STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/27/16 through 9/29/16. Complaints were investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 225 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 11 closed record reviews (Residents #25 through #35).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(b)(11) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157		10/21/16

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

Electronically Signed | 10/21/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and review of facility documentation, it was determined that the facility staff failed to notify the physician when medications were held and not administered as ordered on multiple occasions for one of 35 residents in the survey sample, Resident's #15. The facility staff failed to notify the physician Resident #15's physician ordered Senexon - S tab (used to treat constipation (1)) was held/not administer to Resident #15 on multiple occasions in July and August of 2016.. The findings include: Resident #15 was admitted to the facility on 6/16/16 with diagnoses that included but were not limited to: high blood pressure, dementia, diabetes, depression, constipation, and a history of falls. The most recent MDS (minimum data set) assessment, a significant change assessment,	F 157	1. Corrective Action The physician and responsible party were notified of resident # 15's random refusals of Senexon S Tab 8.6 - 50 MG' 2.Other Potential Residents An audit of the MARS (Medication Administration Records) for all residents has been completed and no other residents were affected. 3.System Changes Unit Managers and 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. A 100% audit of all MARS (Medication Administration Records)will be completed weekly x 3 months to validate compliance with documentation and notification. Any areas of non-compliance will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 157	Continued From page 2 with an assessment reference date of 8/25/16, coded the resident as being moderately impaired to make cognitive daily decisions. Resident #15 was coded as requiring extensive assistance of one staff member for all of her activities of daily living except, eating, in which she was independent after set up assistance was provided. The physician orders dated, 6/18/16, documented, "Senexon - S tab (used to treat constipation (1)) (tablet) 8.6 - 50 MG (milligrams); 1 tablet by mouth twice daily for Bowel Management." The July 2016 MAR (medication administration record) documented, "Senexon S Tab 8.6 - 50 MG; 1 tablet by mouth twice daily for bowel management." The MAR documented, on the following dates, a circle around the initials of the nurse for the 5:00 p.m. scheduled dose: 7/2/16, 7/5/16 through 7/8/16, 7/10/15 through 7/13/16, 7/15/16 through 7/18/16 and 7/25/16 through 7/29/16. This was 17 of the 31 opportunities for administration/documentation. The reverse side of the MAR did not document the reason for not administering the medication on the above dates. The August 2016 MAR documented, "Senexon S Tab 8.6 - 50 MG; 1 tablet by mouth twice daily for bowel management." The MAR documented, on the following dates, a circle around the initials of the nurse for the 5:00 p.m. scheduled dose: 8/2/16 through 8/5/16 and 8/7/16 through 8/10/16. This was eight of the possible 31 opportunities for administration/documentation. The reverse side of the MAR did not document the reason for not administering the medication on the above dates.	F 157	immediately corrected and staff responsible will be counseled. 4. Monitoring Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 157	Continued From page 3	F 157		

The nurse's notes dated, 7/19/16, documented, "Made aware by 7-3 (7:00 a.m. to 3:00 p.m.) shift resident was constipated and (Name of doctor) aware - VO (verbal order) enema STAT (immediately)." Further review of the clinical record reveled no further documentation on the dates above regarding the medication not being administered or notification to the physician then medication was not administered.

The comprehensive care plan dated, 6/20/16 and revised on 9/1/16, documented, "Focus: Bowel Elimination Alteration; Constipation related to lack of exercise, constipation, impaired mobility." The "Interventions" documented in part, "Administer medications per physician order."

An interview was conducted with LPN (licensed practical nurse) #7 on 9/28/16 at 1:23 p.m. When asked what a circle around a nurse's initials on the MAR indicated, LPN #7 stated, "It means it wasn't given. The nurse should document on the back of the MAR why it wasn't given and notify the doctor and the responsible party."

An interview was conducted with LPN #3, the unit manager, on 9/28/16 at 1:32 p.m. When asked what a circle around nurse's initials on the MAR indicated, LPN #3 stated, "It means they didn't administer the medication and they should write on the back of the MAR why they held it and notify the doctor and the responsible party."

The facility policy, "Administering Medications" documented in part, "18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 157	Continued From page 4 According to "Fundamentals of Nursing-Lippincott Williams and Wilkins 2007 page 165: After administering a tablet or capsule, be sure to record: drug given, dose given, date and time of administration, signing out the drug on the patients medication record ...any omission or withholding of a drug for any reason. If a drug is refused, withheld, or omitted for any reason, the prescriber must be notified ... " Administrative staff member (ASM) #1, the administrator, ASM #4, the assistant administrator of clinical services, ASM #4, the assistant administrator, and ASM #6, the medical director, were made aware of the above concern on 9/28/16 at 5:32 p.m. No further information was provided prior to exit. (1) https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=bb2064aa-b820-4e07-962a-a506145942df	F 157		
F 252 SS=D	SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT CFR(s): 483.15(h)(1) The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it	F 252	1.Corrective Action The wheelchair cushion for resident # 12	10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 252	Continued From page 5 was determined that the facility staff failed to provide a clean, comfortable environment for one of 35 residents in the survey sample, Resident #12. The facility staff failed to provide a wheelchair cushion free of tears and exposed foam rubber for Resident #12. The findings include: Resident #12 was admitted to the facility on 10/12/11 with diagnoses including, but not limited to: history of a stroke, dementia, and diabetes. On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 7/21/16, Resident #12 was coded as being severely cognitively impaired for making daily decisions. She was coded as requiring a wheelchair for locomotion in her room and around the facility. On 9/28/16 at 3:00 p.m. and on 9/29/16 at 9:15 a.m., Resident #12 was observed sitting in her wheelchair in the hallway outside her room. On both occasions, the cover of the cushion in Resident #12's wheelchair was observed to be torn, leaving areas of exposed foam rubber. A review of the comprehensive care plan for Resident #12 dated 3/24/15 and most recently updated 7/26/16 revealed, in part, the following: "Pressure redistributing device on bed/chair." On 9/29/16 at 9:50 a.m., CNA (certified nursing assistant) #14 was observed to pass by and interact with Resident #12 as the resident sat in her wheelchair. CNA #14 was asked if she observed anything out of the ordinary with	F 252	was replaced on 9/29/16 2.Other Potential Residents Wheelchair cushions were checked for all other residents that have them in place and no other residents were affected. 3.System Changes Staff were re-educated to observe for wheelchair cushions that need to be repaired or replaced during their daily interactions with residents. 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. 4. Monitoring Results of the rounds will be forwarded to the QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 252	Continued From page 6	F 252		

Resident #12. CNA #14 stated she did not. When asked to look more closely at the resident's wheelchair and accessories, CNA #14 stated: "Oh, I see it." She stated she usually looks at cushions for tears and other abnormalities. She stated she could see a rip in the wheelchair cushion's cover in several places. When asked if this is acceptable for a resident, she stated it was not. When asked if the cushion promoted a clean, comfortable, homelike environment for Resident #12, CNA #14 stated: "No." CNA #14 stated: "We can't clean it." When asked the process to be followed if she observed a cushion in disrepair, she stated: "I would call rehab (rehabilitation services). They will get a new one for her."

On 9/29/16 at 9:55 a.m., LPN (licensed practical nurse) # 15 was interviewed. She stated it was "not okay" for a resident to be seated on a cushion that is torn and displaying exposed foam. She stated: "This is an infection control issue. I would call the wound nurse to help determine what kind of cushion is needed. Not everyone has the same kind of cushion."

On 9/29/16 at 11:25 a.m., ASM (administrative staff member) #1, the administrator, ASM #4, the assistant administrator for clinical services, and ASM #5, the assistant administrator, were informed of these concerns. Policies regarding durable medical equipment condition were requested.

A review of the facility policy entitled "Disinfection/Sterilization" provided no information related to a clean, comfortable environment for residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 252	Continued From page 7 No further information was provided prior to exit.	F 252		
F 278 SS=D	ASSESSMENT ACCURACY/COORDINATION/CERTIFIED CFR(s): 483.20(g) - (j) The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff	F 278	Corrective Action 1.The MDS (Minimum Data Set) for	10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 278	Continued From page 8 failed to maintain a complete and accurate assessment for one of 35 residents in the survey sample, Resident # 16. Resident # 16's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 7/26/16 failed to document Resident # 4 was receiving dialysis. The findings include: Resident # 16 was admitted to the facility on 7/26/16 with diagnoses that included but were not limited to: encephalopathy (1), dysphagia (2), convulsions (3), hypertension (4), kidney failure, Parkinson's disease (5) and heart disease. Resident # 16's most recent comprehensive MDS (minimum data set) an admission assessment, with an assessment reference date (ARD) of 7/26/16, coded the resident as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, two being impaired of cognition for daily decision making. Resident # 16 was coded as requiring extensive assistance of one staff member for activities of daily living. In Section O: "Special Treatments, Procedures and Programs" failed to evidence documentation of dialysis. The POS (physician order sheet) dated 9/01/2016 through 9/30/2016 for Resident # 16 documented, "Dialysis Days: Tuesday, Thursday, and Saturday at (Name of Dialysis Center)." The care plan for Resident # 16 documented, "Renal insufficiency related to acute renal failure. ESRD (end stage renal disease) with hemodialysis (6)."	F 278	Resident # 4 has been corrected to reflect the coding of dialysis. 2.Other Potential Residents An audit of the MDS (Minimum Data Set)for all other residents who were receiving dialysis was completed and no other residents were affected. 3.System Changes The MDS/Care plan Nurses were re-educated on accurate coding of MDS (Minimum Data Set)Assessments for residents receiving dialysis. 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. 4. Monitoring Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 278	Continued From page 9	F 278		

On 9/28/16 at 12:10 p.m. an interview was conducted with RN (registered nurse) # 5, MDS coordinator regarding the missing documentation for Resident # 16's dialysis on the admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 7/26/16. After reviewing the MDS, RN # 5 stated, "He does have a care plan for dialysis, it should have been coded in section "O" on the MDS." When asked what guidance they use for completing the MDS, RN # 5 stated, "We follow the RAI (resident assessment instrument) manual."

CMS's (Centers of Medicare/Medicaid) RAI (resident assessment instrument) Version 3.0 Manual CH 3: MDS documented, "SECTION O: SPECIAL TREATMENTS, PROCEDURES, AND PROGRAMS
Intent: The intent of the items in this section is to identify any special treatments, procedures, and programs that the resident received during the specified time periods.
O0100: Special Treatments, Procedures, and Programs.
Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
Item Rationale
Health-related Quality of Life
·The treatments, procedures, and programs listed in Item O0100, Special Treatments, Procedures, and Programs, can have a profound effect on an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 278	Continued From page 10	F 278		

individual ' s health status, self-image, dignity, and quality of life.
CMS's RAI Version 3.0 Manual CH 3: MDS Items [O]
May 2013 Page O-2
O0100: Special Treatments, Procedures, and Programs (cont.)
Planning for Care
·Reevaluation of special treatments and procedures the resident received or performed, or programs that the resident was involved in during the 14-day look-back period is important to ensure the continued appropriateness of the treatments, procedures, or programs.
·Residents who perform any of the treatments, programs, and/or procedures below should be educated by the facility on the proper performance of these tasks, safety and use of any equipment needed, and be monitored for appropriate use and continued ability to perform these tasks.
Steps for Assessment
1. Review the resident's medical record to determine whether or not the resident received or performed any of the treatments, procedures, or programs within the last 14 days.
Coding Instructions for Column 1
Check all treatments, procedures, and programs received or performed by the resident prior to admission/entry or reentry to the facility and within the 14-day look-back period. Leave Column 1 blank if the resident was admitted/entered or reentered the facility more than 14 days ago. If no items apply in the last 14 days, check Z, none of the above.
Coding Instructions for Column 2
Check all treatments, procedures, and programs received or performed by the resident after admission/entry or reentry to the facility and within

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 278	Continued From page 11	F 278		

the 14-day look-back period.
Coding Tips
·Facilities may code treatments, programs and procedures that the resident performed themselves independently or after set-up by facility staff. Do not code services that were provided solely in conjunction with a surgical procedure or diagnostic procedure, such as IV medications or ventilators. Surgical procedures include routine pre- and post-operative procedures.
·O0100J, Dialysis
Code peritoneal or renal dialysis that occurs at the nursing home or at another facility in this item. Record treatments of hemofiltration, Slow Continuous Ultrafiltration (SCUF), Continuous Arteriovenous Hemofiltration (CAVH), and Continuous Ambulatory Peritoneal Dialysis (CAPD) in this item. IVs, IV medication, and blood transfusions administered during dialysis are considered part of the dialysis procedure and are not to be coded under items K0510A (Parenteral/IV), O0100H (IV medications), or O0100I (transfusions). This item may be coded if the resident performs his/her own dialysis."

On 9/28/16 at approximately 5:30 p.m. ASM (administrative staff member) # 1 the administrator, ASM # 4, assistant administrator for clinical services and ASM # 4, assistant administrator , were made aware of the findings.

No further information was provided prior to exit.

References:

(1) A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 278	Continued From page 12 http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm. (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html. (5) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html. (6) Dialysis treats end-stage kidney failure. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.	F 278		
F 279 SS=D	DEVELOP COMPREHENSIVE CARE PLANS CFR(s): 483.20(d), 483.20(k)(1) A facility must use the results of the assessment	F 279		10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 279	Continued From page 13 to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe 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 §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to develop a comprehensive care plan for one of 35 residents in the survey sample, Resident #1. The facility staff failed to develop a comprehensive care plan for the triggered care area of dental care on Resident #1's significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 9/1/16. The findings include: Resident #1 was admitted to the facility on 1/8/16.	F 279	1. Corrective Action The care plan for Resident #1 was updated to reflect a care plan for the triggered care area of dental care. 2.Other Potential Residents 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. 3.System Changes 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	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 279	Continued From page 14 Resident #1's diagnoses included but were not limited to: mood disorder, muscle weakness and major depressive disorder. Resident #1's most recent MDS, a significant change in status assessment with an ARD of 9/1/16, coded the resident's cognition as severely impaired. Section V "Care Area Assessment (CAA) Summary" documented, "1. Check column A if Care Area is triggered. 2. For each triggered Care Area, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment in the care area. The Care Planning Decision column must be completed within 7 days of completing the RAI (resident assessment instrument) (MDS and CAA(s)). Check column B if the triggered care area is addressed in the care plan..." An "X" was documented in the "Care Area Triggered" and "Care Planning Decision" columns beside the care area of "15. Dental Care" indicating the care area would be care planned. Review of Resident #1's comprehensive care plan initiated on 1/8/16 failed to reveal documentation regarding dental care. On 9/28/16 at 5:45 p.m., an interview was conducted with RN (registered nurse) #5 (MDS coordinator). RN #5 stated a care plan should be developed for a care area that triggers and is documented to be care planned. RN #5 confirmed Resident #1's comprehensive care plan failed to document information regarding the triggered area of dental care. RN #5 stated, "It was just missed." RN #5 stated the MDS coordinators reference the CMS (Centers for Medicare & Medicaid Services) RAI (Resident Assessment Instrument) manual when	F 279	care plan that addresses that need. 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. 4. Monitoring Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 279	Continued From page 15	F 279		

developing care plans based on the triggered care areas on the MDS assessments.

On 9/29/16 at 11:25 a.m., ASM (administrative staff member) #1 (the administrator), ASM #4 (the assistant administrator of clinical services) and ASM #5 (the assistant administrator) were made aware of the above findings.

The CMS RAI manual documented the following: "Coding Instructions for V0200A, CAAs
·Facility staff are to use the RAI triggering mechanism to determine which care areas require review and additional assessment. The triggered care areas are checked in Column A "Care Area Triggered" in the CAAs section. For each triggered care area, use the CAA process and current standard of practice, evidence-based or expert-endorsed clinical guidelines and resources to conduct further assessment of the care area. Document relevant assessment information regarding the resident's status. Chapter 4 of this manual provides detailed instructions on the CAA process, care planning, and documentation.
·For each triggered care area, Column B "Care Planning Decision" is checked to indicate that a new care plan, care plan revision, or continuation of the current care plan is necessary to address the issue(s) identified in the assessment of that care area. The "Care Planning Decision" column must be completed within 7 days of completing the RAI, as indicated by the date in V0200C2, which is the date that the care planning decision(s) were completed and that the resident's care plan was completed."

No further information was presented prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 282	Continued From page 16	F 282		
F 282 SS=D	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN CFR(s): 483.20(k)(3)(ii) The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that facility staff failed to provide services in accordance with the written plan of care for one of 35 residents in the survey sample, Resident # 16. The facility staff failed to provide pudding thickened liquids during his breakfast as ordered by the physician and documented in the comprehensive care plan for Resident # 16. The findings include: Resident # 16 was admitted to the facility on 7/26/16 with diagnoses that included but were not limited to: encephalopathy (1), dysphagia (2), convulsions (3), hypertension (4), kidney failure, Parkinson's disease (5) and heart disease. Resident # 16's most recent comprehensive MDS (minimum data set) an admission assessment, with an assessment reference date (ARD) of 7/26/16, coded the resident as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, two being impaired of cognition for daily decision making. Resident # 16 was coded as requiring extensive assistance of one	F 282	1. Corrective Action 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. 2.Other Potential Residents 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. 3.System Changes Nursing staff were re-educated regarding providing the correct consistency of liquids based on physicians orders. 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.	10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 282	Continued From page 17 staff member for activities of daily living. An observation of Resident # 16 was conducted on 9/28/16 at 8:50 a.m. Resident # 16 was in his room, seated in his wheelchair and appeared neat and clean. The over the bed table was positioned in front of Resident # 16 and his breakfast meal tray was on top of the table in front of him. Resident # 16 was observed eating independently. CNA (certified nursing assistant) # 6 then entered Resident # 16's room carrying a cup of juice and a cup of coffee for Resident # 16. CNA # 6 placed the coffee and juice on Resident # 16's breakfast tray and left the room. Resident # 16 then took a sip of his juice. Observation of Residents #16's coffee and juice appeared to be a honey or nectar thick consistency. Observation of Resident # 16's room revealed a bulletin board with sign that documented, "NO HONEY LIQUIDS. Resident is on PUDDING thick." The "Physician's Telephone Order" dated 8/5/16 for resident # 16 documented, "Diet change to pureed with pudding thick liquids." The POS (physician order sheet) dated 9/01/2016 through 9/30/2016 for Resident # 16 documented, "Diet: Pureed with pudding thick liquids." The facility "Diet Order Tally Report - Selected Special Diets" documented, "Special Diet: Thick Liquids - Spoon." Under "Resident Name" it documented, "(Name of Resident # 16)." The care plan for Resident # 16 with a revision dated of 9/12/2016 documented, "Focus: Nutritional Status as evidenced by actual weight gain related to mech (mechanical) altered therapeutic diet ..." Under "Interventions/Tasks" it	F 282	4. Monitoring Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 282	Continued From page 18	F 282		

documented, "Thickened liquids as ordered. Date initiated 7/27/2016." Under "Focus" it documented, "At risk for alteration in hydration related to UIT (urinary tract infection) HX (history) ESRD (end stage renal disease) with hemodialysis (6)." Under "Interventions/Tasks" it documented, "Thickened liquids as ordered. Date initiated 08/08/2016."

On 9/28/16 at 9:00 a.m. an interview was conducted with CNA # 6. When asked what liquids she brought to Resident # 16 during his breakfast CNA # 6 stated, "His coffee and juice weren't thickened. I took them and thickened them." When asked what consistency the coffee and juice were thickened to for Resident # 16, CNA # 6 stated, "He gets nectar thick liquids."

On 9/28/16 at 9:05 a.m. an interview was conducted with RN (registered nurse) # 4. When asked what the consistency of Resident # 16's liquids should be, RN # 4 stated, "Should be pudding thick." After looking at Resident # 16's coffee and juice, RN # 4 stated, "It's not thickened to pudding consistency."

On 9/28/16 at 9:10 a.m. an interview was conducted with LPN (licensed practical nurse) # 3, unit manager. LPN #3 was asked about the process for ensuring a resident receives the correct liquid consistency. LPN # 3 stated, "There is a list of residents at the nurse's station that lists the consistency for each resident. The CNA checks the list at the beginning of each shift and it is reviewed with the CNA by the nurse during report. " After reviewing the facility's "Diet Order Tally Report - Selected Special Diets", LPN # 3 was asked to define what "Thick Liquids - Spoon" referred to. LPN # 3 stated that spoon

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 282	Continued From page 19	F 282		

was coded for pudding thick liquids.

On 9/28/16 at approximately 5:30 p.m. ASM (administrative staff member) # 1 the administrator, ASM # 4, assistant administrator for clinical services and ASM # 4, assistant administrator, were made aware of the findings.

No further information was provided prior to exit.

References:

(1) A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm.

(2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

(3) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm.

(4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.

(5) A type of movement disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/parkinsonsdi

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 282	Continued From page 20 sease.html. (6) Dialysis treats end-stage kidney failure <https://medlineplus.gov/ency/article/000500.htm >. It removes waste from your blood when your kidneys can no longer do their job. Hemodialysis (and other types of dialysis) does some of the job of the kidneys when they stop working well. This information was obtained from the website: https://medlineplus.gov/ency/patientinstructions/000707.htm.	F 282		
F 315 SS=D	NO CATHETER, PREVENT UTI, RESTORE BLADDER CFR(s): 483.25(d) Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain a urinary catheter in a sanitary manner for one of 35 residents in the survey sample, Resident #5. The facility staff failed to keep Resident #5's urinary catheter bag and tubing off of the physical	F 315	1. Corrective Action The Physical Therapist Responsible for not keeping Resident #5's urinary catheter bag and tubing off the floor was counseled regarding infection control practices and care and maintenance of indwelling Foley catheters. 2.Other Potential Residents	10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 315	Continued From page 21 therapy floor on 9/28/16 at 11:10 a.m. The findings include: Resident #5 was admitted to the facility on 8/15/16 with diagnoses that included but were not limited to: urinary tract infection, alcohol abuse and pressure ulcers. The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 8/29/16 coded the resident as having an eight out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform independently after the tray was set up. An observation was made on 9/28/16 at 11:10 a.m. of Resident #5 in the physical therapy department. The resident was sitting in a wheelchair next to an exercise bike. The resident's urinary catheter and tubing were lying on the floor stretched out approximately two feet in front of the resident. OSM (other staff member) # 9, the physical therapist, had his feet straddling the catheter tubing and with the assistance of another staff member slid the resident onto the exercise bike. During the transfer OSM #9 gently kicked the urinary tubing to the side to prevent stepping on it. At 11:16 a.m. OSM #9 picked up the urinary catheter bag and hung it of the side of the exercise bike. Review of the physician's orders dated 9/1/16 documented, "16 (french, size of catheter) 5 cc (cubic centimeters, amount of water in catheter	F 315	An observation of all residents with indwelling Foley catheters was completed on 9/28/16 and no other residents were affected. 3.System Changes Therapy staff were re-educated regarding infection control practices and care and maintenance of indwelling Foley catheters. An observation of all residents with indwelling Foley catheters will be conducted weekly x 3 months to validate that catheters are not touching the floor . Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4. Monitoring Results of the observations will be forwarded to the QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 315	Continued From page 22	F 315		

balloon). Foley Cath (catheter) (secondary) multiple open wounds. Routine Foley care QD (everyday) + PRN (as needed)...."

Review of the treatment administration record documented, "Insert 16FR (french) 5 cc d/t (due to) excoriation to scrotum and multiple open wounds. Routine Foley cath care daily + prn." It was documented that the catheter was in place and foley catheter care was provided daily.

Review of the resident's care plan initiated on 9/26//16 documented, "Focus. Urinary incontinence related to DECREASED MOBILITY. DEBILITY. MULTIPLE HEALTH ISSUES. FOLEY CATHETER. Interventions. FOLEY CATHETER CARE AS ORDERED."

An interview was conducted on 9/29/16 at 9:20 a.m. with CNA (certified nursing assistant) #9. When asked if it was acceptable to place the urinary catheter bag and tubing on the floor, CNA #9 stated, "No it's not." When asked why, CNA #9 stated, "Infection and germs." When asked how the urinary catheter bag was to be managed, CNA #9 stated, "We attach it to the bed or the wheelchair."

An interview was conducted on 9/29/16 at 9:21 a.m. with RN (registered nurse) #4. When asked if it was acceptable to place the urinary catheter bag and tubing on the floor, RN #4 stated, "No ma'am." When asked why this was not acceptable, RN #4 stated, "Infection control and safety. We don't want them to trip over anything or get it pulled out either."

On 9/29/16 at 10:15 a.m., ASM (administrative staff member) #4, the assistant administrator for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 315	Continued From page 23 clinical services and ASM #5, the assistant administration were made aware of the findings. An interview was conducted on 9/29/16 at 11:45 a.m. with OSM #9, the physical therapist. When asked how a urinary catheter was managed, OSM #9 stated, "I already heard about the cath (catheter). The cath should have been more discrete and cared for." When asked why the catheter should not be left on the floor, OSM #9 stated, "Leakage, contamination and discretion." Review of the facility's policy titled, "Catheter Care, Urinary" documented, "Infection Control. 2. Maintain clean technique when handling or manipulating the catheter, tubing or drainage bag. b. Be sure the catheter tubing and drainage bag are kept off the floor." No further information was provided prior to exit.	F 315		
F 325 SS=D	MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE CFR(s): 483.25(i) Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced	F 325		10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 325	Continued From page 24 by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to provide a physician ordered therapeutic diet for one of 35 residents in the survey sample, Resident # 16. Facility staff failed to provide Resident # 16 with pudding thickened liquids during his breakfast. The findings include: Resident # 16 was admitted to the facility on 7/26/16 with diagnoses that included but were not limited to: encephalopathy (1), dysphagia (2), convulsions (3), hypertension (4), kidney failure, Parkinson's disease (5) and heart disease. Resident # 16's most recent comprehensive MDS (minimum data set) an admission assessment, with an assessment reference date (ARD) of 7/26/16, coded the resident as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, two being impaired of cognition for daily decision making. Resident # 16 was coded as requiring extensive assistance of one staff member for activities of daily living. An observation of Resident # 16 was conducted on 9/28/16 at 8:50 a.m. Resident # 16 was in his room, seated in his wheelchair and appeared neat and clean. The over the bed table was positioned in front of Resident # 16 and his breakfast meal tray was on top of the table in front of him. Resident # 16 was observed eating independently. CNA (certified nursing assistant) # 6 then entered Resident # 16's room carrying a cup of juice and a cup of coffee for Resident # 16. CNA # 6 placed the coffee and juice on Resident	F 325	1. Corrective Action 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. 2.Other Potential Residents 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. 3.System Changes Nursing staff were re-educated regarding providing the correct consistency of liquids based on physicians orders. 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. 4. Monitoring Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 325	Continued From page 25	F 325		

16's breakfast tray and left the room. Resident # 16 then took a sip of his juice. Observation of Residents #16's coffee and juice appeared to be a honey or nectar thick consistency. Observation of Resident # 16's room revealed a bulletin board with sign that documented, "NO HONEY LIQUIDS. Resident is on PUDDING thick."

The (Name of Dysphagia Testing Company) swallow study report dated 8/5/16 documented, "Potential additional risk factors for complications from dysphagia if this patient's condition is not identified and/or treated: Increased respiratory complications secondary to identified dysphagia, Potential hospitalization complications secondary to identified dysphagia, Increased decline in overall cognitive and physical function related to dysphagia, Increased risk for aspiration and choking on food, liquid, and medications." Under "Recommended Diet" it documented, "Puree. Pudding thick liquids."

The "Physician's Telephone Order" dated 8/5/16 for resident # 16 documented, "Diet change to pureed with pudding thick liquids."

The POS (physician order sheet) dated 9/01/2016 through 9/30/2016 for Resident # 16 documented, "Diet: Pureed with pudding thick liquids."

The facility "Diet Order Tally Report - Selected Special Diets" documented, "Special Diet: Thick Liquids - Spoon." Under "Resident Name" it documented, "(Name of Resident # 16)."

The care plan for Resident # 16 with a revision dated of 9/12/2016 documented, "Focus: Nutritional Status as evidenced by actual weight gain related to mech (mechanical) altered

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 325	Continued From page 26	F 325		

therapeutic diet ..." Under "Interventions/Tasks" it documented, "Thickened liquids as ordered. Date initiated 7/27/2016." Under "Focus" it documented, "At risk for alteration in hydration related to UIT (urinary tract infection) HX (history) ESRD (end stage renal disease) with hemodialysis (6)." Under "Interventions/Tasks" it documented, "Thickened liquids as ordered. Date initiated 08/08/2016."

On 9/28/16 at 9:00 a.m. an interview was conducted with CNA # 6. When asked what liquids she brought to Resident # 16 during his breakfast CNA # 6 stated, "His coffee and juice weren't thickened. I took them and thickened them." When asked what consistency the coffee and juice were thickened for Resident # 16 CNA # 6 stated, "He gets nectar thick liquids."

On 9/28/16 at 9:05 a.m. an interview was conducted with RN (registered nurse) # 4. When asked what the consistency of Resident # 16's liquids should be RN # 4 stated, "Should be pudding thick." After looking at Resident # 16's coffee and juice RN # 4 stated, "It's not thickened to pudding consistency."

On 9/28/16 at 9:10 a.m. an interview was conducted with LPN (licensed practical nurse) # 3, unit manager. LPN #3 was asked about the process for ensuring a resident receives the correct liquid consistency. LPN # 3 stated, "There is a list of residents at the nurse's station that lists the consistency for each resident. The CNA checks the list at the beginning of each shift and it is reviewed with the CNA by the nurse during report." After reviewing the facility's "Diet Order Tally Report - Selected Special Diets", LPN # 3 was asked to define what "Thick Liquids - Spoon"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 325	Continued From page 27 referred to. LPN # 3 stated that spoon was coded for pudding thick liquids. On 9/28/16 at approximately 5:30 p.m. ASM (administrative staff member) # 1 the administrator, ASM # 4, assistant administrator for clinical services and ASM # 4, assistant administrator, were made aware of the findings. No further information was provided prior to exit. References: (1) A term for any diffuse disease of the brain that alters brain function or structure. This information was obtained from the website: http://www.ninds.nih.gov/disorders/encephalopathy/encephalopathy.htm. (2) A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html. (3) The term "seizure" is often used interchangeably with "convulsion." A seizure is the physical findings or changes in behavior that occur after an episode of abnormal electrical activity in the brain. This information was obtained from the website: https://medlineplus.gov/ency/article/003200.htm. (4) High blood pressure. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/highbloodpressure.html.	F 325		
F 329	DRUG REGIMEN IS FREE FROM	F 329		10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 329 SS=D	Continued From page 28 UNNECESSARY DRUGS CFR(s): 483.25(l) Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, it was determined that the facility staff failed to ensure a drug regimen free from unnecessary drugs as evidenced by failure to monitor the use of an antipsychotic medication for 1 of 35 residents in the survey sample; Resident #14.	F 329	1.Corrective Action The documentation for Resident #14 has been updated to include quantitative and qualitative documentation and monitoring of the use of Seroquel. 2.Other Potential Residents An audit of the documentation for all	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 329	Continued From page 29 Resident #14 was admitted to the facility on 7/12/16 on the medication Seroquel. As of this survey, there was no evidence of quantitative and qualitative monitoring of the use of this medication. The findings include: Resident #14 was admitted on 7/12/16 with the diagnoses of but not limited to Alzheimer's disease, dementia with behaviors, psychosis, bipolar disorder, anxiety, depression, adult failure to thrive, osteoporosis, chronic obstructive pulmonary disease, and left ulna fracture. The most recent MDS (Minimum Data Set) was an admission assessment with an ARD (Assessment Reference Date) of 7/19/16. The resident was coded as being impaired in ability to make daily life decisions, scoring an 8 out of a possible 15 on the BIMS (Brief Interview for Mental Status) exam. The resident required total care for transfers, dressing, hygiene, and bathing; limited assistance for eating; and was incontinent of bowel and bladder. A review of the clinical record revealed the resident was prescribed Seroquel (an antipsychotic medication (1)) 25 mg (milligrams) twice daily. This medication was ordered at admission on 7/12/16. A review of the progress notes revealed the following: A physician's progress note dated 7/13/16 which documented, "....Alzheimer's dementia stable, cont (continue) hospice care; cont Seroquel 25 mg po (by mouth) bid (twice daily)."	F 329	others residents receiving antipsychotic medications was completed and no other residents were affected. 3.System Changes Unit Managers and licensed nurses have been re-educated on monitoring and documentation for residents receiving antipsychotic medications. A 100% audit of all residents receiving antipsychotic medications will be completed weekly x 3 months to validate compliance with monitoring and documentation related to the use of the medication. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4. Monitoring Results of the audits will be forwarded to the QAPI Committee for further review and recommendations	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 329	Continued From page 30	F 329		

A nurse's note dated 7/14/16 which documented, "Resident continues to roll up and down halls. Hollering she needs help. When asked what she needs She [sic] doesn't know just help...."

A physician's progress note dated 8/5/16 that documented, "Psychotropic review Regulatory: It is clinically contraindicated to dose reduce this patient, as if we believe it is a chemical imbalance, then we are inviting a situation that can and will lead to suffering. This is akin to taking a diabetic off their insulin or a hypertensive off their meds. PT (patient) is at end of life care on hospice and it is appropriate to leave them on their current meds (medications)."

A nurse's note dated 8/26/16 documented, "Resident continuously rings call bell, frequently states "I am going to die today...."

Another nurse's note dated 8/26/16 documented, "Resident alert with confusion. Resident continuously saying I don't want to die...."

A nurse's note dated 8/28/16 documented, "Resident continuously calls staff to room for help. Resident responds to staff stating "I'm dying. I don't want to die, please help me." Guarded imagery and deep breathing exercises attempted, unsuccessful. Medicated with prn (as needed) Xanax (an antianxiety medication (2))."

In addition to the above, it was also documented on 7/16/16, 8/30/16, and 9/6/16 that the resident refused medications.

There was no other evidence provided of quantitative and qualitative documentation and monitoring of the use of Seroquel in the 11 weeks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 329	Continued From page 31	F 329		

(77 days) the resident was in the facility as of the beginning of this survey.

On 9/28/16 at 11:10 a.m., in an interview with LPN #17 (Licensed Practical Nurse, the unit manager) she stated that she does weekly behavior notes on residents on an antipsychotic but that she had not done any on this resident because she did not know she was on Seroquel. She stated she thought the Seroquel had been discontinued when she was admitted to the unit.

A review of the care plan revealed one for "At risk for adverse effects related to use of antipsychotic medication...." initiated on 7/30/16 and included the intervention, "Evaluate effectiveness and side effects of medications for possible decrease/elimination of psychotropic drugs." This intervention was initiated on 7/30/16.

A review of the facility policy, "Medication Monitoring, Medication Management" documented under "Guidelines for Psychotherapeutic Medication Monitoring" the following: "1. Antipsychotics.....b. After initiating or increasing the dose of an antipsychotic medication, the behavioral symptoms must be reevaluated periodically to determine the effectiveness of the antipsychotic and the potential for reducing or discontinuing the dose.....f. Before initiating or increasing an antipsychotic medication for enduring conditions, the target behavior must be clearly and specifically identified and monitored objectively and qualitatively, in order to ensure the behavioral symptoms are: *not due to a medical condition....*persistent or likely to reoccur without continued treatment....*not sufficiently relieved by non-pharmacological interventions....*not due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 329	Continued From page 32 environmental stressors....*not due to psychological stressors or anxiety...." On 9/29/16 at 11:36 a.m., the Administrator and Director of Nursing were made aware of the findings. No further information was provided by the end of the survey. (1) Studies have shown that older adults with dementia (a brain disorder that affects the ability to remember, think clearly, communicate, and perform daily activities and that may cause changes in mood and personality) who take antipsychotics (medications for mental illness) such as quetiapine (Seroquel) have an increased risk of death during treatment. Quetiapine is not approved by the Food and Drug Administration (FDA) for the treatment of behavioral problems in older adults with dementia. (1) Information obtained from https://medlineplus.gov/druginfo/meds/a698019.html (2) Information obtained from https://medlineplus.gov/druginfo/meds/a684001.html	F 329		
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.65 The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441		10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 441	Continued From page 33 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide care and services in a manner to prevent infection for two of 35 residents in the survey	F 441	1. Corrective Action The Physical Therapist Responsible for not keeping Resident #5's urinary catheter bag and tubing off the floor was counseled regarding infection control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 441	Continued From page 34 sample, Resident #5 and Resident #12. 1. Facility staff failed to keep Resident #5's urinary catheter bag and tubing off of the physical therapy floor on 9/28/16 at 11:10 a.m. 2. The facility staff failed to provide Resident #12 with a wheelchair cushion in good repair, allowing it to be cleaned to prevent the transmission of infection. The findings include: 1. Resident #5 was admitted to the facility on 8/15/16 with diagnoses that included but were not limited to: urinary tract infection, alcohol abuse and pressure ulcers. The most recent MDS (minimum data set), a 14 day assessment, with an ARD (assessment reference date) of 8/29/16 coded the resident as having an eight out of 15 on the BIMS (brief interview for mental status) indicating the resident was moderately impaired to make daily decisions. The resident was coded as requiring assistance from staff for activities of daily living except for eating which the resident could perform independently after the tray was set up. An observation was made on 9/28/16 at 11:10 a.m. of Resident #5 in the physical therapy department. The resident was sitting in a wheelchair next to an exercise bike. The resident's urinary catheter and tubing were lying on the floor stretched out approximately two feet in front of the resident. OSM (other staff member) # 9, the physical therapist, had his feet straddling the catheter tubing and with the assistance of another staff member slid the resident onto the	F 441	practices and care and maintenance of indwelling Foley catheters. The wheelchair cushion for resident # 12 was replaced on 9/29/16 2.Other Potential Residents An observation of all residents with indwelling Foley catheters was completed on 9/28/16 and no other residents were affected. Wheelchair cushions were checked for all other residents that have them in place and no other residents were affected. 3.System Changes Therapy staff were re-educated regarding infection control practices and care and maintenance of indwelling Foley catheters. An observation of all residents with indwelling Foley catheters will be conducted weekly x 3 months to validate that catheters are not touching the floor. Nursing Staff were re-educated to observe for wheelchair cushions that need to be repaired or replaced during their daily interactions with residents. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 441	Continued From page 35 exercise bike. During the transfer OSM #9 gently kicked the urinary tubing to the side to prevent stepping on it. At 11:16 a.m. OSM #9 picked up the urinary catheter bag and hung it of the side of the exercise bike. Review of the physician's orders dated 9/1/16 documented, "16 (french, size of catheter) 5 cc (cubic centimeters, amount of water in catheter balloon). Foley Cath (catheter) (secondary) multiple open wounds. Routine Foley care QD (everyday) + PRN (as needed)...." Review of the treatment administration record documented, "Insert 16FR (french) 5 cc d/t due to excoriation to scrotum and multiple open wounds. Routine Foley cath care daily + prn." It was documented that the catheter was in place and foley catheter care was provided daily. Review of the resident's care plan initiated on 9/26//16 documented, "Focus. Urinary incontinence related to DECREASED MOBILITY. DEBILITY. MULTIPLE HEALTH ISSUES. FOLEY CATHETER. Interventions. FOLEY CATHETER CARE AS ORDERED." An interview was conducted on 9/29/16 at 9:20 a.m. with CNA (certified nursing assistant) #9. When asked if it was acceptable to place the urinary catheter bag and tubing on the floor, CNA #9 stated, "No it's not." When asked why, CNA #9 stated, "Infection and germs." When asked how the urinary catheter bag was to be managed, CNA #9 stated, "We attach it to the bed or the wheelchair." An interview was conducted on 9/29/16 at 9:21 a.m. with RN (registered nurse) #4. When asked	F 441	4. Monitoring Results of the observations will be forwarded to the QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 441	Continued From page 36	F 441		

if it was acceptable to place the urinary catheter bag and tubing on the floor, RN #4 stated, "No ma'am." When asked why this was not acceptable, RN #4 stated, "Infection control and safety. We don't want them to trip over anything or get it pulled out either.

On 9/29/16 at 10:15 a.m., ASM (administrative staff member) #4, the assistant administrator for clinical services and ASM #5, the assistant administration were made aware of the findings.

An interview was conducted on 9/29/16 at 11:45 a.m. with OSM #9, the physical therapist. When asked how a urinary catheter was managed, OSM #9 stated, "I already heard about the cath. The cath should have been more discrete and cared for." When asked why the catheter should not be left on the floor, OSM #9 stated, "Leakage, contamination and discretion."

Review of the facility's policy titled, "Catheter Care, Urinary" documented, "Infection Control. 2. Maintain clean technique when handling or manipulating the catheter, tubing or drainage bag. b. Be sure the catheter tubing and drainage bag are kept off the floor."

No further information was provided prior to exit.

2. Resident #12 was admitted to the facility on 10/12/11 with diagnoses including, but not limited to: history of a stroke, dementia, and diabetes.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 441	Continued From page 37	F 441		

On the most recent MDS (minimum data set), a quarterly assessment with assessment reference date 7/21/16, Resident #12 was coded as being severely cognitively impaired for making daily decisions. She was coded as requiring a wheelchair for locomotion in her room and around the facility.

On 9/28/16 at 3:00 p.m. and on 9/29/16 at 9:15 a.m., Resident #12 was observed sitting in her wheelchair in the hallway outside her room. On both occasions, the cover of the cushion in Resident #12's wheelchair was observed to be torn, leaving areas of exposed foam rubber.

A review of the comprehensive care plan for Resident #12 dated 3/24/15 and most recently updated 7/26/16 revealed, in part, the following: "Pressure redistributing device on bed/chair."

On 9/29/16 at 9:50 a.m., CNA (certified nursing assistant) #14 was observed to pass by and interact with Resident #12 as the resident sat in her wheelchair. CNA #14 was asked if she observed anything out of the ordinary with Resident #12. CNA #14 stated she did not. When asked to look more closely at the resident's wheelchair and accessories, CNA #14 stated: "Oh, I see it." She stated she usually looks at cushions for tears and other abnormalities. She stated she could see a rip in the wheelchair cushion's cover in several places. When asked if this is acceptable for a resident, she stated it was not. When asked if the cushion was clean, CNA #14 stated she was not sure. CNA #14 stated: "We can't clean it." When asked the process to be followed if she observed a cushion in disrepair, she stated: "I would call rehab (rehabilitation services). They will get a new one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 441	Continued From page 38 for her." On 9/29/16 at 9:55 a.m., LPN (licensed practical nurse) # 15 was interviewed. She stated it was "not okay" for a resident to be seated on a cushion that is torn and displaying exposed foam. She stated: "This is an infection control issue. I would call the wound nurse to help determine what kind of cushion is needed. Not everyone has the same kind of cushion." On 9/29/16 at 11:25 a.m., ASM (administrative staff member) #1, the administrator, ASM #4, the assistant administrator for clinical services, and ASM #5, the assistant administrator, were informed of these concerns. Policies regarding durable medical equipment condition were requested. A review of the facility policy entitled "Disinfection/Sterilization" provided no information related to providing residents with durable medical equipment in a form that allowed for the equipment to be cleaned. No further information was provided prior to exit.	F 441		
F 465 SS=D	SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON CFR(s): 483.70(h) The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was	F 465	1.Corrective Action	10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 465	Continued From page 39 determined that the facility staff failed to maintain a safe environment in one of four facility shower rooms, the shower room on the Monarch I (one) Unit. A 19 ounce can of "Clorox disinfectant spray" was observed in an unlocked wall mounted cabinet in the shower room on the Monarch I (one) Unit. The findings include: On 9/29/16 at 10:25 a.m. an observation of the shower room on the Monarch I (one) Unit was conducted with OSM (other staff member) # 8, maintenance supervisor. Upon entering the shower room a 19 ounce can of "Clorox disinfectant spray" was observed in an unlocked wall mounted cabinet. When asked who used the disinfectant spray OSM # 8 stated, "Nursing uses it." OSM # 8 was then asked to have the nursing unit manager come to the Monarch I Unit shower room. On 9/29/16 at 10:30 a.m. an interview was conducted with LPN (licensed practical nurse) # 8 and OSM # 8 in the Monarch I Unit shower room. After observing the "Clorox disinfectant spray" in the unlocked wall mounted cabinet, LPN # 8 was asked what it was used for and who uses the disinfectant spray. LPN # 8 stated, "The CNAs (certified nursing assistants) use it for odors." When asked how it should be stored, LPN # 8 stated, "It should be locked in the cabinet when no one is in the shower room." When OSM # 8 and LPN # 8 were asked to determine how much disinfectant was in the can they both agreed that the can was approximately half full.	F 465	The Clorox Disinfectant spray was removed from the shower room by the unit manager. 2.Other Potential Residents All other shower rooms were checked on 9/29/16 and cabinets were locked. 3.System Changes Nursing Staff were re-educated on making sure that the cabinets in the shower rooms are locked when not in use. 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. 4.Monitoring Results of observations will be forwarded to the QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 465	Continued From page 40 The "Safety Data Sheet" documented, "Product Name: Clorox Commercial Solutions® Clorox® Disinfecting Spray." Under "Hazard Identification" it documented, "Causes serious eye irritation. May cause genetic effects. May cause cancer. Flammable aerosol." During the days of the survey, there were no residents observed entering the Monarch I Unit shower room unattended. On 9/29/16 at approximately 10:45 a.m. ASM (administrative staff member) # 1 the administrator, was made aware of the findings. No further information was provided prior to exit.	F 465		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.75(l)(1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review	F 514	1. Corrective Action	10/21/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 514	Continued From page 41 and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate clinical record for two of 35 residents in the survey sample, Resident's #15 and #6. 1. The facility staff failed to document the reason for not administering medication for Resident #15. 2. The facility staff failed to include the hospice records on the facility chart for Resident #6. The findings include: 1. Resident #15 was admitted to the facility on 6/16/16 with diagnoses that included but were not limited to: high blood pressure, dementia, diabetes, depression, constipation, and a history of falls. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 8/25/16, coded the resident as being moderately impaired to make cognitive daily decisions. Resident #15 was coded as requiring extensive assistance of one staff member for all of her activities of daily living except, eating, in which she was independent after set up assistance was provided. The physician orders dated, 6/18/16, documented, "Senexon - S tab (used to treat constipation (1)) (tablet) 8.6 - 50 MG (milligrams); 1 tablet by mouth twice daily for Bowel Management." The July 2016 MAR (medication administration	F 514	Licensed Nurses were re-educated on appropriate documentation on back of MARS (Medication Administration Records) for a medication that is refused The physician and responsible party for Resident # 15 were notified of the refusal of medication. The Hospice provider for Resident #6 was contacted and instructed to place all Hospice notes on the chart 2.Other Potential Residents An audit of the MARS (Medication Administration Records) for all residents has been completed and no other residents were affected. An audit was completed for all hospice residents to validate that the hospice notes were present. No other residents were affected. 3.System Changes 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. A 100% audit of all MARS (Medication Administration Records)will be completed weekly x 3 months to validate compliance with documentation and notification. Unit Managers were re-educated on need for all documentation to be on residents chart. A 100% audit will be completed weekly x 3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 514	Continued From page 42 record) documented, "Senexon S Tab 8.6 - 50 MG; 1 tablet by mouth twice daily for bowel management." The MAR documented, on the following dates, a circle around the initials of the nurse for the 5:00 p.m. scheduled dose: 7/2/16, 7/5/16 through 7/8/16, 7/10/15 through 7/13/16, 7/15/16 through 7/18/16 and 7/25/16 through 7/29/16. This was 17 of the 31 opportunities for administration/documentation. The reverse side of the MAR did not document the reason for not administering the medication on the above dates. The August 2016 MAR documented, "Senexon S Tab 8.6 - 50 MG; 1 tablet by mouth twice daily for bowel management." The MAR documented, on the following dates, a circle around the initials of the nurse for the 5:00 p.m. scheduled dose: 8/2/16 through 8/5/16 and 8/7/16 through 8/10/16. This was eight of the possible 31 opportunities for administration/documentation. The reverse side of the MAR did not document the reason for not administering the medication on the above dates. The nurse's notes dated, 7/19/16, documented, "Made aware by 7-3 (7:00 a.m. to 3:00 p.m.) shift resident was constipated and (Name of doctor) aware - VO (verbal order) enema STAT (immediately)." There was no further documentation on the dates above regarding the medication not being administered. The comprehensive care plan dated, 6/20/16 and revised on 9/1/16, documented, "Focus: Bowel Elimination Alteration; Constipation related to lack of exercise, constipation, impaired mobility." The "Interventions" documented in part, "Administer medications per physician order." An interview was conducted with LPN (licensed	F 514	months of all residents on Hospice Services to validate presence of hospice documentation. Any areas of non-compliance will be immediately corrected and staff responsible will be counseled. 4. Monitoring Results of the audits will be forwarded to the QAPI Committee for further review and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 514	Continued From page 43	F 514		

practical nurse) #7 on 9/28/16 at 1:23 p.m. When asked what a circle around a nurse's initials on the MAR indicated, LPN #7 stated, "It means it wasn't given. The nurse should document on the back of the MAR why it wasn't given and notify the doctor and the responsible party."

An interview was conducted with LPN #3, the unit manager, on 9/28/16 at 1:32 p.m. When asked what a circle around nurse's initials on the MAR indicated, LPN #3 stated, "It means they didn't administer the medication and they should write on the back of the MAR why they held it and notify the doctor and the responsible party."

The facility policy, "Administering Medications" documented in part, "18. If a drug is withheld, refused, or given at a time other than the scheduled time, the individual administering the medication shall initial and circle the MAR space provided for that drug and dose."

According to "Fundamentals of Nursing- Lippincott Williams and Wilkins 2007 page 165: After administering a tablet or capsule, be sure to record: drug given, dose given, date and time of administration, signing out the drug on the patients medication record ...any omission or withholding of a drug for any reason. If a drug is refused, withheld, or omitted for any reason, the prescriber must be notified ... "

Administrative staff member (ASM) #1, the administrator, ASM #4, the assistant administrator of clinical services, ASM #4, the assistant administrator, and ASM #6, the medical director, were made aware of the above concern on 9/28/16 at 5:32 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 514	Continued From page 44	F 514		

No further information was provided prior to exit.

(1)
https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=bb2064aa-b820-4e07-962a-a506145942df

2. Resident #6 was admitted to the facility on 8/15/14 with diagnoses including, but not limited to: history of breast cancer, heart failure and arthritis. On the most recent MDS (minimum data set), a significant change assessment with assessment reference date 8/4/16, Resident #6 was coded as being moderately impaired for making daily decisions. She was coded as receiving hospice services.

A review of the clinical record for Resident #6 revealed an order dated 7/25/16 stating that Resident #6 should be evaluated and admitted to hospice services.

A review of the comprehensive care plan for Resident #6 dated 7/26/16 revealed, in part, the following: "Hospice Care needs due to terminal/end-stage disease."

A review of the facility's clinical record on 9/28/16 at 3:28 p.m. failed to reveal evidence of any other documentation related to Resident #6's hospice services, including nursing visits, social services assessments, hospice aide visits, and chaplain support. At 3:28 p.m. on 9/28/16, LPN (licensed practical nurse) #3 was asked to show the surveyor the documentation provided by the hospice provider regarding Resident #6's hospice services. LPN #3 looked through the chart and stated: "I don't know. I think we usually have a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE 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) COMPLETION DATE
F 514	Continued From page 45	F 514		

tab there for hospice, with all the documentation. I don't see anything. I know the other hospice provider has a notebook for their documentation. I'm not sure where it is for this resident."

On 9/29/16 at 8:20 a.m., LPN #3 and ASM (administrative staff member) #3, the assistant director of nursing, stopped the surveyor in the hallway. LPN #3 stated: "We just got these charts yesterday." She showed the surveyor a chart labeled with the name of Resident #6 and the name of the hospice provider. The chart contained records of nurse, aide, chaplain and other hospice staff visits, as well as care plans. The documents were dated 7/26/16 and following. Each of the pages in the chart had a print date and time of 9/27/16 at 1:43 p.m. (after the surveyors had entered the facility). LPN #3 stated the hospice staff (especially the nurses) usually come in, visit the resident, type their notes, print their notes, and then put the notes directly on the chart. ASM #3 stated: "I don't know who printed these notes or created these notebooks. We do not have access to this information on the hospice company's website." LPN #3 stated: "Yesterday was the first time I have seen these charts. We used to have a tab. Maybe they took the old notes off the charts and reprinted them for these new charts."

On 9/29/16 at 11:25 a.m., ASM (administrative staff member) #1, the administrator, ASM #4, the assistant administrator for clinical services, and ASM #5, the assistant administrator, were informed of these concerns.

A review of the facility policy entitled "Hospice Program" revealed no information related to hospice service documentation being included on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 09/29/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE 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) COMPLETION DATE
F 514	Continued From page 46 the resident's clinical record. No further information was provided prior to exit.	F 514		