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 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. **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. (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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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	(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 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, malignant neoplasm of brain, 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. Interventions directed staff to complete an elopement risk assessment as needed (initiated 04/22/2025). Resident #127's Elopement Risk Tool - V 4 signed by Licensed Practical Nurse (LPN) #18 and dated 04/22/2025, revealed the resident was at low risk for elopement. The Elopement Risk Tool did indicate the resident had a diagnosis of dementia/cognitive impairment. During an interview on 10/17/2025 at 3:20 PM with the Director of Nursing (DON) and the Staff Development Coordinator/Infection Preventionist (SDC/IP), the DON stated Resident #127's elopement risk assessment dated [DATE] should have been marked to indicate the resident had a diagnosis of 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. Resident #127's Order Summary Report revealed an order dated 04/23/2025, that directed staff to check the function of the resident's wander bracelet weekly every Wednesday and check the resident's wander guard band on the resident's left arm every shift. During an interview on 10/18/2025 at 6:19 PM, LPN #18 stated Resident #127 had exit-seeking behaviors and that was why a wander guard was placed on the resident. When asked if Resident #127 tried to leave the facility on 05/11/2025, LPN #18 stated around shift change, the resident walked to the door a few times and had to be redirected. Per LPN #18, geriatric psychology came to talk with the resident on 05/11/2205. Resident #127's progress note electronically signed by the Psychologist and dated 05/11/2025 at 1:00 AM, indicated the resident approached the Psychologist and reported they were ready to leave the facility on 05/11/2025 because no one would help them find out what was (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	going on with their treatment. According to the progress note, the nursing staff reported the resident tried to leave the facility a couple of times on 05/11/2025. During an interview on 10/22/2025 at 9:22 PM, the Psychologist stated over the course of the resident's stay in the facility, they tried to leave the facility a couple of times. The Psychologist stated Resident #127 had a brain tumor, bouts of paranoia and did not make connections between their symptoms and reality. The Psychologist stated he thought the best thing for the resident was to speak with the nurse practitioner first thing Monday morning (05/12/2025). The Psychologist stated he tried to settle the resident down in an attempt to convince the resident to hang in until the next morning (05/12/2025). When asked what the resident's demeanor was at the conclusion of his visit, the Psychologist stated, not in good shape and that he told the nurse that the resident needed to be checked on. Resident #127's progress note electronically signed by LPN #20 and dated 05/11/2025, indicated At resume of shift rounds resident was noted to be alert and was seating in [his/her] room watching TV. At 8pm resident still in [his/her] room where [he/she] received [his/her] night medications at 08:09pm. [Resident #127] was cooperative all through. At 08:45pm resident was walking down the hallway and said I have gotten all my medications? Writer said yes, is there anything you need? [he/she] said NO, and [he/she] sat down in the small living room between the 200 and 300 unit, [he/she] was reading a magazine. At 08:55pm writer checked on resident in small living room, [he/she] wasn't there and not in [his/her] room. Writer called the CNA [certified nursing assistant] and a search was done in the 200 unit. Writer informed other units a search was done. DON, Administrator and 911 was called. RP [responsible party] made aware. Resident #127's progress note electronically signed by LPN #20 and dated 05/11/2025 at 11:01 PM, indicated Resident [family member] called the facility informing us that resident called [their spouse], and [he/she] wants us to know this. 911 dispatched informed us that resident was identified in a nearby school compound. Resident returned with 911 officer in a stable condition. [Resident #127] also stated [he/she] took off [his/her] alarm bracelet. During an interview on 10/16/2025 at 12:32 PM, LPN #20 stated Resident #127 was an exit-seeker and on 05/11/2025 around 7:00 PM/8:00 PM, the resident was seated in the community room and she went to attend to a concern in another resident's room and when she returned, she noticed the resident was not in the community room or their room. LPN #20 stated she and another aide searched the resident's room, the bathroom, and the living room and did not find the resident. LPN #20 stated she called a Code Orange and everyone started to look for the resident. LPN #20 stated she did not hear a door alarm sound, so she felt the resident was still in the facility. LPN #20 stated they searched the inside of the facility for about 15 minutes then decided to call the Administrator, DON, and 911. LPN #20 stated when the resident returned to the facility, the resident stated they took off their wander guard. Per LPN #20, the documentation in the resident progress note that specified the resident went missing at 8:55 PM was accurate. During an interview on 10/17/2025 at 3:34 PM, LPN #17 stated she was aware Resident #127 was an elopement risk and recalled the incident when the resident eloped from the facility. According to LPN #17, LPN #20 informed her that she could not find Resident #127. LPN #17 stated they went room to room and the outside perimeter of the facility looking for the resident. LPN #17 stated she did not recall a Code Orange being announced. When asked what time Resident #127 was discovered missing, LPN #17 replied she really did not know, it was late evening after 8:00 PM. LPN #17 stated she was unaware who all LPN #20 had informed or who found the resident, but that a family member of the resident called the facility to inform the staff, Resident #127 was located at a ball field. When asked what time the police was called, LPN #20 stated she did not know. LPN #20 stated she was not sure if she completed the Code Orange paperwork. During a follow-up interview on 10/18/2025 at 4:44 PM, LPN #17 was asked if she heard anyone announce a Code Orange over the facility's intercom/paging system and she replied, no. When asked should a Code Orange have been announced, LPN #17 answered, absolutely. LPN #17 stated she was not aware what all LPN #20 did before she informed her that the resident was missing. According to LPN #17, all the staff that worked in the facility during the time the resident eloped did not participate in (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	the search for the resident. During a follow-up interview on 10/21/2025 at 3:26 PM, LPN #17 stated LPN #20 came and told her that resident was missing and she followed LPN #20 back to Unit 200 where all rooms were searched, then they searched the gym and service hall and outside perimeter of the facility. LPN #17 stated areas that had locked doors were not searched and no one was stationed at all exit doorways. When asked if other units were searched, LPN #17 stated not that she recalled, but should not speak about LPN #20 did before she was notified. LPN #17 stated it was her understanding that the resident had been missing about an hour before LPN #20 notified her the resident was missing. LPN #17 acknowledged no one from the administrative staff talked during the elopement incident investigation. Contained within the facility's investigation was written statement for an incident dated 05/11/2025 by the former Administrator, which indicated I was called at 10:48 pm on Sunday (05/11/2025) night and was notified that resident [Resident #127] was missing. During an interview on 10/17/2025 at 1:42 PM, the former Administrator stated she could not recall the details of the elopement, did not recall the name of the resident, who notified her, or how long the resident was missing but that a nursing staff member called her and she asked if a Code Orange had been called and she was told yes, so she instructed the staff to call the police. When asked why the nurse documented the resident was missing at 8:55 PM and she was not notified until 10:48 PM, the former Administrator stated she did not know why. The former Administrator stated she did recall Resident #127 informed the staff that they cut off their wander guard. The former Administrator stated the staff never found the resident's wander guard. During a follow-up interview on 10/18/2025 at 1:26 PM, the former Administrator she did not know how staff announced the Code Orange but it should have been announced over the facility's intercom system. The former Administrator explained the process for a Code Orange. Per the former Administrator, Code Orange should be announced three times over the facility's intercom system, the search should start in the inside perimeter of the facility and staff had assignments on where they should search. After 15 minutes, staff should search the outside perimeter of the facility and if not found, the search should extend to the community. When asked when the police should be called, the former Administrator stated she did not remember what the policy specified, but she had the staff to call the police immediately. The former Administrator was asked if during the investigation, did the facility determine what door the resident exited out of and she stated she did not recall. The former Administrator was asked if the facility replaced supervision of the resident with a wander guard and she replied, there was no reason to believe Resident #127 needed anything else. The former Administrator acknowledged she was not aware Resident #127 voiced to the Psychologist earlier in the day (on 05/11/2025) that they wanted to leave the facility. During an interview on 10/18/2025 at 10:38 PM, a dispatcher with the local police department stated a nurse named (LPN #20) called the police department on 05/11/2025 at 10:52 PM and reported a resident was missing. During an interview on 10/20/2025 at 10:42 AM, a sergeant with the local police department stated on 05/11/2025 at 11:22 PM, the resident was found by a police officer at the baseball park. Per the sergeant, a family member of the resident called the police department at 11:18 PM and stated they pinged the resident's cell phone and notified the local police. During an interview on 10/17/2025 at 3:13 PM, the Administrator acknowledged she did not work at the facility when Resident #127 eloped. The Administrator stated it was the facility's policy that administration be notified immediately when a resident was noted to be missing. When asked what interventions were in place to prevent the resident from eloping from the facility, the Administrator replied, a wander guard. During a follow-up 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. Per the Administrator, there was no documentation to indicate LPN #20 announced the Code Orange as specified in the facility's policy. During an interview on 10/21/2025 at 1:37 PM, the Maintenance Director stated a resident could only have exited out of the front door of the facility (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	facility ever called them to notify them the resident was missing. During a follow-up interview on 10/22/2025 3:44 PM, Resident #133's RP stated they had the resident' cell phone call log for 05/11/2025, which showed the resident called them on 05/11/2025 at 11:08 PM to report they were at the baseball game, cold, and needed to be picked up. Review of Talk activity documentation for the billing period 04/21/2025 - 05/20/2025, provided by Resident #133's RP revealed a call from the resident's cell phone number to RP on 05/11/2025 at 11:08 PM During an 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. Per the Administrator, she would expect the resident's elopement risk assessment to be accurate. 2. An admission Record revealed the facility admitted Resident #133 on 08/09/2025. According to the admission Record, the resident had a medical history that included diagnoses of muscle weakness, lack of coordination, and dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/15/2025, revealed Resident #133 had a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident had moderate cognitive impairment. Resident #133's Elopement Risk Tool - V 4 signed by Licensed Practical Nurse (LPN) #9 and dated 08/09/2025, revealed the resident was at low risk for elopement. The Elopement Risk Tool did indicate the resident had a diagnosis of dementia/cognitive impairment. Resident #133's Behavior Note electronically signed by LPN #21 and dated 09/19/2025 at 6:45 AM, indicated the resident tried to exit the door and set off the alarm. Resident #133's Behavior Note electronically signed by LPN #5 and dated 09/22/2025 at 11:50 AM, indicated the resident attempted to get out of the side door on Unit 400. Resident #133's Behavior Note electronically signed by LPN #5 and dated 09/24/2025 at 3:17 PM, indicated the resident attempted to exit the door on Unit 400. Resident #133's medical record revealed no evidence of a completed Elopement Risk Tool Assessment once the resident displayed exit seeking behaviors on 09/19/2025, 09/22/2025, and 09/24/2025. Resident #133's Order Summary Report contained an order dated 10/13/2025, for a wander guard to left ankle, check placement every shift and an order dated 10/16/2025, to begin 10/22/2025, to check wander guard function every Wednesday.Resident #133's Care Plan Report included a focus area initiated 10/14/2025, that indicated the resident was at risk for elopement related to dementia and exit seeking. Interventions directed staff to check wander guard function weekly, placement every shift, and replace elopement band as needed (initiated 10/16/2025) and complete an elopement risk assessment as needed (initiated 10/14/2025).During a concurrent observation of the front desk and interview on 10/19/2025 at 2:25 PM, the Administrator showed the surveyor a binder and stated the binder contained a picture and face sheet (admission record) of all the residents who had a wander guard. The binder did not contain the picture and face sheet for Resident #133. During an interview on 10/19/2025 at 2:43 PM, the Administrator confirmed Resident #133's information was missing from the binder. During an interview on 10/19/2025 at 2:29 PM, Service Ambassador (SA) #24 stated there was an elopement book at the desk that contained pictures of the residents. SA #24 stated if a resident got close to the door and the alarm sounded, he looked in the book to see if the resident's photo was in the book. Per SA #24, if the resident's picture was not in the book, the resident was free to leave the facility. During an interview on 10/20/2025 at 1:16 PM, SA #25 stated she had the responsibility to ensure no resident with a wander guard exited the facility without staff knowledge. SA #25 stated the only way she knew which resident wore a wander guard was the reference binder. Resident #133's Behavior Note electronically signed by LPN #5 and dated 10/17/2025 at 10:52 AM, indicated the resident removed their wander guard from their left ankle and their responsible party (RP) replaced it. During a telephone interview on 10/19/2025, Resident #133's RP stated when they visited the resident on 10/17/2025, the resident was in bed asleep during the entire visit and they found Resident #133's wander guard on the resident's dresser. The RP stated they asked the nurse and was told it was a wander guard and it should be on the (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	resident. The RP stated they did not know how the resident took the wander guard off, but they (RP) placed it back on Resident #133. The RP stated they got the impression that the certified nursing assistants and nurses knew the wander guard was not on the resident. During a telephone interview on 10/20/2025 at 3:57 PM, LPN #5 was asked about what happened with Resident #133's wander guard on 10/17/2025. LPN #5 stated Resident #133's RP came out of the resident's room and asked if the resident was supposed to be wearing the wander guard. LPN #5 stated she replied yes and Resident #133's RP informed her that the resident did not have the wander guard on and that they (RP) placed it back on the resident. LPN #5 acknowledged Resident #133 had exit-seeking behavior and on 09/24/2025, the resident pushed the door on Unit 400 and the alarm sounded. During an interview on 10/19/2025 at 4:39 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 she was not aware Resident #133 removed their wander guard on 10/17/2025 as no one reported it to her. The SDC/IP confirmed the resident's care plan was not updated to include the resident removed their wander guard and there was not increased monitoring of the resident. Per the SDC/IP, the nurse should have used all available resources to ensure the resident's safety and determine what enabled the resident to remove their wander guard. The SDC/IP acknowledged Resident #133's elopement risk assessment dated [DATE] was not accurate as it did not reference the resident's dementia diagnosis. According to the SDC/IP, another elopement risk assessment should have been completed when the resident displayed exit-seeking behavior on 09/19/2025, 09/22/2025, and 09/24/2024. The SDC/IP states she expected the elopement risk assessments to be accurate and that if it could not confidently determine how a wander guard was removed, the event was likely to recur and staff would need to implement different interventions. During an interview on 10/20/2025 at 1:33 PM, LPN #21 stated she was familiar with Resident #133. When asked if Resident #133 displayed exit-seeking behavior, LPN #21 replied yes and stated the resident went around the facility looking for a way out and would state they needed to find a way out. LPN #21 stated on 09/19/2025, Resident #133 pushed on the door and the alarm sounded and the resident kicked her when she attempted to redirect the resident. When asked if she was supposed to do an assessment (elopement risk assessment) of the resident, LPN #21 replied she did not know. During an interview on 10/20/2025 at 10:26 AM, the Administrator stated she expected the staff to notify the DON when a resident's wander guard was removed and/or not on the resident as assessed. Per the Administrator, she expected the elopement risk assessment to be accurate and that the interdisciplinary team meet to discuss when a resident displayed exit-seeking behavior. During a follow interview on 10/23/2025 at 10:07 AM, the SDC/IP stated an elopement risk assessment should be completed when a resident admitted to the resident, quarterly, and as-needed. When asked what was meant by as-needed, the SDC/IP, stated if an assessment was incorrect. During a follow-up interview on 10/23/2025 at 11:56 AM, the Administrator stated she expected staff to complete an elopement risk assessment when the resident admitted to the facility, quarterly, and whenever the resident had exit-seeking behaviors. The facility submitted a removal plan that was accepted by the state survey agency on 10/23/2025 at 11:20 PM. The removal plan indicated the following: F689 Accidents and Hazards Removal Plan1. Plan Corrective Action for those residents found to be affected by the deficient practice:Resident #127 was placed on 1:1 supervision to ensure safety and to not leave the building unattended once returned to the building on 05/11/2025. Resident #127 was evaluated by nursing staff with no new impairments on 05/11/2025 and seen by the nurse practitioner (NP) on 05/12/2025. Resident remained on 1:1 supervision and discharged from the facility on 05/20/2025. Resident #133 was placed on 1:1 supervision as a precaution on 10/20/2025. The [wander guard] was placed back on the resident and secured the same day it was observed to be off on 10/17/2025. admission Record for Resident #133 was placed in the elopement binder at the front desk on 10/19/2025, all other binders on the units were already updated. 2. Corrective Actions taken for residents with potential to be affected by deficient practice:All residents who are at risk of elopement have the potential to be (continued on next page)

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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	affected by this deficient practice. The facility licensed nursing staff will conduct new elopement assessments on all residents to determine elopement risk on 10/23/2025 with follow-up based on findings. Any newly identified residents will be assessed for a [wander guard] by Director of Nursing, and it will be placed appropriately. The order and

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to organize and participate in resident/family groups in the facility. Based on interview, record review, document review, and facility policy review, the facility failed to ensure prompt resolution of grievances voiced by 3 (Residents #72, #80, and #96) of 8 residents who attended the Resident Council meeting.Findings included: A facility policy titled, Service Concerns/Grievances, effective 03/01/2025, indicated, The Administrator is responsible for ensuring that the management staff are trained in appropriately resolving in-house patient/family service concerns and grievances at the point of service as promptly as possible. The management staff of the Health and Rehabilitation Center is charged with listening and responding to questions, needs, problems, or concerns brought to their attention by patients and/or families within the Health and Rehabilitation Center. The patient has the right to voice/file grievances/complaints without fear of discrimination or reprisal. The Administrator serves as the grievance official of the Center and is responsible for overseeing the grievance process and for receiving and tracking to their conclusion. During the Resident Council meeting on 09/23/2025 at 1:41 PM, Resident #72 stated they have asked over and over again about the stickiness on the floor on the 200 Hall. Resident 372 stated it did not matter when one went to the 200 Hall that the floor was always nasty and sticky. Resident #72 stated they talked about it all time and was told by staff they would look at it. Resident #72 told the surveyor that if they went to the 200 Hall, they would guarantee them that the floor would be sticky. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/04/2025, revealed Resident #72 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. Resident #96 stated since they have been in the facility, the floors have not been cleaned. According to Resident #96, they have asked and asked for the floors to be shampooed but nothing has happened. A quarterly MDS, with an ARD of 08/02/2025, revealed Resident #96 had a BIMS score of 15, which indicated the resident had intact cognition. Resident #80 stated the hallway on the 200 Hall was nasty and there were stains everywhere in the carpet that was peeling. A quarterly MDS, with an ARD of 07/28/2025, revealed Resident #80 had a BIMS score of 15, which indicated the resident had intact cognition. The Resident Council minutes for the time frame 03/2025 to 08/2025 revealed the following concerns were reported by the residents during the Resident Council meeting:-On 05/29/2025, the residents voiced the carpets needed to be shampooed more often.-On 06/26/2025, the residents voiced the dining areas were dirty and the carpet in the rooms needed to be shampooed more often.-On 07/31/2025, the residents voiced the dining room floors were sticky.-On 08/28/2025, the residents voiced the carpet needed to vacuumed and shampooed more often. During an interview on 09/24/2025 at 3:35 PM, the Housekeeping Director (HD) stated she did not have anything to show that the concerns expressed by the residents had been followed up on. During a concurrent interview and observation of the 200 Hall on 09/25/2025 at 11:44 AM with the HD, the surveyor noted the floor in the dining room was dirty and had a sticky glaze on the floor. The HD stated the floor stayed that way and the staff tried to mop it regularly. The HD confirmed the carpet was heavily stained and frayed and needed to be replaced. According to the HD, the facility's brushing machine had been broken, and they had not been able to shampoo the carpet. During an interview on 09/26/2025 at 10:40 AM, the Director of Nursing stated she expected a follow-up to all grievances voiced by the residents during the Resident Council meeting. During an interview on 09/26/2025 at 11:08 AM. The Administrator stated grievances voiced during the Resident Council meeting should be addressed.

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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, interview, record review, and facility policy review, the facility failed to promote the dignity of 6 (Residents #7, #8, #41, #47, #97, and #112) of 27 sampled residents. Specifically, staff failed to knock and gain permission before they entered the room of Resident #41 and Resident #112; failed to perform a fingerstick blood sugar reading for Resident #7 in a private area; and failed to serve the lunch meal for Residents #8, #47, and #97, who were all seated at a table together at the same time.Findings included: A facility policy titled, Resident Rights Annual Review, dated 02/2004 revealed, It is the policy at this Healthcare Center that all Residents shall have the following rights and privileges: Per the policy, 12. To be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs. 1. An admission Record revealed the facility admitted Resident #112 on 05/20/2021. According to the admission Record, the resident had a medical history that included a diagnosis of dementia. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/18/2025, revealed Resident #112 had a Brief Interview for Mental Status (BIMS) score of 6, which indicated the resident had severe cognitive impairment. During a concurrent interview and observation on 09/22/2025 at 10:02 AM, Licensed Practical Nurse (LPN) #5 walked into Resident #112's room and did not knock at the door or ask permission to enter the resident's room LPN #5 proceeded into the room and handed the resident a medicine cup with pills and a cup of water and did not communicate with the resident until she was exiting the room, when she told the resident that she would be back with the resident's treatment. Resident #112 stated the staff never knocked before they entered their room and always just walked right in. Resident #112 stated, I wish they would knock. During an interview on 09/24/2025 at 9:29 AM, LPN #5 stated the facility process was to knock on the door and tell the resident that she had their medication and tell them who she was because some residents forgot. LPN #5 stated that when knocking at residents' doors, sometimes she waited to be invited in and If the door was closed, she waited, but if the door was opened, she was able to see the resident she would announce herself and then go on in. LPN #5 stated it was oversight on her part, that she was rushing on 09/22/2025 when she did not knock or request permission to enter Resident #112's room. 2. An admission Record revealed the facility admitted Resident #7 on 12/17/2021. According to the admission Record, the resident had a medical history that included a diagnosis of type 2 diabetes mellitus. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/11/2025, revealed Resident #7 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. Resident #7's Care Plan Report included a focus area initiated 07/08/2025, that indicated the resident was at risk for complication and blood glucose fluctuations related to a diagnosis of diabetes mellitus with insulin use. Interventions directed the staff to administer insulin and medications as ordered. (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation on 09/23/2025 at 12:16 PM, Licensed Practical Nurse (LPN) #3 entered the dining area and performed a fingerstick blood sugar on Resident #7, while the resident was seated at a dining table with other residents. There was a total of 11 residents in the dining area and one visitor. During an observation on 09/23/2025 at 12:52 PM, Certified Nursing Assistant (CNA) #4 approached the dining table and started to feed Resident #7 their lunch meal, while she stood over the resident. At 12:59 PM, CNA #4 left Resident #7 to deliver a meal tray to a resident's room. At 1:02 PM, CNA #4 came back to Resident #7 and continued to feed the resident while she stood over the resident. During an interview on 09/23/2025 at 1:12 PM, LPN #3 confirmed he completed Resident #7's fingerstick blood sugar reading while the resident was at the dining table. During an interview on 09/23/2025 at 1:08 PM, CNA #4 stated she was the person assigned to feed Resident #7 and that she usually would sit down next to the resident and give them a bite of each item on their plate, but on 09/23/2025, she stood up and fed the resident because it was just easier. 3. An admission Record revealed the facility admitted Resident #41 on 02/22/2016. According to the admission Record, the resident had a medical history that included a diagnosis of mild cognitive impairment. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/12/2025, revealed Resident #41 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated the resident had severe cognitive impairment. During an observation on 09/24/2025 at 9:23 AM, Certified Nursing Assistant (CNA) #2 entered Resident #41's room and did not knock or announce herself before she entered the resident's room. During an interview on 09/24/2025 at 9:26 AM, CNA #2 stated when entering a resident's room, the process was to knock before entering the room, introduce yourself, self, and if the resident was up, to ask them if they needed anything. CNA #2 stated she did not remember knocking before she entered Resident #41's room but did talk to the resident. CNA #2 stated she did not know why she did not knock before she entered the resident's room, and that she was not thinking about it. During an interview on 09/26/2025 at 9:03 AM, the Director of Nursing (DON) stated fingerstick blood sugar checks should happen based on the physician order and should be done in an area of privacy of the resident's choosing. The DON stated she expected the resident be moved to a private area to complete their fingerstick blood sugar check. The DON stated regarding standing to feed residents and interrupted feeding of a dependent resident, residents were to be gathered in the dining room, and those residents who needed assistance were to be seated in close proximity. The DON stated she expected the residents to be served their meals at the same time and the staff should sit down to feed the resident and engage them in conversation. The DON stated she expected the residents to have an uninterrupted meal experience. During an interview 09/26/2025 at 11:20 AM, the Administrator stated that related to dignity while doing medications, the process was that the nurse should ask the resident if they wanted to do it in private, or did they want to do it in an opened area. Per the Administrator, staff should encourage residents to go to another area. The Administrator stated her expectations were that medical procedures should not be done in opened areas. The Administrator stated related to staff standing (continued on next page)

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	while feeding residents and uninterrupted feeding of dependent residents, staff should be seated next to the resident and feed one resident at a time. According to the Administrator, the CNA should sit next to the resident for the entire meal, and she expected the staff stay with the resident for the entirety of the meal, seated. 4. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 07/31/2025, revealed the facility admitted Resident #8 on 11/14/2021. The MDS indicated Resident #8 had a Brief Interview for Mental Status (BIMS) score of 4, which indicated the resident had severe cognitive impairment. The MDS indicated the resident required substantial/maximal assistance with eating. A MDS, with an ARD of 08/16/2025, revealed the facility admitted Resident #47 on 02/07/2025. The MDS indicated the resident had Staff Assessment for Mental Status (SAMS) that indicated the resident was severely impaired in cognitive skills for daily decision making. The MDS indicated the resident required extensive assistance of one person for eating. A MDS, with an ARD of 09/04/2025, revealed the facility admitted Resident #97 on 04/13/2023. The MDS indicated Resident #97 had a BIMS score of 2, which indicated the resident had severe cognitive impairment. The MDS indicated the resident was totally dependent on staff for eating. During an observation of the lunch meal on 09/23/2025 at 12:29 PM, the surveyor noted Residents #8, #47, and #97 were seated at a table in the dining room awaiting their lunch meal. At 12:55 PM, Resident # 8 received their meal tray and began to feed themself while Resident #47 and Resident #97 continued to wait for their meal. Resident # 47 received their meal at 1:03 PM and Resident # 97 received their meal tray at 1:06 PM. During an interview on 09/25/2025 at 11:02 AM, CNA #7 stated Residents #8, #47, and #97, were all seated at the table together, should have been served at the same time, but they were not. During an interview on 09/25/2025 at 11:29 AM, the Director of Nursing (DON) stated staff were to serve the residents in the dining room and then those on the floor. Per the DON, all residents in the dining areas were supposed to be served at the same time. During an interview on 09/25/2025 at 11:54 AM, the Administrator stated she expected all residents seated together should be served their meal tray at the same time.

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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. Based on observation, interview, record review, and facility policy review, the facility failed to conduct an ongoing quarterly assessment to determine if a resident could safely administer their medication(s) as directed by the facility policy for 1 (Resident #72) of 2 sampled residents reviewed for choices. The facility further failed to have evidence of a completed assessment to determine if a resident was able to self-administer their albuterol inhaler for 1 (Resident #87) of 2 sampled residents reviewed for choices. Findings included: A facility policy titled, Self-Administration of Medication at Bedside, effective 01/29/2024, revealed, Policy A licensed nurse will assess patient's ability to self-administer medication. Procedure 1. The patient may request to keep medications at bedside for self-administration in a lock box. 2. Complete Medication Self-Administration Safety Screen assessment. 3. The Interdisciplinary Team will review the assessment and together, use clinical judgement to determine if the patient is eligible. 4. If eligible, medications that are ordered by a provider to be self-administered will be identified in the medical record. 5. A licensed nurse will monitor and chart self-administered medications and will monitor for proper storage on each medication pass. 6. The Medication Self-Administration Safety Screen assessment will be reviewed quarterly by the Interdisciplinary Team. 1. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 09/04/2025, revealed the facility admitted Resident #72 on 03/17/2023. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. According to the MDS, the resident had active diagnoses to include heart failure, hypertension, and diabetes mellitus. Resident #72's Care Plan Report included a focus area initiated 02/20/2024 and revised 09/12/2025 that indicated the resident preferred to self-administer their medications. Interventions directed staff to review self-administration safety screens quarterly and as needed with change of condition (initiated 02/20/2024), provide bedside lockbox (initiated 02/202/2024), and the interdisciplinary team would reassess appropriateness of self-administration as needed (initiated 02/20/2024). Resident #72's Medication Self-Administration Safety Screen – V 1, dated 08/16/2024, revealed, Ongoinf [Ongoing] assessment should occur at a minimum of quarterly. Review of Resident #72's medical record revealed no evidence to indicate staff completed an ongoing assessment at a minimum of quarterly. During a concurrent interview and observation on 09/22/2025 at 11:18 AM, Resident #72 stated they self-administered their medications. The surveyor noted a locked black utility box in the resident's room. Per Resident #72, the locked box contained their medications. During an interview on 09/26/2025 at 7:58 AM, the Director of Nursing (DON) stated if a resident desired to self-administer their medication, the interdisciplinary team assessed the resident and once the resident was approved, a care plan was implemented, and a quarterly assessment should be conducted to determine if the resident was still appropriate to self-administer their medication(s). The DON acknowledged a quarterly assessment had not been completed for Resident #72 since the assessment was completed 08/16/2024. During an interview on 09/26/2025 at 11:33 AM, the Administrator stated she expected a resident to (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	be assessed quarterly to determine if a resident was still able to self-administer their medication(s). 2. An admission Record revealed the facility admitted Resident #87 on 01/23/2025. According to the admission Record, the resident had a medical history that included diagnoses of emphysema, chronic respiratory failure, and anxiety disorder. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/012025, revealed Resident #87 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. Resident #87's Care Plan Report included a focus area initiated 04/30/2025, that indicated the resident preferred to self-administer their inhaled medications. Resident #87's Order Summary Report revealed an order dated 01/24/2025, for Atrovent HFA inhalation aerosol solution 17 micrograms per actuation, inhale two puffs orally four times a day for chronic obstructive pulmonary disease unsupervised self-administration. Resident #87's medical chart revealed no evidence of a medication self-administration safety screen assessment During a concurrent observation and interview on 09/22/2025 at 2:32 PM, Resident #87 was observed with an inhaler in the left breast pocket on their shirt. Resident #87 stated They know I have it and explained they kept their inhaler on them in case of an emergency. Resident #87 stated they got short winded and liked to have their inhaler on them, so they did not have to wait on the staff to bring it to them. Resident #87 stated they did their own breathing treatments. it. During an interview on 09/24/2025 at 12:51 PM, Certified Nursing Assistant #11 stated Resident #87 administered their inhaler and kept it in their pocket or the top drawer in their room. During an interview on 09/24/2025 at 2:57 PM, Registered Nurse (RN) #12 stated Resident #87 kept their albuterol inhaler in their pocket and administered the medication whenever it was needed. RN #12 stated the resident liked to keep it in case of an emergency as it made them feel safe. Per RN #12, the resident should have an assessment to self-administer the medication, but she was not sure the resident did. During an interview on 09/26/2025 at 7:58 AM, the Director of Nursing stated if a resident desired to self-administer their medication, the interdisciplinary team assessed the resident and once the resident was approved, a care plan was implemented, and a quarterly assessment should be conducted to determine if the resident was still appropriate to self-administer their medication(s). During an interview on 09/26/2025 at 11:33 AM, the Administrator stated she expected a resident to be assessed quarterly to determine if a resident was still able to self-administer their medication(s).

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

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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. 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 (continued on next page)

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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.

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F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. Based on observation, interview, record review, document review, and facility policy review, the facility failed to ensure 1 (Resident #5) of 27 sampled residents' rooms was free of pests.Findings included: A facility policy titled, Pest Control, effected 01/01/2019, indicated Policy: The Center environment will be monthly inspected and treated for pests by a corporate-approved contractor. A pest service receipt dated 06/30/2025, revealed pest control maintenance was completed on 06/30/2025. The facility was unable to provide any other documentation of monthly inspections for pest control as specified in their policy. A quarterly Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 08/17/2025, revealed the facility admitted Resident #5 on 05/02/2017. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident had intact cognition. Per the MDS, Resident #5 had active diagnoses to include stroke, heart failure and hypertension. During a concurrent observation and interview on 09/22/2025 at 3:53 PM, Resident #5 stated they always had to kill stink bugs in their room. The surveyor noted 20 dead stink bugs on the floor that led to the outside area and two stink bugs were noted to crawl on the curtain and ceiling in the resident's room. Resident #5 stated they asked for the area to be sprayed but was told it could not be due to the other residents in the room. During a concurrent observation and interview on 09/23/2025 at 8:30 AM, the surveyor noted dead bugs on the floor of Resident #5's room that led to the patio. Resident #5 stated the bugs on the floor were the same ones from 09/22/2025. Resident #5 stated the bugs were pointed out to the staff, but nobody had done anything. According to Resident #5, the Maintenance Director informed them that he could not spray or do anything about the bugs. During a concurrent observation and interview on 09/23/2025 at 12:22 PM, the surveyor noted 18 dead stink bugs on the floor and four stink bugs that were alive on Resident #5's window and curtains. Resident #5 stated those were new bugs that they killed on 09/23/2025. During a concurrent observation and interview on 09/25/2025 at 10:40 AM, the Maintenance Director stated 09/25/2025 was his second day working in the facility. Per the Maintenance Director, the previous Maintenance Director left about two weeks ago, and the maintenance technician was on vacation. When the surveyor and the Maintenance Director entered Resident #5's room, the Maintenance Director stated he saw why there were stink bugs in the resident's room. The Maintenance Director stated there was a gap in the door around the seal to the wall that allowed the bugs to enter the resident's room. The Maintenance Director stated she would get the area fixed. During an interview on 09/25/2025 at 11:42 AM, the Director of Nursing stated she was not aware of a concern in Resident #5's room with bugs or a gap in the door which allowed bugs to enter the resident's room. During an interview on 09/25/2025 at 11:48 AM, the Administrator stated she was not aware of a concern in Resident #5's room with bugs.