PRINTED: 11/11/2020 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495096	B. WING			10/27/2020	
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER-CANTERBURY OF RICHMOND				STREET ADDRESS, CITY, STATE, ZIP CODE  1600 WESTBROOK AVE  RICHMOND, VA 23227			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		ΕC	000			
	Survey was conducted was in substantial conducted 483.73 emergency prohas implemented The Medicaid Services and	d Emergency Preparedness d 10-27-2020. The facility npliance with 42 CFR Part eparedness regulations, and Centers for Medicare & d Centers for Disease d practices to prepare for					
F 000	The census in this 15a 135 at the time of the INITIAL COMMENTS	8 certified bed facility was survey.	F 0	000			
	was conducted 10-27- required for compliand infection control regula implementation of The Medicaid Services and Control recommended	e Centers for Medicare &					
	The census in this 158 135 at the time of the COVID-19 Testing-Re CFR(s): 483.80 (h)(1)-	sidents & Staff	F 8		F886 COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1-6)		
	must test residents an individuals providing s and volunteers, for CC	9 Testing. The LTC facility and facility staff, including services under arrangement DVID-19. At a minimum,			Address how correction will be accomplicated to those residents/staff found to have been affected by the deficient practice:     a.) Resident #105 had a PCA sale swab for SCA sale shades at 14/4/2000 and sale swab.	SARS-	11/4/2020
	for all residents and faindividuals providing s and volunteers, the LT §483.80 (h)((1) Condu	ervices under arrangement C facility must:			CoV-2 completed on 11/4/2020 and results we negative. b.) Resident #106 had a PCR nasal swab for SCoV-2 completed on 11/4/2020 and results we negative.	SARS-	11/4/2020
ABORATORY		UPPLIER MEPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk () denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

**Electronically Signed** 

Event ID: IOBN11

Facility ID: VA0269

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495096	B. WNG		10/	10/27/2020		
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER-CANTERBURY OF RICHMOND			STREET ADDRESS, CITY, STATE, ZIP CODE  1600 WESTBROOK AVE  RICHMOND, VA 23227					
(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 886	F 886 Continued From page 1 parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility; (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19.		F 886	c.) Resident #107 had a PCR nasal swab for SARS-CoV-2 completed on 11/4/2020 and results were negative. d.) Resident #101 had a PCR nasal swab for SARS-CoV-2 completed on 11/4/2020 and results were negative.				
				negative. e.) C.N.A. "A" Employee was on vacation from 10/12/2020-10/26/2020, so no labs were missed. After her return, she had a PCR nasal swab for SARS-CoV-2 completed on 11/04/2020 and results were negative. f.) R.N. "A" had a PCR nasal swab for SARS-CoV-2		11/4/2020		
				completed on 10/16/20 and results were negative.  2. Address how the facility will identify other residents/staff having the potential to be affected by the same deficient practice:  a) An audit will be completed by the Unit Managers				
				to ensure that 100% of all current residents had either a Rapid Antigen test and/or PCR na swab for SARS-CoV-2 completed within the padays.  b) An audit will be completed by the Infection	ave asal ast 7	11/16 /2020 11/16 /2020		
	is consistent with curre conducting COVID-19			Preventionist to ensure that all staff, Vendors individuals providing services have been teste COVID-19 via Rapid Antigen test and/or PCR swab for SARS-CoV-2 completed within the padays.	ed for nasal	11/10/2020		
	§483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing			Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.				
	was offered, completed (as appropriate to the resident's testing status), and the results of each test.		Residents will be tested every Wednesday an identified outbreak using the specified parameters set forth by the Secretary for a mill of 14 days with no further positive results.		11/4/2020			
	§483.80 (h)((4) Upon individual specified in symptoms consistent with COVID for COVID-19, take actransmission of COVID	this paragraph with 0-19, or who tests positive tions to prevent the		b)The Assistant Director of Nursing will put a schedule for staff testing into place to ensure temployees are to be tested within specified parameters set forth by the Secretary of 3-7 depending on positivity rate for the County, aft outbreak is identified for the duration of the pandemic.	ays,	11/16/2020		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED		
		495096	B. WING		10/27/2020			
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER-CANTERBURY OF RICHMOND			1	STREET ADDRESS, CITY, STATE, ZIP CODE  1600 WESTBROOK AVE  RICHMOND, VA 23227				
(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 886	§483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who		F 886	c) The Facility Educator will inservice staff on need to test residents and staff per protocol, a forth by the Secretary, via Rapid Antigen test a PCR nasal swab for SARS-CoV-2 as stated at	11/16/2020			
	emergencies due to te contact state and local health depail efforts, such as obtain processing test results. This REQUIREMENT by:  The findings included.  The facility staff failed #105, 106, 107, and 1 RN A) for COVID-19 eoutbreak, for a period the most recent positive.  On 9/30/2020, the fact H), who worked on the who tested positive for the facility was then coutbreak of COVID-19 testing of all staff and until no one tested positive for the facility, who worked facility, who tested positive for the facility was then coutbreak of COVID-19 testing of all staff and until no one tested positive for the facility, who worked facility, who tested positive for the facility, who tested positive for 10/7/2020, the fact (CNA F), who worked facility, who tested positive for the facility, who tested positive for the fact (CNA F), who worked facility, who tested positive for the fact (CNA F), who worked facility, who tested positive for the fact (CNA F), who worked facility, who tested positive for the fact (CNA F), who worked facility, who tested positive for the fact (CNA F), who worked facility, who tested positive for the fact (CNA F), who worked facility, who tested positive for the fact (CNA F), who worked facility, who tested positive for the fact (CNA F), who worked facility who tested positive for the fact (CNA F), who worked facility who tested positive for the fact (CNA F), who worked facility who tested positive for the fact (CNA F).	necessary, such as in esting supply shortages, rements to assist in testing sing testing supplies or solutions. It is not met as evidenced  to test Residents (Resident O1) and staff (CNAA and every 3-7 days following an of at least 14 days since we result.  It is first floor within the facility, or COVID-19. As a result, considered to be in an of and needed to conduct residents every 3-7 days estive for at least 14 days.  It is fit had another employee on the third floor of the sitive for COVID-19. This of the facility testing every 10/21/2020.		4.Indicate how the facility plans to monitor performance to make sure that solutions a sustained:  a) The Infection Preventionist/ Designee will rall COVID Lab results daily during the Pander Any abnormalities will be reported to the Direc Nursing / Designee immediately. Any variance abnormalities will be discussed with the QAPI committee monthly during the regularly sched meetings for further recommendations if needs b) The Assistant Director of Nursing will ensurall staff/ vendors/ volunteers are testing accord the outbreak protocol and / or county positivity during the pandemic. Any abnormalities to the Director of Nursing/ Designee immediately. An audit abnormalities related to staff/ vendors/ volunteers to the QAPI committee at the next regularly scheduled meeting. c) The Facility Educator/ Designee will report education provided to staff related to any COV training and report any feedback or recommendations as needed at the regularly scheduled QAPI meetings. d) The Unit Managers will report any variance abnormalities on their units with the QAPI commonthly during the regularly scheduled meeting further recommendations if needed. e) The Facility Educator/ Designee will report education provided to staff related to any COV training and report any feedback or recommendations to the QAPI committee for recommendations to the QAPI committee for recommendations as needed at the regularly scheduled QAPI meetings.		11/16/2020 11/16/2020 11/16/2020 11/16/2020		
		of the clinical record for esided on the first floor, sted for COVID-19 on						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495096	B. WING			10/27/2020	
NAME OF PROVIDER OR SUPPLIER  WESTMINSTER-CANTERBURY OF RICHMOND				10	TREET ADDRESS, CITY, STATE, ZIP CODE 600 WESTBROOK AVE LICHMOND, VA 23227		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPRIATE OF THE APPROPRIA			(X5) COMPLETION DATE
F 886	noted after 10/7/2020 between 10/7/2020 are 10/7/2020, review Resident #106 reveals floor of the facility. RecovID-19 on 10/9/20 10/19/2020 and 10/09/2020 and 10/09/2020 are 10/09/2020 are 10/09/2020 are 10/09/2020 are 10/09/2020 and 10/09/2020 and 10/09/2020 and 10/09/2020 and 10/09/2020 and 10/09/2020 are 10/27/2020, review Resident #101 reveals third floor of the fatested for COVID-19 are 10/19/2020 and 10/09/2020 are 10/19/2020 and 10/09/2020 are 10/19/2020 are 10/19/2020, There are 10/19/2020.	O20. No other testing was There are 14 days and 10/21/2020.  W of the clinical record for ed they resided on the third esident #106 was tested for 20 and again on re 9 days between 2020. There are 10 days and 10/19/2020.  ew of the clinical record for ed they also resided on the #107 was tested for 20, 10/19/2020, and re 9 days between 2020. There are 10 days and 10/19/2020, and re 9 days between 2020. There are 10 days and 10/19/2020.  W of the clinical record for red they were a Resident on ricility. Resident #101 was on 10/9/2020 and again on re 9 days between 2020. There are 10 days and 10/19/2020.  Wealed she was tested for 20 and 10/19/2020.  Wealed she was tested for 20 and 10/7/2020. There 10/7/2020 and 10/21/2020.  Wealed testing for COVID-19 D20, 10/16/2020, and re 9 days between 10/7/2020	F	386			

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STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_\_ 495096 B. WING 10/27/2020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1600 WESTBROOK AVE WESTMINSTER-CANTERBURY OF RICHMOND RICHMOND, VA 23227 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 5 F 886 infection). Continue to test all staff and residents that tested negative every 3-7 days until 14 days since the most recent positive result has passed". On 10/27/2020 at 5:30 PM, during an end of day meeting the facility Administrator was made aware of the findings and stated, "I can't tell you a reason why we did that". No further information was submitted.