Printed: 07/02/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancashire Post Acute	287 School Street Kilmarnock, VA 22482

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews, and facility policy review, the facility failed to implement interventions to aid in the prevention and decline of pressure ulcers for one resident (Resident (R) R110) out of four residents reviewed for pressure ulcers. The facility's failure to implement pressure ulcer prevention interventions resulted in multiple pressure ulcers after admission, including one stage 4 and one stage 3 pressure ulcer, along with three unstageable pressure ulcers and has the potential for other residents to develop pressure ulcers.Findings include: Review of R110's Face Sheet located under the Face Sheet tab of the EMR, revealed he was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, urinary incontinence, incontinence of feces, multi-system degeneration of the autonomic nervous system, osteoarthritis of hip, pain in right hip, and generalized muscle weakness. R110 discharged from the facility on 02/22/25.Review of R110's admission Minimum Data Set (MDS) with an assessment reference date (ARD) of 01/22/25, located under the MDS tab of the EMR, revealed he had a Brief Interview for Mental Status (BIMS) score of 11 out of 15, which indicated he had moderate cognitive impairment. The assessment documented R110 had no pressure injuries upon admission. The assessment also revealed that R110 required substantial/maximal assistance for bed mobility.Review of R110's admission Risk Assessments found under the Assessments tab of the EMR, revealed a Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE], which indicated R110 was at risk for developing pressure sores.Review of R110's admission assessment dated [DATE] located under the Assessments tab of the EMR revealed a skin assessment was completed with documentation No areas of discoloration or altered skin integrity identified.Review of R110's Care plan dated 01/16/25 located under the Care plans tab of the EMR, revealed R110 had the potential for altered skin integrity or had altered skin integrity with a goal R110 would not experience impaired skin integrity or would demonstrate wound healing. Interventions dated 01/16/25 included that staff were to assist R110 with positioning, encourage R110 to reposition as able, and apply skin barrier cream.Review of R110's Braden Score found under the Assessments tab of the EMR, dated 01/23/25, indicated R110 was a risk for developing pressure sores. Review of R110's Care plan located under the Care plans tab of the EMR updated on 01/24/25 with an intervention that an air mattress was applied, then changed to an air overlay on 01/28/25.Review of R110's Progress Notes, dated 01/29/25 located under the Notes tab of the EMR, revealed a purple bruise to the left forearm from a fall was noted.Review of R110's Care plan dated 01/29/25 located under the Care plans tab of the EMR, revealed R110 had the potential for or had altered skin integrity and was at risk for pressure ulcer with interventions that staff were to administered wound treatments as ordered, check skin for redness, skin tears, swelling, or pressure areas and report any signs of skin breakdown, per nutritional screening and adjust diet/supplements as indicated, use pillows, pads, or wedges, to reduce pressure on heels and pressure points, turn/reposition. Review of R110's Treatment Administration Record (TAR) dated January 2025 revealed an order for skin check two times weekly for four weeks ordered 01/16/25. The skin checks dated 01/18/25, 01/22/25, and 01/25/25 documented no new areas identified.Review of R110's TAR dated February 2025 revealed an order for skin check two times weekly for four weeks dated 01/16/25. The skin check dated (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Lancashire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 287 School Street Kilmarnock, VA 22482	

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 0686 Level of Harm - Actual harm Residents Affected - Few	02/01/25, evenings documented there were no new areas identified.Review of R110's Progress Notes dated 02/02/25 located under the Notes tab of the EMR, revealed R110 had areas of discoloration to both heels and feet with skin intact. R110 had very poor bed mobility and frequently rested his feet on his footboard. R110's heels were repositioned and floated on pillows. The physician and wound care nurse were notified. The document did not mention the other wounds.Review of R110's Pressure Ulcer Skin Documentation/Assessment Form dated 02/02/25 and located under the Assessments tab of the EMR revealed R110 had the following wounds:Left heel - developed after admissionRight heel - developed after admissionRight ankle - developed after admissionLeft lateral foot - developed after admissionThere were no measures or assessments of the wounds documented on the 02/02/25 Pressure Ulcer Skin Documentation/Assessment Form.Review of R110's TAR dated February 2025, revealed the wound treatment, lab orders, and heel boots were implemented. Heel boots were documented as applied three times daily beginning 02/03/25.Review of R110's Physician Progress Note dated 02/04/25, located under the Documents tab of the EMR revealed documentation of skin was skin discoloration feet, bruise left forearm.Review of R110's Care plan dated 02/04/25 located under the Care plans tab of the EMR revealed R110 had pressure areas to both feet with interventions of pressure relieving boots as tolerated, nutritional screening and adjust diet/supplements as indicated, use pillows, pads, or wedges to reduce pressure on heels and pressure points, turn/reposition, pressure reducing mattress and cushion, and provide wound care per order. There was no documented evidence that the pressure reducing chair cushion or turning and repositioning of the resident was implemented.Review of R110's Pressure Ulcer Skin Documentation/Assessment Form dated 02/05/25 and, located under the Assessments tab of the EMR revealed R110 had the following wounds:Left heel - unstageable with slough and/or eschar and measured 2.5 centimeters (cm) by 2 cmRight heel - unstageable with suspected deep tissue injury (DTI) and measured 1.5 centimeters (cm) by 1 cm with EscharRight ankle- unstageable with slough and/or eschar and measured 1 cm by 1 cmLeft lateral foot - unstageable with DTI and measured 1 cm by 1 cmReview of R110's Dining Services Periodic Assessment [Nutrition assessment] dated 02/11/25 revealed recommendations for Vitamin C 500mg daily, Zinc 220mg daily, double portions protein for meals, and LiquaCel 30 milliliters (ml) 3 times daily. There was no documented evidence that these recommendations were implemented. Review of R110's Pressure Ulcer Skin Documentation/Assessment Form dated 02/12/25 and located under the Assessments tab of the EMR revealed R110 had the following Left heel- measured 2.5 cm by 1.5 cm. Right heel - measured 2.5 cm by 1.5 cmRight ankle - measured 1.5 cm by 1.2 cmLeft lateral foot - measured 1.5 cm by 1.5 cm with skin intact and maroon discolorationReview of R110's Specialty Physician Wound Evaluation & Management Summary dated 02/12/25, located under the Documents tab of the EMR, revealed documentation by the physician included the visit was conducted via telemedicine. non-pressure wound of the left, plantar heel full thickness. Dressing treatment plan: Primary Dressing(s) - Leptospermum honey apply every two days for 30 days; Alginate calcium apply every two days for 30 days. Secondary Dressing(s) - Superabsorbent gelling fiber w/ silicone bdr [border] & faced apply every two days for 30 days. Peri Wound Treatment - Skin prep apply every two days for 30 days. Plan of care reviewed and addressed. Recommendations: Off-Load Wound; Pressure Off-Loading Boot. Non-pressure wound of the right, posterior heel full thickness. Dressing treatment plan: Primary Dressing(s) - Leptospermum honey apply every two days and as needed for 30 days; Alginate calcium apply every two days and as needed for 30 days. Secondary Dressing(s) - Superabsorbent gelling fiber w/ silicone bdr & faced apply every two days and as needed soiled or loosened for 30 days. Peri Wound Treatment - Skin prep apply every two days and as needed for 30 days. Plan of care reviewed and addressed. Recommendations - Pressure Off-Loading Boot. Non-pressure wound of the right, lateral foot. Dressing treatment plan: Primary Dressing(s) - Skin prep apply once daily for 30 days. Plan of care reviewed and addressed. Recommendations - Pressure Off-Loading Boot. non-pressure wound of the right ankle full thickness. Dressing treatment plan: Primary Dressing(s) - Alginate (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Lancashire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 287 School Street Kilmarnock, VA 22482	

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 0686 Level of Harm - Actual harm Residents Affected - Few	calcium apply every two days for 30 days; Leptospermum honey apply every two days for 30 days. Secondary Dressing(s) - Superabsorbent gelling fiber w/ silicone bdr & faced apply every two days for 30 days. Peri Wound Treatment - Skin prep apply every two days for 30 days. Plan of care reviewed and addressed. Recommendations - Pressure Off-Loading Boot. RECOMMENDED (CMP) [lab order] ON 2/12/2025Review of R110's Pressure Ulcer Skin Documentation/Assessment Form dated 02/14/25 and located under the Assessments tab of the EMR revealed R110 had the following:Right buttock-developed unstageable with DTI and measured 5.6 cm long by 6 cm wide by 0.1 cm deepReview of R110's Pressure Ulcer Skin Documentation/Assessment Form dated 02/18/25 and located under the Assessments tab of the EMR revealed R110 had the following: Left heel- Stage 4 and measured 1.6 cm long by 1 cm wide by 0.1 cm deep Right heel - measured 0.9 cm by 0.5 cmRight ankle - Stage 3 and measured 1.5 cm long by 1.6 cm wide, by 0.3 cm deepLeft lateral foot - measured 2.7 cm by 4 cm with blister blood filledRight buttocks- unstageable with DTI and measured 5.6 cm long by 6 cm wide by 0.1 cm deepReview of R110's Specialty Physician Wound Evaluation & Management Summary dated 02/18/25 located under the Documents tab of the EMR revealed documentation by the physician that included: Stage 4 pressure wound of the left, posterior heel full thickness. Dressing treatment plan: Primary Dressing(s) - Leptospermum honey apply three times per week for 30 days; Methylene blue foam apply three times per week for 30 days: Hydrofera Blue Classic. Secondary Dressing(s) - Gauze sponge sterile apply three times per week for 30 days: may substitute for ABD pad.; Gauze roll (kerlix) 4.5 apply three times per week for 30 days: Wrap from toe crease to just below the knee.; Tape (retention) apply three times per week for 30 days. Peri Wound Treatment - Skin prep apply three times per week for 30 days. Plan of care reviewed and addressed. Recommendations - Off-Load Wound; Pressure Off-Loading Boot; Grippy socks only: avoid shoes with therapy; Protein supplementation and Thyroid Function Tests (TSH/Ft4); Vitamin C 500mg Twice daily PO; Zinc Sulphate 220mg Once Daily PO for 14 Day. Unstageable DTI [deep tissue injury] of the right, posterior heel full thickness . Skin prep apply three times per week for 30 days . Recommendations - Pressure Off-Loading Boot; Grippy socks only; avoid shoes w/ therapy. Unstageable DTI of the right, lateral foot undetermined thickness. Dressing treatment plan: Primary Dressing(s) - Skin prep apply three times per week for 24 days. Plan of care reviewed and addressed. Recommendations - Pressure Off-Loading Boot. Stage 3 pressure wound of the right, lateral ankle full thickness. Dressing treatment plan - Primary Dressing(s) - Leptospermum honey apply three times per week for 30 days; Methylene blue foam apply three times per week for 30 days: Hydrofera Blue Classic cutto size, wet foam with NS, then dry with gauze and place on wound already cover with primary dressing --i.e., honey paste. Secondary Dressing(s) - Gauze sponge sterile apply three times per week for 30 days: may substitute for ABD pad; Gauze roll (kerlix) 4.5 apply three times per week for 30 days: Wrap from toe crease to just below the knee; Tape (retention) apply three times per week for 30 days. Peri Wound Treatment - Skin prep apply three times per week for 30 days. Plan of care reviewed and addressed. Recommendations - Pressure Off-Loading Boot.Unstageable DTI of the right buttock undetermined thickness. Additional wound detail - Found by nursing on 1/23 and started on Triad paste for MASD [moisture associated skin damage]. Progressed to develop DTI with peri-wound dermatitis. Dressing treatment plan: Primary Dressing(s) - Hydrocolloid paste (triad) apply Q-shift [every shift] (3x/day) and as needed for 30 days: to non-intact. Peri Wound Treatment - Skin prep apply Q-shift (3xday) and as needed for 30 days: to intact/periwound. Plan of care reviewed and addressed. Recommendations - Upgrade offloading chair cushion: Roho cushion when OOB [out of bed].Review of R110's Medication Administration Record (MAR) and TAR dated February 2025, located under the Orders tab of the EMR and Care Plans under the Care Plans tab of the EMR did not reveal any documentation that the recommendations or changes in dressing treatment plans from the Specialty Physician Wound Evaluation & Management Summary dated 02/18/25, were implemented as ordered above. Review of R110's discharge MDS with an ARD of 02/22/25 located under the MDS tab of the EMR revealed a BIMS score of 99 which indicated R110 was unable to complete the interview (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Lancashire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 287 School Street Kilmarnock, VA 22482	

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 0686 Level of Harm - Actual harm Residents Affected - Few	and a staff assessment for mental status as moderately cognitively impaired. The assessment also showed documentation that R110 had one Stage 4 pressure ulcer, one Stage 3 pressure ulcer, and two unstageable pressure ulcers that were not present on admission. During an interview on 02/19/26 at 4:58 PM, the Wound Care Nurse (WCN) stated R110 developed pressure ulcers while admitted to the facility that were not present on admission. The WCN stated R110 required assistance of two staff for turning/repositioning while in bed.The WCN stated R110 was in a lot of pain and would yell a lot during Activities of Daily Living (ADL) care. The WCN stated that the typical protocol for residents with wounds were for ProStat, vitamin c, zinc, and talk with the dietician for supplements recommended.During an interview on 02/20/26 at 6:14 PM, Licensed Practical Nurse (LPN) 5 stated R110 didn't want to participate and just wanted to sleep a lot. LPN5 stated that R110 had an ulcer on his bottom but wound care was done during the day, so she didn't see his feet. LPN5 couldn't remember what pressure relieving interventions R110 had in place.During an interview on 02/20/26 at 7:42 PM, the Director of Nursing (DON) stated R110 developed pressure wounds during his stay. The DON stated the Registered Dietician (RD) conducts nutritional assessments and makes recommendations and sends them to us. The DON stated there should have been no reason the RD's recommendations were not implemented. Review of the facility's policy titled, Prevention of Pressure Injuries revised 04/01/20, indicated Nutrition: Establish and implement a nutrition care plan for any resident with or at risk of a pressure injury who is malnourished or at risk of malnutrition. Provide optimal hydration, nutrient, protein and calorie requirements as established by current practiceguidelines. include nutritional supplements in the resident's diet to increase calories and protein, as indicated in the care plan. Mobility/Repositioning: Reposition all residents with or at risk of pressure injuries on an individualized schedule, as determined by the interdisciplinary care team. Choose a frequency for repositioning based on the resident's risk factors and current clinical practice guidelines. Monitoring: Evaluate, report and document potential changes in the skin.Review the interventions and strategies for effectiveness on an ongoing basis.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Lancashire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 287 School Street Kilmarnock, VA 22482	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, record review, and review of the facility policy, the facility failed to ensure activities of daily living were provided for four residents (Residents (R)4, R18, R56, and R59) in a total sample of 32. The facility failed to provide showers per the shower schedule and resident preference for R4, R18, R56, and R59. This failure placed residents at risk for skin breakdown and a diminished quality of life.Findings include: 1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R4 was admitted to the facility on [DATE] with a diagnosis of a stroke. Review of the significant change assessment Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 12/09/25 revealed R4 had a Brief Interview of Mental Status (BIMS) score of 15 out of 15 which indicated R4 was cognitively intact and was dependent on staff for bathing. Review of the 04/12/21 Care Plan Report located in the Care Plan tab of the EMR revealed, R4 has the potential for health and safety concerns related to ADL [Activities of Daily Living] needs and mobility status. CVA [stroke] with left side paralysis. Interventions indicated, Assist R4 with bathing as needed. Review of a Grievance log provided by the Administrator revealed R4 had made a care concern on 10/06/25 which indicated, Resident reported she can't remember when she last had a shower. Mondays are her shower day, and her hair is to be washed on Mondays in the shower. R4 confirmed that she didn't have a shower on 09/29/25 and 10/06/25 nor was she offered a shower. The DON [Director of Nursing] did an in-service with staff about shower schedules. During an interview on 02/17/26 at 10:52 AM, R4 stated, Monday was my shower day but I did not get one. My hair was washed last Thursday because I yelled and screamed about it. I have to yell to get a shower. Review of the Tasks located in the EMR revealed R4 was to receive two showers per week on Monday and Thursday day shift. The documentation revealed R4 had only one shower which was on 02/16/26 in the last 30 days. 2. Review of the admission Record located in the Profile tab of the EMR revealed R18 was admitted to the facility on [DATE] with diagnoses that included seizures diabetes, and an irregular heart rhythm. Review of the admission MDS located in the MDS tab of the EMR with an ARD of 12/24/25 revealed that R18 had a BIMS score of 10 out of 15 which indicated R18 was moderately impaired in cognition and required moderate assistance with bathing. Review of the 12/24/25 Care Plan Report located in the Care Plan tab of the EMR revealed, R18 had the potential for health and safety concerns related to ADL needs and mobility status. Intervention indicated, Assist R18 with bathing as needed. During an interview on 02/17/26 at 11:17 AM, R18 stated, I have had at the most two showers since I have been here. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Lancashire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 287 School Street Kilmarnock, VA 22482	

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Tasks tab located in EMR revealed that R18 was to receive two showers per week on Wednesday and Saturdays during the day shift. The documentation revealed that in the last 30 days R18 had a shower on 01/21/26, The 01/28/26 shower was marked no. On Saturdays, R18 had a shower on 1/24/26 and on 01/31/26 it was documented as refused. There has been no other shower documentation since 01/31/26. 3. Review of the admission Record located in the Profile tab of the EMR revealed R59 was admitted to the facility on [DATE] with diagnoses of cerebral palsy (a neurological disorder identified at birth) and paraplegia (paralysis of two limbs.) Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 11/14/25 revealed R59 had a BIMS score of 15 out of 15 which indicated R59 was cognitively intact and required substantial assistance with bathing. Review of the 08/12/26 Care Plan Report located in the Care Plan tab of the EMR revealed, Bathing-[R59] is totally dependent on the staff. Interventions indicated, Tub or Shower two times weekly. During an interview on 02/17/26 at 10:20 AM, R59 stated, I am supposed to get a shower two times a week on the afternoon shift. It's been over a month since I had a shower. Review of the Tasks tab located in the EMR revealed R59 was to receive two showers weekly on Tuesday and Friday on the afternoon shift. Documentation revealed on 02/10/26 the resident refused, however, there was no further documentation of R59 having had a shower. During an interview on 02/19/26 at 9:01 AM, Certified Nurse Aide (CNA)10 stated, We can't always get to the showers as we are short staffed all the time. During an interview on 02/20/26 at 5:15 PM, the DON acknowledged that staff are to provide the residents with showers per their shower schedule. 4. Review of R56's admission record located under the Profile tab of the EMR revealed R56 was admitted to the facility on [DATE] with diagnoses which included hemiplegia, osteoarthritis and Type 2 Diabetes. Review of R56's quarterly MDS with an ARD of 12/19/25 and located under the MDS tab, reveal R56 has a BIMS score of 15 out of 15 which indicated R56 was cognitively intact and moderate assistance with bathing. Review of R56's undated Care Plan located in the EMR under the Care Plan tab revealed Assist resident with bathing as needed During an interview on 02/17/26 at 2:30 PM, R56 stated I haven't had a shower in weeks, I ask for a shower and the CNA tell me they don't have time, they're too busy. They keep changing my shower day, then tell me I have to wait. I was supposed to get a shower this morning. They stated that they would get to me in the morning. Interview on 02/18/26 at 10:00AM, R56 stated, I didn't get my shower again. They said it wasn't my shower day. They have it all mixed up. Review of the facility's policy titled, Activities of Daily Living, Daily Life Functions, dated 04/06/05 (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancashire Post Acute	287 School Street Kilmarnock, VA 22482

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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	revealed, .To assist resident (sic) in achieving maximum function .To provide assistance to residents as necessary .To improve the quality of life . 5. The facility failed to ensure sufficient staffing to meet the needs of the 108 residents. (Refer to F725 Sufficient Staffing for additional information.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancashire Post Acute	287 School Street Kilmarnock, VA 22482

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. Based on observations, interviews, record reviews, and facility policy review, the facility failed to ensure sufficient staffing to meet the needs of the 108 residents in the facility. Six residents (Resident (R) 46, R56, R4, R18, R59 and R110), five Certified Nursing Assistants (CNA5, CNA7, CNA8, CNA10 and CNA17) and the Staff Coordinator voiced concerns regarding sufficient staffing. The facility exhibited multiple failures related to a lack of sufficient staffing throughout the survey which has the potential to affect the residents quality of life. Findings include: 1.Review of the undated Facility Assessment provided by the facility indicated Staffing Guidelines: Our facility has created a base staffing pattern to ensure a sufficient number of qualified staff to meet the needs of our residents on a consistent basis. Our staffing pattern is further developed based on the assessed nursing care needs of our residents, acuity, and census. The base staffing pattern represents typical staffing based upon the average daily census of the facility. The facility adjusts staffing based upon multiple factors, including but not limited to, shifts in resident census, acuity, communicable disease outbreaks, and admission or discharge volume. Revisions to staffing based upon currently identified resident needs may be reflected in an increase or decrease in staffing from what is noted in the base staffing pattern. Registered Nurse (RN) = 2 on 7-3 and 3-11 shifts; Licensed Practical Nurse (LPN) = 2 on 7-3 and 3-11 shifts, 3 on 11-7 shift; CNAs = 11 on 7-3 shift, 8 on 3-11 shift, and 5 on 11-7 shift. Review of the Daily Staffing Sheets and Daily Nursing schedules provided by the facility for 01/15/25 through 02/28/25, revealed the average daily census was 80 residents and was unable to locate any shift that was fully staffed per the Facility Assessment – staffing guidelines 2.During an interview on 02/17/26 at 2:30 PM, R56 stated I haven't had a shower in weeks, I ask for a shower and the CNAs tell me they don't have time, they're too busy. They keep changing my shower day, then tell me I have to wait. I was supposed to get a shower this morning. They said they will get to me in the morning. Follow-up interview on 02/18/26 at 10:00AM, R56 stated, I didn't get my shower again. They said it wasn't my shower day. They have it all mixed up. 3. During an observation on 02/17/26 at 2:45 PM, R46's hair appeared oily. R46's sheet and blanket had pieces of sloppy joe meat on them. During an interview on 02/17/26 at 3:27PM, CNA7 was asked if R46 should have been left with food on her blanket following lunch. CNA7 stated, I was busy. I had to make rounds. (Refer to F677) 4.During an interview on 02/17/26 at 10:53 AM, R4 was asked if she felt there was sufficient staff to meet her needs. R4 stated, There are not enough staff working on the 3:00 PM to 11:00 PM shift and at times I feel like I am all alone here as my call light does not get answered. Review of the significant change Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 12/09/25 revealed R4 had a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R4 was cognitively intact. 5. During an interview on 02/17/26 at 11:17 AM, R18 stated, I think nothing happens here in a timely (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Lancashire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 287 School Street Kilmarnock, VA 22482	

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 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	manner. I have to wait 45 minutes to an hour for assistance. You push the light and push the light, and no one comes. Review of the admission MDS located in the MDS tab of the EMR with an ARD of 12/24/25 revealed R18 had a BIMS score of 10 out of 15 which indicated R18 was moderately impaired in cognition. 6.During an interview on 02/17/26 at 9:56 AM, R59 stated, No, there are not enough staff, especially on the 3:00 PM to 11:00 PM shift. At times you have to wait more than 30 minutes. There are a lot of staff who call off work. Review of the quarterly MDS located in the MDS tab of the EMR with an ARD of 11/14/25 revealed R59 had a BIMS score of 15 out of 15 which indicated R59 was cognitive. 7. During an interview on 02/19/26 at 9:01 AM, CNA10 stated, We are short-staffed all the time. There are a lot of people who call off work. 8.During an interview on 02/19/26 at 9:05 AM, CNA5 stated, Staffing is the biggest issue right now. There are a lot of call offs. I picked up this shift today. 9. During an interview on 02/19/26 at 9:10 AM, the Staff Coordinator (SC) stated, I have been in the role since January 2026. We are working on the call outs. I know we need more staff. We do not use agency staff, and we used to have care assistants who would ensure water was passed to the residents. 10. During an interview on 02/20/26 at 11:56 AM, CNA7 stated, No, there is not enough staff. I have more residents than I can care for in a day. 11. During an interview on 02/20/26 at 6:33 PM, CNA17 stated I don't feel we have enough staff. Sometimes we have to help out the other units. We aren't able to get our charting done because we are providing care for the residents. 12. During an interview on 02/20/2026 at 6:47 PM, CNA8 stated We are usually short aides on Fridays and weekends. There's just not enough staff, and there are issues with staff calling off. When we are short staffed, we have a hard time completing our tasks. With only two aides on the unit, we are only able to give bed baths and not showers because of safety concerns. 13. During an interview on 02/20/26 at 7:42 PM, the Director of Nursing (DON) stated There are staffing concerns with not enough aides. We've always had issues with staffing. Follow-up interview on 02/20/26 at 5:15 PM the DON stated, The management team rounds every morning, and we address issues and will pitch in and help, however, we live in an area that is hard to recruit staff as we are fairly rural, and we have other competitors in town for staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Lancashire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 287 School Street Kilmarnock, VA 22482	

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observations, interviews, and facility policy, the facility failed to perform hand hygiene between contact with residents while serving lunch trays for 28 of 108 residents in the facility and failed to remove gloves and perform hand hygiene prior to carrying bagged dirty linen in the hall. This failure had the potential to spread infection between residents.Findings include:During an observation on 02/17/26 from 12:29 PM until 1:28 PM, Certified Nurse Assistant (CNA) 4, CNA18, and the Assistant Director of Nursing (ADON)1 were serving lunch trays to residents. The staff assisted residents with sanitizing hand wipes prior to eating. The three staff members were observed touching residents while assisting them to sit down, distracting them until their tray was served to prevent the resident from touching another resident's tray, or touching the resident's arm or shoulder. During observation, the three staff members did not perform hand hygiene between contact with residents. While assisting a resident with eating, CNA2 was observed to brush her hair out of her face with her hands and picked up her cell phone off the floor without performing hand hygiene. CNA4 was encouraging residents to eat and was observed giving one resident a bite to eat and then going to another resident and giving them a bite to eat without performing hand hygiene between residents. CNA18 was not observed going behind the nurse's station. The only wall sanitizer station was located near the exit doors of the secured unit, between the gate and the exit doors. During an observation on 02/17/26 at 3:00 PM, CNA18 carried plastic bag of dirty linen with a gloved hand down hall to dirty utility room. The CNA touched the gate to open it and then entered the code on the door of the soiled utility room. During an interview on 02/17/26 at 2:35 PM, CNA4 stated, I didn't sanitize my hands while passing lunch trays. I have no answer as to why I didn't sanitize my hands.During an interview on 02/17/26 at 2:40 PM, CNA2 stated I used the moist sanitizer napkin that was sitting on the tray after I brushed my hair and picked up my cell phone off the floor.During an interview on 02/17/26 at 2:54 PM, the ADON1 stated I had sanitizing wipes in my pocket, but I did not sanitize my hands between each resident. I should sanitize my hands between each resident.During an interview on 02/17/26 at 3:03 PM, CNA18 stated I went behind the nurse's station to wash my hands between each resident while passing lunch trays. CNA18 stated I would wash my hands in the resident's room after patient care if soiled, otherwise I would wash my hands behind the nursing station. During an interview on 02/20/26 at 7:42 PM, the DON stated my expectation is for staff to wash their hands before passing meal trays. Staff should hand sanitize between touching residents. Dirty linens should be bagged, and staff carry the bag using one gloved hand to the soiled utility. Staff should then wash their hands or perform hand hygiene. Staff should wash their hands before exiting resident rooms to carry dirty linen to soiled utility room. There are no hand sanitizer stations in the memory care unit. If staff do not wash their hands prior to exiting a resident's room, they could potentially carry transmitted infections throughout the unit.Review of the facility's policy titled, Handwashing/Hand Hygiene revised 10/01/23, indicated This facility considers hand hygiene the primary means to prevent the spread of healthcare associated infections. Indications for hand hygiene - Hand hygiene is indicated: immediately before touching resident; . after contact with blood, body fluids, or contaminated surfaces; after touching a resident; after touching the resident's environment; . immediately after glove removal. The use of gloves does not replace hand washing/hand hygiene.Review of the facility's policy titled, Standard Precautions dated 08/01/21, indicated . Gloves (clean, non-sterile) are worn when in direct contact with blood, body fluids, mucous membranes, non-intact skin, and other potentially infected material. Gloves are worn when in direct contact with a resident who is infected or colonized with organisms that are transmitted by direct contact. Gloves are worn when handling or touching resident care equipment that is visibly soiled or potentially contaminated with blood, body fluids, or infectious organisms. Gloves are removed promptly after use, before touching non-contaminated items and environmental surfaces, and before going to another resident. After gloves are removed, wash hands immediately to avoid transfer of microorganisms to (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancashire Post Acute	287 School Street Kilmarnock, VA 22482

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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	other residents or environments. Linen soiled with blood, body fluids, secretions, excretions are handled and processed in a mannerthat prevents skin and mucous membrane exposures, contamination of clothing, and avoids transfer of microorganisms to other residents and environments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Lancashire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 287 School Street Kilmarnock, VA 22482	

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to provide information and choices to one of one resident (Resident (R)13) family member (FM) that R13 was receiving psychiatric visits. This deficient practice has the potential to affect the resident's quality of life.Findings included.Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R13 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, atrial fibrillation and dementia.Review of the significant change Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 10/31/25 revealed a Brief Interview of Mental Status (BIMS) score of 99 which indicated R13 was severely impaired in cognition.Review of the psychiatric visits dated 01/27/26 and the 02/13/26 provided by the facility by the psychiatric Nurse Practitioner (NP) made no mention of consultation with FM13.Review of the Progress Notes in the EMR under the Progress Notes tab indicated no documentation that FM13 was informed of the risks and benefits or made aware that psychiatric visits were being made bi-weekly. During an interview on 02/19/26 at 10:13AM, FM13 was asked if she had been consulted about R13 having psychiatric visits. She stated, No, and we would not have agreed to that. [R13] has been completely uncommunicative for months. She [R13] babbles at times but rarely opens her eyes anymore.During an interview on 02/19/26 at 11:00 AM, the Director of Nursing (DON) was asked if FM13 should have been made aware of R13 seeing a psychiatrist. The DON stated, Yes, they should have been notified. During an interview on 02/19/26 at 11:30 AM, the Administrator was asked if FM13 should have been made aware of R13's psychiatric visits. The Administrator stated, Yes, they should have been notified. The Administrator stated, We have engaged with a mental health group, so they had more access to psychiatric treatment. They were pretty much given blanket access to see anyone on any mood-altering medications. Since [R13] was on Lorazepam the psychiatric NP saw her since [R13's name] pulled over on a list of residents on mood-altering drugs.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancashire Post Acute	287 School Street Kilmarnock, VA 22482

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 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to ensure residents were free from verbal abuse by staff for one resident (Resident (R) 59) in a total sample of 32. This failure placed residents at risk of being demeaned and lower self-esteem.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R59 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy (a neurological disorder identified at birth), paraplegia (paralysis of two limbs), and malignant colon cancer.Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 11/14/25 revealed R59 had a Brief Interview of Mental Status (BIMS) of 15 out of 15 which indicated R59 was cognitive and was always incontinent of bowel.Review of the 05/16/25 Administrator Statement provided by the Administrator revealed, . On May 11, 2025, DON [director of nursing] received a report from a CNA [certified nurse aide] that R59 told her that another CNA, [CNA1] had used profanity while providing care for R59 on Friday, May 10, 2025 .R59 said that as he was being given a shower, he had a bowel movement in [sic] the floor while sitting on the shower chair. R59 reports the CNA became upset with him and called him an 'A-hole.' The team member [CNA1] was not scheduled the day report was received. Management staff has been unable to reach the team member for a statement after multiple attempts .The team member [CNA1] has been removed from the schedule and terminated .During an interview on 02/17/26 at 9:41 AM, R59 stated, CNA1 wheeled me into the shower, I had to have a bowel movement, and it went all over the floor. CNA1 called me an 'A-hole' which made me feel terrible, but when you have to go you have to go. CNA1 did clean it up and I went and told the head nurse [DON], and she told me that CNA1 will never bother me again. During the interview R31, who was R59's roommate, was in the room at the time and confirmed that CNA1 had verbally abused R59.During an interview on 02/18/26 at 09:47 AM, the Administrator stated, CNA1 was only an employee for a short time. When I spoke to R31 she stated that though she had not been verbally abused by CNA1 she confirmed that CNA1 had verbally abused R59. The Administrator was asked if she had documented this conversation. The Administrator stated, No. We just talked with residents and only documented that we did this only in the Administrator Statement.Review of the facility's policy titled, Resident Abuse Policy and Procedure, dated 10/31/22. revealed, .It is the policy of this facility to ensure the resident will be free from abuse, neglect, misappropriation of resident property, and exploitation .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Lancashire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 287 School Street Kilmarnock, VA 22482	

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 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of facility policy, the facility failed to thoroughly investigate an allegation of verbal abuse for one resident (Resident (R) 59) in a total sample of 32. This failure placed residents at risk of further abuse and a diminished quality of life.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R59 was admitted to the facility on [DATE] with diagnoses that included cerebral palsy (a neurological disorder identified at birth), paraplegia (paralysis of two limbs), and malignant colon cancer.Review of the quarterly Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 11/14/25 revealed R59 had a Brief Interview of Mental Status (BIMS) of 15 out of 15 which indicated R59 was cognitive and was always incontinent of bowel.Review of the 05/16/25 Administrator Statement provided by the Administrator revealed, . On May 11, 2025, DON [director of nursing] received a report from a CNA [certified nurse aide] that R59 told her that another CNA, [CNA1] had used profanity while providing care for R59 on Friday, May 10, 2025 .R59 said that as he was being given a shower, he had a bowel movement in [sic] the floor while sitting on the shower chair. R59 reports that CNA1 became upset with him and called him an 'A-hole.' The team member [CNA1] was not scheduled the day report was received. Management staff has been unable to reach the team member for a statement after multiple attempts .The team member [CNA1] has been removed from the schedule and terminated .The facility investigation has been unable to determine if there was indeed profanity used by the team member [CNA1] .Residents on the same hall were interviewed with no complaints of abuse or mistreatment by any staff member .During an interview on 02/18/26 at 9:47 AM, the Administrator was asked if she had any documentation to show that she had spoken to other residents on the unit and if they had experienced any verbal abuse by CNA1 and what their response was. The Administrator stated, No. In our previous ownership we did not do this. We just talked with the residents, but I did mention this in the Administrator Statement. The Administrator was asked if she had spoken to other staff members regarding the allegation of verbal abuse and if she had documented these conversations. The Administrator stated, No.During a follow-up interview on 02/19/26 at 4:30 PM, the Administrator was asked who was the unknown CNA that reported the allegation and if she/he was interviewed for your investigation. The Administrator stated, I don't know who that was.Review of the facility's policy titled, Resident Abuse Policy and Procedure, dated 10/31/22 revealed, .All alleged violations involving mistreatment, neglect, exploitation or abuse, including injuries of an unknown source and misappropriation of resident property, must be reported immediately to the Administrator/designee of the facility. The facility must complete a thorough written investigation and must prevent further potential abuse while the investigation is in process .

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancashire Post Acute	287 School Street Kilmarnock, VA 22482

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 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident?s assessment data and transmit these data to the State within 7 days of assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, and record review, the facility failed to electronically transmit the Minimum Data Set (MDS) assessment withing 14 days of completing the assessment for two residents (Residents (R)89 and R117) in a total sample of 32. This failure placed residents at risk of unmet health needs.Findings include:1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R89 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, chronic kidney disease, and heart disease.Review of the quarterly MDS located in the MDS tab of the EMR with an assessment reference date (ARD) of 10/26/25 revealed that the MDS was 15 days overdue for transmission to the Center for Medicare and Medicaid Services (CMS).During an interview on 02/19/26 at 11:34 AM, the MDS Coordinator (MDSC) confirmed that the assessment was overdue for transmission to CMS.2. Review of the admission Record located in the Profile tab of the EMR revealed R117 was admitted to the facility on [DATE] with diagnoses that included pressure ulcers.Review of the admission MDS located in the MDS tab of the EMR with an ARD of 02/03/26 revealed that the MDS was nine days overdue for transmission to CMS.During an interview on 02/19/26 at 4:53 PM, the MDSC confirmed that the admission MDS was overdue for transmission to CMS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancashire Post Acute	287 School Street Kilmarnock, VA 22482

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 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. Based on record review, interviews, and facility policy review, the facility failed to refer two residents (Resident (R)8 and R97) in a sample of 31 for Level II Pre admission Screening and Resident Review (PASARR) evaluation and determination after each was identified with a new diagnosis of mental illness. This failure created the potential for a lack of specialized and rehabilitation services to benefit the residents.Findings include:1.Review of R8's admission Record located under the profile tab of the electronic medical record (EMR) indicated an admission date of 12/11/19 with diagnoses of dementia (added 10/16/23), cognitive communication deficit (added 10/16/23), bipolar disease (added 03/21/25), major depressive disorder (added 10/16/23), and schizophrenia (added 10/16/23).Review of R8's Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions provided by the facility with a screening date of 12/06/19 indicated R8 did not have a current serious mental illness.Review of R8's quarterly Minimum Data Set (MDS) found under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 09/15/25 indicated diagnoses of bipolar disorder, psychotic disorder, and schizophrenia.2.Review of R97's admission Record located under the profile tab of the EMR indicated an admission date of 04/05/23 with diagnoses of depression, anxiety disorder, and nightmare disorder.Review of R97's Screening for Mental Illness, Mental Retardation/Intellectual Disability, or Related Conditions provided by the facility with a screening date of 02/28/23 indicated R97 did not have a current serious mental illness. Review of R97's MDS found under the MDS tab of the EMR with an ARD of 12/05/25 indicated a diagnosis of post-traumatic stress disorder (PTSD).During an interview on 02/18/26 at 3:43PM the Regional Director of Social Work (RDSW) stated that documentation could not be found for R8 and R97 to support a referral was made for PASARR Level II.During an interview on 02/20/26 at 6:10PM the Regional Director of Operations (RDO) stated that going forward an audit would be conducted for all new diagnoses and ensure that residents with diagnoses that meet criteria would be referred for appropriate PASARR review.Review of the facility's admission Criteria policy dated 2001 indicated that 8. All new admissions and readmissions are screened for mental disorders (MD), intellectual disabilities (ID) or related disorders (RD) per the Medicaid Pre-admission Screening and Resident Review (PASARR) process. a. The facility conducts a level I PASARR screen for all potential admissions, regardless of payer source, to determine if the individual meets the criteria for MD, ID, or RD. b. If the level 1 screen indicates that the individual may meet the criteria for a MD, ID, or RD, he or she is referred to the state PASARR representative for the Level II (evaluation and determination) screening process.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026
NAME OF PROVIDER OR SUPPLIER Lancashire Post Acute		STREET ADDRESS, CITY, STATE, ZIP CODE 287 School Street Kilmarnock, VA 22482	

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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. Based on observations, interviews, and record review, the facility failed to ensure the Fall Care Plan was updated to include interventions related to a fractured wrist for one resident (Resident (R) 20) in a total sample of 32. This failure placed residents at risk for increased complications.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R20 was admitted to the facility diabetes and congestive heart failure.Review of the annual Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 12/06/25 revealed R89 had a Brief Interview of Mental Status (BIMS) score of 11 out of 15 which indicated R89 was moderately impaired in cognition, had a fall history and had one non-injury fall since the previous MDS.Review of the Nursing Note located in the Notes tab of the EMR revealed, .On 01/06/26 resident attempting to transfer from wheelchair to bed, lost her balance resident found lying on floor yelling out saying my wrist hurts. Not able to do complete ROM [range of motion] due to extreme pain to right arm. MD notified gave an order to send to ER [emergency room] for evaluation and treatment .Review of an 01/06/26 Nursing Note located in the Notes tab of the EMR revealed, .Resident returned to facility with medical transport after being seen post fall .X-ray of right elbow and right wrist. DX [diagnosis] closed fracture of right wrist .Resident is to leave splint in place until she sees ortho .Review of the Fall Care Plan located in the Care Plan tab of the EMR revealed, R20 has the potential for pain + Left femur fracture (history) + Restless leg syndrome + 1/6/26 Fracture right wrist. Interventions included: Encourage R20 to tell nurse when pain interventions are not being effective, if unable monitor for non-verbal indicators of pain .Provide therapy consult as ordered by a physician .Report to physician when medications or other interventions are not being effective .Sling to right arm as ordered .Administer pain meds as ordered .Follow up Ortho appointment as ordered .During an observation and interview on 02/17/26 at 10:46 AM, R20 stated that she broke her wrist recently. A wrist splint with Velcro ties were observed on her right wrist, however, the Velcro ties were not connected. R20 was asked why the Velcro ties were connected. R20 was unable to answer the question. During an observation on 02/17/26 at 2:51 PM, R20 had the right wrist splint on but the Velcro ties were connected. R20 was observed removing the splint and laying it on her bed. R20 stated, I remove the splint and put it back on when I want to.During an interview on 02/18/26 at 2:38 PM, Registered Nurse (RN) 1, confirmed that R20 was independent in applying and removing her wrist brace.During an interview on 02/20/26 at 5:15 PM, the Director of Nursing (DON) acknowledged that the care plan should have been updated to include R20's independent applying and removing of the right wrist brace.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancashire Post Acute	287 School Street Kilmarnock, VA 22482

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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews, and record review, the facility failed to provide care and services for one resident (Resident (R) 20) in a total sample of 31. The facility failed to monitor a fractured right wrist for increased swelling and bruising for R20. This failure placed the residents at risk of medical complications.Findings include:Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R20 was readmitted to the facility on [DATE] with a diagnosis of a right closed fractured wrist.Review of the significant change Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 02/12/26 revealed R20 had a Brief Interview of Mental Status (BIMS) score of nine out of 15 which indicated R20 was moderately impaired in cognition, had a fall history, and one major injury fall since the previous MDS.Review of a Nursing Note located in the Notes tab of the EMR revealed, On 01/06/26 resident attempting to transfer from wheelchair to bed, lost her balance resident found lying on floor yelling out saying my wrist hurts. Not able to do complete ROM [range of motion] due to extreme pain to right arm. MD notified gave an order to send to ER for evaluation and treatment. EMT [emergency medical technician] splinted right arm before transferring to stretcher.Review of a Nursing Note located in the Notes tab of the EMR revealed, On 01/06/26 resident returned to facility with medical transport after being seen post fall. Noted test-CT [computerized tomography-a medical imaging test], X-ray of right elbow and right wrist. Dx [diagnosis] closed fracture of right wrist. Resident is to follow up with MD and orthopedics .Resident is to leave splint in place until she sees ortho.During an interview on 02/17/26 at 10:46 AM, R20 confirmed that she broke her wrist. An observation revealed that a soft splint was on her right wrist, however, the Velcro straps were not attached. R20 had removed the splint independently. The wrist showed bruising and swelling on the back side of the wrist/forearm. R20 was asked if she was in pain. R20 stated, No. There were no signs or symptoms of non-verbal cues of pain observed.A review of the January 2025 Medication Administration Record and the Treatment Administration Record both located in the Orders tab of the EMR revealed no documentation that nursing staff were monitoring R20's right wrist for increased or decreased swelling and bruising.During an interview on 02/18/26 at 2:38 PM, Registered Nurse (RN)1 confirmed that there was no monitoring of the wrist or brace removal by R20 in the EMR.During an interview on 02/18/26 at 2:54 PM, the Director of Nursing (DON) was asked what her expectation was regarding monitoring of the wrist fracture. The DON stated, It should have been monitored.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancashire Post Acute	287 School Street Kilmarnock, VA 22482

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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure an active physician order for oxygen administration for one resident (Resident (R) 9) reviewed for oxygen administration of 31sample residents. This failure had the potential for the residents to receive increased oxygen causing hyperoxia (cells, tissues and organs are exposed to an excess supply of oxygen).Findings include:Review of R9's admission Record located in the Profile tab of the electronic medical record (EMR) revealed admitted on [DATE] with diagnosis chronic obstructive pulmonary disease, end stage renal disease and Type 2 Diabetes. Review of R9's significant change Minimum Data Set (MDS) located under the MDS tab of the EMR with an Assessment Reference Date (ARD) of 12/12/25, revealed a Brief Interview for Mental Status (BIMS) score of 15 out of 15 which indicated R1 was cognitively intact. Review of R9's Care Plan located under the Care Plan tab of the EMR dated 10/06/20 and revised on 01/08/26 revealed the resident was not care planned for oxygen. Review of R9's Physician Orders located under the Orders tab in the EMR, dated 01/08/26, revealed no current order for oxygen. During observations 02/17/26, at 1:15PM and on 02/18/26 at 8:35 AM the resident was lying in bed using a nasal cannula and the oxygen concentrator was set at four liters per minute (LPM). During an interview on 02/20/26 at 2:00PM Licensed Practical Nurse (LPN)1 confirmed R9 received oxygen and that a resident should not receive oxygen without a physician order.During an interview on 02/20/26 at 2:20PM, Registered Nurse (RN)1 confirmed R9 received oxygen and that a resident should not receive oxygen without a physician order. During an interview on 02/20/26 at 5:22 PM, the Director of Nursing (DON) stated that a resident should not receive oxygen without a physician order. That R9 had been in and out of the hospital and it must have been overlooked.No oxygen policy was provided by the facility.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495345	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Lancashire Post Acute	287 School Street Kilmarnock, VA 22482

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 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and facility policy review, the facility failed to provide documentation, when declined, that indicated that the resident and/or representative was provided education of the risks/benefits of the influenza and pneumonia vaccines for three of five residents (Residents (R)2, R19, and R20) reviewed for influenza and pneumonia vaccinations in a total sample of 31. This failure placed the residents or representatives of not knowing what the risk/benefits were of the influenza and pneumococcal vaccines before declining the vaccine.Findings included:1. Review of the admission Record located in the Profile tab of the electronic medical record (EMR) revealed R2 was admitted to the facility on [DATE] with diagnosis that included Alzheimer's disease and dementia.Review of the annual Minimum Data Set (MDS) located in the MDS tab of the EMR with an assessment reference date (ARD) of 11/08/25 revealed R2 had a Brief Interview of Mental Status (BIMS) score of 99 which indicated R2 was severely impaired in cognition and was offered and declined the influenza vaccine.2. Review of the admission Record located in the Profile tab of the EMR revealed R19 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder and major depressive disorder.Review of quarterly MDS located in the MDS tab of the EMR with an ARD of 01/04/26 revealed R19 had a BIMS score of 15 out of 15 which indicated R19 was cognitive and offered and declined both the influenza and pneumococcal vaccines.3. Review of the admission Record located in the Profile tab of the EMR revealed R20 was admitted to the facility on [DATE] with diagnoses that included diabetes and heart failure.Review of the annual MDS located in the MDS tab of the EMR with an ARD of 12/06/25 revealed R20 had a BIMS score of 10 out of 15 which indicated R20 was moderately impaired in cognition and was offered and refused the influenza and pneumococcal vaccinations.During an interview on 02/10/26 at 12:44 PM, the Infection Preventionist (IP) stated, I was not aware that there needed to documentation when a resident or representative declines the vaccines.Review of the facility's policy titled, Pneumococcal Vaccine and Influenza Vaccine, dated August 2025 revealed, .The resident (or representative) has the right to refuse vaccines. If refused, the date of and stated reason for the refusal of the vaccine are documented in the resident's medical record .