 mg, Tylenol 500 mg (2 tablets) and Cymbalta 30 mg. Clinical records for R5 and R6 included no physician's order or assessment indicating the residents were safe to self-administer medications. The facility's policy titled General Guidelines for Medication Administration (effective 9/2018) documented, Medications are administered as prescribed in accordance with good nursing principles and practices .When medications are administered by mobile cart taken to the resident's location (room, dining area, etc.), medications are administered at the time they are prepared. Medications are not prepoured either in advance of the med pass or for more than one resident at a time .Medications are administered within 60 minutes of the scheduled administration time .Residents are permitted to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications .The resident is always observed after administration to ensure that the dose was completely ingested .The individual who administers the medication dose records the administration on the resident's MAR [medication administration record] directly after the medication is given . These findings were reviewed with the administrator and regional nurse consultant during a meeting on 6/11/25 at 10:30 a.m. with no further information presented prior to the end of the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to follow physician orders for medication administration for one of eight residents in the survey sample (Resident #4). The findings include: Resident #4 (R4) was admitted to the facility with diagnoses that included osteomyelitis, MRSA (methicillin resistant staphylococcus aureus), end stage renal disease, protein-calorie malnutrition, anemia, hypertension and diabetes. The minimum data set (MDS dated [DATE] assessed R4 as cognitively intact. R4's closed clinical record documented a physician's order dated 1/30/25 for Zosyn (piperacillin - tazobactam) intravenous (IV) solution reconstituted 4.5 (4-0.5) grams with instructions to give 4.5 grams intravenously every 12 hours until 3/5/25 for treatment of acute osteomyelitis. R4's medication administration record (MAR) for February 2025 documented Zosyn was scheduled for administration at 6:00 a.m. and 6:00 p.m. each day. The MAR documented Zosyn was not administered on 2/11/25 at 6:00 a.m. as ordered/scheduled. A nursing note dated 2/11/25 at 6:16 a.m. documented, . Informed IV completed. There was no other explanation in the clinical record indicating why the dose was not administered. The clinical record included no order to discontinue or stop the IV Zosyn. Medication administration continued after the 2/11/25 6:00 a.m. dose through 3/5/25 as ordered. On 6/10/25 at 3:09 p.m., the director of nursing (DON) and the registered nurse infection preventionist (RN #1) were interviewed about R4's missed dose of IV Zosyn on 2/11/25. RN #1 and the DON stated the Zosyn order was not discontinued or completed on 2/11/25 as listed in the note. RN #1 stated the medication was ordered every 12 hours through 3/5/25 and no changes were made to the order during the resident's stay. RN #1 and the DON stated they did not understand the note written on 2/11/15 by licensed practical nurse (LPN #3) indicating the IV medicine was complete. On 6/11/25 at 8:20 a.m., the regional nurse consultant (administration #3) was interviewed about R4's missed dose of Zosyn on 2/11/24. The regional nurse consultant stated the 6:00 a.m. dose on 2/11/25 was not given as ordered. The regional nurse consultant stated she was not sure why the medicine was not given. The regional nurse consultant stated the resident's Zosyn order was not completed or discontinued on 2/11/25 as written in the note. On 6/11/25 at 8:53 a.m., the nurse practitioner (other staff #1) caring for R4 was interviewed about the missed dose of IV Zosyn. The NP stated she was aware of the missed dose. The NP stated the resident's labs and vital signs remained stable during the resident's stay and there was no indication to add or extend the IV antibiotic treatment due the missed dose. The NP stated the Zosyn was administered per recommendations from the hospital. The NP stated R4 did not miss a significant number of doses and there was no change to the resident's overall outcome based on the missed dose of Zosyn. LPN #3, responsible for giving the 6:00 a.m. dose of Zosyn on 2/11/25 was not available for interview as she was not working during the survey and attempts to call her were unanswered. (continued on next page)

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Albemarle Health & Rehabilitation Center	1540 Founders Place Charlottesville, VA 22902

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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 - Few	The facility's policy titled General Guidelines for Medication Administration (revised 8/2020) documented, . Medications are administered in accordance with written orders of the prescriber . This finding was reviewed with the administrator and regional nurse consultant during a meeting on 6/11/25 at 10:30 a.m. with no further information presented prior to the end of the survey.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to ensure medications remained secured in locked compartments and/or carts for two of eight residents in the survey sample (Residents #5 and #6). The findings include: Resident #5 (R5) was admitted to the facility with diagnoses that included diabetes, asthma, atrial fibrillation, anorexia, depression, neuropathy, chronic kidney disease, anxiety and insomnia. The minimum data set (MDS) dated [DATE] assessed R5 as cognitively intact. Resident #6 (R6) was admitted to the facility with diagnoses that included spinal stenosis, osteoporosis, peripheral vascular disease, gastroesophageal reflux disease, insomnia, depression, anxiety and hypertension. The MDS dated [DATE] assessed R6 as cognitively intact. 1. The medication Trelegy Ellipta inhaler was observed stored unsecured on Resident #5's bedside table. On 6/10/25 at 10:45 a.m., R5 was observed in her room with a Trelegy Ellipta inhaler device located on the bedside table. R5 was interviewed at this time about the Trelegy Ellipta. R5 stated she thought a nurse had left the Trelegy Ellipta inhaler in the room, but she did not recall when that occurred or how long the Trelegy Ellipta inhaler had been in her room. R5's clinical record documented a physician's order dated 6/27/24 for Trelegy Ellipta inhalation aerosol powder breath activated 100-62.5-25 micrograms/actuation with instructions to inhale one puff orally once per day with mouth rinse after for treatment of asthma. R5's clinical record documented no physician's order for self-administration of medications and no assessment indicating the resident was deemed safe to self-administer medications. On 6/10/25 at 11:50 a.m., the licensed practical nurse (LPN #2) caring for R5 was interviewed about the Trelegy Ellipta inhaler. LPN #2 stated R5 had not been assessed to self-administer medications and that the Trelegy Ellipta inhaler should not be at the resident's bedside. Accompanied by LPN #2, the Trelegy Ellipta inhaler was observed on the resident's bedside table. LPN #2 stated she was not aware the device was at the bedside. LPN #2 stated, A nurse must have left it in the room. LPN #2 stated four doses had been activated from the device and LPN #2 located an empty Trelegy Ellipta box in the medication cart labeled for R5. On 6/10/25 at 3:09 p.m., the director of nursing (DON) and registered nurse staff development coordinator (RN #1) were interviewed about the Trelegy Ellipta inhaler left unsecured/unattended in the resident's room. The DON stated medications were not to be left at the bedside. The DON stated residents assessed to self-administer medications were required to keep medications stored in a locked box. RN #1 stated it was not acceptable for nurses to leave medications unsecured and that R5 had no order or assessment for self-administration of medications. (continued on next page)

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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 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's policy titled General Guidelines for Medication Administration (effective 9/2018) documented, . Medications are administered within 60 minutes of the scheduled administration time .During administration of medication, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart .The resident is always observed after administration to ensure that the dose was completely ingested . 2. On the evening of 2/22/25, oral medications for R5 and R6 were prepared and left unsecured in the residents' rooms. On 6/10/25 at 12:10 p.m., licensed practical nurse (LPN #1) that cared for R5 and R6 on the evening of 2/22/25 was interviewed about an allegation that medications had been left at the bedside. LPN #1 stated R5 and R6 liked to be the first residents to get their evening medicines. LPN #1 stated on 2/22/25 around 5:30 or 6:00 p.m., R5 and R6 were in the dining room. LPN #1 stated she told R5 and R6 that she had prepared their bedtime medicines and had put the medicines on their bedside tables for them to take when they returned to their rooms. LPN #1 stated she was in hallway the entire evening passing medications to other residents. LPN #1 stated after dinner, R5 returned to her room. LPN #1 stated R5 reported that she took the prepared medications but that she did not witness R5 take the medicines. LPN #1 stated later in the evening, R6 asked about her bedtime medications, she then accompanied R6 to the room and found the medicines still on the bedside table. LPN #1 stated she witnessed R6 take the prepared medications. LPN #1 stated the medications prepared and left for the residents were medicines scheduled for 9:00 p.m. that evening. LPN #1 stated she was aware that she was not supposed to leave medicines unattended. When asked why she prepared the medicines ahead and left them unattended, LPN #1 stated she was trying to get them [medications] out of the way and get ahead. LPN #1 stated medications were supposed to be administered within an hour before or after the scheduled administration time. On 6/10/25 at 3:09 a.m., the director of nursing (DON) and registered nurse staff development coordinator (RN #1) were interviewed about LPN #1 preparing and leaving medicines for R5 and R6 to self-administer. The DON stated nurses were not expected to leave medications at the bedside unattended or unsecured. The DON stated residents assessed to self-administer medicines were required to keep medicines stored in a locked box in their rooms. The facility's policy titled General Guidelines for Medication Administration (effective 9/2018) documented, . Medications are administered within 60 minutes of the scheduled administration time .During administration of medication, the medication cart is kept closed and locked when out of sight of the medication nurse or aide. No medications are kept on top of the cart .The resident is always observed after administration to ensure that the dose was completely ingested . These findings were reviewed with the administrator and regional nurse consultant during a meeting on 6/11/25 at 10:30 a.m. with no further information presented prior to the end of the survey.