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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/7/2023 through 3/9/2023. The facility was in substantial compliance with 42 CFR 483.73, Requirement for Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced onsite Medicare/Medicaid standard survey was conducted 03/7/2023 through 03/9/2023. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. One(1) complaint was investigated during the survey: VA00056835 One allegation: Substantiated without deficient practice. The census in this 52 certified bed facility was 39 at the time of the survey. The survey sample consisted of twelve (12) current Resident reviews and three (3) closed record reviews.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to complete an accurate minimum data set (MDS) for one of fifteen residents in the survey sample (Resident #32).	F 641	1.MDS coordinator made correction to section O of resident #32 MDS upon being notified of the inaccurate coding. 2.100% audit of current residents who are coded on section O of the MDS as having hospice services has been completed. All	4/18/23

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

Electronically Signed | 04/07/2023

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F 641	Continued From page 1 The findings include: Resident #32's MDS inaccurately documented the resident received hospice services. Resident #32 was admitted to the facility with diagnoses that included Alzheimer's dementia, anxiety, mood disorder, cerebral infarction, pelvic fracture, and depression. The MDS dated 12/16/22 assessed Resident #32 with severely impaired cognitive skills. Section O. of Resident #32's MDS (minimum data set), dated 12/16/22, documented the resident received hospice services while in the nursing facility. Review of Resident #32's clinical record documented no provision of hospice services. The record documented a physician's order dated 12/14/22 for a "Do Not Hospitalize" status, in addition to a Do Not Resuscitate/Do Not Intubate order. The record also documented a physician's order dated 12/14/22 for a hospice consult, but there was no order for enrollment in a hospice service. Resident #32's plan of care (initiated 12/20/22) listed that the resident was receiving comfort/palliative care. On 3/8/23 at 1:20 p.m., the registered nurse (RN #1) caring for Resident #32 was interviewed about the MDS indicating the provision of hospice services. RN #1 stated that the resident's family discussed hospice but never elected their services. RN #1 stated the resident was currently with comfort/palliative care orders. RN #1 stated, "The family never elected hospice." On 3/8/23 at 1:25 p.m., the MDS coordinator (RN	F 641	residents have an order to receive hospice services. No other residents were identified to have incorrect coding on section O of the MDS. 3.Administrator and/ or designee provided in-service education to MDS Coordinators regarding proper coding of the MDS and that all residents who are coded as receiving hospice services have an order for resident to receive hospice services. 4.Prior to the weekly submission of MDS□, the Director of Nursing and/or designee will audit section O weekly for 6 weeks to ensure proper coding and randomly thereafter. The Director of Nursing and/or designee will monitor and report any finding or trends to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations.	

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F 641	Continued From page 2 #2) was interviewed about Resident #32's MDS of 12/16/22 listing hospice services. RN #2 reviewed the 12/16/22 MDS and stated there was an order for a hospice consult but that Resident #32 "never went on hospice." RN #2 stated that the MDS was inaccurately coded with hospice services for Resident #32. The Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual on page O-2 concerning section O. for coding special treatments, procedures, and programs, documented "...Check all treatments, procedures, and programs received or performed by the resident after admission/entry or reentry to the facility..." Page O-5 documented concerning coding for hospice care, "...Code residents identified as being in a hospice program for terminally ill persons where an array of services is provided for the palliation and management of terminal illness and related conditions. The hospice must be licensed by the state as a hospice provider and/or certified under the Medicare program as a hospice provider..." (1) This finding was reviewed with the administrator and director of nursing during a meeting on 3/8/23 at 4:20 p.m. (1) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Version 1.17.1, Centers for Medicare & Medicaid Services, Revised October 2019	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		4/18/23

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F 656	Continued From page 3	F 656		

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

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F 656	Continued From page 4 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive care plan for one of fifteen residents in the survey sample (Resident #25). The findings include: Resident #25, treated with a hypnotic medication for insomnia, had no plan of care developed addressing sleep problems. Resident #25 was admitted to the facility with diagnoses that included hypothyroidism, insomnia, osteoarthritis, hyperlipidemia, depressed mood, and atrial fibrillation. The minimum data set (MDS) dated 2/14/23 assessed Resident #25 as cognitively intact. Resident #25's clinical record documented a physician's order dated 2/14/22 for Ambien (zolpidem tartrate) 5 milligrams at each bedtime for insomnia. Resident #25's medication administration record documented nightly administration of the Ambien from 3/1/23 through 3/7/23. Resident #25's plan of care (dated 2/6/23) included no problems, goals and/or interventions regarding insomnia. On 3/8/23 at 4:47 p.m., the director of nursing (DON) was interviewed about a plan of care regarding Resident #25's insomnia treated with	F 656	1.MDS Coordinator corrected Resident #25 Care plan to include focus addressing sleeping difficulties with goals and interventions to address insomnia. 2.100% audit of current residents was completed on all residents who are receiving a sedative/hypnotic medication. 3.Nurse Educator and/ or designee provided in-service education to current RN□s and LPN□s that when a resident is started on a sedative/hypnotic medication, the resident care plan is updated to reflect a focus area with goals and interventions. 4.The Director of Nursing and/or designee will audit any resident receiving new orders for sedative/hypnotic medication weekly for 6 weeks and randomly thereafter. The Director of Nursing and/or designee will monitor and report any finding or trends to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations.	

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F 656	Continued From page 5 nightly Ambien. The DON stated she thought there should be a plan about insomnia since the resident was taking medication for sleep. The DON stated the MDS coordinator was responsible for care plan development. On 3/8/23 at 3:54 p.m., the registered nurse MDS coordinator (RN #2) was interviewed about a plan of care addressing Resident #25's sleeping difficulties. RN #2 stated that the plan listed the resident was prescribed a hypnotic. When asked for assistance in locating the documentation, RN #2 found nothing in the plan of care addressing the resident #25's insomnia/sleeping difficulties. This finding was reviewed with the administrator and director of nursing during meeting on 3/8/23 at 4:20 p.m.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility policy review, the facility staff failed to ensure professional standards of nursing were followed for one of 15 residents, Resident #4. Findings include: Resident # 4 was admitted to the facility 2/7/23 with diagnoses to include, but were not limited to: orthopedic aftercare, heart failure, and diabetes.	F 658	1.The expired insulin was immediately removed from medication cart and discarded. Medical Director was notified of expired medication being administrated to resident #4. There were no adverse effects to resident #4. 2.No other residents were affected by this expired medication. 3.Nurse Educator and/ or designee provided in-service education to current	4/18/23

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F 658	Continued From page 6 The admission MDS (minimum data set) dated 2/13/23 had Resident # 4 assessed as cognitively intact with a score of 13/15. On 3/9/23 at 8:20 a.m., accompanied by licensed practical nurse (LPN) #2, a medication cart on the second floor was inspected. An opened 10 ml (milliliter) vial of Lantus insulin (100 units/ml) was stored in the cart. The vial was marked with an opened date of 2/8/23 and was labeled for a current resident (Resident #4). LPN # 2 stated the insulin should have been discarded 3/7/23. On 3/9/23 at approximately 10:05 a.m., the DON (director of nursing) was made aware of the finding. When asked if it was known if the expired insulin had been administered, the DON stated that she would check. The DON returned a few minutes later and stated "Yes, the insulin was administered last night." A copy of the facility policy for medication administration and medication labeling/storage was then requested. On 3/9/23 at approximately 10:25 a.m., the blood sugars for Resident # 4 was reviewed. The blood sugars did not reveal any issues as far as adequate coverage; on 3/8/23 at 10:00 p.m. when the insulin was administered, the blood sugar reading was recorded as 382 mg/dl. At 8:00 a.m. on 3/9/23 the blood sugar was recorded as 204 mg/dl. The resident did not appear to have any negative effect from receiving the expired insulin. On 3/9/23 at approximately 10:40 a.m., the DON stated there was no policy specific to medication administration to include expired medications. She further stated "The expectation is that staff is to call the pharmacy at least three (3) days prior	F 658	RN□s and LPN□s that they are to review expiration dates of medication prior to administrating medication to residents. 4.The Director of Nursing and/or designee will audit medication carts 2 times per week for 6 weeks to ensure no expired medications are available on the medication carts. After 6 weeks, Director of Nursing and/or designee will monitor medication carts for expired medication monthly. The Director of Nursing and/or designee will monitor and report any finding or trends to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations.	

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F 658	Continued From page 7 to expiration and reorder the medication. If the order has not been received by the time the medication expires, they are to check the cubex (a medication dispenser) or the insulin stat box and pull from there. The open date is put on the label, staff should look at that date and ensure the medication is not expired prior to administration." The facility policy "Storage of Drugs" directed "13. Drugs shall not be kept on hand after the expiration date on the label....." The administrator and DON were informed of the above findings during a meeting with facility staff at 10:45 a.m. 3/9/23. No further information was provided prior to the exit conference.	F 658		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to follow physician orders for one of 15 residents, Resident #4. Findings include: Resident # 4 was admitted to the facility on	F 684	1.Upon the Administrator and Director of Nursing (DON) being notified of insulin medication being held for resident #4 without proper doctor notification, LPN #1 was provided in-service education regarding holding medications and notification to doctor. Medical Director	4/18/23

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F 684	Continued From page 8 2/7/23, with diagnoses to include, but were not limited to: orthopedic aftercare, heart failure, and diabetes. The admission MDS (minimum data set) dated 2/13/23 had Resident # 4 assessed as cognitively intact with a score of 13/15. On 3/8/23 at approximately 1:45 p.m., Resident #4's clinical record was reviewed. A nurses note, dated 2/23/23 at 3:45 a.m., documented "Insulin Glargine -Inject 20 units at bedtime for Diabetes Mellitus type 2. Held per nursing judgement. Res noted to not have much of an appetite and refused bedtime snack with BS of 118." On 3/8/23 at approximately 3:05 p.m., the administrator and DON (director of nursing) were asked if they were aware of the above note. The administrator stated that she was not and thought the expectation was to call the doctor prior to a held medication. When asked if the nurse who wrote the note was working, the Administrator stated that nurse was not scheduled to work until tonight, 11-7 shift. On 3/8/23 at approximately 3:15 p.m. during a conversation with LPN (licensed practical nurse) # 2, LPN # 1, identified as the nurse who had written the note, was at the medication cart. She stated she usually worked nights but came in to work the evening shift. LPN # 1 was interviewed about the held insulin. LPN # 1 stated "I'm a travel nurse from another state, and we do not have to notify physicians for a nursing judgement; we usually have parameters ordered for when to call the physician, and then use our nursing judgement based on the physician ordered parameters." LPN # 1 was asked about parameters for Resident # 4. LPN # 1 stated, "She [Resident #4] has sliding scale orders... the	F 684	was notified of medication being held for resident #4. There were no adverse effects to resident #4. 2.No other residents were affected by the held medication. 3.Nurse Educator and/ or designee provided in-service education to current RN□s and LPN□s regarding medication administration. Nurses are required to follow Doctor Orders and if a nurse has a concern about medication dosage, holding, resident refusal; nurse must notify doctor for further orders/ clarification. 4.The Director of Nursing and/or designee will audit Medication Administration Records (MAR) for any medications being held, 3 times per week for 6 weeks to ensure Doctor notification was completed on all medications held. After 6 weeks, Director of Nursing and/or designee will monitor held medication weekly for 1 month and randomly thereafter. The Director of Nursing and/or designee will monitor and report any finding or trends to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations.	

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F 684	Continued From page 9 resident was a new admit and had no parameters for when to call the Dr, and since she had not eaten dinner and refused her bedtime snack, her blood sugar was 118 so I held it as had I given it, she would have bottomed out. I did not call the Dr; I did report on it at shift change." On 3/8/23 at approximately 4:20 p.m,. the administrator and DON presented a copy of the education provided to LPN # 1. The education "Medication Holds" included "Nurses are to follow doctors orders for medication administration. If nurse has a concern about medication dosage, holding, resident refusal; nurse must notify doctor for further orders/clarification. This includes insulin orders that are within normal parameters." The administrator further stated that LPN # 1 had been educated immediately, and all nursing staff would be educated for the plan of correction. The end of the day meeting was also held at that time with the administrator and DON. No further information was provided prior to the exit conference.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent	F 686		4/18/23

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F 686	Continued From page 10 with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, and staff interview, the facility staff failed for one of 15 residents in the survey sample (Resident # 2) to provide pressure ulcer treatment consistent with professional standards of practice. Staff failed to properly clean work surfaces, as well as employ handwashing during a dressing change. The findings were: Resident # 2 in the survey sample was admitted with diagnoses that included epilepsy, anemia, gastroesophageal reflux disease, thyroid disorder, seizure disorder, cataracts, Stage IV sacral pressure ulcer, constipation, dysuria, erythemia intertrigo, pain, urinary retention. Resident #2 was also admitted under palliative care. According to an Admission Minimum Data Set with an Assessment Reference Date of 2/15/2023, Resident #2 was assessed under Section C (Cognitive Patterns) as having short and long term memory problems, with severely impaired daily decision making skills. Under Section G (Functional Status), Resident #2 was assessed as totally dependent with one person physical assist for bathing; as needing extensive assistance with two persons physical assist for dressing; as needing extensive assistance with one person physical assist for eating and person hygiene; as transferring and having locomotion on and off the nursing unit with two persons physical assist only once or twice; and, as not	F 686	1.LPN#4 was provided in-service education regarding proper procedures for resident wound dressing changes including proper hand hygiene and surface disinfection. There were no adverse effects to resident #2. 2.No other residents were affected by this deficient practice. 3.Nurse Educator and/ or designee provided in-service education to current RN□s and LPN□s regarding proper procedures for resident wound dressing changes including proper hand hygiene and surface disinfection. 4.The Director of Nursing and/or designee will monitor random resident wound dressing changes 2 times per week for 6 weeks to ensure proper wound dressing procedures are followed. After 6 weeks, Director of Nursing and/or designee will monitor randomly thereafter. The Director of Nursing and/or designee will monitor and report any finding or trends to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations.	

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F 686	Continued From page 11	F 686		

walking in the room or unit corridor.

Resident # 2 had the following physician's order for wound care: "Clean sacral wound with Dakin's or Vashe solution everyday, gently fill wound bed and pack any cavities with Aquacel Ag, then cover with gauze and Allevyn type dressing everyday until healed (measure/document every Wednesday)."

At approximately 10:30 a.m. on 3/8/2023, LPN # 4 (Licensed Practical Nurse) was observed performing a dressing change to Resident # 2's sacral pressure ulcer. Without cleaning or sanitizing the surface, LPN # 4 placed the dressing change supplies directly on the resident's overbed table.

(NOTE: "Disinfection and Sterilization...Surface areas to treat. All dirty surfaces and areas must be fully exposed to disinfecting and sterilizing agents. Noncritical items must be disinfected. Some of these items include...Bedside trays and client furniture." Ref. Fundamentals of Nursing, 7th Edition, 2009, Potter-Perry, Chapter 34, pages 658 - 659.)

With gloves on, LPN # 4 assisted the resident to turn in bed and then pulled back the resident's incontinence brief. The resident was soiled with bowel movement, which LPN # 4 cleaned using wet washcloths. LPN # 4 removed her gloves, reached in to the supply bag and retrieved a hand sanitizer wipe (towelette) which she then used to wipe her hands. After putting on clean gloves, LPN # 4 removed the soiled pressure ulcer dressing from Resident # 2's sacrum.

Upon observation, Resident # 2's sacral pressure

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 12	F 686		

ulcer appeared to be clean, and without signs of infection. The wound was approximately two inches in length and one inch wide. There was dark colored slough (necrotic - nonviable tissue) on approximately 25% of the wound bed.

LPN # 4 then took off her right glove, retrieved a bottle of Dakin's solution, a tube of Santyl ointment, dressings/gauze, from the supply bag and placed them on the overbed table. LPN # 4 then removed her left glove and put on another pair of gloves.

Using a template and a cotton tipped applicator, LPN # 4 measured the size and depth of Resident # 2's pressure ulcer. After removing the template, LPN # 4 removed her gloves and put on another pair of clean gloves. LPN # 4 then obtained a clean pad from the resident's closet, placed it under the resident, cleansed the pressure ulcer with Dakin's solution/gauze, applied Santyl ointment, packed Aquacel gauze into the wound, and then covered the ulcer with a foam border dressing. LPN # 4 then repositioned Resident #2 before removing and discarding her gloves. She then put the dressings/treatments back into the supply bag, discarded the soiled items, and washed her hands prior to leaving the room.

The Progress Notes in Resident # 2's Electronic Health Record included the following entry:

3/8/2023 - "Sacral wound measures 5cm (centimeters) x (by) 2.5cm x 1.25cm. Tunneling at 12 o'clock measures 2.1cm, has moderate amount of serosanguinous drainage present at this time. Epibole on 9 - 6 o'clock edge. Wound has 75% granulation tissue, 25% slough present."

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 13 At approximately 10:55 a.m. on 3/8/2023, LPN # 4 was interviewed regarding the dressing change on Resident # 2's sacral pressure ulcer. Asked about placing the supplies on the overbed table without cleaning it first, LPN # 4 stated the supplies were in a plastic bag. Regarding hand hygiene during the dressing change, LPN # 4 said that she should have washed her hands after cleaning the bowel movement, instead of using a sanitizer wipe (towelette). When asked about handwashing, LPN # 4 said that she usually performed hand hygiene between glove changes. The findings during the dressing change observation were discussed at meeting at 4:00 p.m. on 3/8/2023 that included the Administrator, Director of Nursing, and survey team.	F 686		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately	F 761		4/18/23

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 761	Continued From page 14 locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, and staff interview, the facility staff failed to ensure expired insulin was not available for use on one of two inspected medication carts (second-floor cart). The findings include: A vial of Lantus insulin for a current resident that had been opened beyond 28 days was available for use on a second-floor medication cart. On 3/9/23 at 8:20 a.m., accompanied by licensed practical nurse (LPN) #2, a medication cart on the second floor was inspected. An opened 10 ml (milliliter) vial of Lantus insulin (100 units/ml) was stored in the cart. The vial was marked with an opened date of 2/8/23 and was labeled for a current resident (Resident #4). On 3/9/23 at 8:22 a.m., LPN #2 was interviewed about the opened vial of Lantus and the discard date. LPN #2 stated that the insulin was supposed to be discarded 28 days after opening. LPN #2 stated that the Lantus insulin in the cart "was actually past the date" for use. LPN #2 stated that the opened vial of Lantus insulin should have been discarded after 3/6/23.	F 761	1.Medication was immediately removed from medication cart and discarded. Medical Director was notified of expired medication being administrated to resident #4. There were no adverse effects to resident #4. 2.No other residents were affected by this expired medication. 3.Nurse Educator and/ or designee provided in-service education to current RN□s and LPN□s that they are to review expiration dates of medication prior to administrating medication to residents. 4.The Director of Nursing and/or designee will audit medication carts 2 times per week for 6 weeks to ensure no expired medications are available on the medication carts and medications are properly dated. After 6 weeks, Director of Nursing and/or designee will monitor medication carts for expired and properly dated medication monthly. The Director of Nursing and/or designee will monitor and report any finding or trends to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations.	

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 15	F 761		

On 3/9/23 at 8:36 a.m., the director of nursing (DON) was interviewed about storage time of opened insulin. The DON stated all insulins were to be discarded 28 days after opening. On 3/9/23 at 9:13 a.m., the DON stated the opened vial of Lantus insulin found in the medication cart should have been discarded on 3/7/23. The DON stated nurses were supposed to check and discard any out-of-date insulin prior to their expiration. The DON stated medication expiration dates were posted on a chart in the medication room for reference by nurses as needed.

The posting titled Medication Expiration Dates (undated) documented insulin of all types expired 28 days after opening. This protocol documented, "...Medications will be discarded according to date open expiration date or according to the manufacturer expiration date, whichever comes first..."

The facility's policy titled Storage of Drugs (revised 5/1/93) documented, "...Drugs shall not be kept on hand after the expiration date on the label, and no contaminated or deteriorated drugs shall be available..."

The Nursing 2022 Drug Handbook on page 790 describes Lantus insulin as a long-acting antidiabetic agent used for the treatment of diabetes. Page 791 of this reference documents regarding administration precautions, "...opened vial in use can be kept unrefrigerated for up to 28 days...Opened vials, whether or not refrigerated, must be used within a 28-day period or they must be discarded..." (1)

This finding was reviewed with the administrator and director of nursing on 3/9/23 at 10:45 a.m.

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 16 (1) Woods, Anne Dabrow. Nursing 2022 Drug Handbook. Philadelphia: Wolters Kluwer, 2022.	F 761		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be	F 880		4/18/23

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17 reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, clinical record review, staff interview, and review of facility policy and procedure, the facility staff failed for one of 15 residents in the survey sample (Resident # 2) to follow infection control practices during a pressure ulcer dressing change. The staff	F 880	1.LPN#4 was provided in-service education regarding proper procedures for resident wound dressing changes including proper hand hygiene and surface disinfection. There were no adverse effects to resident #2.	

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18 member performing the dressing change failed to establish a clean surface for supplies, and failed to perform hand hygiene during glove changes. The findings were: Resident # 2 in the survey sample was admitted with diagnoses that included epilepsy, anemia, gastroesophageal reflux disease, thyroid disorder, seizure disorder, cataracts, Stage IV sacral pressure ulcer, constipation, dysuria, erythemia intertrigo, pain, urinary retention. The resident #2 was also admitted under palliative care. According to an Admission Minimum Data Set with an Assessment Reference Date of 2/15/2023, Resident #2 was assessed under Section C (Cognitive Patterns) as having short and long term memory problems with severely impaired daily decision making skills. Under Section G (Functional Status), the resident was assessed as totally dependent with one person physical assist for bathing; as needing extensive assistance with two persons physical assist for dressing; as needing extensive assistance with one person physical assist for eating and person hygiene; as transferring and having locomotion on and off the nursing unit with two persons physical assist only once or twice; and, as not walking in the room or unit corridor. Resident # 2 had the following physician's order for wound care: "Clean sacral wound with Dakin's or Vashe solution everyday, gently fill wound bed and pack any cavities with Aquacel Ag, then cover with gauze and Allevyn type dressing everyday until healed (measure/document every Wednesday)."	F 880	2.No other residents were affected by this deficient practice. 3.Nurse Educator and/ or designee provided in-service education to current RN□s and LPN□s regarding proper procedures for resident wound dressing changes including proper hand hygiene and surface disinfection. 4.The Director of Nursing and/or designee will monitor wound dressing changes 2 times per week for 6 weeks to ensure proper wound dressing procedures are followed including proper hand hygiene and surface disinfection. After 6 weeks, Director of Nursing and/or designee will monitor randomly thereafter. The Director of Nursing and/or designee will monitor and report any finding or trends to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations.	

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 _____	C 03/09/2023

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 880	Continued From page 19	F 880		

At approximately 10:30 a.m. on 3/8/2023, LPN # 4 (Licensed Practical Nurse) was observed performing a dressing change to Resident # 2's sacral pressure ulcer. Without cleaning or sanitizing the surface, LPN # 4 placed the dressing change supplies directly on the resident's overbed table.

(NOTE: "Disinfection and Sterilization...Surface areas to treat. All dirty surfaces and areas must be fully exposed to disinfecting and sterilizing agents. Noncritical items must be disinfected. Some of these items include...Bedside trays and client furniture." Ref. Fundamentals of Nursing, 7th Edition, 2009, Potter-Perry, Chapter 34, pages 658 - 659.)

With gloves on, LPN # 4 assisted the resident to turn in bed and then pulled back the resident's incontinence brief. The resident was soiled with bowel movement, which LPN # 4 cleaned using wet washcloths. LPN # 4 removed her gloves, reached in to the supply bag and retrieved a hand sanitizer wipe (towelette) which she then used to wipe her hands. After putting on clean gloves, LPN # 4 removed to soiled pressure ulcer dressing from Resident # 2's sacrum.

LPN # 4 then took off her right glove, retrieved a bottle of Dakin's solution, a tube of Santyl ointment, dressings/gauze, from the supply bag and placed them on the overbed table. LPN # 4 remove her left glove and put on another pair of gloves.

Using a template and a cotton tipped applicator, LPN # 4 measured the size and depth of Resident # 2's pressure ulcer. After removing the

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20	F 880		

template, LPN # 4 removed her gloves and put on another pair of clean gloves. LPN # 4 then obtained a clean pad from the resident's closet, placed it under the resident, cleansed the pressure ulcer with Dakin's solution/gauze, applied Santyl ointment, packed Aquacel gauze into the wound and then covered the ulcer with a foam border dressing. LPN # 4 then repositioned the resident before removing and discarding her gloves. She then put the dressings/treatments into the supply bag, discarded the soiled items, and washed her hands prior to leaving the room.

At approximately 10:55 a.m. on 3/8/2023, LPN # 4 was interviewed regarding the dressing change on Resident # 2's sacral pressure ulcer. Asked about placing the supplies on the overbed table without cleaning it first, LPN # 4 stated the supplies were in a plastic bag. Regarding hand hygiene during the dressing change, LPN # 4 said she should have washed her hands after cleaning the bowel movement instead of using a sanitizer wipe (towelette). When asked about handwashing, LPN # 4 said she usually performed hand hygiene between glove changes.

(NOTE: "Applying Dry and Moist Dressings: Step 1. Perform hand hygiene....Step 13. Fold dressing with drainage inside, and remove gloves inside out. With small dressings, remove gloves inside out over dressing. Dispose of gloves and soiled dressings in disposable bag. Perform hand hygiene." Ref. Fundamentals of Nursing, 7th Edition, 2009, Potter-Perry, Chapter 48, pages 1314 - 1315.)

At approximately 8:30 a.m. on 3/9/2023, RN # 5 (Registered Nurse), the Infection Preventionist, was interviewed regarding the dressing change

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21	F 880		

on Resident # 2. RN # 5 said handwashing after cleaning the resident's bowel movement would have been the preferred method of hand cleaning instead of using a sanitizer wipe. RN # 5 also said the overbed table should have been cleaned/sanitized prior to the placement of dressing change supplies, and that infection control protocols require the use of hand sanitizer or hand washing between glove changes.

The facility furnished the following policies for review:

Hand Washing: "...Hand hygiene (using soap and water or alcohol based hand rub) should be performed...Before touching a resident...After touching a resident...After touching a resident('s) surroundings...Hand washing should be performed...Before and after all clean or aseptic techniques/procedures (i.e., before and after changing wound dressing or bandages...After bodily fluid exposure...Before and after removing gloves. Wearing gloves alone is not enough to prevent the spread of infection...When you hands look dirty...."

Hand Rub (Antiseptic): "Alcohol based hand sanitizers can quickly reduce the number of germs on hands in some situations, but sanitizers do not eliminate all types of germs. NOTE: HAND(S) SHOULD BE WASHED WITH SOAP AND WATER AFTER DIRECT CONTACT, EXAMPLE...positioning resident with direct contact, dressing changes, etc...."

The findings regarding hand hygiene were discussed at meeting at 4:00 p.m. on 3/8/2023 that included the Administrator, Director of Nursing, and survey team.

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908 SS=E	Essential Equipment, Safe Operating Condition CFR(s): 483.90(d)(2) §483.90(d)(2) Maintain all mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review and staff interview, the facility staff failed to ensure proper function of one of two walk-in freezers serving the main kitchen. The findings include: The walk-in freezer in the main kitchen was observed with heavy ice build-up across the ceiling and on the floor with frozen drips noted on the outside of food packaging. Staff reported this frozen condensation build-up had been ongoing for over five months. On 3/7/23 at 11:13 a.m., accompanied by a dining manager (other staff #2) and the registered dietitian (other staff #3), the walk-in freezer in the main kitchen was inspected. Thick, frozen condensation was observed across the entire ceiling. The left ceiling area had heavier ice build-up several inches thick. Dripped condensation was frozen on boxes of food stored on the top shelf of the freezer. Ice approximately one inch thick was observed across the floor of the freezer. On 3/7/23 at 11:20 a.m., the sous chef (other staff #1) was interviewed about the widespread ice build-up on the freezer ceiling and floor. The sous chef stated, "That's in work order status." The sous chef stated that there was humidity and when the freezer went into defrost mode,	F 908	1.Dining Services Director and Facility Services Director will have removal of the ice build-up completed by April 14, 2023. 2.No residents were affected by this deficient practice. 3.Administrator and/ or designee provided in-service education to Dining and Facility Services associates regarding proper and timely reporting of equipment malfunction and timely follow up with resolution. 4.Dining Services Director and/or designee will monitor main dining room freezer 2 times per week for 6 weeks to ensure condensation and ice build-up are not occurring. After 6 weeks, Dining Services Director and/or designee will monitor randomly thereafter. The Dining Services Director and/or designee will monitor and report any finding or trends to the Quality Assurance Performance Improvement (QAPI) Committee for further recommendations.	4/18/23

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 23	F 908		

condensation remained frozen, dripped from the ceiling, and resulted in ice accumulation. The sous chef stated a work order was written "sometime last year" about the ice build-up. The sous chef stated that maintenance worked on the freezer once, but the condition was not repaired. The sous chef stated staff members "scraped" the ice down occasionally, but the ice accumulated again with time. The sous chef stated packaging protected food from any drips and freezer temperatures had not deteriorated due to the ice.

On 3/7/23 at 12:14 p.m., the dining service manager (other staff #4) was interviewed about the ice build-up in the walk-in freezer. The dining service manager stated, "That's been back and forth. Right now, it is worse than usual."

On 3/7/23 at 4:30 p.m., the facilities director (other staff #5) was interviewed about the ice build-up in the main kitchen's freezer. The facilities director stated that a work order was entered on 9/8/22 regarding the ice/condensation build-up. The facilities director stated that the door and gasket were repaired and he was not aware the ice build-up was not fixed. The facilities director stated that there were no further work orders entered since 9/8/22 to address the continued problems with the freezer.

The facilities director presented a copy of work order #90931 dated 9/8/22. This work order documented, "... Appliance not working properly...I went to check the freezer and it was frozen up on the coil in the back...had some frost at the top front of the freezer and the door..." The work order was marked completed on 9/19/22.

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 _____	C 03/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY BLUE RI	250 PANTOPS MOUNTAIN RD CHARLOTTESVILLE, VA 22911

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 908	Continued From page 24 This finding was reviewed with the administrator and director of nursing during a meeting on 3/8/23 at 4:20 p.m.	F 908		