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	10/25/2025

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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, record review, and document review, the facility failed to ensure the accuracy of the Minimum Data Set (MDS) for 1 (Resident #127) of 4 sampled residents reviewed for accidents.Findings included: The Centers for Medicare & Medicaid Services Long-Term Care Facility Resident Assessment Instrument [RAI] 3.0 User's Manual dated 10/2024, revealed Section E: Behavior Intent: The items in this section identify behavioral symptoms in the last seven days that may cause distress to the resident, or may be distressing or disruptive to facility residents, staff members or the care environment. These behaviors may place the resident at risk for injury, isolation, and inactivity and may also indicate unrecognized needs, preferences or illness. Behaviors include those that are potentially harmful to the resident themself. The emphasis is identifying behaviors, which does not necessarily imply a medical diagnosis. Identification of the frequency and the impact of behavioral symptoms on the resident and on others is critical to distinguish behaviors that constitute problems from those that are not problematic. Once the frequency and impact of behavioral symptoms are accurately determined, follow-up evaluation and care plan interventions can be developed to improve the symptoms or reduce their impact. Per the manual, Steps for Assessment 1. Review the medical record and interview staff to determine whether wandering occurred during the 7-day look-back period. Wandering is the act of moving from place to place with or without a specified course or known direction. Wandering may or may not be aimless. The wandering resident may be oblivious to their physical or safety needs. The resident may have a purpose such as searching to find something, but they persist without knowing the exact direction or location of the object, person or place. The behavior may or may not be driven by confused thoughts or delusional ideas. 2. If wandering occurred, determine the frequency of the wandering during the 7-day look-back period. An admission Record revealed the facility admitted Resident #127 on 04/22/2025. According to the admission Record, the resident had a medical history that included diagnoses of muscle weakness, dementia, seizures, cognitive communication deficit, and difficulty walking. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 04/28/2025, revealed Resident #127 had a Brief Interview for Mental Status (BIMS) score of 5, which indicated the resident had severe cognitive impairment. According to the MDS, the resident did not exhibit any wandering behaviors during the last seven days. Resident #127's Care Plan Report included a focus area created 04/22/2025, that indicated the resident was at risk for elopement related to dementia. Resident #127's progress note electronically signed by Licensed Practical Nurse (LPN) #34 and dated 04/23/2025 at 3:36 PM, indicated the resident had a history of exit-seeking behavior while at the hospital. The progress note indicated the resident wandered to the other units during the day but could be redirected. Per the progress note, due to safety concerns a wander guard was placed on the resident's left arm. During an interview on 10/22/2025 at 12:04 PM, LPN #34 stated the progress note electronically signed by her and dated 04/23/2025 indicated Resident #127 wandered to the other units in the facility during the day. LPN #34 stated due to the resident's wandering, she notified the provider to get an order for a wander guard for safety reasons. During an interview on 10/21/2025 at 2:40 PM, the MDS Coordinator stated Resident #127's MDS with an ARD of 04/28/2025 was not completed accurately and should have indicated the presence of wandering in the past one to three days. During an interview on 10/23/2025 at 10:07 AM, the Staff Development Coordinator/Infection Preventionist, who assumed the role of the Director of Nursing as of 10/16/2025, stated Resident #127's MDS was not accurate for wandering and she expected the MDS to be accurate and for staff to follow the RAI manual. During an interview on 10/23/2025 at 11:56 AM, the Administrator stated she expected the MDS to be accurate and for staff to follow the RAI manual.

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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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, document review, and facility policy review, the facility failed to: provide supervision for a resident identified as having exit-seeking behaviors; develop and implement interventions to prevent a resident elopement; ensure the accuracy of elopement risk assessments and timeliness of reassessment upon the identification of exit-seeking behaviors; ensure the facility's protocol for a missing resident (Code Orange) was promptly and correctly implemented when Resident #127 eloped from the facility on 05/11/2025 without staff knowledge; ensure Resident #133, identified by the facility as being at risk for elopement had their admission Record included in the facility's elopement binder; and ensure Resident #133's wander guard was securely attached. These failures affected 2 (Resident #127 and Resident #133) of 4 sampled residents reviewed for accidents. It was determined the facility's non-compliance with one or more requirements of participation had caused, or was likely to cause, serious injury, serious harm, serious impairment, or death to residents. The Immediate Jeopardy (IJ) was related to State Operations Manual, Appendix PP, F689, Accidents at a scope and severity of J. The IJ began on 05/11/2025 when Resident #127 identified by the facility as having exit-seeking behaviors, eloped from the facility without staff knowledge and the facility failed to timely and correctly implement their missing person protocol. The survey team notified the Administrator, the Staff Development Coordinator/Infection Preventionist (SDC/IP), and the Regional Director of Clinical Services of the IJ and provided the IJ template on 10/23/2025 at 4:40 PM. A removal plan was requested. The facility's removal plan was accepted by the state survey agency on 10/23/2025 at 11:20 PM. The IJ was removed on 10/24/2025, after the survey team performed onsite verification that the removal plan had been implemented. Noncompliance for F689 remained at a lower scope and severity of D, isolated, with the potential for more than minimal harm. Findings included: A facility policy titled, Elopement/Exit-Seeing Behaviors, effective 01/29/2024, revealed The Elopement Risk Tool Assessment will be used to evaluate a patient's risk of elopement/exit seeking behaviors. According to the policy, 1. Upon admission to the center, each patient will be assessed for elopement/exit seeking history and/or behaviors using the Elopement Risk Tool Assessment and 4. If a patient begins demonstrating unsafe and exit seeking behaviors after the initial admission to the center, utilize the Elopement Risk Took Assessment as needed and re-evaluate at least quarterly and update care plan accordingly.1. A facility policy titled, Code Orange, effective 01/23/2020, revealed Immediately upon notification of a missing patient [resident], Code Orange will be activated throughout the Health and Rehabilitation Center. All established search and recover plans will be initiated in full force to locate and secure the patient as quickly as possible. All staff members will be pre-assigned and trained on their duties and responsibilities during this critical event. The policy specified, Code Orange First 15 Minutes Critical Action Plan Notify: Any time a staff member identifies that a patient is missing they must immediately notify the Charge Nurse/or Supervisor. Announce: The Charge Nurse/Supervisor will immediately activate Code Orange by announcing three times the following message on the paging system: Attention All Staff Code Orange Mr./Mrs. (Patient's Name) please come to the Nursing Station. Secure: Pre-assigned staff members will immediately take their pre-assigned posts at all exit doorways. Search: Designated staff members will immediately search the entire premises sweeping all assigned perimeters both inside and outside the Center. Report: Convene in the lobby 15 minutes from the announced code to report findings from assigned perimeter sweeps. Per the policy, 5. If the patient is not found the Administrator/Assistant Administrator or DON [Director of Nursing] will assume the role of Search Coordinator. Based on the search findings reported by actions already taken by the staff, the Search Coordinator will reactivate a second 15-minute expanded search and recovery, assigning staff members to predetermined specific perimeters in and outside of the building. According to the policy, 7. If the patient is not found within thirty minutes from the initial alert the Search Coordinator will activate a Phase II Extended Search which will include contacting 911/Police, the Attending Physician, the Responsible Party, the Medical Director, the Regional [NAME] President of Operations, and Corporate Compliance Intermediary. 8. The company Missing Patient Profile Extended Search form will be copied and distributed to all search members. 9. The Administrator and his/her designated staff will continue intense search efforts with local authorities until the patient is located. 10. Documentation on the following forms is to be timely completed and submitted as directed: Missing Patient Initial Search , Phase 1 Missing Patient Profile Extended Search , Phase II An admission Record revealed

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interview, record review, document review, and facility policy review, the facility failed to ensure ordered medication was available for administration for 1 (Resident #128) of 1 sampled resident reviewed for change of condition. Findings included: A facility policy titled, General Guidelines for Medication Administration, revised 08/2020, indicated The facility had sufficient staff and a medication distribution system to ensure safe administration of medications without unnecessary interruptions. Resident #128's Admission/readmission Nursing Collection Tool V15-V2, indicated the facility admitted the resident on 08/01/2021 with a medical history to include a diagnosis of alcoholic cirrhosis. Resident #128's Order Summary Report revealed an order dated 08/01/2025, for gabapentin (a prescription medication used to treat nerve pain) capsule, 100 milligrams by mouth three times a day for alcoholic cirrhosis of liver and an order dated 08/01/2025, for sucralfate (a prescription medication used to treat ulcers) oral tablet, 1 gram give one tablet by mouth two times a day for alcoholic cirrhosis of liver. Resident #128's Care Plan Report, included a focus area initiated 08/01/2025, that indicated the resident was at risk for pain. Interventions directed staff to administer medications as ordered (initiated 08/01/2025) and observe for physical indicators of pain (initiated 08/01/2025). Resident #128's Medication Administration Record [MAR] for the timeframe 08/01/2025 - 08/31/2025, revealed no evidence to indicate the 9:00 PM dose of gabapentin and sucralfate for 08/01/2025 was administered to the resident. Per the MAR, Licensed Practical Nurse (LPN) #15 documented on the MAR a 9 for the administration of the 08/01/2025 9:00 PM dose of gabapentin and sucralfate, which indicated Other / See Progress Notes. Resident #128's progress notes for the timeframe 07/24/2025 to 08/23/2025, revealed no evidence to indicate why the 08/01/2025 9:00 PM dose of gabapentin and sucralfate were not administered to the resident. The pharmacy Delivery Manifest dated 08/02/2025 at 10:18 AM, revealed gabapentin and sucralfate were delivered to the facility from the pharmacy and signed by an LPN on 08/02/2025 at 10:04 AM. On 09/24/2025 at 12:02 PM and 09/25/2025 at 12:16 PM, a telephone interview was attempted with LPN #15, an agency nurse; however, there was no answer, and the surveyor was unable to leave a message. During an interview on 09/24/2025 at 12:06 PM, the Director of Nursing (DON) stated the pharmacy delivered medications to the facility between 11:00 PM and 12:00 midnight and the next delivery time would be the next morning. The DON stated Resident #128 arrived at the facility around 2:00 PM on 08/01/2025 and most of the resident's medications were not due to be administered until 08/02/2025. During an interview on 09/26/2025 at 11:47 AM, LPN #14 stated the facility had an automated medication management system that contained gabapentin; however, a lot of the agency nurses did not have access to the system. During an interview on 09/25/2025 at 2:50 PM, the Regional Director of Clinical Services stated that per her conversation with the pharmacy, no medication was ever pulled for the facility's automated medication management system for Resident #128.

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F 0835 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Administer the facility in a manner that enables it to use its resources effectively and efficiently. Based on interview and document review, the administrative staff failed to conduct a thorough investigation into the elopement of Resident #127 from the facility on 05/11/2025. This deficient practice affected 1 (Resident #127) of 4 sampled residents reviewed for accidents.Findings included: The Job Description for the Administrator revised 04/2023, indicated The Administrator is directly responsible for the overall successful operations of the healthcare center. The primary role of the Administrator is to plan, direct and lead the day-to-day functions of the facility in accordance with current, federal, state, and local standards, guidelines, and regulations that govern skilled nursing facilities to ensure that residents are consistently receiving care and services in line with the company's vision of Care Beyond Care. The Job Description for the Director of Nursing (DON) revised 05/2023, indicated The Director of Nursing is responsible for the overall management, supervision, and direction of the nursing services department. The DON implements and maintains nursing department goals and objectives, ensures compliance with current standards of nursing practice, company policy and procedure, as well as applicable federal, state, and local guidelines and regulations. On 05/11/2025 at 8:55 PM, Resident #127, identified by the facility as having exit-seeking behaviors, eloped from the facility without staff knowledge. Licensed Practical Nurse (LPN) #20, assigned to the care of the resident, failed to ensure the facility's missing person protocol (Code Orange) was implemented as specified. Per facility documents, the Administrator was not made aware of the resident's elopement until 10:48 PM on 05/11/2025. The facility staff failed to notify the resident's responsible party that the resident was missing. On 05/11/2025 at 11:08 PM, the resident used their cell phone and called a family member and reported they were at a baseball game, cold, and needed to be picked up. The resident's responsible party then notified the facility staff of the resident's whereabouts, and the resident was returned to the facility by the local police and a staff member. The facility's investigation file only contained a statement from LPN #20; there were no other interviews with the staff that were on duty at the time of the resident elopement or interviews with the staff that participated in the search for the resident. Refer to F689. During an interview on 10/18/2025 at 3:54 PM, the Administrator stated from a review of the facility's investigation, LPN #20 enacted the Code Orange and no other staff were interviewed during the investigation of Resident #127's elopement from the facility. The Administrator stated possibly more interviews were needed and should have been conducted. During a follow-up interview on 10/20/2025 at 10:26 AM, the Administrator stated her expectation for the investigation was that a root cause analysis was determined so that the facility would know where the break down in the process was not followed. The Administrator stated she expected there should have been interviews with all the staff that worked and everyone who participated in the Code Orange.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on interview, document review, and facility policy review, the facility failed to ensure a resident elopement involving 1 (Resident #127) of 4 sampled residents reviewed for accidents was reviewed by the facility's Quality Assurance and Performance Improvement (QAPI) committee.Findings included:On 05/11/2025 at 8:55 PM, Resident #127, identified by the facility as having exit-seeking behaviors, eloped from the facility without staff knowledge. Licensed Practical Nurse (LPN) #20, assigned to the care of the resident, failed to ensure the facility's missing person protocol (Code Orange) was implemented as specified. Per facility documents, the Administrator was not made aware of the resident's elopement until 10:48 PM on 05/11/2025. The facility staff failed to notify the resident's responsible party that the resident was missing. On 05/11/2025 at 11:08 PM, the resident used their cell phone and called a family member and reported they were at a baseball game, cold, and needed to be picked up. The resident's responsible party then notified the facility staff of the resident's whereabouts, and the resident was returned to the facility by the local police and a staff member. The facility's investigation file only contained a statement from LPN #20; there were no other interviews with the staff that were on duty at the time of the resident elopement or interviews with the staff that participated in the search for the resident. Refer to F689. A facility document titled, Quality Assurance and Performance Improvement Leadership Guide, dated 09/2017, revealed, Quality Assurance and Performance Improvement Committee The management process is vested in the Center's Quality Assurance and Performance Improvement Committee. The QAPI Committee identifies potential markers of quality within their center that may need to be evaluated or investigated. These areas may or may not represent a potential or undesirable outcome. The QAPI Committee collects and analyzes data from various sources. These sources may include, but are not limited to, internal and external audits, surveys, reports, subcommittee reports, or other administrative initiatives. The Center QAPI Committee develops and implements appropriate plans of action to correct any undesirable outcomes and monitors the effect of implemented changes, making revisions to the action plans as needed. The document indicated, At the quarterly meetings the Committee will collect and analyze potential or actual undesirable outcomes from various data sources. The sources include but are not limited to: -Reportable incidents and -Environmental/operational/safety issues related to patient/staff safety from the Safety Management Subcommittee. A facility policy titled, QAPI, effective 09/23/2024, indicated, 5. The Center maintains center specific quality clinical and service indicators that are to be monitored and improved by QAPI Committee if undesirable patterns or trends are established. The Administrator is responsible for overseeing the QAPI Committee's initiatives to sustain and/or improve quality outcomes of problems identified within his/her Center. 6. In addition to Center established indicators and surveys, the Administrator and the QAPI Committee are responsible for targeting and monitoring specific services and/or operational areas of on-going studies within the Center. These are identified as a priority for high risk, high volume, problem prone processes, or value-added care or service relationships and/or opportunities for improving dimensions of performance. Feedback is regularly obtained from multiple parties including but not limited to resident council, patient and family survey responses, and staff feedback. The Center's QAPI committee decides which process to measure and monitor and what approaches are to be implemented. During an interview on 10/18/2025 at 4:40 PM, the Staff Development Coordinator/Infection Preventionist (SDC/IP), who assumed the role of the Director of Nursing (DON) as of 10/16/2025, stated Resident #127's elopement had not been reviewed by the facility's QAPI committee. During an interview on 10/23/2025 at 11:56 AM, the Administrator stated Resident #127's elopement was not reviewed by the facility's QAPI committee. The Administrator stated she did not know why it was not reviewed in QAPI, but it should have been. During a follow-up interview on 10/25/2025 at 10:52 AM, the Administrator stated her expectation was that the QAPI committee should have reviewed Resident #127's elopement. She stated if it had been reviewed by QAPI, they could have conducted a root cause analysis to determine if there were processes that were broken; identified additional steps the facility needed to take, such as staff training; and determined whether a Performance Improvement Plan (PIP) needed to be developed.