STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495225	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Canterbury Blue RI	250 Pantops Mountain Rd Charlottesville, VA 22911

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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 - Actual harm 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, resident, staff, and family interviews, the facility staff failed to ensure safe transfer from bed to wheelchair for one (1) of 24 residents (Resident #7) in the survey sample, which resulted in harm, sustaining a right hip fracture. The findings included: Resident #7 was originally admitted to the facility on [DATE] and most recently transferred to the local hospital on 4/10/26, diagnosed with a hip fracture and readmitted to the nursing facility on 4/15/26. The current diagnoses included: incomplete paraplegia and relapsing remitting Multiple Sclerosis.The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 03/02/26, coded the resident as having completed the Brief Interview for Mental Status (BIMS) and scoring 15 out of a possible 15. This indicated that Resident #7's cognitive abilities for daily decision-making were intact. [NAME] BlvdIn section GG (Functional Abilities), the resident was coded as dependent in personal hygiene, upper-body dressing, lower-body dressing, toileting hygiene, oral hygiene, shower/bathe self, and chair-bed-to-chair transfer. The resident required set-up/clean-up and assistance with eating.The person-centered care plan dated 3/03/26, read that Resident #7 has a self-care deficit relating to muscle weakness, multiple sclerosis, arthritis, and functional limitation in the range of motion to bilateral upper/lower extremities. The goal is for the resident to maintain the current level of function in the Activities of Daily Living (ADL) through the next review date. The interventions include a Hoyer lift (brand name for full mechanical lift) with 2 staff for all transfers and PT recommendations; turn/rotate every 2 hours for skin integrity; transfer to a wheelchair once a day. A review of the facility synopsis of the event dated 4/10/26 read that a Registered Nurse (RN) was alerted by two Certified Nursing Assistants (CNAs) on 4/10/26 (CNAs) stating the wheelchair had toppled over when in the resident's room, providing care, and she fell from the chair. Employee action: The wheelchair was pulled from the floor immediately and investigation was initiated. Registered Nurse was alerted by two Certified Nursing Assistants on 4/10/26 (CNAs) stating the wheelchair had toppled over when in the resident's room, providing care, and she fell from the chair. Employee action: Registered Nurse (RN) to assess and comfort resident; the Director of Nursing (DON) notified who came immediately to assist with assessment; Medical Doctor (MD) and Responsible Party (RP) notified, and resident was sent to the hospital. The wheelchair was pulled from the floor immediately and investigation initiated. A review of the medical progress notes dated 4/10/26 at 5:48 pm noted that Resident #7 fell out of her wheelchair when the back of the wheelchair collapsed, throwing the resident from the wheelchair. The resident sustained a hip fracture because of the incident.A review of the hospital Emergency Department notes dated 4/10/26 read that the resident was diagnosed with an acute closed right hip (Femoral neck) fracture after a fall from a wheelchair transfer at her facility.On 4/15/26 at approximately 3:25 pm., an interview was conducted with the resident's Family Member (FM) #1. The resident's family member said he received a call from the resident's caregiver, who reported that the resident had been dropped from the Hoyer lift during a bed-to-wheelchair transfer and had slid out of the wheelchair. The family member said that he received a call from the doctor at the hospital saying that her hip is broken.On 4/15/26, at approximately 3:55 PM, an interview was conducted with (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 - Actual harm Residents Affected - Few	Resident #7, who had been admitted to the facility that day. Resident #7 was observed lying in her bed with FM#2 (husband) sitting at the bedside. Resident #7 and FM#2 said, We don't know what actually happened, except that I (Resident #7) fell out of the wheelchair during transfer from my bed and broke my hip.On 4/15/26 at approximately 4:00 pm., an interview was conducted with Certified Nursing Assistant (CNA) #3. CNA #3 said she was informed by nursing staff that, as the resident was being transferred via Hoyer lift from her bed to her wheelchair, the backrest malfunctioned and gave way, causing the resident to slide.On 4/15/26, an interview was conducted at approximately 4:20 pm with the Assistant Director of Nursing (ADON). The ADON said that she wasn't present but was told that during the Hoyer lift transfer from the resident's bed to the wheelchair, the wheelchair collapsed after the transfer was completed. The ADON also said that the wheelchair was a high-back chair, but she had never known of a wheelchair collapsing in the facility.On 4/15/26 at approximately 4:38 pm, an interview was conducted with CNA #1. CNA #1 said that she and another aide (CNA #2) transferred the resident from bed to wheelchair using a Hoyer lift, the chair lock located in the back of the chair to help the chair recline, and sat up quickly, causing the resident to slide down to the foot pedal, onto the floor. CNA #1 said, Her hip went to the front of the wheelchair, and she slid out onto the floor. She slid onto the foot pedal and the floor. I stayed with the resident. A nurse (RN #1) was in the room. I called interim Director of Nursing/IDON), they took over. It took about 5 minutes before the ambulance arrived. The witness statement of CNA #1 read as follows: CNA #2 was assisting me with transferring the resident from the bed to the chair via hoyer. We had transferred her to the chair and disconnected the sling and pulled the hoyer machine away. When we transfer the resident it is best to have the back of the chair reclined once we had her in the chair, we tried to raise the back of the chair up so resident would sit straight up. When we released the brakes and had the back set up it suddenly unlocked and the back fell sending the resident sliding forward out of the chair. The resident landed on the floor, with the foot pedals under her legs, her feet had slid under the radiator on the wall. On 4/15/26 at approximately 4:44 pm, a return phone call was received from CNA #2 concerning the above-mentioned incident. CNA #2 said that while she was helping another CNA (CNA #1) to transfer a resident from bed via Hoyer lift to her wheelchair, as she unhooked the Hoyer lift, the backrest of the wheelchair broke down, causing the resident to slide to the floor. CNA #2 also mentioned they tried to lift the resident up, but couldn't move her, The wheels were locked, and the transfer was complete. We had removed the Hoyer pads from the lift. I stood along the side of the chair (wheelchair), and it broke down. I had never had issues with wheelchairs before.On 4/15/26 at approximately 5:10 pm, an interview was conducted with the Occupational Therapist (OT) and with the Physical Therapist (PT). The OT said that the Resident's wheelchair was a Tilt and Space Chair with elevating leg rests to provide pressure relief. The PT said they examined the wheelchair after the incident but were not able to determine a malfunction. On 4/15/26 at approximately 5:30 pm, an interview was conducted with the Director of Facilities (DOF). The DOF demonstrated, using the actual Tilt and Space wheelchair with elevating legs used during the transfer of Resident #7, that the wheelchair could be safely positioned. The DOF said no mechanical issues were found, but they have removed similar wheelchairs from a few residents pending further investigations.The following were inconsistencies surrounding the incident that resulted in Resident #7's hip fracture on 4/10/26:Facility synopsis of event dated 4/10/26, the wheelchair toppled over the resident, and she fell from the chair.Medical progress notes dated 4/10/26 at 5:48 pm indicated the resident fell out of her wheelchair when the back of the wheelchair collapsed, throwing the resident from the wheelchair.Review of the ER notes dated 4/10/26, acute closed right hip (Femoral Neck) fracture after a fall from the wheelchair.During an interview with FM#1 on 4/15/26 at 3:25 pm, the facility said that the resident slid from the wheelchair.During an interview with FM#2 and Resident #7 on 4/15/26 at 3:55 pm, they were not sure how it happened but were told a hip fracture resulted from a fall out of the wheelchair during transfer from bed.During the interview with CNA#1 on 4/15/26 at 4:38 pm, after the resident was transferred to the wheelchair using the Hoyer lift, the back of the chair sat up quickly, causing the resident to (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	slide down to the foot pedal onto the floor. This same CNA's written statement indicated she and another CNA tried to raise the back of the chair up so the resident could sit up straight, and when they released the brakes and had the back straight up, it suddenly unlocked and the back fell, sending the resident forward out of the chair to the floor with the foot pedals under her legs, her feet slid under the radiator.During an interview with the CNA (#2) on 4/15/26 at 4:44 pm, who assisted with the transfer, the back of the wheelchair broke down, causing the resident to slide to the floor.During an interview with OT and PT on 4/15/26 at 5:10 pm, they were not able to determine a malfunction of the wheelchair. On 4/15/26 at approximately 7:25 pm, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. The administrator said that the manufacturer is coming to check all wheelchairs in the facility on Friday. An opportunity was offered to the facility's staff to present additional information, but none was presented.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident and staff interviews, and a review of clinical records, the facility staff failed to accurately assess and classify an open wound for 1 of 24 residents (Resident #30) in the survey sample. The findings included: Resident #30 was admitted to the facility on [DATE]. The residents' current diagnoses included a stroke with left hemiplegia. The significant change Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 04/03/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 11 out of 15. This indicated that Resident #30's cognitive abilities for daily decision-making were moderately impaired. The resident's person-centered care plan with a revision date of 3/27/26 stated that the resident had an activity of daily living self-care performance deficit related to an activity intolerance, Disease Process, and limited mobility. The goal stated that the resident would maintain the current level of function through the review date. The interventions stated to provide substantial/maximal assistance for oral/dental care, total care with showering/bathing, bed mobility, personal hygiene, dressing, transfers, and toileting, and set-up assistance for eating.On 4/3/26, a Braden Scale assessment was completed, yielding a score of 11. The document stated that if the score was 14 or below, obtain treatment orders and place them on the Treatment Administration Record; notify the Registered Dietitian for supplements; obtain an air mattress for the bed; enter a task to turn and reposition the resident every 2 hours; and notify the physician and family. A review of the Physician's Order Summary revealed an order dated 4/13/26 to clean any sheared areas on the buttocks and sacrum with normal saline or Vashe, cover the areas with Xeroform, and apply Allevyn every day until healed.On 3/31/26 at 1:48 PM, a nurses' note stated that the Writer noted new unstageable eschar on midline sacrum when dressings were changed: vertical strip of lt. brown eschar measures 4x1cm. max LxW. Denuded areas on R buttock have slowly decreased in number. Dr. [NAME] was asked to come assess areas and he agree with plan to continue Xeroform and Allevyns QD. RP has been updated. Staff trialled a Texas cath but can't anchor it reliably 2/2 skin damage risk so it comes off. MD asked that it be used as able.On 4/14/26 at 4:08 PM, a nurses' note stated that Writer obtained an order from MD for OT to address pressure-relief measures when resident is seated in his recliner. Superficial skin damage related to incontinence has progressed to an unstageable area over R aspect of lower sacrum: area was assessed with NP Monday and will be re-checked tomorrow to determine needed tx changes. RP is already aware of area and skin changes and was pleased with plan for OT intervention--they are already addressing WC positioning.The resident's wounds were observed on 4/15/26 at 1:45 PM by the Clinical Care Coordinator (CCC). The wound to the right buttock was large and appeared to be 2 areas at one point. It was clean and presented with epithelial tissue. The sacral wound was much smaller, measuring approximately 1.5 cm by 1.0 cm by 0.5 cm. It presented with a dry, yellowish tissue in the wound bed. On 4/14/26 at approximately 4:40 PM, an interview was conducted with the CCC. The CCC stated that she is the primary assessor of wounds and that she obtains assistance from the Nurse Practitioner or the physician whenever the desired response is not achieved. The CCC further stated that Resident #30 was admitted with numerous skin concerns, mostly skin tears secondary to frail skin and moisture-associated dermatitis from frequent urinary leakage onto the skin. She stated that many of the open wounds had healed, but a minor bump to the resident's skin could reopen them. The CCC stated she always believed the sacral wound was caused by pressure, but complicated by moisture. The CCC stated she had no formal education in assessing and staging wounds or determining the root cause analysis, but she knew the interventions instituted would promote healing regardless of the cause. On 4/15/26 at approximately 7:00 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. The Administrator (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	stated that the above information showed an opportunity for education regarding wounds and pressure ulcers.

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F 0837 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Establish a governing body that is legally responsible for establishing and implementing policies for managing and operating the facility and appoints a properly licensed administrator responsible for managing the facility. Based on staff interviews and review of facility documents, the facility's Governing Body failed to ensure facility policies were implemented regarding management and operation of the facility to ensure effective systems were in place to assure the quality of life for the residents in the area of foot care and treatment/services to prevent/heal pressure ulcers.The findings included:During the recertification survey completed on 4/15/26 the facility failed to provide podiatry services for Resident #11 and provide treatment and services to prevent and heal pressure ulcers for Resident #30. On 4/15/26 at 4:12 PM an interview was conducted with the Administrator and the Director of Nursing (DON) regarding podiatry services and treatment and services to prevent and heal pressure ulcers. The Administrator stated that she is not sure if the Quality Assurance and Performance Improvement (QAPI) committee discussed foot care and podiatry services. The Administrator also stated that the facility identified issues regarding podiatry services but no action plan was put in place. The Administrator further stated that the facility identified issues with pressure ulcer's however no action plan was developed. The facility's Quality Assurance and Performance Improvement (QAPI) policy with a last revised date of 6/17/2022 reads, Responsibilities: The Health Services Administrator is responsible for overseeing the QAPI program. On 4/15/26 at approximately 7:25 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interviews and review of facility documents, the facility staff failed to adequately identify, keep systems functioning properly, and implement necessary action plans to assure the quality of life for the residents using the Quality Assurance and Performance Improvement (QAPI) committee to identify deficiencies if the area of foot care and treatment/services to prevent/heal pressure ulcers.The findings included:During the recertification survey completed on 4/15/26 the facility failed to provide podiatry services for Resident #11 and provide treatment and services to prevent and heal pressure ulcers for Resident #30. On 4/15/26 at 4:12 PM an interview was conducted with the Administrator and the Director of Nursing (DON) regarding podiatry services and treatment and services to prevent and heal pressure ulcers. The Administrator stated that she is not sure if the Quality Assurance and Performance Improvement (QAPI) committee discussed foot care and podiatry services. The Administrator also stated that the facility identified issues regarding podiatry services but no action plan was put in place. The Administrator further stated that the facility identified issues with pressure ulcer's however no action plan was developed. The facility's Quality Assurance and Performance Improvement (QAPI) policy with a last revised date of 6/17/2022 reads, Procedures: 8. The QAPI plan provides evidence that it has, through the Quality Assessment and Assurance committee, identified its own quality deficiencies, and are making a good faith attempt to correct them. On 4/15/26 at approximately 7:25 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and a review of the clinical record, the facility staff failed to treat 1 of 24 residents (Resident 20) in the survey sample with respect and dignity. The findings included: Resident #20 was admitted to the facility on [DATE]. The residents' current diagnoses included dementia and diabetes. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/11/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 3 out of 15. This indicated that Resident # 20's cognitive abilities for daily decision making were severely impaired. In section GG0130 (Functional Abilities), the resident was coded as requiring setup or clean-up assistance with oral hygiene, supervision or touching assistance with eating, substantial/maximal assistance with shower/bathe self and upper body dressing, dependent with Lower body dressing, personal hygiene, and putting on/taking off footwear.On 4/13/26 at approximately 12:50 PM, Resident #20 was observed seated at the dining table eating lunch. Shortly after the resident stopped eating the meal, dessert was requested. Resident #20 was told by the personal sitter with a resonating voice that he could not have a dessert because his sugar was too high. The resident again requested a dessert, and Licensed Practical Nurse (LPN) #8 stated publicly that the resident could not have one because his wife was concerned about his elevated blood sugar. LPN #8 then stated that he could be served sugar-free pudding if any were available. The personal sitter assisted the resident in leaving the table, without any dessert being served. A review of the resident's person-centered care plan failed to identify an intervention to withhold dessert if his blood sugar was elevated. On 4/14/26 at approximately 4:30 PM, the above information was presented to the facility's staff. The Clinical Care Coordinator (CCC) and the Registered Dietitian stated that the resident should have received a dessert.On 4/15/26 at approximately 7:00 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews, the facility staff failed to ensure that resident care equipment was kept clean for 1 of 24 residents (Resident 31) in the survey sample.The findings included: Resident #31 was admitted to the facility on [DATE]. The residents' current diagnoses included dementia and heart failure. The quarterly Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/2/26, coded the resident as unable to complete the Brief Interview for Mental Status (BIMS). The staff interview was coded for long-term and short-term memory problems, as well as severe impairment for daily decision making.In section GG0130 (Functional Abilities), the resident was coded as requiring setup or clean-up assistance with eating; being dependent with shower/bathe; and with upper body dressing, lower body dressing, personal hygiene, and putting on/taking off footwear. The resident was also coded at section GG0170. (Mobility) dependent on the use of a wheelchair operated by staff.On 4/13/26 and 4/14/26, Resident #31 was observed in the dining room at the lunch meal. The entire left wheel of the wheelchair was splattered with a dense white substance. On 4/14/26 at approximately 4:30 PM, the above information was presented to the facility's staff. The CCC stated that the resident's wheelchair would be cleaned. On 4/15/26 at approximately 7:00 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. The Administrator stated that the resident's wheelchair was cleaned.

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and a review of the clinical record, the facility staff failed to ensure that 1 of 24 residents (Resident 49) in the survey sample was free from a physical restraint. The findings included: Resident #49 was admitted to the facility on [DATE]. The residents' current diagnoses included dementia and Parkinson's disease. The resident had not been admitted to the facility long enough for the Minimum Data Set (MDS) to be completed; therefore, the following information was obtained from the Nurses' admission Functional assessment with a lock date of 4/11/26. The admission assessment revealed the resident was oriented to person only, and his cognitive status was severely impaired. The assessment also indicated that the resident was dependent in all activities of daily living (ADL). On 4/14/26 at approximately 10:59 AM, Resident #49 was observed in a reclined chair in the living room area. An interview with the Clinical Care Coordinator (CCC) was conducted at 12:48 PM. The CCC stated that the resident had a history of falls because of balance and gait problems, including the loss of his upper-body balance, which increased his risk for falls. The CCC also stated that the resident's wife was adamant that falls be prevented; therefore, the use of a recliner chair was necessary because the resident did not have a personal sitter, and there was not enough staff to maintain his safety. On 4/14/26 at approximately 4:30 PM, the above information was presented to the facility's staff. The CCC stated that the resident had a history of urinary problems because of kidney problems, a history of UTIs, and the need to scan his bladder four times each day. On 4/15/26 at approximately 7:00 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interview, staff interview, facility document review, it was determined that facility staff failed to report an allegation of verbal abuse in a timely manner to the appropriate state agencies for 1 of 24 residents (Resident #11) in the survey sample. Resident #11 was originally admitted to the facility 6/10/24 after an acute care hospital stay and re-admitted on [DATE] from an acute care facility. The current diagnoses included; Foot Drop, Peripheral Vascular Disease.The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/02/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #11 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goals) the resident was coded as dependent with oral hygiene, toileting hygiene, shower/bathe self. Requires set-up or clean-up assistance with eating.The person-centered care plan dated 03/06/26 read the resident has an ADL self-care performance deficit r/t Activity Intolerance, Disease Process h/o Covid, Fatigue, Musculoskeletal impairment. The Goal for Resident #11 will be to maintain current level of function in ADLs and mobility. The interventions for the resident included: Nurse to check with resident if she refuses her shower. Document refusal in progress notes as scheduled and avoid scrubbing & pat dry sensitive skin.A review of the Facility Synopsis dated 4/14/26 read: Incident Date: 4/13/26. Resident reported that she was afraid of staff. Incident Type: Resident self-reported an allegation of abuse/mistreatment. The resident reported to the Assistant Director of Nursing (ADON) that she was afraid of the CNA who was her caregiver last evening. The resident described her as: loud, rude, snippy and disrespectful. Name of employee: CNA #6. Employee action initiated or taken: The Director of Nursing (DON) and Nursing Home Administrator (NHA) made aware; investigation initiated; Human Resources (HR) notified; employee placed on leave until investigation is complete.On 04/14/2026 at approximately 12:13 pm., during the initial tour Resident #11 was asked if she was being abused by someone. Resident #11 said that Certified Nursing Assistant (CNA) #6 was loud, bossy and boisterous towards her. The resident mentioned that she didn't want CNA #6 to give her a shower last (4/13/26) night but told her that she could shower her on Thursday (4/16/26). The resident said the CNAs words and body language and Rudeness last night made her feel scared. The resident also said that she asked another CNA (CNA #5) to get a nurse (ADON) so I could report it. The nurse (ADON) told CNA #5 that she would be in ASAP but I never saw her. I informed her before 11 am. They fired a CNA last year that was always in a bad mood. The people were afraid of her.On 4/14/26 at approximately 12:35 pm, an interview was conducted with CNA #5 concerning Resident #11. CNA #5 said that around 10 am this morning Resident #11 informed her that CNA #6 was rude and abrupt with her. The resident said that CNA #6 told her, to turn down your tv now. The resident said she was afraid to report it.Timeline of events:4/13/26 CNA #6 verbally abused resident. Resident #11 felt afraid, refused her shower.4/14/26 at 10:00 am., Resident #11 informed CNA #5 about CNA being rude to her and feeling afraid. Resident #11 wanted to speak to the ADON to report the incident to her. CNA #5 said she informed the ADON that the resident needed to talk to her.4/15/26 CNA #5 approaches the ADON again informing her of the above, the ADON finally speaks to Resident #11 with concerns of verbal abuse and feeling afraid.On 4/15/26 at approximately an interview was conducted with the ADON. The ADON mentioned that CNA #5 did approach her concerning Resident #11 wanting to speak with her but was not aware of the seriousness. The ADON said she would have spoken to the resident right away had she known. The ADON also educated CNA #5 on the importance of telling staff right away concerning abuse.The policy revised 3/06/18 read: It is policy to provide care in a manner that's professional, compassionate and respectful of resident's rights, abuse and neglect mistreatment or misappropriation of resident property. Verbal Abuse refers to any oral, written, or gestured language (continued on next page)

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	495225	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster Canterbury Blue RI	250 Pantops Mountain Rd Charlottesville, VA 22911

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	that willfully includes disparaging and derogatory terms to residents or their families within hearing distance regardless of their age, ability to comprehend or disability.On 4/15/26 at approximately 7:25 pm, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. The Educator said staff were educated to report everything within 2 hours. The administrator said they should notify someone immediately. An opportunity was offered to the facility's staff to present additional information

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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 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate foot care. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interviews and clinical record review, the facility staff failed to ensure 1 resident (Resident #11), in the survey sample of 24 Residents who were unable to carry out activities of daily living receive the necessary services to maintain podiatry services.The findings included: Resident #11 was originally admitted to the facility 6/10/24 after an acute care hospital stay and re-admitted on [DATE] from an acute care facility. The current diagnoses included; Foot Drop, Peripheral Vascular Disease. The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 3/02/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 13 out of a possible 15. This indicated Resident #11 cognitive abilities for daily decision making were intact. In sectionGG(Functional Abilities Goals) the resident was coded as dependent with oral hygiene, toileting hygiene, shower/bathe self. Requires set-up or clean-up assistance with eating. The person-centered care plan dated 03/06/26 read the resident has an ADL self-care performance deficit r/t Activity Intolerance, Disease Process h/o Covid, Fatigue, Musculoskeletal impairment. The Goal for Resident #11 will be to maintain current level of function in ADLs and mobility. The interventions for the resident included: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse. On 4/13/26 at approximately 3:20 pm, during the initial tour. Resident #11 was asked if she had received a visit from her foot doctor lately. Resident #11 said that concerned about not getting her toenails trimmed. The resident said she's been asking the nurse for 3 months. Permission was received from the resident to observe her toenails with a staff member. Registered Nurse (RN) #3 walked in Shortly thereafter. The Resident's 3rd and 4th toe on her left foot was observed yellowish, thick, long and curvy and an observation of the resident's right great toe, 3rd and 4th toes on her right foot were observed to be thick, yellowish, long and curvy. The nurse informed the resident that he will put in a nurse's note and add her name to the Podiatry list. On 4/14/26 at approximately 8:55 am., an interview was conducted with the Medical Records Coordinator (MRC) concerning Podiatry Services. The MRC said that if the nurse or Certified Nursing Assistant notices during the assessment that a resident need Podiatry services, they will call the Podiatrist to make an appointment. The MRC also said that she is only responsible for setting up regular appointments for residents. On 4/14/26 at approximately 9:15 am., an interview was conducted with Licensed Practical Nurse (LPN) #2 concerning Podiatry care. LPN #2 said that the nurses will evaluate the residents while completing skin assessments to see if there's a need for podiatry services. LPN #2 also said that the Podiatrist visits every other Thursday, the staff will alert him ahead of time if a resident requests or needs services. Policy on Podiatry Care last revised on 3/18/18. Reads: The facility will ensure that residents receive proper treatment and care to maintain good foot health. The facility will ensure that foot care is provided as needed for resident and is consistent with professional standards of practice. Specific Procedures/Requirements: Residents will have frequent inspection of their feet to identify need for foot care; such inspections may include but are not limited to: Skin inspections by licensed nurse per facility protocol. Inspection in collaboration with assistance in activities of daily living, including bathing, dressing, etc. A review of the podiatry list does not list resident as receiving services. A review of the latest Podiatry Note dated 10/23/25 read: Resident was treated at the healthcare center 3rd floor for an evaluation of the elongated, deformed toenails x 10. She is unable to care for her feet and wants her toenails trimmed. Assessment: Elongated Dystrophic, bilateral discolored nails x 10 with pain. Plan: Clinic Visit, Reduction of deformed toenails x 10. Re-appointment in 3 months. On 4/15/26 at approximately 9:00 am., a brief interview was conducted with the Assistant Director of Nursing (ADON) concerning Podiatry Services. The ADON said that the resident has no history of refusals for Podiatry services and an appointment has bee set for tomorrow at 3:00 pm with the Podiatrist. A review of the Ad Hoc QAPI dated 4/15/26 regarding Podiatry: Problem: lack of documentation regarding podiatry services (continued on next page)

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F 0687 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	provided to healthcare residents. Root Cause: Nurses said Resident #11 refused podiatry services when MD arrived; however, there is no documentation supporting refusal of services. Goal: Proper documentation regarding podiatry services provided to residents and refusals. Interventions: A new spreadsheet has been provided to track resident refusals and services provided. On 4/15/26 at approximately 7:25 pm, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and a review of the clinical record, the facility staff failed to provide necessary incontinence care for 1 of 24 residents (Resident 20) in the survey sample. The findings included: Resident #20 was admitted to the facility on [DATE]. The residents' current diagnoses included dementia, diabetes, and a history of recurrent urinary tract infections secondary to hydronephrosis related to obstruction. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/11/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 3 out of 15. This indicated that Resident # 20's cognitive abilities for daily decision making were severely impaired. In section GG0130 (Functional Abilities), the resident was coded as requiring setup or clean-up assistance with oral hygiene, supervision or touching assistance with eating, substantial/maximal assistance with shower/bathe self and upper body dressing, dependent with lower body dressing, personal hygiene, and putting on/taking off footwear.On 4/13/26 at approximately 1:00 PM, Resident #20 was observed receiving assistance from the personal sitter to leave the dining table. Resident #20 was observed with urine-soaked pants along the brief line on the left side. At approximately 1:42 PM, the resident was observed seated in a chair in his room, wearing the same pants he was wearing in the dining room. An interview was conducted with the personal sitter. The personal assistant was unaware of how long it had been since the resident received incontinence care. She stated that she was not authorized to provide incontinence care; therefore, when the Certified Nursing Assistant (CNA) became available, the resident would receive necessary care. The person-centered care plan dated 2/7/26 stated that the resident had mixed bladder incontinence related to confusion, a history of UTIs, and impaired mobility. One goal read that the resident would remain free from skin breakdown due to incontinence and brief use through the review date. The intervention included checking the resident every 2 hours and, as required for incontinence, washing, rinsing, and drying the perineum, and changing his clothing as needed after incontinence episodes. On 4/14/26 at approximately 4:30 PM, the above information was presented to the facility's staff. The Clinical Care Coordinator (CCC) stated that the resident had a history of urinary problems because of kidney problems, a history of UTIs, and they scanned his bladder four times each day.On 4/15/26 at approximately 7:00 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interviews, and a review of the clinical record, the facility staff failed to serve 1 of 24 residents (Resident 20) in the survey sample the food necessary to support nutritional needs. The findings included: Resident #20 was admitted to the facility on [DATE]. The residents' current diagnoses included dementia and diabetes. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 2/11/26, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 3 out of 15. This indicated that Resident # 20's cognitive abilities for daily decision making were severely impaired. In section GG0130 (Functional Abilities), the resident was coded as requiring setup or clean-up assistance with oral hygiene, supervision or touching assistance with eating, substantial/maximal assistance with shower/bathe self and upper body dressing, dependent with Lower body dressing, personal hygiene, and putting on/taking off footwear.On 4/13/26 at approximately 12:50 PM, Resident #20 was observed seated at the dining table eating lunch. Shortly after the resident stopped eating the meal, dessert was requested. The personal sitter assisted the resident in leaving the table, without a dessert being served. On 4/14/26 at approximately 4:30 PM, the above information was presented to the facility's staff. The Registered Dietitian stated that the resident should have received the dessert or a compatible substitute, as the order was intended to meet his nutritional needs for that meal. The person-centered care plan had a problem dated 2/8/26, which stated the resident has the potential for unintentional weight loss related to increased activities of daily living (ADL) needs, Alzheimer's disease with variable appetite, and acute infection (UTI) as evidenced by the weight record showing his weight is at the low end of his usual body weight (UBWR). The care plan goal stated that the resident will maintain adequate nutritional status as evidenced by maintaining a weight of 170-175 pounds, no signs or symptoms of malnutrition, and consuming at least 50% of meals daily through the review date. The interventions included providing the ordered diet, monitoring intake, and recording each meal. On 4/15/26 at approximately 7:00 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information. They had no further comments and voiced no concerns regarding the above information.

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations during the medication administration task, staff interviews, and a review of the clinical record, the facility staff failed to ensure that its medication error rate was not 5% or greater. The medication error rate was identified as 11.54%.The findings included:On 4/14/26, Licensed Practical Nurse (LPN) #2 failed to complete the administration of MiraLax Oral Powder 17 GM/SCOOP (polyethylene glycol 3350), 17000 MG Powder for Oral Solution to 3 of 3 residents observed during the medication administration task:1. Resident #32's MiraLax was not administered as ordered by the physician and/or Practitioner.Resident #32 was admitted to the facility on [DATE]. The residents' current diagnoses included atrial fibrillation and anemia. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 03/05/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 7 out of 15. This indicated that Resident #32's cognitive abilities for daily decision-making were severely impaired.The Physician's Order Summary revealed an order for MiraLax Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350). Give 17 grams by mouth once daily for constipation. Mix the powder in at least 4 ounces of liquid. On 04/14/2026 at 10:06 AM, LPN #2 prepared the resident's medication as ordered, handed the cup to the resident, and left. During a flower arrangement activity in the dining room on 4/14/26 at 11:40 AM, the resident was observed with the cup of medication beside her. It had not been consumed.On 4/14/26 at approximately 4:30 PM, the above information was presented to the facility's staff. The Clinical Care Coordinator stated that the LPN #2 should have stayed with the resident until the medication was completed. On 4/14/26 at approximately 6:00 PM, the above information was shared with LPN #2. LPN #2 stated she failed to administer MiraLax to Resident #32 completely.On 4/15/26 at approximately 7:00 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. The team was informed that, because of the above errors during the medication administration task, the facility's medication error rate was 11.54%. They acknowledged understanding, requested no clarification, and voiced no concerns. 2. Resident #10's MiraLax was not administered as ordered by the physician and/or Practitioner.Resident #10 was admitted to the facility on [DATE]. The residents' current diagnoses included Alzheimer's disease. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 02/19/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 3 out of 15. This indicated that Resident #10's cognitive abilities for daily decision-making were severely impaired.The Physician's Order Summary revealed an order for MiraLax Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350). Give 17 grams by mouth once daily for constipation. Mix the powder in at least 4 ounces of liquid, on 04/14/2026 at 10:31 AM. LPN #2 prepared the resident's medication as ordered, handed the cup to the resident, and assisted her in sipping the liquid. The resident slowly sipped with great prompting. Eventually, LPN #2 stopped assisting the resident and poured approximately 65% of the liquid containing MiraLax into the water fountain drain. On 4/14/26 at approximately 4:30 PM, the above information was presented to the facility's staff. The Clinical Care Coordinator stated that LPN #2 should have continued assisting the resident with the medication unless the resident refused it. On 4/14/26 at approximately 6:00 PM, the above information was shared with LPN #2. LPN #2 stated she failed to administer MiraLax to Resident #10 completely.On 4/15/26 at approximately 7:00 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. The team was informed that, because of the above errors during the medication administration task, the facility's medication error rate was 11.54%. They acknowledged understanding, requested no clarification, and voiced no concerns. 3. Resident #14's MiraLax was not administered as ordered by the physician and/or Practitioner.Resident #14 was (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	admitted to the facility on [DATE]. The residents' current diagnoses included Alzheimer's disease. The admission Minimum Data Set (MDS) assessment, with an assessment reference date (ARD) of 03/06/2026, coded that the resident completed the Brief Interview for Mental Status (BIMS) and scored 8 out of 15. This indicated that Resident #14's cognitive abilities for daily decision-making were moderately impaired.The Physician's Order Summary revealed an order for MiraLax Oral Powder 17 GM/SCOOP (Polyethylene Glycol 3350). Give 17 grams by mouth once daily for constipation. Mix the powder in at least 4 ounces of liquid, on 04/14/2026 at 11:01 AM. LPN #2 prepared the resident's medication as ordered and handed the cup to the resident, explaining that it was MiraLax. The resident sipped the liquid, and LPN #2 left the room before the resident finished it. On 4/14/26 at approximately 4:30 PM, the above information was presented to the facility's staff. The Clinical Care Coordinator stated that LPN #2 should have stayed with the resident until the medication was completed. On 4/14/26 at approximately 6:00 PM, the above information was shared with LPN #2. LPN #2 stated she failed to administer MiraLax to Resident #14 completely.On 4/15/26 at approximately 7:00 PM, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. The team was informed that, because of the above errors during the medication administration task, the facility's medication error rate was 11.54%. They acknowledged understanding, requested no clarification, and voiced no concerns.

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F 0921 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that the nursing home area is safe, easy to use, clean and comfortable for residents, staff and the public. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview and staff interview, the facility's staff failed to provide a homelike environment for one resident (Resident #4) in the survey sample of 24 residents. Resident #4 was originally admitted to the facility 02/06/23 after an acute care hospital and readmitted on [DATE]. The current diagnoses included; Major depressive disorder and Muscle weakness, generalized.The annual Minimum Data Set (MDS) assessment with an assessment reference date (ARD) of 02/02/26 coded the resident as completing the Brief Interview for Mental Status (BIMS) and scoring 14 out of a possible 15. This indicated Resident #4 cognitive abilities for daily decision making were intact. On 4/14/26 at approximately 11:30 am., during the initial tour of room [ROOM NUMBER]-1 Resident #4 was observed sitting in his recliner. The wall located behind the resident's recliner was observed to have a medium sized hole in it. Resident #4 stated I never knew it was there. The wall to the right of the resident's recliner had peeling outer layer of the sheetrock. Resident #4 said he knew about that and it had been there for a while.On 4/14/26 at 12:00 pm., an interview was conducted with Certified Nursing Assistant (CNA) #4 concerning the medium sized hole on the resident's wall and peeling area on resident's wall near the right side of his recliner. The CNA replied, I've been here for 1 year and I've always noticed the hole in the wall.On 4/15/26 at approximately 7:25 pm, a final interview was conducted with the Administrator, Director of Nursing, Regional [NAME] President of Operations, admission Coordinator, Nurse Educator, Rehab Manager, and Assistant Director of Nursing. An opportunity was offered to the facility's staff to present additional information.