STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

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

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 1/25/23 through 1/27/23 and 1/30/23 through 1/31/23. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Five complaints were investigated during the survey (VA00057547 - Substantiated without deficiency; VA00057361 - Substantiated with deficiency; VA00057510 - Unsubstantiated; VA00056963 - Substantiated without deficiency; VA00057575 - Substantiated with deficiency). The census in this 225 certified bed facility was 201 at the time of the survey. The survey sample consisted of eight current resident reviews and four closed record reviews.	F 000		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 580		2/21/23

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

Electronically Signed | 02/13/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 580	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to notify the physician of a resident's change in condition for one of 12 residents in the survey sample, Resident #7.	F 580	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following plan of correction constitutes the facility□s	

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F 580	Continued From page 2 The findings include: For Resident #7, the facility staff failed to notify the physician/nurse practitioner (NP) that the resident had not had a bowel movement between 4/27/22 and 5/8/22. A review of R7's point of care documentation completed by CNAs (certified nursing assistants) revealed the resident was not documented to have a bowel movement from the evening shift (3:00 p.m. - 11:00 p.m.) on 4/27/22 until the day shift (7:00 a.m. - 3:00 p.m.) on 5/8/22. A review of R7's progress notes for April and May 2022 failed to reveal any evidence that any staff member notified a provider (either a nurse practitioner or the attending physician) that the resident had not had a bowel movement between 4/28/22 and 5/8/22. A review of R7's care plan dated 2/3/22 revealed, in part: "[R7] has bowel elimination alteration; constipation related to lack of exercise, medications...Administer medications per physician order...Report signs and symptoms of constipation such as abdominal cramping, diarrhea, nausea/vomiting, no bowel movement for three days." On 1/31/23 at 9:37 a.m., LPN (licensed practical nurse) #2 was interviewed. When asked how she evaluates a resident for bowel movements, she stated she can look at the point of care records on the EMR (electronic medical record), can ask the CNA taking care of the resident, and, if the resident is a reliable historian, can ask the resident. She stated she tries every day to evaluate each resident for whether or not they	F 580	allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F 580 Notify of Changes (Injury/Decline/Room, etc.) 1. Resident # 7 no longer resides in the facility. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator or designee will educate the licensed nurses on physician notification for residents with a significant change in condition and on the process for documentation in resident□s clinical record. The monitoring of bowel dysfunction /elimination with physician notification. 4. The Unit Managers or designee will complete a weekly audit of on residents with significant change in conditions, complaints of bowel dysfunction/elimination. The physician was notified, and documentation is complete. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 5. Date of Compliance: 2.21.2023	

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F 580	Continued From page 3	F 580		

have had a bowel movement "in the last couple of days." She stated if a resident has not had a bowel movement in the last three days, she would call the provider. After reviewing R7's point of care records "I would have called [the provider]." She stated a resident who has not had a bowel movement in 10 days is at high risk for bowel rupture.

On 1/31/23 at 11:32 a.m., LPN #6, R7's unit manager, was interviewed. She stated the facility's bowel protocol is for the provider to be notified if a resident has not had a bowel movement in three days. She stated an alert appears on the clinical dashboard of the resident's EMR alerting the staff of this. She stated the nurse should go to the resident and/or the CNA to determine if the resident might have had a bowel movement, but the staff was unaware. If the resident and/or the CNA confirms the lack of a bowel movement in the last three days, the nurse should contact the provider to alert the provider, and to request a new intervention. She stated if a resident has a prn (as-needed) order for an additional bowel agent, the nurse should offer that to the resident, and still contact the provider. She stated nurses should be looking at bowel movement frequency "every day." She stated: "They have the capability to look every day. They can to the [point of care] records. And they can certainly ask the patient while they are passing meds." After reviewing R7's bowel records, she stated: "I can't see we did anything. I will go look."

On 1/31/23 at 12:05 p.m., LPN #3 was interviewed. When asked if the facility had a protocol for monitoring the frequency of residents' bowel movements, she stated, "If it's been longer

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F 580	Continued From page 4	F 580		

than five days, you are supposed to notify the doctor." She stated the doctor might order an additional bowel agent. She stated I would ask the aides to let me know about the bowel movements, and continue to check on the resident.

On 1/31/23 at 12:12 p.m., RN (registered nurse) #2, a nurse practitioner, was interviewed. She stated she never met or took care of R7. When asked if the facility had a bowel protocol, she stated to her understanding, everyone is on Miralax, which is a gentle laxative. She stated nurses should be monitoring residents every shift for bowel movements. She stated: "I want to be notified after two days of a resident not having a bowel movement." After reviewing R7's bowel movement records and physician's orders, she stated: "I would have wanted to have been notified sooner that he had not had a bowel movement. We would have started something else."

On 1/31/23 at 12:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and ASM #4, the regional director of clinical services, were informed of these concerns. They were informed of the concern for harm for R7.

On 1/31/23 at 1:20 p.m., LPN #6 stated: "I can't find anything to say we did something for [R7]."

On 1/31/23 at 2:03 p.m., LPN #4 was interviewed. She stated if a resident has not had a bowel movement in three days, she would do an abdominal assessment and let the provider know so the provider could put something in place.

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F 580	Continued From page 5	F 580		

On 1/31/23 at 3:48 p.m., ASM #2 stated she had spoken to ASM #6, R7's attending physician who was in charge of the resident's care until 5/6/22. She stated ASM #6 was going to be unavailable by phone for a while, but had told her that he was aware the resident "had not had a bowel movement." She stated ASM #6 could provide copies of studies showing it is not abnormal for elderly people to go seven days without having a bowel movement. ASM #2 stated ASM #6 told her he was aware, and there were interventions. ASM #2 was asked to provide documentation of ASM #6's awareness. When asked if she could find any evidence in the clinical record that the staff notified the provider that the resident did not have a bowel movement, she stated: "No, not in the documentation we have."

On 1/31/23 at 4:32 p.m., ASM #5, the facility's current medical director, was interviewed. ASM #5 stated: "I never saw this patient. I took over a week before everything happened. From what I was told the patient had an ileus at the end. He was sent out, and unfortunately passed away. We had him on a stool softener. I believe we did everything right." When ASM #5 was asked if the staff should have notified him or the NP about the resident's lack of bowel movements, he asked: "There is nothing charted at all?"

On 1/31/23 at 4:40 p.m., LPN #6 stated she had located a text message that she sent to ASM #6. She provided a screen shot of the text exchange. The text exchange documented the following on 5/4/23 at 12:10 p.m.: "LPN #6: [R7's first initial and last name] - no BM in 72 hrs (hours). Colace Bio (sic) and supp (suppository) prn." "ASM #6: Ok." LPN #6 was asked if she ordinarily used text

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F 580	Continued From page 6	F 580		

messages to communicate with providers about specific residents. She said: "Yes, it's how we notify physicians." When asked if the information she texted to ASM #6 was correct regarding the number of days without a bowel movement. LPN #6 again reviewed R7's bowel records, and stated: "No. I told [ASM #6] it had only been three days, when it really had been six days." LPN #6 stated she did not document her text conversation with ASM #6 in the medical record.

A review of the facility policy, "Significant Change of Condition," revealed, in part: "All staff members shall communicate any information about patient status change to appropriate licensed personnel immediately upon observation...A licensed nurse shall assess the patient for signs and symptoms of physical or mental change of condition. This assessment shall be reported to primary physician or designated alternate."

No further information was provided prior to exit.

(1) This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569564./

"Ileus is a temporary lack of the normal muscle contractions of the intestines....Other causes include drugs, especially opioid analgesics and anticholinergic drugs...The symptoms of ileus are abdominal bloating and pain caused by a buildup of gas and liquids, nausea, vomiting, severe constipation, loss of appetite, and cramps. People may pass watery stool...Treatment: Temporary restriction of food and fluids by mouth, Fluids given by vein, Suction via nasogastric tube." This information is taken from the website

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F 580	Continued From page 7 https://www.merckmanuals.com/home/digestive-disorders/gastrointestinal-emergencies/ileus.	F 580		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not	F 655		2/21/23

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F 655	Continued From page 8 limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to develop a complete baseline care plan for one of 12 residents in the survey sample, Resident #6. The findings include: For Resident #6 (R6), the facility staff failed to develop a complete baseline care plan for falls. R6 was admitted to the facility on 12/23/22. R6's baseline care plan created on 12/23/22 documented, "The resident is at risk for falls related to decreased mobility med (medication) use and incontinent episodes Dementia hemiplegia CVA (cerebrovascular accident) HTN (hypertension) generalized muscle weakness resident with multiple health issues." Further review of R6's care plan failed to document any interventions to address falls (until after the resident's discharge). A nurse's note dated 12/24/22 documented the resident sustained a fall with no injury on that date. Further review of the baseline care plan failed to reveal it was reviewed and revised to include interventions implemented after the 12/24/22 fall (until after the resident's discharge).	F 655	F655 Baseline Care Plan 1. Resident #6 no longer resides in the facility, 2. Current residents have the potential to be affected. 3. The Regional Director of MDS or designee will educate MDS staff and nursing management. (DON, ADON, Unit Managers and Supervisors) on the process for the development and requirements of the resident□s baseline care plan for falls. 4. The Director of MDS or designee will review 5 baseline care plans weekly to ensure the baseline care plan was initiated for falls. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 5. Date of Compliance: 2.21.2023	

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F 655	Continued From page 9 On 1/31/23 at 12:18 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the purpose of the care plan is to do the plan of care while the resident is in the facility. LPN #5 stated if a resident is deemed at risk for falls upon admission, interventions to prevent falls should be added to the care plan. LPN #5 stated if a resident falls, a new intervention should be added to the care plan to show a new intervention to prevent future falls was implemented. On 1/31/23 at 3:34 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the assistant director of nursing) were made aware of the above concern. The facility policy titled, "Resident Assessment & Care Planning" documented, "A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental and psychosocial well-being of the patient.: No further information was presented prior to exit.	F 655		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and	F 656		2/21/23

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F 656	Continued From page 10 §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must-	F 656		

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WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

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F 656	Continued From page 11 (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement the comprehensive care plan for one of 12 residents in the survey sample, Resident #7. The findings include: For Resident #7 (R7), the facility staff failed to implement the care plan to report a lack of bowel movement to the physician, and to administer physician-ordered medication to treat constipation. On the most recent MDS (minimum data set), a quarterly/discharge no return anticipated assessment with an ARD (assessment reference date) of 5/12/22, R7 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). The resident was coded as requiring the extensive assistance of staff for bed mobility, and for all activities of daily living, including eating. A review of R7's care plan dated 2/3/22 revealed, in part: "[R7] has bowel elimination alteration; constipation related to lack of exercise, medications...Administer medications per physician order...Report signs and symptoms of constipation such as abdominal cramping, diarrhea, nausea/vomiting, no bowel movement for three days." A review of R7's point of care documentation completed by CNAs (certified nursing assistants)	F 656	F656 Develop/Implement Comprehensive Care Plan 1. Resident #7 no longer resides in the facility. 2. Current residents have the potential to be affected. 3. The staff development coordinator or designee will educate all licensed nurses to follow and implement interventions per resident□s care plan for at risk/actual bowel dysfunction/elimination. 4. The unit managers or designee will review weekly 10 residents□ clinical records to identify signs and symptoms of bowel dysfunction/elimination, no bowel movements in 3 days, ADL documentation for bowel movements and will verify interventions were implemented with physician notified if required for bowel elimination and documented. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists and sustained by licensed nurses are following the care plan for bowel dysfunction/elimination the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 5. Date of Compliance: 2/21/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

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F 656	Continued From page 12	F 656		

revealed the resident was not documented to have a bowel movement from the evening shift (3:00 p.m. - 11:00 p.m.) on 4/27/22 until the day shift (7:00 a.m. - 3:00 p.m.) on 5/8/22.

A review of R7's physician's orders revealed the following order: "2/3/22 Bisacodyl suppository 10 mg (milligrams) Insert 1 suppository rectally as needed daily for constipation."

A review of R7's MAR (medication administration record) for April and May 2022 revealed the resident failed to receive a Bisacodyl suppository between 4/28/22 and 5/8/22.

A review of R7's progress notes for April and May 2022 failed to reveal any evidence that any staff member notified a provider (either a nurse practitioner or the attending physician) that the resident had not had a bowel movement between 4/28/22 and 5/8/22.

On 1/31/23 at 1:43 p.m., LPN (licensed practical nurse) #6, the unit manager for R7, was interviewed. When asked the purpose of a care plan, she stated: "It tells you what to do with your patient." She stated the nurses are responsible for the implementation of the care plan. When asked if the facility staff implemented R7's care plan for constipation prevention, she stated: "They are not following the care plan if they don't call the doctor."

On 1/31/23 at 2:03 p.m., LPN #4 was interviewed. She stated the purpose of a care plan is to plan out the resident's care for their stay at the facility. She stated all staff members are responsible for implementing the care plan.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

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F 656	Continued From page 13	F 656		

On 1/31/23 at 3:48 p.m., ASM #2 stated she had spoken to ASM #6, R7's attending physician who was in charge of the resident's care until 5/6/22. She stated ASM #6 was going to be unavailable by phone for a while, but had told her that he was aware the resident "had not had a bowel movement." She stated ASM #6 could provide copies of studies showing it is not abnormal for elderly people to go seven days without having a bowel movement. ASM #2 stated ASM #6 told her he was aware, and there were interventions. ASM #2 was asked to provide documentation of ASM #6's awareness. When asked if she could find any evidence in the clinical record that the staff notified the provider that the resident did not have a bowel movement or that the staff had given the resident a suppository as ordered, she stated: "No, not in the documentation we have."

On 1/31/23 at 4:40 p.m., LPN #6 stated she had located a text message that she sent to ASM #6. She provided a screen shot of the text exchange. The text exchange documented the following on 5/4/23 at 12:10 p.m.: "LPN #6: [R7's first initial and last name] - no BM in 72 hrs (hours). Colace Bio (sic) and supp (suppository) prn." "ASM #6: Ok." LPN #6 was asked if she ordinarily used text messages to communicate with providers about specific residents. She said: "Yes, it's how we notify physicians." When asked if the information she texted to ASM #6 was correct regarding the number of days without a bowel movement. LPN #6 again reviewed R7's bowel records, and stated: "No. I told [ASM #6] it had only been three days, when it really had been six days." LPN #6 stated she did not document her text conversation with ASM #6 in the medical record.

A review of the facility policy, "Care Plans,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

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F 656	Continued From page 14 Comprehensive Person-Centered," revealed, in part: "The Interdisciplinary Team (IDT), in conjunction with the resident and his/her family or legal representative, develops and implements a comprehensive, person-centered care plan for each resident." No further information was provided prior to exit. (1) This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569564./ "Ileus is a temporary lack of the normal muscle contractions of the intestines....Other causes include drugs, especially opioid analgesics and anticholinergic drugs...The symptoms of ileus are abdominal bloating and pain caused by a buildup of gas and liquids, nausea, vomiting, severe constipation, loss of appetite, and cramps. People may pass watery stool...Treatment: Temporary restriction of food and fluids by mouth, Fluids given by vein, Suction via nasogastric tube." This information is taken from the website https://www.merckmanuals.com/home/digestive-disorders/gastrointestinal-emergencies/ileus.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician.	F 657		2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

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F 657	Continued From page 15 (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to review and revise the comprehensive care plan for two of 12 residents in the survey, Residents #4 and #9. The findings include: 1. a. For Resident #4 (R4), the facility staff failed to review and revise the resident's comprehensive care plan for a risk for injury from hot liquids. A review of R4's clinical record revealed a hot liquid safety evaluation dated 6/4/22 that documented the following safety factors: "The resident is easily agitated or their mood	F 657	F657 Care Plan Timing and Revision 1. Resident #4 care plan was initiated for hot liquids. The timeframe has passed for the fall revision. The fall care plan was reviewed with appropriate interventions. Resident #9 the timeframe has passed for fall revision. The care plan was reviewed with appropriate interventions. 2. Current residents have the potential to be affected. 3. The Regional Director of MDS or designee will educate MDS staff and nursing management. (DON, ADON, Unit Managers and Supervisors) on care plans initiation, revisions/updated after a fall, hot liquid spill or change in condition. 4. The Director of MDS or designee will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

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F 657	Continued From page 16 varies over the course of the day. The resident has frequent impulsive acts and/or is short tempered. The resident is cognitively impaired." The evaluation further documented: "If Two or more indicators of risk are checked in Safety Factors section 2, than the resident is at risk for injury from hot liquids and requires an intervention selected from below: [a check mark beside] resident to wear clothing protector/lap protector while drinking hot beverages; staff to assist with drinking of hot beverages." A review of R4's comprehensive care plan revised on 12/4/22 failed to reveal the care plan was reviewed and revised regarding the risk for injury from hot liquids. On 1/31/23 at 12:18 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the purpose of the care plan is to do the plan of care while the resident is in the facility. LPN #5 stated residents at risk for injury from hot liquids should have their care plans reviewed and revised to include this and the care plans should include the necessary interventions. On 1/31/23 at 3:34 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the assistant director of nursing) were made aware of the above concern. The facility policy titled, "Resident Assessment & Care Planning" documented, "6. Computerized care plans will be updated by each discipline on an ongoing basis as changes in the patient occur..."	F 657	review 5 care plans weekly to assess the care plan reflects the initiation revision/updated for a fall or hot liquid spill . The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 5. Date of Compliance: 2.21.2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

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

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F 657	Continued From page 17 No further information was presented prior to exit. 1.b. For Resident #4 (R4), the facility staff failed to review and revise the resident's comprehensive care plan after the resident fell on 8/5/22. A review of R4's clinical record revealed a nurse's note dated 8/5/22 that documented the resident fell and sustained a skin tear on the right arm. A review of R4's comprehensive care plan revised on 9/8/22 failed to reveal the care plan was reviewed and revised regarding R4's 8/5/22 fall. On 1/31/23 at 12:18 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the purpose of the care plan is to do the plan of care while the resident is in the facility. LPN #5 stated if a resident falls, a new intervention should be added to the care plan to show a new intervention to prevent future falls was implemented. On 1/31/23 at 12:56 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the assistant director of nursing) were made aware of the above concern. No further information was presented prior to exit. 2. For Resident #9 (R9), the facility staff failed to review and revise the resident's comprehensive care plan after the resident fell on 11/5/22 and 11/28/22. A review of R9's clinical record revealed the resident sustained a fall with no injury on 11/5/22	F 657		

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	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

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F 657	Continued From page 18 and another fall with no injury on 11/28/22. A review of R9's comprehensive care plan revised on 12/19/22 failed to reveal the care plan was reviewed and revised regarding both falls. On 1/31/23 at 12:18 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated the purpose of the care plan is to do the plan of care while the resident is in the facility. LPN #5 stated if a resident falls, a new intervention should be added to the care plan to show a new intervention to prevent future falls was implemented. On 1/31/23 at 3:34 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the assistant director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 657		
F 684 SS=G	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide clinical services for a resident	F 684	F 684 Quality of Care 1. Residents #7 no longer resides in the	2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

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WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

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F 684	Continued From page 19 experiencing bowel dysfunction for one of 12 residents in the survey sample, Resident #7, resulting in harm. The findings include: The facility staff failed to identify Resident #7's (R7's) lack of a bowel movement for 10 days, and failed to administer a physician-ordered suppository to treat the lack of bowel movements. The resident developed an ileus ("By definition, ileus is an occlusion or paralysis of the bowel preventing the forward passage of the intestinal contents, causing their accumulation proximal to the site of the blockage." 1), which required transfer to a local hospital. On the most recent MDS (minimum data set), a quarterly/discharge no return anticipated assessment with an ARD (assessment reference date) of 5/12/22, R7 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). The resident was coded as requiring the extensive assistance of staff for bed mobility, and for all activities of daily living, including eating. A review of R7's point of care documentation completed by CNAs (certified nursing assistants) revealed the resident was not documented to have a bowel movement from the evening shift (3:00 p.m. - 11:00 p.m.) on 4/27/22 until the day shift (7:00 a.m. - 3:00 p.m.) on 5/8/22. A review of R7's physician's orders revealed the following orders: "2/3/22 Polyethylene Glycol (Miralax) Powder 17	F 684	facility. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator or designee will educate all the licensed nurses on the process for bowel management including monitoring, physician notification for bowel dysfunction/elimination and implementing interventions per physician orders. 4. The unit manager or designee with audit residents clinical record weekly to review documented bowel dysfunction/elimination to verify the process for bowel management was followed with physician notification and interventions implemented. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 5. Date of Compliance: 2.21.2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20	F 684		

gm/scoop (grams per scoop). Give one scoop orally in the morning for bowel management. Mix in 6-8 ounces of liquid."

"2/3/22 Docusate sodium capsule (stool softener) 100 mg (milligrams) Give 1 capsule orally two times a day for bowel management."

"2/3/22 Bisacodyl suppository 10 mg (milligrams) Insert 1 suppository rectally as needed daily for constipation."

A review of R7's MAR (medication administration record) for April and May 2022 revealed the resident received Miralax and docusate sodium as ordered, however the resident failed to receive a Bisacodyl suppository between 4/28/22 and 5/8/22.

A review of R7's progress notes for April and May 2022 failed to reveal any evidence that any staff member notified a provider (either a nurse practitioner or the attending physician) that the resident had not had a bowel movement between 4/28/22 and 5/8/22.

A review of a progress note written by the NP (nurse practitioner) on 5/6/22 revealed, in part: "Chief Complaint: Recertification visit to review medications, diagnoses, labs (laboratory results), vital signs and current plan of care. Pt (patient) is new to our medical practice, this is our initial patient encounter and all previous medical records reviewed. Pt seen for abnormal lab results review...review of systems...Gastrointestinal negative...Physical examination...Abdomen: Soft; BS (bowel sounds) X4 (in all four quadrants) heard...Assessment and Plan...severe protein calorie malnutrition...weight

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 21	F 684		

loss noted, dietician following...pt reports adequate appetite...chronic pain, per pt not controlled, d/c (discontinue) oxycontin (an opioid medication for pain)...start Morphine ER (extended release) (an opioid medication for pain) 15 mg q 12h (every 12 hours)...supportive care...FULL CODE." This NP was not available for interview during the survey.

A review of R7's May 2022 MAR revealed the resident received the Morphine twice a day as ordered.

A review of a dietary progress note dated 5/9/22 revealed, in part: "Quarterly/Significant Weight Loss Assessment...PO (by mouth) intake: Varies - 25 - 50%."

A review of progress notes dated 5/11/2022 revealed, in part:

"10:02 a.m...Note Text: Resident refused all morning meds, resident states 'the medicines makes me sicker.'"

"12:28 p.m...Note Text: Resident vomited x1, noted with distended abdomen, very weak in appearance, NP...at bedside, new order in place for sodium chloride 0.9% for 2 days, stat (immediate) KUB (abdominal X-ray) in place. NACL (sodium chloride) 0.9% infusing at 100cc/hr (cubic centimeters per hour) to left lower arm, at this time, resident tolerating well, resident is own RP (responsible party), this writer attempted to reach resident's daughter via phone."

"1442 (2:42 p.m.)...Note Text: Chief Complaint: Pt seen per nursing request for tachycardia (rapid

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

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F 684	Continued From page 22	F 684		

heartbeat) and abdominal distention...Review of symptoms...Gastrointestinal: Nausea/vomiting; abdominal pain; Other: abd (abdominal distention)...Physical examination: Abdomen: Distended. BS X4 heard...Assessment and Plan...abdominal distention/nausea/vomiting X 2 days per pt, start PIV (peripheral intravenous fluids)...stat KUB."

A review of the radiology report for R7 dated 5/11/22 at 7:20 p.m. revealed, in part: "History: Nausea/Vomiting...Findings: Moderate stool column is seen in the left to the level of the hepatic flexure. Dilated small bowel is seen in the mid abdomen. Impression: Large amount of rectal stool needs evacuation and there appears to be a small bowel ileus. Follow-up is suggested."

A review of R7's progress notes dated 5/12/22 revealed, in part:

"0244 (2:44 a.m.)...Radiology review; abnormal results...vomiting X 1 and abdominal distention...Report: stool up to hepatic flexure, large amount of stool in rectum; small bowel ileus, patient seen with nurse. Patient c/o (complains of) shortness of breath and having no appetite. States he would take his constipation meds (medications)...Give Bisacodyl suppository 10 mg pr (by rectum) X 1 dose." This note was written by a physician who provided a telehealth visit.

"4:20 a.m...Note Text: Resident sent out 911 to [name of local hospital] for evaluation due to change in condition. Resident observed with hypoxia (low oxygen) and tachycardia (rapid heart rate)."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 23	F 684		

A review of R7's care plan dated 2/3/22 revealed, in part: "[R7] has bowel elimination alteration; constipation related to lack of exercise, medications...Administer medications per physician order...Report signs and symptoms of constipation such as abdominal cramping, diarrhea, nausea/vomiting, no bowel movement for three days."

On 1/31/23 at 9:37 a.m., LPN (licensed practical nurse) #2 was interviewed. When asked how she evaluates a resident for bowel movements, she stated she can look at the point of care records on the EMR (electronic medical record), can ask the CNA taking care of the resident, and, if the resident is a reliable historian, can ask the resident. She stated she tries every day to evaluate each resident for whether or not they have had a bowel movement "in the last couple of days." She stated if a resident is on narcotics/opioids or antibiotics, it is especially important to evaluate for bowel movements, as both of these types of medications can be constipating. She stated if a resident has not had a bowel movement in the last three days, she would call the provider. She stated if a resident has an as-needed order for an oral laxative or suppository, she would also administer that medication. After reviewing R7's point of care records and R7's order for an as-needed suppository, she stated: "I would have given the suppository, and I still would have called [the provider]." She stated a resident who has not had a bowel movement in 10 days is at high risk for bowel rupture.

On 1/31/23 at 9:55 a.m., CNA #4 was interviewed. She stated she took care of R7 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

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F 684	Continued From page 24	F 684		

most of the time he spent at the facility. She stated: "I kept [the resident] turned and changed. (R7) lost a lot of weight while he was here." She stated she remembered the resident's steep decline, but that the resident had never been placed on comfort care. She stated: "At the end, even bowel movements were just liquid." When asked to elaborate, she stated R7 was always incontinent of both bowel and bladder and always needed to be changed. She stated the last couple of times she cared for the resident, the bowel movements were "nothing more than water." She stated the last time she took care of the resident, the resident was nauseated and vomiting. She stated she informed the nurse of the liquid bowel movements.

A review of R7's point of care records revealed CNA #4's signature on day shift on 5/8/23 and 5/11/23. On these dates, CNA #4's documentation indicated the resident had a medium sized bowel movement, was incontinent, and required the extensive of staff to be cleaned.

On 1/31/23 at 11:32 a.m., LPN #6, R7's unit manager, was interviewed. She stated the facility's bowel protocol is for the provider to be notified if a resident has not had a bowel movement in three days. She stated an alert appears on the clinical dashboard of the resident's EMR alerting the staff of this. She stated the nurse should go to the resident and/or the CNA to determine if the resident might have had a bowel movement, but the staff was unaware. If the resident and/or the CNA confirms the lack of a bowel movement in the last three days, the nurse should contact the provider to alert the provider, and to request a new intervention. She stated if a resident has a prn

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

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

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F 684	Continued From page 25	F 684		

(as-needed) order for an additional bowel agent, the nurse should offer that to the resident, and still contact the provider. She stated nurses should be looking at bowel movement frequency "every day." She stated: "They have the capability to look every day. They can to the [point of care] records. And they can certainly ask the patient while they are passing meds." After reviewing R7's bowel records, orders, and MARs, she stated: "I can't see we did anything. I will go look." When asked if R7 was ever considered for palliative care or hospice services, she stated: "He wanted everything done."

On 1/31/23 at 12:05 p.m., LPN #3 was interviewed. When asked if the facility had a protocol for monitoring the frequency of residents' bowel movements, she stated, "If it's been longer than five days, you are supposed to notify the doctor." She stated the doctor might order an additional bowel agent. She stated I would ask the aides to let me know about the bowel movements, and continue to check on the resident.

On 1/31/23 at 12:12 p.m., RN (registered nurse) #2, a nurse practitioner, was interviewed. She stated she never met or took care of R7. When asked the possible effects of switching from Oxycodone to Morphine on a resident's bowels movements, she stated the Morphine is stronger than Oxycodone, and can slow down the bowels even more than Oxycodone. She stated she counters this with the use of stool softeners. She stated the bowels have a naturally fluctuating movement, and this movement is slowed by opioids. She stated when this happens, stool builds up in the bowel, and can turn into an ileus. She stated an ileus is lack of movement in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

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F 684	Continued From page 26	F 684		

bowels. She stated if an ileus is not treated, a bowel can continue to grow larger in diameter, with a possibility of rupturing. When asked if the facility had a bowel protocol, she stated to her understanding, everyone is on Miralax, which is a gentle laxative. She stated symptoms of an ileus can include abdominal discomfort, cramping, nausea, vomiting, and abdominal pain. She stated some residents may also have a moderate amount of loose, watery stool, but nothing that is formed. She stated nurses should be monitoring residents every shift for bowel movements. She stated: "I want to be notified after two days of a resident not having a bowel movement." After reviewing R7's bowel movement records and physician's orders, she stated: "I would have wanted to have been notified sooner that he had not had a bowel movement. We would have started something else."

On 1/31/23 at 12:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and ASM #4, the regional director of clinical services, were informed of the concern for harm for R7.

On 1/31/23 at 1:20 p.m., LPN #6 stated: "I can't find anything to say we did something for [R7]."

On 1/31/23 at 2:03 p.m., LPN #4 was interviewed. She stated if a resident has not had a bowel movement in three days, she would do an abdominal assessment and let the provider know so the provider could put something in place.

On 1/31/23 at 3:48 p.m., ASM #2, the director of nursing stated she had spoken to R7's attending physician (ASM #6) who was in charge of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 27	F 684		

resident's care until 5/6/22. She stated ASM #6 was going to be unavailable by phone for a while, but had told her that he was aware the resident "had not had a bowel movement." She stated ASM #6 could provide copies of studies showing it is not abnormal for elderly people to go seven days without having a bowel movement. ASM #2 stated ASM #6 told her he was aware, and there were interventions. ASM #2 was asked to provide documentation of ASM #6's awareness. ASM #2 stated she wanted to address the point of care records regarding frequency of bowel movements. She stated there were no clinical alerts for the staff on the EMR because on some of the shifts, the CNAs had charted "not applicable." She stated a clinical alert is only generated if there is no bowel movement charted at all. When asked if she could find any evidence in the clinical record that the staff notified the provider that the resident did not have a bowel movement or that the staff had given the resident a suppository as ordered, she stated: "No, not in the documentation we have."

On 1/31/23 at 4:32 p.m., ASM #5, the facility's current medical director, was interviewed. ASM #5 stated: "I never saw this patient. I took over a week before everything happened. From what I was told the patient had an ileus at the end. He was sent out, and unfortunately passed away. We had him on a stool softener. I believe we did everything right." When ASM #5 was asked if the staff should have notified him or the NP about the resident's lack of bowel movements, he asked: "There is nothing charted at all?" He added: "He was not eating at all. If he is eating less than 25%, he is not going to have a bowel movement."

On 1/31/23 at 4:40 p.m., LPN #6 stated she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

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F 684	Continued From page 28	F 684		

located a text message that she sent to ASM #6. She provided a screen shot of the text exchange. The text exchange documented the following on 5/4/23 at 12:10 p.m.: "LPN #6: [R7's first initial and last name] - no BM in 72 hrs (hours). Colace Bio (sic) and supp (suppository) prn." "ASM #6: Ok." LPN #6 was asked if she ordinarily used text messages to communicate with providers about specific residents. She said: "Yes, it's how we notify physicians." When asked if the information she texted to ASM #6 was correct regarding the number of days without a bowel movement. LPN #6 again reviewed R7's bowel records, and stated: "No. I told [ASM #6] it had only been three days, when it really had been six days." When asked what she understood ASM #6's "ok" to mean, she stated: "He meant to continue with the stool softener and suppository." When asked if she administered a suppository to R7 at that time, she stated she did not. She stated: "I told the nurse to give it. But it was not signed off." She added: "You can lead a horse to water, but you can't make them drink." When asked if there was any evidence that R7 had received the suppository, she stated: "With it not being signed off, we can't say it was given. There is no signature or note that day about the suppository." LPN #6 stated she did not document her text conversation with ASM #6 in the medical record.

On 1/31/23 at 5:00 p.m., ASM #2 was asked to review R7's point of care records regarding meal percentages consumed during May 2022. ASM #2 stated the following meal percentages for R7 (B=breakfast, L=lunch, D=dinner):

May 1 B=0; L=0; D=51-75
May 2 = nothing all day
May 3 B=76-100; L=26-50; D=26-50

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 29	F 684		

May 4 B 26-50; L 26-50; D=0
May 5 = nothing all day
May 6 = nothing all day
May 7 B=76-100; L 36-50; D26-50
May 8 B=51-75; L 51-75; D=0
May 9 B=76-100; L 76-100; L=0
May 10 = nothing all day
May 11 B, L=0; D=51-75

May 1 through May 11 - R7 was offered and accepted a bedtime snack each evening.

When asked if ASM #5 was accurate in saying R7 "was not eating anything," ASM #2 stated: "Some days, yes. Some days, no." She stated: "It's not like he totally quit eating. Yes, he was eating some. But some days he wasn't." She added that the record only documented that evening snacks were offered and accepted by the resident. There was no documentation regarding how much of the snack the resident consumed.

A review of the facility policy, "Constipation Prevention," revealed, in part: "Nurse will routinely review to determine patients in need of intervention to facilitate bowel movement...Document bowel movements in the clinical record. Contact physician for any needed orders...The plan for prevention of constipation will be documented on the comprehensive care plan."

No further information was provided prior to exit.

(1) This information is taken from the National Institutes of Health website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5569564./

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

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F 684	Continued From page 30 "Ileus is a temporary lack of the normal muscle contractions of the intestines....Other causes include drugs, especially opioid analgesics and anticholinergic drugs...The symptoms of ileus are abdominal bloating and pain caused by a buildup of gas and liquids, nausea, vomiting, severe constipation, loss of appetite, and cramps. People may pass watery stool...Treatment: Temporary restriction of food and fluids by mouth, Fluids given by vein, Suction via nasogastric tube." This information is taken from the website https://www.merckmanuals.com/home/digestive-disorders/gastrointestinal-emergencies/ileus.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement interventions to prevent falls for two of 12 residents in the survey sample, Residents #6 and #4. The findings include: 1. For Resident #6, per the baseline care plan dated 12/23/22, the resident was at risk for falls. The facility staff failed to immediately implement interventions to prevent falls; the resident fell on	F 689	F689 Free of Accident Hazards/Supervision/Devices 1. Residents #6 no longer resides in the facility. Resident #4 The timeframe has passed for the fall revision. The fall care plan was reviewed with appropriate interventions. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator or designee will educate all licensed nurses on the process for implementing an	2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 31 12/24/22. R6 was admitted to the facility on 12/23/22. R6's baseline care plan created on 12/23/22 documented, "The resident is at risk for falls related to decreased mobility med (medication) use and incontinent episodes Dementia hemiplegia CVA (cerebrovascular accident) HTN (hypertension) generalized muscle weakness resident with multiple health issues." Further review of R6's care plan failed to document any interventions to address falls (until after the resident's discharge). A nurse's note dated 12/24/22 documented the resident sustained a fall with no injury on that date. On 1/31/23 at 12:18 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated that if residents are deemed at risk for falls upon admission, then staff should come up with interventions to prevent the residents from falling. On 1/31/23 at 3:34 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the assistant director of nursing) were made aware of the above concern. The facility policy titled, "Falls Management Program" documented, "The Center considers all patients to be at risk for falls and provides an environment as safe as practicable for all patients. The center utilizes a systems approach to a Falls Management Program that conducts multi-faceted, interdisciplinary assessments with evidence-based interventions to develop individual care strategies."	F 689	intervention after a fall to reduce/prevent further falls. The Regional Director of MDS or designee will educate IDT (MDS staff , Director of Rehab, and nursing management (DON, ADON, Unit Managers and Supervisors) on the process for reviewing, revising/updating care plan after a fall with intervention to prevent further falls. 4. The unit manager or designee with audit residents clinical record weekly to review documented falls to verify the care plan was initiated, revised/updated with intervention to prevent further falls. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 5. Date of Compliance: 2.21.2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 32 No further information 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. A review of R4's clinical record revealed a nurse's note dated 8/5/22 that documented the resident fell and sustained a skin tear on the right arm. Further review of R4's clinical record (including August 2022 nurses' notes and R4's comprehensive care plan revised on 9/8/22) failed to reveal the facility staff implemented interventions to prevent future falls. On 1/31/23 at 12:18 p.m., an interview was conducted with LPN (licensed practical nurse) #5. LPN #5 stated if a resident falls, staff should come up with a new intervention to try to prevent the resident from falling again and that intervention should be added to the care plan to show a new intervention was implemented to try to prevent future falls. On 1/31/23 at 3:34 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the assistant director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 689		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services,	F 697		2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	7300 FOREST AVE RICHMOND, VA 23226

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 33 consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement a complete pain management program for one of 12 residents in the survey sample, Resident #7. The findings include: For Resident #7 (R7), the facility failed to assess and document the location of the resident's pain prior to the administration of prn (as-needed) pain medication for five opportunities in May 2022. On the most recent MDS (minimum data set), a quarterly/discharge no return anticipated assessment with an ARD (assessment reference date) of 5/12/22, R7 was coded as being moderately impaired for making daily decisions, having scored 12 out of 15 on the BIMS (brief interview for mental status). The resident was coded as having pain frequently during the look back period, and the resident rated the pain as minimal. A review of R7's clinical record revealed the following order dated 2/3/22: "Oxycodone 5 mg (milligrams) Give 0.5 tablet by mouth every 6 hours as needed for pain," A review of R7's MAR (medication administration record) revealed the resident received the 2.5 mg of as needed Oxycodone on 5/6/22, 5/8/22, twice on 5/9/22, and 5/10/22. Further review of the clinical record failed to reveal documentation of	F 697	F697 Pain Management 1. Residents #7 no longer resides in the facility. 2. Current residents have the potential to be affected. 3. The Staff Development Coordinator or designee will educate all licensed nurses on the process for pain management including assessment and documentation of pain site location prior to the administration of a prn pain medication. 4. The unit manager or designee with audit residents clinical record weekly to review prn pain medications administered has a pain site location documented. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 5. Date of Compliance: 2.21.2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 34	F 697		

the location of the resident's pain for these administrations.

A review of R7's care plan dated 2/3/22 revealed no information related to assessing and documenting the location of a resident's pain prior to administering an as needed pain medication.

On 1/31/23 at 9:37 a.m., LPN (licensed practical nurse) #2 was interviewed. She stated before she gives a prn pain medication, she asks the resident to rate the pain on a scale of one to ten, asks the resident the location of the pain and what makes the pain better or worse, attempts non-pharmacological interventions, and then gives the medication. She stated the nurse should include the location of the pain either in the notes on the MAR or in the progress notes.

On 1/31/23 at 11:32 a.m., LPN #6 stated the nurse should document the resident's pain rating on a scale of one to ten, and should document the location of the pain. She stated the prompt to enter this information appears in the EMR (electronic medical record) each time a nurse administers a prn pain medication. LPN #6 reviewed R7's May 2022 MARs and progress notes. She stated she did not see the resident's pain location documented on 5/6/22, 5/8/22, twice on 5/8/22 or 5/10/22.

On 1/31/23 at 12:55 p.m., ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, ASM #3, the assistant director of nursing, and ASM #4, the regional director of clinical services, were informed of these concerns.

No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 01/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPORT REHABILITATION AND NURSING CENTER	**7300 FOREST AVE RICHMOND, VA 23226**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 921 SS=D	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to maintain a comfortable environment for two of 106 resident rooms; rooms #317 and #331. The findings include: 1. For room #317, the facility staff failed to maintain the wall across the room from the beds in good repair. On 1/30/23 at 12:46 p.m., observation was made of room 317. The entire length of the wall across from the residents' beds contained multiple dark marks, chips, and black scratches from the floor up approximately four feet. 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 maintenance staff conducts monthly room audits to ensure the walls in resident rooms are in good repair. On 1/31/23 at 3:09 p.m., the wall in room 317 was observed with OSM #1. OSM #1 stated the maintenance staff should re-paint the wall. On 1/31/23 at 3:34 p.m., ASM (administrative staff member) #1 (the administrator), ASM #2 (the director of nursing) and ASM #3 (the	F 921	F921 Safe/Functional/Sanitary/Comfortable Environ 1. Rooms #317 and room #331 walls were repaired. 2. All walls in the resident care areas have the potential be affected. 3. The Director of Maintenance will educate the maintenance staff regarding the process for preventative maintenance, work orders and repair of walls in resident care areas. 4. The Director of Maintenance or designee will complete a weekly audit on 10 resident□s rooms and resident care to assess walls condition and repair if identified. The results of the review will be discussed at the monthly QAPI meeting. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator/Director of Nursing are responsible for implementation of the plan of correction. 5. Date of compliance: 2.21.2023	2/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 921	Continued From page 36	F 921		

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 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 (the director of nursing) and ASM #3 (the

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F 921	Continued From page 37 assistant director of nursing) were made aware of the above concern. No further information was presented prior to exit.	F 921		