PRINTED: 02/15/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495227	B. WING		C 01/31/2023
	PROVIDER OR SUPPLIER	I AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 01/31/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTIO
F 000	INITIAL COMMENT	ΓS	F 000		
	survey was conducted and 1/30/23 through corrections are requirements.	Medicare/Medicaid abbreviated ted 1/25/23 through 1/27/23 th 1/31/23. Significant uired for compliance with 42 eral Long Term Care			
	survey (VA0005754 deficiency; VA0005 deficiency; VA0005 VA00056963 - Subs	7 - Substantiated without 7361 - Substantiated with 7510 - Unsubstantiated; stantiated without deficiency; stantiated with deficiency).			
	201 at the time of the consisted of eight of four closed record in	Injury/Decline/Room, etc.)	F 580		2/21/23
	§483.10(g)(14) Not (i) A facility must im consult with the resconsistent with his representative(s) w (A) An accident inversults in injury and physician interventi (B) A significant characterioration in heastatus in either lifeclinical complication (C) A need to discontinua a need to discontinua consultation (I) A facility mental (I) (I) A need to discontinuation (I) A facility mental (I)	ification of Changes. Imediately inform the resident; ident's physician; and notify, or her authority, the resident hen there is- olving the resident which I has the potential for requiring on; ange in the resident's physical, ocial status (that is, a Ith, mental, or psychosocial threatening conditions or			
ABORATORY	/ DIRECTOR'S OR PROVI	DER/SUPPLIER REPRESENTATIVE'S SIGI	NATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

02/13/2023

Electronically Signed

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.

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	COM	E SURVEY PLETED
		495227	B. WING _		1	C 31/2023
	PROVIDER OR SUPPLIER	N AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	, , ,	
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F 580	(D) A decision to tresident from the fights \$483.15(c)(1)(ii). (ii) When making reconstruction of this section all pertinent inform is available and prophysician. (iii) The facility must resident and the reconstruction of the facility must resident and the reconstruction of the facility must specified in \$48 (B) A change in resident and the reconstruction of the facility must be facility of the facility must be facility for the facility for t	form of treatment); or ransfer or discharge the acility as specified in notification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the st also promptly notify the esident representative, if any, om or roommate assignment (3.10(e)(6); or sident rights under Federal or ations as specified in paragraph ion. It is the second and periodically is (mailing and email) and the resident mose in its admission agreement aration, including the various prise the composite distinct exify the policies that apply to ween its different locations	F 58			
	review, and clinica failed to notify the	erview, facility document I record review, the facility staff physician of a resident's n for one of 12 residents in the esident #7.		The facility sets forth the followicorrection to remain in complian federal and state regulations. The has taken or will take the actions in the plan of correction. The following plan of correction constitutes the	ce with all ne facility s set forth lowing	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′				E SURVEY PLETED
		495227	B. WING				31/ 2023
	PROVIDER OR SUPPLIER ORT REHABILITATION	I AND NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226	1 01/1	517 2 020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	The findings included For Resident #7, the physician/nurse resident had not had 4/27/22 and 5/8/22. A review of R7's possible to prove the completed by CNA revealed the resided have a bowel move (3:00 p.m 11:00 p. shift (7:00 a.m 3:00 p.m 3:00 p.m 11:00 p. shift (7:00 a.m 3:00 p.m 11:00 p. shift (7:00 a.m 3:00 p.m 3:00 p	e: e facility staff failed to notify practitioner (NP) that the day a bowel movement between int of care documentation (certified nursing assistants) as not documented to ement from the evening shift o.m.) on 4/27/22 until the day 00 p.m.) on 5/8/22. Ogress notes for April and May all any evidence that any staff provider (either a nurse attending physician) that the day a bowel movement between	F 5	80	allegation of compliance. All allege deficiencies cited have been or will corrected by the date or dates indice. F 580 Notify of Changes (Injury/Decline/Room, etc.) 1. Resident # 7 no longer resides facility. 2. Current residents have the pote be affected. 3. The Staff Development Coording designee will educate the licensed on physician notification for resider a significant change in condition and the process for documentation in resident so clinical record. The more of bowel dysfunction /elimination with physician notification. 4. The Unit Managers or designed complete a weekly audit of on reside with significant change in condition complaints of bowel dysfunction/elimination. The physic was notified, and documentation is complete. The results of the review discussed at the monthly QAPI me Once the QAPI committee determing problem no longer exists, the review decompleted on a random basis. Administrator/Director of Nursing a responsible for implementation of tof correction. 5. Date of Compliance: 2.21.2023	in the ential to nator or nurses its with id on nitoring ith e will lents s, ian will be eting. nes the ws will The re he plan	

				B) DATE SURVEY COMPLETED		
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F 580	have had a bowel days." She stated bowel movement i call the provider. A care records "I wo She stated a resid movement in 10 darupture. On 1/31/23 at 11:3 manager, was intefacility's bowel pronotified if a resider movement in three appears on the clir resident's EMR alestated the nurse slithe CNA to determ had a bowel move unaware. If the resident's the lack of a bowe days, the nurse shalert the provider, intervention. She sides (as-needed) order the nurse should be looking "every day." She sides to look every day. "She sides to look every day. "She sides and they while they are pass R7's bowel records did anything. I will on 1/31/23 at 12:0 interviewed. When	movement "in the last couple of if a resident has not had a in the last three days, she would after reviewing R7's point of all have called [the provider]." ent who has not had a bowel ays is at high risk for bowel as at high risk for bowel as at high risk for bowel as a care, LPN #6, R7's unit reviewed. She stated the tocol is for the provider to be at has not had a bowel as days. She stated an alert nical dashboard of the enting the staff of this. She nould go to the resident and/or ine if the resident might have ment, but the staff was aident and/or the CNA confirms I movement in the last three ould contact the provider to and to request a new stated if a resident has a print for an additional bowel agent, and ovider. She stated nurses at bowel movement frequency tated: "They have the capability They can to the [point of care] can certainly ask the patient sing meds." After reviewing a, she stated: "I can't see we go look."	F 58			
		oring the frequency of residents' . she stated. "If it's been longer				

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F 580	than five days, yo doctor." She state additional bowel at the aides to let m movements, and resident. On 1/31/23 at 12 #2, a nurse pract stated she never asked if the facilit stated to her und Miralax, which is nurses should be for bowel movement movement record stated: "I would hnotified after two bowel movement movement. We welse." On 1/31/23 at 12 staff member) #1 director of nursing, and A clinical services, concerns. They wharm for R7. On 1/31/23 at 1:2 find anything to support the movement in threadominal assess	page 4 ou are supposed to notify the ed the doctor might order an agent. She stated I would ask e know about the bowel continue to check on the 12 p.m., RN (registered nurse) itioner, was interviewed. She met or took care of R7. When by had a bowel protocol, she erstanding, everyone is on a gentle laxative. She stated monitoring residents every shift ents. She stated: "I want to be days of a resident not having a" After reviewing R7's bowel ds and physician's orders, she ave wanted to have been eat he had not had a bowel would have started something 155 p.m., ASM (administrative and the had not had a bowel would have started something 156 p.m., ASM (administrative and the edministrator, ASM #2, the gray was did something for [R7]." 157 p.m., LPN #6 stated: "I can't have did something for [R7]." 158 p.m., LPN #4 was interviewed. Sident has not had a bowel see days, she would do an sement and let the provider know ould put something in place.	F	580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 580	On 1/31/23 at 3:4 spoken to ASM # was in charge of She stated ASM # by phone for a whaware the resider movement." She copies of studies elderly people to bowel movement he was aware, ar #2 was asked to #6's awareness. any evidence in the notified the provide a bowel movemed documentation where the was sent out, and him on a stock was sent out, and had him on a stock werything right." staff should have resident's lack of "There is nothing on 1/31/23 at 4:4 located a text me She provided a signal for the text exchang 5/4/23 at 12:10 pand last name] - Bio (sic) and supplies the stated of the pand last name] - Bio (sic) and supplies the stated and su	8 p.m., ASM #2 stated she had 6, R7's attending physician who the resident's care until 5/6/22. #6 was going to be unavailable hile, but had told her that he was nt "had not had a bowel stated ASM #6 could provide showing it is not abnormal for go seven days without having a . ASM #2 stated ASM #6 told her not there were interventions. ASM provide documentation of ASM When asked if she could find the clinical record that the staff der that the resident did not have nt, she stated: "No, not in the e have." 2 p.m., ASM #5, the facility's irector, was interviewed. ASM er saw this patient. I took over a sything happened. From what I ent had an ileus at the end. He is unfortunately passed away. We of softener. I believe we did When ASM #5 was asked if the notified him or the NP about the bowel movements, he asked:	F 5	580			

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F 580	specific residents. notify physicians." she texted to ASM number of days wi #6 again reviewed stated: "No. I told [days, when it really stated she did not conversation with A review of the fac of Condition," reveshall communicate status change to a immediately upon shall assess the particular of physician or design No further information (1) This information Institutes of Health https://www.ncbi.nl.69564./ "Ileus is a temporal contractions of the include drugs, espenticholinergic drug abdominal bloating of gas and liquids, constipation, loss of may pass watery strestriction of food as services."	She said: "Yes, it's how we When asked if the information #6 was correct regarding the thout a bowel movement. LPN R7's bowel records, and ASM #6] it had only been three had been six days." LPN #6 document her text ASM #6 in the medical record. ASM #6 in the medical records. ASM #6 in the	F 58			

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F 580	Continued From pa	ge 7	F 5	80		
			F 6	55		2/21/23
	Planning §483.21(a) Baseline §483.21(a)(1) The filimplement a baseline that includes the inseffective and persorthat meet profession. The baseline care profession of the baseline care profession. (ii) Be developed with admission. (iii) Include the minimacessary to proper including, but not lirus (A) Initial goals base (B) Physician order (C) Dietary orders. (D) Therapy services (E) Social services. (F) PASARR recoms §483.21(a)(2) The fromprehensive care care plan if the comprehensive in the same services of the same services.	facility must develop and the care plan for each resident structions needed to provide in-centered care of the resident nal standards of quality care. It is a plan must thin 48 hours of a resident's mum healthcare information ray care for a resident inted to-led on admission orders. Ses. Immendation, if applicable. Facility may develop a le plan in place of the baseline interprehensive care plan-				
	admission. (ii) Meets the requir (b) of this section (e) this section). §483.21(a)(3) The resident and their re	thin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of facility must provide the epresentative with a summary e plan that includes but is not				

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		495227	B. WING _			31/ 2023
	PROVIDER OR SUPPLIER	N AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	<u>, </u>	
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F 655	limited to: (i) The initial goals (ii) A summary of dietary instructions (iii) Any services a administered by the on behalf of the factive (iv) Any updated in of the comprehens. This REQUIREME by: Based on staff interview, and clinical failed to develop a for one of 12 resident #6. The findings include Resident #6 (Finderview) and clinical failed to develop a for one of 12 resident #6. The findings include R6 was admitted to develop a completed to decrease use and incontiner hemiplegia CVA (concept (hypertension)) general decrease use and incontiner hemiplegia CVA (concept (hypertension)) general decrease use and incontiner hemiplegia CVA (concept (hypertension)) general decrease use and incontiner hemiplegia CVA (concept (hypertension)) general with multipreview of R6's care interventions to addressed to the baseline care previewed and revised and revised and revised and revised to the baseline care previewed and revised and revised to the first provided to the baseline care previewed and revised to the baseline care previewed to th	s of the resident. The resident's medications and stand treatments to be a facility and personnel acting cility. Information based on the details sive care plan, as necessary. INT is not met as evidenced arview, facility document a record review, the facility staff complete baseline care plan ents in the survey sample, Ite: R6), the facility staff failed to be baseline care plan for falls. The facility on 12/23/22 aresident is at risk for falls are mobility med (medication) and episodes Dementia believed muscle weakness and health issues." Further a plan failed to document any dress falls (until after the plan failed to reveal it was seed to include interventions the 12/24/22 fall (until after the plan failed to reveal it was seed to include interventions the 12/24/22 fall (until after the	F 65	F655 Baseline Care Plan 1. Resident #6 no longer resides facility, 2. Current residents have the police affected. 3. The Regional Director of MDS designee will educate MDS staff a nursing management. (DON, ADON, Unit Managers and Supervisors) on the process for the development and requirements of resident so baseline care plan for the 4. The Director of MDS or designereview 5 baseline care plans week ensure the baseline care plans week ensure the baseline care plan was initiated for falls. The results of the will be discussed at the monthly Q meeting. Once the QAPI committed determines the problem no longer the reviews will be completed on a random basis. The Administrator/ of Nursing are responsible for implementation of the plan of corresponded to the plan of the plan of corresponded to the plan	tential to or nd e the falls. nee will ly to e review API ee exists, Director	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	COM	E SURVEY IPLETED
		495227	B. WING			C 31/2023
	PROVIDER OR SUPPLIER	I AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 017	31/2023
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F 655	On 1/31/23 at 12:18 conducted with LPN LPN #5 stated the pdo the plan of care facility. LPN #5 starisk for falls upon aprevent falls should LPN #5 stated if a rintervention should show a new interve was implemented. On 1/31/23 at 3:34 staff member) #1 (the director of nurs assistant director of the above concern. The facility policy tift Care Planning" doccordination with the develops and imple plan for each patier person-centered can health-related care maintain the highest	B p.m., an interview was N (licensed practical nurse) #5. Durpose of the care plan is to while the resident is in the ted if a resident is deemed at dmission, interventions to be added to the care plan. The esident falls, a new be added to the care plan to ntion to prevent future falls p.m., ASM (administrative he administrator), ASM #2 sing) and ASM #3 (the finursing) were made aware of	F 65	55		
F 656 SS=D	Develop/Implement CFR(s): 483.21(b)(F 65	56		2/21/23
	§483.21(b)(1) The timplement a compr care plan for each i	chensive Care Plans facility must develop and rehensive person-centered resident, consistent with the orth at §483.10(c)(2) and				

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F 656	§483.10(c)(3), that objectives and time medical, nursing, a needs that are ider assessment. The odescribe the follow (i) The services that or maintain the resphysical, mental, a required under §48 (ii) Any services that under §483.24, §44 provided due to the under §483.10, incommendations findings of the PAS rationale in the reservice in the resident's desired outcomes. (B) The resident's future discharge. Further the resident community was as local contact agency entities, for this pure (C) Discharge pland pland, as appropriate requirements set for section. §483.21(b)(3) The	includes measurable eframes to meet a resident's and mental and psychosocial ntified in the comprehensive comprehensive care plan musting - at are to be furnished to attain ident's highest practicable and psychosocial well-being as 33.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not a resident's exercise of rights luding the right to refuse 483.10(c)(6). If services or specialized ces the nursing facility will of PASARR If a facility disagrees with the SARR, it must indicate its ident's medical record. With the resident and the attaive(s)-goals for admission and preference and potential for acilities must document ant's desire to return to the sessed and any referrals to cies and/or other appropriate	F6	56			

TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMP		E SURVEY IPLETED			
	495227	B. WING _			C 31/2023
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		<u> </u>
WESTBORT BEHARM ITATION A	ND NUDSING CENTED		7300 FOREST AVE		
WESTPORT REHABILITATION A	IND NURSING CENTER		RICHMOND, VA 23226		
PREFIX (EACH DEFICIENCY M	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656 Continued From page		F 6	56		
	petent and trauma-informed. is not met as evidenced				
Based on staff intervireview, and clinical refailed to implement the for one of 12 resident Resident #7. The findings include: For Resident #7 (R7), implement the care plemovement to the physician-ordered meconstipation. On the most recent Meduarterly/discharge not assessment with an Adate) of 5/12/22, R7 verice moderately impaired thaving scored 12 out interview for mental seconded as requiring the staff for bed mobility, living, including eating A review of R7's care in part: "[R7] has bowe constipation related to medicationsAdminist physician orderRepresentation such as adiarrhea, nausea/vorm for three days."	IDS (minimum data set), a preturn anticipated ARD (assessment reference was coded as being for making daily decisions, of 15 on the BIMS (brief tatus). The resident was extensive assistance of and for all activities of daily g. plan dated 2/3/22 revealed, rel elimination alteration; or lack of exercise, ester medications per ort signs and symptoms of		1. Resident #7 no longer resifacility. 2. Current residents have the be affected. 3. The staff development coordesignee will educate all licens to follow and implement interveresident scare plan for at risk bowel dysfunction/elimination. 4. The unit managers or desireview weekly 10 residents crecords to identify signs and sybowel dysfunction/elimination, movements in 3 days, ADL do for bowel movements and will interventions were implemente physician notified if required for elimination and documented. To fithe review will be discussed monthly QAPI meeting. Once committee determines the prolonger exists and sustained by nurses are following the care phowel dysfunction/elimination will be completed on a random Administrator/Director of Nursiresponsible for implementation of correction. 5. Date of Compliance: 2/21/	des in the potential to rdinator or ed nurses entions per /actual gnee will inical rmptoms of no bowel cumentation verify d with r bowel the results at the the QAPI blem no licensed lan for he reviews basis. The ng are of the plan	

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F 656	revealed the reside have a bowel move (3:00 p.m 11:00 p shift (7:00 a.m 3: A review of R7's ph following order: "2/3 mg (milligrams) Ins needed daily for co. A review of R7's Marecord) for April and resident failed to rebetween 4/28/22 ard A review of R7's progresident failed to rebetween 4/28/22 ard A review of R7's progresident failed to reveat member notified a practitioner or the aresident had not had 4/28/22 and 5/8/22. On 1/31/23 at 1:43 nurse) #6, the unit interviewed. When plan, she stated: "It patient." She stated for the implemental asked if the facility plan for constipation "They are not follow call the doctor."	ment from the evening shift of the ment of the	F 65	56		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		INSTRUCTION	COM	E SURVEY MPLETED
		495227	B. WING				C / 31/2023
	PROVIDER OR SUPPLIE	ON AND NURSING CENTER		7300	FOREST AVE MOND, VA 23226	<u> </u>	0172020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		D BE	(X5) COMPLETION DATE
F 656	On 1/31/23 at 3:4 spoken to ASM #6 was in charge of the She stated ASM #6 by phone for a what was aware the resider movement." She copies of studies elderly people to go bowel movement he was aware, and #2 was asked to put #6's awareness. It was awareness. It was a wareness. It	page 13 8 p.m., ASM #2 stated she had 6, R7's attending physician who the resident's care until 5/6/22. 66 was going to be unavailable tile, but had told her that he was at "had not had a bowel stated ASM #6 could provide showing it is not abnormal for go seven days without having a ASM #2 stated ASM #6 told her differ were interventions. ASM provide documentation of ASM when asked if she could find the clinical record that the staff fer that the resident did not have not or that the staff had given the sitory as ordered, she stated: cumentation we have." 10 p.m., LPN #6 stated she had seage that she sent to ASM #6. Exceen shot of the text exchange. The documented the following on m.: "LPN #6: [R7's first initial to BM in 72 hrs (hours). Colace to (suppository) prn." "ASM #6: asked if she ordinarily used text municate with providers about a She said: "Yes, it's how we will when asked if the information of the was correct regarding the pithout a bowel movement. LPN to R7's bowel records, and [ASM #6] it had only been three by had been six days." LPN #6 and document her text ASM #6 in the medical record.	F6	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _		C 01/31/2023	
	PROVIDER OR SUPPLIER	I AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226		01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 656	part: "The Interdisc conjunction with the legal representative comprehensive, pe each resident." No further information Institutes of Health https://www.ncbi.nlr.69564./ "Ileus is a temporar contractions of the include drugs, esperanticholinergic drug abdominal bloating of gas and liquids, is constipation, loss of may pass watery strestriction of food a given by vein, Sucti information is taken https://www.merckrisorders/gastrointes Care Plan Timing a CFR(s): 483.21(b)(s) \$483.21(b) Compres \$483.21(b)(2) A combe- (i) Developed within the comprehensive	rson-Centered," revealed, in iplinary Team (IDT), in e resident and his/her family or a, develops and implements a rson-centered care plan for ion was provided prior to exit. In is taken from the National website m.nih.gov/pmc/articles/PMC55 Ty lack of the normal muscle intestinesOther causes exially opioid analgesics and psThe symptoms of ileus are and pain caused by a buildup nausea, vomiting, severe of appetite, and cramps. People oolTreatment: Temporary and fluids by mouth, Fluids on via nasogastric tube." This in from the website manuals.com/home/digestive-destinal-emergencies/ileus. In Revision (2)(i)-(iii) The phensive Care Plans prehensive care plan must in 7 days after completion of assessment. Interdisciplinary team, that imited to	F 65			2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION	COMI	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			31/ 2023
	PROVIDER OR SUPPLIE	R ON AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CC 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 657	resident. (C) A nurse aide versident. (D) A member of (E) To the extent the resident and the resident and the resident and their resident not practicable for resident's care place (F) Other appropridisciplines as det or as requested be (iii)Reviewed and team after each a comprehensive a assessments. This REQUIREM by: Based on staff in review, and clinicated to review and care plan for two Residents #4 and The findings included the findings included the findings. A review of R4's coliquid safety evaluated the findings included the findings inc	with responsibility for the with responsibility for the food and nutrition services staff. practicable, the participation of he resident's representative(s). ust be included in a resident's the participation of the resident representative is determined remined by the resident's needs by the resident. revised by the interdisciplinary seessment, including both the nd quarterly review ENT is not met as evidenced terview, facility document al record review, the facility staff and revise the comprehensive of 12 residents in the survey, #9. de: t #4 (R4), the facility staff failed	F6	F657 Care Plan Timing and 1. Resident #4 care plan wa hot liquids. The timeframe ha the fall revision. The fall care reviewed with appropriate int Resident #9 the timeframe ha fall revision. The care plan w with appropriate interventions 2. Current residents have th be affected. 3. The Regional Director of designee will educate MDS s nursing management. (DON, ADON, Unit Managers Supervisors) on care plans in revisions/updated after a fall, spill or change in condition. 4. The Director of MDS or condition.	as initiated for as passed for plan was erventions. as passed for as reviewed s. are potential to MDS or staff and as and anitiation, hot liquid	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	PLE CONSTRUCTION		E SURVEY PLETED
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		495227	D. WING _			31/2023
	PROVIDER OR SUPPLIEF	N AND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		Œ	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 657	is short tempered. The resident is confine evaluation fur more indicators of Factors section 2, injury from hot liquintervention select [a check mark besprotector/lap prote beverages; staff to beverages." A review of R4's confine revised on 12/4/22 was reviewed and injury from hot liquing. On 1/31/23 at 12: conducted with LFLPN #5 stated the dothe plan of care facility. LPN #5 st from hot liquids should inclue on 1/31/23 at 3:34 staff member) #1 (the director of nurassistant director of the above concern the facility policy are Planning" do care plans will be	gnitively impaired." ther documented: "If Two or risk are checked in Safety than the resident is at risk for aids and requires an red from below: side] resident to wear clothing ector while drinking hot assist with drinking of hot comprehensive care plan revised regarding the risk for aids. 18 p.m., an interview was PN (licensed practical nurse) #5. purpose of the care plan is to exhibit the resident is in the ated residents at risk for injury rould have their care plans sed to include this and the care de the necessary interventions. 4 p.m., ASM (administrative (the administrator), ASM #2 rsing) and ASM #3 (the of nursing) were made aware of	F 65	review 5 care plans weekly to care plan reflects the initiation revision/updated for a fall or h. The results of the review will discussed at the monthly QAF Once the QAPI committee de problem no longer exists, the be completed on a random ba Administrator/Director of Nurs responsible for implementation of correction. 5. Date of Compliance: 2.21	not liquid spill be PI meeting. termines the reviews will asis. The sing are on of the plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING				C / 31/2023
	PROVIDER OR SUPPLIE	ON AND NURSING CENTER		7300	ET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE HMOND, VA 23226		10112020
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F 657	Continued From	page 17	F 6	657			
	No further inform	ation was presented prior to exit.					
	to review and rev	#4 (R4), the facility staff failed ise the resident's are plan after the resident fell on					
	note dated 8/5/22 fell and sustained review of R4's co on 9/8/22 failed to	clinical record revealed a nurse's that documented the resident a skin tear on the right arm. A mprehensive care plan revised preveal the care plan was ised regarding R4's 8/5/22 fall.					
	conducted with L LPN #5 stated the do the plan of car facility. LPN #5 s intervention shou	218 p.m., an interview was PN (licensed practical nurse) #5. The purpose of the care plan is to be while the resident is in the stated if a resident falls, a new lid be added to the care plan to be vention to prevent future falls discontinuous.					
	staff member) #1 (the director of nu	:56 p.m., ASM (administrative (the administrator), ASM #2 ursing) and ASM #3 (the of nursing) were made aware of n.					
	No further inform	ation was presented prior to exit.					
	review and revise	9 (R9), the facility staff failed to the resident's comprehensive e resident fell on 11/5/22 and					
		clinical record revealed the d a fall with no injury on 11/5/22					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		C 01/31/2023	
	PROVIDER OR SUPPLIER	I AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	01/31/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE	
F 657	review of R9's com on 12/19/22 failed to reviewed and revise On 1/31/23 at 12:18 conducted with LPN LPN #5 stated the plan of care facility. LPN #5 stated intervention should show a new intervewas implemented.	h no injury on 11/28/22. A prehensive care plan revised to reveal the care plan was ed regarding both falls. B p.m., an interview was N (licensed practical nurse) #5. purpose of the care plan is to while the resident is in the sted if a resident falls, a new be added to the care plan to ention to prevent future falls	F 65	7		
	staff member) #1 (the director of nurs assistant director of the above concern.	p.m., ASM (administrative the administrator), ASM #2 sing) and ASM #3 (the f nursing) were made aware of ion was presented prior to exit.	F 684	4	2/21/23	
	applies to all treatmer facility residents. But assessment of a restruction that residents received accordance with proportion of the compression	fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered		F 684 Quality of Care 1. Residents #7 no longer resides in	the	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		E CONSTRUCTION		SURVEY PLETED
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	PROVIDER OR SUPPLIER	N AND NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226	0170	7172020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	experiencing boweresidents in the surresulting in harm. The findings include the facility staff fair (R7's) lack of a bown failed to administer suppository to treat the resident development of the resident development of the site of the block transfer to a local harmonic of the most recent quarterly/discharge assessment with a date) of 5/12/22, Romoderately impaired having scored 12 conterview for mental coded as requiring staff for bed mobililiving, including each of the side have a bowel move (3:00 p.m 11:00 p. shift (7:00 a.m 3:00 p. of the surrey of R7's perfollowing orders:	I dysfunction for one of 12 rvey sample, Resident #7, e: led to identify Resident #7's wel movement for 10 days, and a physician-ordered the lack of bowel movements. oped an ileus ("By definition, or paralysis of the bowel ward passage of the intestinal cheir accumulation proximal to kage." 1), which required nospital. t MDS (minimum data set), a eno return anticipated in ARD (assessment reference 7 was coded as being ed for making daily decisions, but of 15 on the BIMS (brief al status). The resident was the extensive assistance of ty, and for all activities of daily	F6	i84	facility. 2. Current residents have the pote be affected. 3. The Staff Development Coordin designee will educate all the license nurses on the process for bowel management including monitoring, physician notification for bowel dysfunction/elimination and implem interventions per physician orders. 4. The unit manager or designeer audit residents clinical record week review documented bowel dysfunction/elimination to verify the process for bowel management was followed with physician notification interventions implemented. The rest the review will be discussed at the monthly QAPI meeting. Once the Committee determines the problem longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing as responsible for implementation of the Correction. 5. Date of Compliance: 2.21.2023	enting with ly to sand cults of QAPI no ene plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01	C / 31/2023
	PROVIDER OR SUPPLIER	N AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		
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F 684	Continued From p	age 20	F 68	4		
		per scoop). Give one scoop ng for bowel management. Mix quid."				
		sodium capsule (stool softener) s) Give 1 capsule orally two wel management."				
		suppository 10 mg (milligrams) ry rectally as needed daily for				
	record) for April an resident received I as ordered, howev	MAR (medication administration and May 2022 revealed the Miralax and docusate sodium ver the resident failed to receive sitory between 4/28/22 and				
	2022 failed to reve member notified a practitioner or the	rogress notes for April and May eal any evidence that any staff provider (either a nurse attending physician) that the ad a bowel movement between 2.				
	(nurse practitioner "Chief Complaint: medications, diagr vital signs and curnew to our medical patient encounter records reviewed. results reviewrev systemsGastroir examinationAbd	ress note written by the NP c) on 5/6/22 revealed, in part: Recertification visit to review noses, labs (laboratory results), rent plan of care. Pt (patient) is all practice, this is our initial and all previous medical Pt seen for abnormal lab view of ntestinal negativePhysical omen: Soft; BS (bowel sounds) drants) heardAssessment and				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495227	B. WING				/31/2023
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F 684	loss noted, dietician adequate appetite controlled, d/c (disc medication for pain (extended release) 15 mg q 12h (every careFULL CODE for interview during A review of R7's Maresident received the ordered. A review of a dietar revealed, in part: "C Loss Assessment 25 - 50%." A review of progress revealed, in part: "10:02 a.mNote 1 morning meds, ress makes me sicker." "10:28 p.mNote 1 morning meds, ress makes me sicker." "12:28 p.mNote 1 noted with distended appearance, NPa for sodium chlorided (immediate) KUB (in NACL (sodium chlorocy) (responsattempted to reach phone."	in followingpt reportschronic pain, per pt not continue) oxycontin (an opioid)start Morphine ER (an opioid medication for pain) (12 hours)supportive ." This NP was not available the survey. ay 2022 MAR revealed the ne Morphine twice a day as by progress note dated 5/9/22 Quarterly/Significant Weight .PO (by mouth) intake: Varies - cs notes dated 5/11/2022 Fext: Resident refused all ident states 'the medicines	F6	84			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01	C / 31/2023	
	PROVIDER OR SUPPLIE	R ON AND NURSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 684	heartbeat) and at symptomsGast abdominal pain; (distention)Phys Distended. BS X4 Planabdominal days per pt, start fluids)stat KUB. A review of the ra 5/11/22 at 7:20 p. Nausea/Vomiting column is seen in hepatic flexure. District flexu	odominal distentionReview of rointestinal: Nausea/vomiting; Other: abd (abdominal ical examination: Abdomen: 4 heardAssessment and distention/nausea/vomiting X 2 PIV (peripheral intravenous		584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING				C 31/2023
	PROVIDER OR SUPPLIE	ON AND NURSING CENTER		7300	EET ADDRESS, CITY, STATE, ZIP CODE D FOREST AVE HMOND, VA 23226	<u>, </u>	0112020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			(X5) COMPLETION DATE
F 684	A review of R7's of in part: "[R7] has constipation related medicationsAdriphysician order] constipation such diarrhea, nauseal for three days." On 1/31/23 at 9:3 nurse) #2 was interested she can loo on the EMR (elect the CNA taking caresident is a relial resident. She stated aboved days." She stated narcotics/opioids important to evaluate each reshave had a bowed narcotics/opioids important to evaluate of these type constipating. She a bowel movement would call the prohas an as-needed suppository, she was uppository, she suppository, and provider]." She state of the prohase of the suppository, and provider]." She state of the prohase	care plan dated 2/3/22 revealed, bowel elimination alteration; ed to lack of exercise, ninister medications per Report signs and symptoms of as abdominal cramping, vomiting, no bowel movement 7 a.m., LPN (licensed practical erviewed. When asked how she ent for bowel movements, she ok at the point of care records tronic medical record), can ask are of the resident, and, if the ole historian, can ask the ed she tries every day to ident for whether or not they movement "in the last couple of if a resident is on or antibiotics, it is especially late for bowel movements, as as of medications can be stated if a resident has not had not in the last three days, she wider. She stated if a resident dorder for an oral laxative or would also administer that reviewing R7's point of care order for an as-needed stated: "I would have given the still would have called [the atted a resident who has not had not in 10 days is at high risk for 5 a.m., CNA #4 was stated she took care of R7 for	F6	884			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495227	B. WING		01	C / 31/2023
	PROVIDER OR SUPPLIE	R ON AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	most of the time I stated: "I kept [the (R7) lost a lot of a stated she remer decline, but that the placed on comforeven bowel move asked to elaborate incontinent of both needed to be charted the last time the resident was stated the last time the resident was stated she inform movements. A review of R7's processed to the last time the resident was stated she inform movements. A review of R7's processed to the last time documentation in medium sized both and required the continuous and required the continuous and the contract of the last of a bow days, the nurse stated the nu	page 24 he spent at the facility. She e resident] turned and changed. weight while he was here." She he resident had never been it care. She stated: "At the end, ements were just liquid." When ite, she stated R7 was always in bowel and bladder and always inged. She stated the last couple id for the resident, the bowel inothing more than water." She he she took care of the resident, hauseated and vomiting. She he dates, CNA #4's dicated the resident had a wel movement, was incontinent, extensive of staff to be cleaned. 32 a.m., LPN #6, R7's unit herviewed. She stated the otocol is for the provider to be ent has not had a bowel he days. She stated an alert linical dashboard of the lerting the staff of this. She should go to the resident and/or mine if the resident might have he ment, but the staff was he sident and/or the CNA confirms he movement in the last three hould contact the provider to he and to request a new he stated if a resident has a prn	F	584		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	N AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	(as-needed) order the nurse should o still contact the proshould be looking a "every day." She sto look every day. records. And they while they are pass R7's bowel records stated: "I can't see When asked if R7 palliative care or he "He wanted everyt!" On 1/31/23 at 12:0 interviewed. When protocol for monito bowel movements than five days, you doctor." She stated additional bowel agthe aides to let me movements, and cresident. On 1/31/23 at 12:1 #2, a nurse practiti stated she never masked the possible Oxycodone to Mor movements, she s than Oxycodone, a even more than Ox counters this with t stated the bowels I movement, and thi opioids. She stated builds up in the box	for an additional bowel agent, ffer that to the resident, and ovider. She stated nurses at bowel movement frequency tated: "They have the capability They can to the [point of care] can certainly ask the patient sing meds." After reviewing s, orders, and MARs, she we did anything. I will go look." was ever considered for ospice services, she stated:	F6	84		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUI A. BUILD		(X3) DATE SURVEY COMPLETED			
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		495227	B. WING			01/	31/2023
	PROVIDER OR SUPPLIEF DRT REHABILITATIO	N AND NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE CICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 684	bowels. She state bowel can continu with a possibility of facility had a bowe understanding, every gentle laxative. She can include abdornausea, vomiting, stated some reside amount of loose, of formed. She state residents every she stated: "I want to be resident not having reviewing R7's borneysician's orders wanted to have be	d if an ileus is not treated, a le to grow larger in diameter, of rupturing. When asked if the el protocol, she stated to her eryone is on Miralax, which is a ne stated symptoms of an ileus minal discomfort, cramping, and abdominal pain. She ents may also have a moderate watery stool, but nothing that is d nurses should be monitoring nift for bowel movements. She be notified after two days of a g a bowel movement." After wel movement records and a she stated: "I would have been notified sooner that he had novement. We would have	F	584			
	staff member) #1, director of nursing of nursing, and AS clinical services, vharm for R7. On 1/31/23 at 1:20 find anything to sa On 1/31/23 at 2:03 She stated if a resmovement in three abdominal assess so the provider co	the administrator, ASM #2, the ASM #3, the assistant director of Were informed of the concern for the provider was interviewed. By me, LPN #6 stated: "I can't ay we did something for [R7]." By p.m., LPN #4 was interviewed. Sident has not had a bowel a days, she would do an ament and let the provider know all put something in place. By p.m., ASM #2, the director of a had spoken to R7's attending the content of the provider to R7's attending the content of the provider to R7's attending the R7's attend					
	nursing stated she	e had spoken to R7's attending b) who was in charge of the					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495227	B. WING				C 31/2023
	PROVIDER OR SUPPLIER	N AND NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE 0 FOREST AVE CHMOND, VA 23226	<u>, , , , , , , , , , , , , , , , , , , </u>	01/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	resident's care untivas going to be unbut had told her that "had not had a bow ASM #6 could provit is not abnormal fedays without having stated ASM #6 told were interventions. documentation of A stated she wanted records regarding movements. She salerts for the staff of the shifts, the CI applicable." She stagenerated if there is at all. When asked in the clinical recorprovider that the removement or that the	I 5/6/22. She stated ASM #6 available by phone for a while, at he was aware the resident wel movement." She stated ride copies of studies showing or elderly people to go seven g a bowel movement. ASM #2 her he was aware, and there ASM #2 was asked to provide ASM #6's awareness. ASM #2 to address the point of care frequency of bowel tated there were no clinical on the EMR because on some NAs had charted "not ated a clinical alert is only s no bowel movement charted if she could find any evidence d that the staff notified the sident did not have a bowel the staff had given the resident ridered, she stated: "No, not in	F6	84			
	current medical dir #5 stated: "I never week before every! was told the patien was sent out, and it had him on a stool everything right." W staff should have n resident's lack of b "There is nothing of was not eating at a 25%, he is not goin	p.m., ASM #5, the facility's ector, was interviewed. ASM saw this patient. I took over a thing happened. From what I t had an ileus at the end. He unfortunately passed away. We softener. I believe we did /hen ASM #5 was asked if the otified him or the NP about the owel movements, he asked: harted at all?" He added: "He II. If he is eating less than ag to have a bowel movement."					

STATEMENT OF DEFICIENCIES (X1) F		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DAT	E SURVEY IPLETED
		495227	B. WING				C
NAME OF	PROVIDER OR SUPPLIER	433221	D: W		ET ADDRESS, CITY, STATE, ZIP CODE	01/	31/2023
		N AND NURSING CENTER		7300	FOREST AVE MOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 684	located a text mess She provided a scr The text exchange 5/4/23 at 12:10 p.m and last name] - no Bio (sic) and supp Ok." LPN #6 was a messages to comm specific residents. notify physicians." It she texted to ASM number of days wit #6 again reviewed stated: "No. I told [adays, when it really asked what she un mean, she stated: "stool softener and she administered a she stated she did nurse to give it. But added: "You can le can't make them did any evidence that it suppository, she stoff, we can't say it it signature or note the LPN #6 stated she conversation with A On 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of percentages consulting the stated she conversation with A or 1/31/23 at 5:00 review R7's point of the stated she conversation with A or 1/31/23 at 5:00 review R7's point of the stated she conversation with A or 1/31/23 at 5:00 review R7's point of the stated	sage that she sent to ASM #6. een shot of the text exchange. documented the following on n.: "LPN #6: [R7's first initial of BM in 72 hrs (hours). Colace (suppository) prn." "ASM #6: sked if she ordinarily used text nunicate with providers about She said: "Yes, it's how we When asked if the information #6 was correct regarding the hout a bowel movement. LPN R7's bowel records, and ASM #6] it had only been three of had been six days." When derstood ASM #6's "ok" to "He meant to continue with the suppository." When asked if a suppository to R7 at that time, not. She stated: "I told the tit was not signed off." She and a horse to water, but you rink." When asked if there was R7 had received the ated: "With it not being signed was given. There is no not day about the suppository." did not document her text ASM #6 in the medical record. p.m., ASM #2 was asked to f care records regarding meal amed during May 2022. ASM wing meal percentages for R7 noch, D=dinner): =51-75 day	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495227	B. WING				C /31/2023
	PROVIDER OR SUPPLIE	N AND NURSING CENTER		7300	ET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 684	May 4 B 26-50; L May 5 = nothing a May 6 = nothing a May 7 B=76-100; May 8 B=51-75; L May 9 B=76-100; May 10 = nothing May 11 B, L=0; D May 1 through Ma accepted a bedtin When asked if AS R7 "was not eatin "Some days, yes. "It's not like he tot eating some. But added that the recevening snacks w resident. There w how much of the A review of the fa Prevention," revereview to determine the review of the factorial record. CoordersThe plan will be documented that the review to determine the review of the factorial review of the factorial review of the factorial review to determine the review to determine the review to determine the review of the factorial review of the	26-50; D=0 all day all day L 36-50; D26-50 . 51-75; D=0 L 76-100; L=0 all day =51-75 ay 11 - R7 was offered and ne snack each evening. SM #5 was accurate in saying g anything," ASM #2 stated: Some days, no." She stated: rally quit eating. Yes, he was some days he wasn't." She cord only documented that rere offered and accepted by the as no documentation regarding snack the resident consumed. cility policy, "Constipation aled, in part: "Nurse will routinely ne patients in need of silitate bowel ment bowel movements in the ontact physician for any needed for prevention of constipation ad on the comprehensive care ation was provided prior to exit.	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C 01/31/2023
	PROVIDER OR SUPPLIER	N AND NURSING CENTER		STREET ADDRESS, CI 7300 FOREST AVE RICHMOND, VA 2	TY, STATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BE RENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=D	contractions of the include drugs, espanticholinergic drug abdominal bloating of gas and liquids, constipation, loss of may pass watery sestriction of food a given by vein, Such information is take https://www.merck isorders/gastrointere of Accident H CFR(s): 483.25(d)	ry lack of the normal muscle intestinesOther causes ecially opioid analgesics and gsThe symptoms of ileus are and pain caused by a buildup nausea, vomiting, severe of appetite, and cramps. People toolTreatment: Temporary and fluids by mouth, Fluids tion via nasogastric tube." This in from the website manuals.com/home/digestive-d stinal-emergencies/ileus. azards/Supervision/Devices (1)(2)	F 6			2/21/23
	as free of accident §483.25(d)(2)Each supervision and as accidents. This REQUIREME by: Based on staff intereview, and clinical failed to implement for two of 12 residents #6 and and the findings included the findings inc	resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced erview, facility document record review, the facility staff tinterventions to prevent falls ents in the survey sample, #4.		1. Residents facility. Resident #4 T for the fall revirewed with 2. Current rebe affected. 3. The Staff designee will expressions.	Accident ervision/Devices #6 no longer resides in the timeframe has passe ision. The fall care plan vappropriate interventions esidents have the potention development Coordinate educate all licensed nursis for implementing an	ed was s. al to or or

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIE	R ON AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIF 7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	12/24/22. R6 was admitted baseline care pla documented, "Th related to decreasuse and incontine hemiplegia CVA ((hypertension) geresident with multiverventions to a resident's dischart 12/24/22 docume fall with no injury date. On 1/31/23 at 12: conducted with LL LPN #5 stated that for falls upon adnup with interventifrom falling. On 1/31/23 at 3:3 staff member) #1 (the director of nuassistant director the above concerting the above concerting the facility policy program" document as spatients. The cento a Falls Managemulti-faceted, intervention in the care and th	to the facility on 12/23/22. R6's in created on 12/23/22 eresident is at risk for falls sed mobility med (medication) ent episodes Dementia cerebrovascular accident) HTN eneralized muscle weakness tiple health issues." Further replan failed to document any ddress falls (until after the rege). A nurse's note dated ented the resident sustained a on that 18 p.m., an interview was PN (licensed practical nurse) #5. at if residents are deemed at risk hission, then staff should come ons to prevent the residents 4 p.m., ASM (administrative (the administrator), ASM #2 ursing) and ASM #3 (the of nursing) were made aware of in. titled, "Falls Management ented, "The Center considers all risk for falls and provides an afe as practicable for all inter utilizes a systems approach ement Program that conducts endisciplinary assessments with interventions to develop	F 68	intervention after a fall to further falls. The Regional Director of designee will educate IDT Director of Rehab, and numanagement (DON, ADO Managers and Supervisor process for reviewing, reveare plan after a fall with inprevent further falls. 4. The unit manager or a audit residents clinical recreview documented falls the plan was initiated, revised intervention to prevent further monthly QAPI meeting QAPI committee determing the monthly QAPI meeting QAPI committee determing the monthly QAPI meeting QAPI committee determing the monthly planed on a random but the monthly determined in the monthly of the review of the revie	MDS or (MDS staff, ursing DN, Unit rs) on the vising/updating intervention to designee with cord weekly to to verify the care d/updated with ther falls. The pe discussed at g. Once the ness the problem ews will be pasis. The Nursing are tation of the plan		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
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		495227	B. WING		01/	31/2023
	PROVIDER OR SUPPLIER ORT REHABILITATION	N AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION DATE
F 689	Continued From pa	nge 32	F 6	89		
	No further informat	ion was presented prior to exit.				
	2. Resident #4 (R4) fell on 8/5/22. The facility staff failed to implement interventions to prevent future falls.					
	note dated 8/5/22 the fell and sustained a Further review of R August 2022 nurse comprehensive car	e plan revised on 9/8/22) facility staff implemented				
	conducted with LPN LPN #5 stated if a recome up with a new the resident from fa intervention should	8 p.m., an interview was N (licensed practical nurse) #5. resident falls, staff should w intervention to try to prevent alling again and that be added to the care plan to ention was implemented to try lls.				
	staff member) #1 (the director of nurs	p.m., ASM (administrative the administrator), ASM #2 sing) and ASM #3 (the f nursing) were made aware of				
F 697 SS=D	Pain Management	ion was presented prior to exit.	F 6	97		2/21/23
		anagement. nsure that pain management is ts who require such services,				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	FIPLE CONSTRUCTION NG	COM	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C 31/2023
	PROVIDER OR SUPPLIE	R ON AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP (7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 697	consistent with prithe comprehensive and the residents. This REQUIREM by: Based on staff in review, and clinic failed to impleme program for one of sample, Resident. The findings inclusive for Resident #7 (and document the prior to the admin medication for five On the most recequarterly/discharg assessment with date) of 5/12/22, moderately impaint having scored 12 interview for mencoded as having back period, and minimal. A review of R7's following order data (milligrams) Give hours as needed. A review of R7's forecord) revealed of as needed Oxy	rofessional standards of practice, we person-centered care plan, 'goals and preferences. ENT is not met as evidenced terview, facility document al record review, the facility staff int a complete pain management of 12 residents in the survey #7. Ide: R7), the facility failed to assess a location of the resident's pain instration of prn (as-needed) pain a opportunities in May 2022. Int MDS (minimum data set), a ge no return anticipated an ARD (assessment reference R7 was coded as being red for making daily decisions, out of 15 on the BIMS (brief tal status). The resident was pain frequently during the look the resident rated the pain as clinical record revealed the lated 2/3/22: "Oxycodone 5 mg 0.5 tablet by mouth every 6	F6	F697 Pain Management 1. Residents #7 no longer facility. 2. Current residents have be affected. 3. The Staff Development designee will educate all lic on the process for pain management inclusussessment and document site location prior to the adra prn pain medication. 4. The unit manager or deaudit residents clinical recoreview prn pain medication has a pain site location docresults of the review will be the monthly QAPI meeting. QAPI committee determine no longer exists, the review completed on a random ba Administrator/Director of Niresponsible for implementa of correction. 5. Date of Compliance: 2.	the potential to t Coordinator or tensed nurses ding tation of pain ministration of esignee with ord weekly to s administered cumented. The discussed at Once the es the problem vs will be sis. The ursing are tion of the plan	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		495227	B. WING				C 31/2023
	PROVIDER OR SUPPLIE	ON AND NURSING CENTER		73	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226	<u>, </u>	0112020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 697	the location of the administrations. A review of R7's on information rel documenting the to administering at On 1/31/23 at 9:3 nurse) #2 was integives a prn pain resident to rate the asks the resident what makes the pron-pharmacolog gives the medicate should include the the notes on the MOn 1/31/23 at 11:1 nurse should docorn a scale of one the location of the enter this informate (electronic medical administers a prn reviewed R7's Manotes. She stated pain location documents on 1/31/23 at 12:1 staff member) #1 director of nursing of nursing, and Asclinical services, acconcerns.	resident's pain for these are plan dated 2/3/22 revealed ated to assessing and ocation of a resident's pain prior in as needed pain medication. 7 a.m., LPN (licensed practical erviewed. She stated before she nedication, she asks the e pain on a scale of one to ten, the location of the pain and ain better or worse, attempts ical interventions, and then ion. She stated the nurse e location of the pain either in MAR or in the progress notes. 32 a.m., LPN #6 stated the nument the resident's pain rating to ten, and should document a pain. She stated the prompt to tion appears in the EMR al record) each time a nurse pain medication. LPN #6 y 2022 MARs and progress she did not see the resident's mented on 5/6/22, 5/8/22, twice	F6	97			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER ORT REHABILITATION	I AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP 7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD E IE APPROPRI	
F 921 SS=D	S483.90(i) Other Er The facility must present the facility maintain a comfort the findings included the findings included the facility maintain the wall are in good repair. On 1/30/23 at 12:40 of room 317. The efform the residents' marks, chips, and the from the residents' marks, chips, and the from the facility marks, chips, and the from the residents' marks, chips, and the from the market the walls repair. On 1/31/23 at 2:51 conducted with OS maintenance staff of the facility of the facility maintenance staff of the facility of the facility must be formulated to the facility of the facility must be facility of the facility of the facility must be facility of the facility of	tion, staff interview, and facility he facility staff failed to able environment for two of cross #317 and #331. e: the facility staff failed to cross the room from the beds of p.m., observation was made ntire length of the wall across beds contained multiple dark black scratches from the floor	F 93	F921 Safe/Functional/Sanitary/CEnviron 1. Rooms #317 and room were repaired. 2. All walls in the residen have the potential be affected. 3. The Director of Mainter educate the maintenance of the process for preventative work orders and repair of weare areas. 4. The Director of Mainter designee will complete a weare 10 resident some some some some some some some some	m #331 want care are cted. enance will staff regar walls in researched or enance or esident can be determined the review of the review of the staff of the the review of the staff of the s	alls as I rding nance, sident dit on are to will be ting. es the s will he

F 921 Continued From page 36 assistant director of nursing) were made aware of the above concern. The facility policy titled, "Quality of Life- Homelike Environment" documented, "Resident are provided with a safe, clean, comfortable and homelike environment" No further information was presented prior to exit. 2. For room #331, the facility staff failed to maintain the half wall between the "A" bed and the bathroom in good repair. On 1/30/23 at 3:04 p.m., the half wall between the "A" bed and the bathroom in room 331 was observed. The bottom portion of the wall (approximately five feet in width by five inches in height) was in disrepair, with the paint removed, gouges, the interior foam exposed in one place and the left lower corner gouged approximately two inches in depth to where the stud was exposed. On 1/31/23 at 2:51 p.m., an interview was conducted with OSM (other staff member) #1 (the maintenance assistant). OSM #1 stated the	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER (X4) ID PREFIX TAG CONTINUED FREGULATORY OR LSC IDENTIFYING INFORMATION) F. 921 Continued From page 36 assistant director of nursing) were made aware of the above concern. The facility policy titled, "Quality of Life- Homelike Environment." No further information was presented prior to exit. 2. For room #331, the facility staff failed to maintain the half wall between the "A" bed and the bathroom in good repair. On 1/30/23 at 3:04 p.m., the half wall between the "A" bed and the left lower corner gouged approximately two inches in height) was in disrepair, with the paint removed, gouges, the interior foam exposed in one place and the left lower corner gouged approximately two inches in depth to where the stud was exposed. On 1/31/23 at 2:51 p.m., an interview was conducted with OSM (other staff member) #1 (the maintenance assistant). OSM #1 stated the			495227	B. WING					
FREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 921 Continued From page 36 assistant director of nursing) were made aware of the above concern. The facility policy titled, "Quality of Life- Homelike Environment" documented, "Resident are provided with a safe, clean, comfortable and homelike environment" No further information was presented prior to exit. 2. For room #331, the facility staff failed to maintain the half wall between the "A" bed and the bathroom in good repair. On 1/30/23 at 3:04 p.m., the half wall between the "A" bed and the bathroom in room 331 was observed. The bottom portion of the wall (approximately five feet in width by five inches in height) was in disrepair, with the paint removed, gouges, the interior foam exposed in one place and the left lower corner gouged approximately two inches in depth to where the stud was exposed. On 1/31/23 at 2:51 p.m., an interview was conducted with OSM (other staff member) #1 (the maintenance assistant). OSM #1 stated the	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE				
assistant director of nursing) were made aware of the above concern. The facility policy titled, "Quality of Life- Homelike Environment" documented, "Resident are provided with a safe, clean, comfortable and homelike environment" No further information was presented prior to exit. 2. For room #331, the facility staff failed to maintain the half wall between the "A" bed and the bathroom in good repair. On 1/30/23 at 3:04 p.m., the half wall between the "A" bed and the bathroom in room 331 was observed. The bottom portion of the wall (approximately five feet in width by five inches in height) was in disrepair, with the paint removed, gouges, the interior foam exposed in one place and the left lower corner gouged approximately two inches in depth to where the stud was exposed. On 1/31/23 at 2:51 p.m., an interview was conducted with OSM (other staff member) #1 (the maintenance assistant). OSM #1 stated the	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI	D BE	COMPLETION	
maintenance staff conducts monthly room audits to ensure the walls in resident rooms are in good repair. On 1/31/23 at 2:57 p.m., the wall in room 331 was observed with OSM (other staff member) #1 (the maintenance assistant). OSM #1 stated the wall needed to be fixed. On 1/31/23 at 3:34 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2	F 921	assistant director of the above concern. The facility policy ti Environment" docuprovided with a saf homelike environment. No further informat. 2. For room #331, maintain the half with the bathroom in go. On 1/30/23 at 3:04 "A" bed and the bathroom in go. On 1/30/23 at 3:04 "A" bed and the bathroom in deproximately five height) was in disregouges, the interior and the left lower of two inches in depthexposed. On 1/31/23 at 2:51 conducted with OS maintenance assis maintenance staff to ensure the walls repair. On 1/31/23 at 2:57 observed with OS maintenance assis needed to be fixed. On 1/31/23 at 3:34	f nursing) were made aware of titled, "Quality of Life- Homelike mented, "Resident are e, clean, comfortable and ent" ion was presented prior to exit. the facility staff failed to all between the "A" bed and od repair. p.m., the half wall between the throom in room 331 was tom portion of the wall feet in width by five inches in epair, with the paint removed, or foam exposed in one place orner gouged approximately in to where the stud was p.m., an interview was M (other staff member) #1 (the teant). OSM #1 stated the conducts monthly room audits in resident rooms are in good p.m., the wall in room 331 was M (other staff member) #1 (the tant). OSM #1 stated the wall in room 331 was M (other staff member) #1 (the tant). OSM #1 stated the wall in room 331 was M (other staff member) #1 (the tant). OSM #1 stated the wall in room 331 was M (other staff member) #1 (the tant). OSM #1 stated the wall in room 331 was M (other staff member) #1 (the tant). OSM #1 stated the wall in room 331 was M (other staff member) #1 (the tant). OSM #1 stated the wall in room 331 was M (other staff member) #1 (the tant).	FS	921				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
						С			
		495227	B. WING			01/	31/2023		
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 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 PROVIDER'S PLAN OF CORREC' PREFIX (EACH CORRECTIVE ACTION SHOIL TAG CROSS-REFERENCED TO THE APPR DEFICIENCY)			_D BE COMPLÉTION		
F 921	the above concern.	f nursing) were made aware of	F 9	021	DEFICIENCY)				