STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495280	A. Building B. Wing	01/22/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster at Lake Ridge	12185 Clipper Drive Lake Ridge, VA 22192

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. Based on observations, interviews and facility document review, the facility staff failed to maintain a safe environment for one of thirty-seven residents in the survey sample (Resident #1). Four oxygen cylinders were observed unsecured constituting the identification of immediate jeopardy (IJ) at Level Four, Isolated scope and severity and substandard quality of care. Upon verification of the removal of the IJ, the scope and severity were lowered to Level Two, Isolated. The findings include:On 1/20/26 at 12:46PM, during initial rounds, four oxygen e-tanks were observed stored freestanding in an upright position, not contained in a stand or holder in Resident #1's room on the secured Memory Care Unit. (An E tank (or E-cylinder) is a common medical oxygen cylinder, typically holding around 680 liters (about 23-24 cubic feet) of oxygen, with dimensions of roughly 4.4 inches in diameter and 24-28 inches in height, weighing around 10 lbs. empty, and used for home, travel, and emergency oxygen needs.) On 1/20/26 at 1:00PM, a second observation of Resident #1 was conducted by the survey team. The oxygen cylinder tanks were observed freestanding approximately 3 inches from the wall immediately to the left side of the door as you enter the room. Resident #1 was sitting in his wheelchair, with the cylinders approximately 2 1/2 feet directly behind his chair. Resident #1's wife was observed visiting him in the room.Resident #1, whose room the oxygen cylinders were observed in, was admitted to the facility Health Care Center on 12/18/25 with diagnoses including but not limited to acute respiratory failure with hypoxia (dangerously low supply of oxygen), hypertensive heart disease, chronic obstructive pulmonary disease, pneumonia and atrial fibrillation (irregular heart rhythm). Resident #1 was admitted to Hospice services on 12/19/25 for hypertensive heart disease. Resident #1's most recent MDS (Minimum Data Set) Assessment with ARD (Assessment Reference Date) 12/31/25 was coded in Section C. Cognitive Pattern with a score of 2 out of 15 indicating severe cognitive impairment and impaired safety awareness. Resident #1 had a physician order for oxygen 2 liters per minute via nasal cannula.On 1/20/26, at approximately 1:15PM, a third observation was conducted and again the cylinder tanks were observed stored unsecured, to the left of the door as you entered the room. An interview was conducted with LPN-B. According to LPN-B, the oxygen tanks had been there over a week or so and they had called Hospice to come and pick them up. LPN-B was interviewed on how oxygen cylinder tanks should be stored and she stated, the tanks should be stored in rolling stands. Further interview with LPN-B on why they should be stored in rolling stands she replied, so that they don't fall over and so the resident can move about the unit with his family.On 1/20/26 at 1:45PM, an observation and interview were conducted with the Director of Nursing and Assistant Director of Nursing. The observation again revealed four oxygen cylinder tanks freestanding approximately 3 inches from the wall immediately to the left side of the door as you enter the room. The Director of Nursing (DON) indicated that the oxygen tanks were not stored properly and should be secured in a stand or holder and stated the tanks could fall over or accidentally be knocked over by staff or visitors causing the cylinder to propel and/or explode, potentially inflicting harm to residents and staff. According to the DON, the tanks had been delivered by Hospice, and the facility nurse had called last week to have them come and pick them up. The Director of Nursing and the Assistant Director of Nursing immediately removed the four-cylinder oxygen tanks from Resident #1's room and (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	stored them in the facility's oxygen storage area in stands and racks.On 1/20/26 at 3:15PM, the survey team conducted a sweep of the entire facility and there were no other unsecured oxygen tanks found in the facility. An inspection of the facility's oxygen storage area was conducted where seventy-two (72) cylinder tanks were observed securely stored in stands and/or racks.On 1/20/26 at 4:00PM, a meeting was conducted with the Administrator and the Director of Nursing to inform them of Immediate Jeopardy due to the observation of four (4) oxygen cylinder tanks stored unsecured in Resident #1's room on the secured Memory Unit. The risk of these unsecured tanks posing an imminent risk of safety for residents, visitors and staff is high due to the resident population on the secured unit consisting of residents with cognitive impairments and impaired safety awareness.A review of the facility's policy Oxygen Administration dated, October 2024 read in part:Paragraph entitled, Equipment and Supplies: The Following will be necessary when performing this procedure. 1. Portable oxygen cylinder (strapped to the stand).On 1/20/26 at 6:04PM, the Administrator submitted an Immediate Jeopardy (IJ) Removal Plan. The IJ Removal Plan was reviewed by the survey team, sent to the State Agency for review and the IJ Removal Plan was accepted.The facility's IJ Removal Plan read: 1. Immediate action taken for the residents to have been affected:Tanks were immediately removed from residents' room.Hospice notified not to deliver oxygen tanks, only to provide concentrators to residents.Identification of other residents having the potential to be affected was accomplished by:The facility identified potential residents of 10 residents on oxygen at risk.Actions taken/systems put into place to reduce the risk of future occurrence include:Audit of all residents on oxygen for placement of concentrators and removal of oxygen tanks if identified on 1/20/26 by 5:00PM.Education provided to all current staff and prior to assigned scheduled shift on oxygen safety - storage/handling by 1/21/26 by 10:00AM.All staff unassigned will be educated via phone and will be required to sign acknowledgement of education upon next scheduled shift.All contracted Hospice companies to be notified of providing only concentrators to SNF (skilled nursing facility) Hospice residents.Alleged compliance 1/21/26 by 10:00AM.On 1/21/26 from 10:30AM to 3:45PM, interviews were conducted with multiple staff of varying departments related to the storage of oxygen. All staff interviewed confirmed they had received education on storage of oxygen tanks on 1/20/26 and/or 1/21/26 and could verbalize proper storage of oxygen tanks that all portable oxygen tanks are to be in a secure carrier such as a stand or rolling holder, never free standing.In addition to interviewing staff on receiving education on proper oxygen storage, education attendance records were reviewed and verified to confirm all staff working had received education. Rounds were conducted to verify no other oxygen tanks were observed unsecured. A review of email confirmations to the two Hospice providers to verify they had received a call from the facility administration regarding no further delivery of oxygen tanks to the facility. After verifying completion of all components of the IJ Removal Plan, the immediacy was removed effective 1/21/26 at 11:30AM. The Administrator, Director of Nursing and the Director of Clinical Operations were made aware that the IJ Removal Plan was verified and IJ removed.On 1/20/26 at approximately 3:15PM, a phone call was placed to the facility's contracted Hospice company (name redacted) who was providing Hospice services to Resident #1 regarding when the oxygen tanks were delivered to Resident #1 and their expectations of proper oxygen storage. According to the Hospice provider's Regional Director (Other-F), portable oxygen tanks should be stored securely in a holder/carrier/dolly or stand, the oxygen was delivered for Resident #1 on 12/30/25, at which time the IJ began.On 1/21/26 at 4:00pm, the Administrator produced a delivery receipt from the Hospice company's oxygen supplier (name redacted) dated 12/30/25 confirming the oxygen was delivered to Resident #1 on 12/30/25 at 11:44AM.On 1/22/26, a list of residents on the Memory Care unit was requested to include their BIMS score (Brief Interview of Mental Status), a short, mandatory cognitive screening tool used in long-term care facilities to assess resident's cognitive, attention and memory. The list included 8 out of 9 residents residing on the Memory Care Unit with a BIMS score of 9 or less, indicating significant cognitive impairment (1 out of the 9 residents was coded as 99 indicating the resident was unable to complete the interview).On 1/22/26 (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	during end of day meeting, with the Administrator, Director of Nursing, Assistant Director of Nursing and Director of Clinical Operations, the facility team was asked if any residents residing on the Memory Care Unit had impaired safety awareness. The Director of Clinical Operations (Employee-D) responded, Yes, I would say all of them, due to their cognitive impairment potentially affecting their safety awareness. No further information was provided.

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F 0843 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have an agreement with at least one or more hospitals certified by Medicare or Medicaid to make sure residents can be moved quickly to the hospital when they need medical care. Based on staff interview and facility documentation review, the facility staff failed to ensure there was a written transfer agreement with a local hospital which had the potential to affect all residents residing on 3 of 3 units. Findings included:On 1/21/2026 at 1:15 p.m. as a part of the extended survey, an interview was conducted with the Administrator who was asked provide evidence of a transfer agreement with the hospital. The Administrator stated he would look for a copy of the agreement. On 1/22/2026 at 9:20 a.m., the Administrator stated he could not find any evidence of a transfer agreement with the hospital. He stated he was sure the facility would have an agreement but could not find it. There was no evidence of a transfer agreement in the facility's documentation.On 1/22/2026 at 10:30 a.m., an interview was conducted with the Clinical Nurse Consultant who stated the Administrator had checked but could not find a transfer agreement. She stated a transfer agreement was necessary and the hospital had been contacted. During the end of day debriefing on 1/22/2026, the facility Administrator, Director of Nursing, Director of Informatics and Corporate Clinical Nurse Consultant were informed of the findings. The Administrator stated he did not see any transfer agreements with a hospital He stated he had reached out to the hospital administrative staff but had not received any information. No further information was provided.