State of Virginia

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | VA0270 | A. BUILDING: ______<br>B. WING ______ | 09/29/2016 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| WESTPORT REHABILITATION AND NURSING CENTEI | 7300 FOREST AVE<br>RICHMOND, VA 23226 |

| (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) COMPLETE DATE |
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| F 000 | Initial Comments<br><br>An unannounced biennial State Licensure Inspection was conducted 9/27/16 through 9/29/16. Corrections are required for compliance with the following with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.<br><br>The census in this 225 licensed/certified bed facility was 178 at the time of the survey. The survey sample consisted of 24 current resident reviews (Residents #1 through #24)) and 35 closed record reviews (Residents #25 through #35). | F 000 | | |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>12 VAC 5 - 371 - 360 Clinical Records cross references to F 514<br>Resident assessment and care planning<br>F278 cross reference 12VAC5-371-250E<br><br>Nursing Services<br>F282 cross reference 12VAC5-371-220A<br>F325 cross reference 12VAC5-371-220 C5<br><br>Maintenance and Housekeeping<br>F465 cross reference 12VAC5-371-370L<br><br>12VAC5-371-250. Resident assessment and care planning<br>cross reference to F279<br><br>12VAC5-371-370. Maintenance and housekeeping<br>Cross reference to F-252 | F 001 | Cross Reference F514<br>1. Corrective Action<br>The physician and responsible party were notified of residents random refusals of Senexon S Tab 8.6 - 50 MG<br><br>The Hospice provider for Resident #6 was contacted and instructed to place all Hospice notes on the chart<br><br>2.Other Potential Residents<br>An audit of the MARS (Medication Administration Records) for other residents on unit 3 was completed and no other residents were affected.<br><br>An audit was completed for all hospice residents to validate that the hospice notes were present. No other residents | 10/21/16 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 10/21/16

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| F 001 | Continued From page 1 | F 001 | were affected.<br><br>3.System Changes<br>Licensed Nurses were re-educated on appropriate documentation on back of MARS (Medication Administration Records) for a medication that is refused and the need for physician notification regarding the refusal.<br>A 100% audit of all MARS (Medication Administration Records)will be completed weekly x 3months to validate compliance with documentation and notification.<br><br>Unit Managers were re-educated on need for all documentation to be on residents chart.<br>A 100% audit will be completed weekly x 3 months of all residents on Hospice Services to validate presence of hospice documentation.<br><br>Any areas of non-compliance will be immediately corrected and staff responsible will be counseled.<br><br>4. Monitoring<br>Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.<br><br>Cross Reference F278<br>Corrective Action<br>1.The MDS (Minimum Data Set) for Resident # 4 has been corrected to reflect the coding of dialysis.<br><br>2.Other Potential Residents<br>An audit of the MDS (Minimum Data | |

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| F 001 | Continued From page 2 | F 001 | Set)for all other residents who were receiving dialysis was completed and no other residents were affected.<br><br>3.System Changes<br>The MDS/Care plan Nurses were re-educated on accurate coding of MDS (Minimum Data Set)Assessments for residents receiving dialysis.<br>A 100% audit of the MDS (Minimum Data Set)for all dialysis residents will be completed weekly x 3 months to validate accurate coding of dialysis.Any areas of non-compliance will be immediately corrected and staff responsible will be counseled.<br><br>4. Monitoring<br>Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.<br><br>Cross Reference F282<br>1. Corrective Action<br>The CNA Responsible for providing pudding thickened liquids to Residents #16 was immediately counseled and re-educated regarding providing the correct consistency of liquids based on physicians orders.<br><br>2.Other Potential Residents<br>A review of all residents with physicians orders for thickened liquids was conducted on 9/28/16 for the lunch time meal and no other residents were affected.<br><br>3.System Changes<br>Nursing staff were re-educated regarding | |

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| **WESTPORT REHABILITATION AND NURSING CENTEI** | **7300 FOREST AVE RICHMOND, VA 23226** |

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| F 001 | Continued From page 3 | F 001 | providing the correct consistency of liquids based on physicians orders.<br>An observation of all residents with physicians orders for thickened liquids will be conducted weekly x 3 months to validate that the resident is receiving the correct consistency of thickened liquids. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled.<br><br>4. Monitoring<br>Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.<br><br>Cross Reference F325<br>1. Corrective Action<br>The CNA Responsible for providing pudding thickened liquids to Residents #16 was immediately counseled and re-educated regarding providing the correct consistency of liquids based on physicians orders.<br><br>2.Other Potential Residents<br>A review of all residents with physicians orders for thickened liquids was conducted on 9/28/16 for the lunch time meal and no other residents were affected.<br><br>3.System Changes<br>Nursing staff were re-educated regarding providing the correct consistency of liquids based on physicians orders.<br>An observation of all residents with physicians orders for thickened liquids will be conducted weekly x 3 months to validate that the resident is receiving the | |

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| F 001 | Continued From page 4 | F 001 | correct consistency of thickened liquids. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled.<br><br>4. Monitoring<br>Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.<br><br>Cross Reference F465<br>1.Corrective Action<br>The Clorox Disinfectant spray was removed from the shower room by the unit manager.<br><br>2.Other Potential Residents<br>All other shower rooms were checked on 9/29/16 and cabinets were locked.<br><br>3.System Changes<br>Nursing Staff were re-educated on making sure that the cabinets in the shower rooms are locked when not in use.<br>An observation of all shower rooms will be conducted weekly x 3 months to validate that the cabinets are being kept locked. Any areas of non compliance will be immediately corrected and staff responsible will be counseled.<br><br>4.Monitoring<br>Results of observations will be forwarded to the QAPI Committee for further review and recommendations.<br><br>Cross Reference F279<br>1. Corrective Action<br>The care plan for Resident #1 was updated to reflect a care plan for the | |

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| F 001 | Continued From page 5 | F 001 | triggered care area of dental care.<br><br>2.Other Potential Residents<br>An audit of the Care Plan for residents that triggered for dental care on the CAA (Care Area Assessment)was completed and no other residents were affected.<br><br>3.System Changes<br>MDS/Care plan nurses were re-educated on process to ensure that the care plan for residents that trigger in the CAA (Care Area Assessment) for dental care has a care plan that addresses that need.<br>A 100% audit of all residents that trigger in the CAA (Care Area Assessment) for dental care will be completed weekly x 3 months to validate presence of the care plan for dental care. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled.<br><br>4. Monitoring<br>Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.<br><br>Cross Reference F252<br>1.Corrective Action<br>The wheelchair cushion for resident # 12 was replaced on 9/29/16<br><br>2.Other Potential Residents<br>Wheelchair cushions were checked for all other residents that have them in place and no other residents were affected.<br><br>3.System Changes<br>Staff were re-educated to observe for | |

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| F 001 | Continued From page 6 | F 001 | wheelchair cushions that need to be repaired or replaced during their daily interactions with residents.<br>Rounds of all units will be completed weekly x 3 months to validate that residents have appropriate wheelchair cushion's that are not in need of repair or replacement Any areas of non-compliance will be immediately corrected and staff responsible will be counseled.<br><br>4. Monitoring<br>Results of the rounds will be forwarded to the QAPI Committee for further review and recommendations. | |