PRINTED: 05/24/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495227	B. WING	3. WING			C 05/10/2023	
NAME OF PR	ROVIDER OR SUPPLIER	10022		STI	REET ADDRESS, CITY, STATE, ZIP CODE	05/	10/2023	
WESTPOR	RT REHABILITATION ANI	D NURSING CENTER			00 FOREST AVE CHMOND, VA 23226			
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS		F	000				
F 600 SS=D	standard survey was 05/10/23. Corrections compliance with 42 C Term Care requireme investigated during the (VA00058091-substant VA00058797-substant VA00058773-substant VA00058763-substant VA00058317-substant VA00058317-substan	FR Part 483 Federal Long ints. Six complaints were e survey intiated with deficiency, itiated with deficiency, itiated with deficiency, itiated with deficiency, itiated with deficiency and itiated with deficiency and itiated with deficiency and itiated with deficiency. 5 certified bed facility was survey. The survey sample ent reviews. Neglect m Abuse, Neglect, and right to be free from abuse, ition of resident property, efined in this subpart. This itied to freedom from involuntary seclusion and ical restraint not required to edical symptoms. y must- e verbal, mental, sexual, or oral punishment, or	F	600	Past noncompliance: no plan of			
LABORATORY		SLIPPLIER REPRESENTATIVE'S SIGNATUR			TITI F		(X6) DATE	

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

05/22/2023

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.

Electronically Signed

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING				C 10/2023	
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	10/2020	
				7	300 FOREST AVE			
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		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 CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(X5) COMPLETION DATE	
F 600	Continued From page	e 1	F	600				
	it was determined tha	iew and clinical record review at the facility failed to protect in the survey sample from property.			correction required.			
	The findings include:							
	protect the resident f), the facility staff failed to rom misappropriation of 023 R7's Rolex watch was sing.						
	quarterly assessmen reference date) of 4/6 15 out of 15 on the B mental status), indica	MDS (minimum data set), a t with an ARD (assessment 6/2023, the resident scored MMS (brief interview for ating the resident was making daily decisions.						
	conducted with R7 in their Rolex watch wa they had gone to be and woke up the nex stated that they had it to the nursing supervhad searched the roc stated that the therap room and could not fi Monday evening the for them and they car stated that the nurses Saturday evening had their jacket off the way wrist and they had pustated that the watch the double clasp on i remembered it falling	p.m., an interview was I their room. R7 stated that Is missing. R7 stated that If with the watch on their wrist It morning with it gone. R7 I reported the watch missing I risor that Sunday and they I om and could not find it. R7 I oist had also searched the I ind it. R7 stated that on I facility contacted the police I me to take statements. R7 I is aide who worked with them I d stated that when they took I it it on the nightstand. R7 I had not fallen off because of I t and they would have I off. R7 stated that the I urses aide home until the						

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		495227	B. WING _				C 10/2023	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COL 7300 FOREST AVE RICHMOND, VA 23226)E	, , ,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE	
F 600	last one to have seen the investigation was but they were not hop back. R7 stated that nurses aide back in the state of R7 preported to state was missing. (Name the watch to bed on the but when he awoke of watch was missing from the free watch was missing from the	inpleted because he was the in the watch. R7 stated that still going on with the police beful that they would get it they had not seen the ine facility since that Monday. In of events dated 2/13/2023 In on Feb. 12, 2023, (Name off that his gold Rolex watch of R7) remembers wearing the night of Feb. 11, 2023, on the next morning, the om his left wrist. RP and Law Enforcement notified. In The final report of the documented in part, ation and findings the opriation of property is investigation against (Name sing assistant) #7) remains inforcement. (Name of CNA oyed with the facility. The cation on the abuse policy riation of property" If we record for CNA #7 are hired as a TNA sisistant) beginning on the file revealed a Virginia and check completed prior to be checks and a signed the applicant. Ational sign-in sheets for the port abuse inservice dated	Fé					

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NAME OF P	ROVIDER OR SUPPLIER	1,00==:		ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	10/2023		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER			000 FOREST AVE ICHMOND, VA 23226				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	I	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPRODEFICIENCY)			(X5) COMPLETION DATE		
F 600	Continued From pag	e 3	F	600					
	policy. Abuse educa reviewed and verified Implementation of the resident interviews a concerns were identi	fied. p.m., an interview was							
	member) #4, assista #4 stated that R7's w weekend and they w ASM #4 stated that to came in to file a reporesident had reported bad on 2/11/2023 an ASM #4 stated that to early and he did not	ont director of nursing. ASM reach went missing over a sere notified on Monday. They contacted the policy who wrt. ASM #4 stated that the did that they had started feeling did had gone to bed early. The CNA had put him to bed remember the watch falling							
	ASM #4 stated that the because they were the and CNA #7 told then when they were putting had picked it up and ASM #4 stated that the shift CNA who stated	ne morning with it gone. They interviewed CNA #7 The person who put R7 to bed The watch had come off The matter in the bed and they They interviewed the night That R7 had slept all night They interviewed the restroom.							
	ASM #4 stated that the had looked in on R7 ASM #4 stated that win Sunday morning at the watch was gone. searched the room a ASM #4 stated that a CNA #7 as the last possible the police came in to was suspended. AS investigation was still	the night CNA stated that they but had not noticed a watch. When the day shift CNA went and R7 woke up they noticed ASM #4 stated that they and could not find the watch. It that point they identified that point they identified the erson to see the watch so interview him and then he M #4 stated that the police I ongoing. ASM #4 stated in was completed and they							

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		495227	B. WING			1	C	
NAME OF B	ROVIDER OR SUPPLIER	495221	B. WING _	STDEE	ET ADDRESS, CITY, STATE, ZIP CODE	05/	10/2023	
NAME OF P	ROVIDER OR SUPPLIER				FOREST AVE			
WESTPOR	RT REHABILITATION	AND NURSING CENTER			MOND, VA 23226			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFII TAG	×	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	COMPLETION DATE	
F 600	Continued From pa	age 4	F	500				
		IA #7 based on him having the e watch. ASM #4 stated that						
	they did not want p	people in their facility that were						
		ney could not prove that he did						
		that R7 would know if the						
		d they said it did not happen. t they had completed education						
		that staff were educated upon						
		etrained annually. ASM #4						
	stated that R7 was							
	ASM #4 stated tha							
	the misappropriation							
	education was con							
	_	going. ASM #4 stated that the						
	1 -	ed with residents and						
		nts to send any high dollar Iditional concerns regarding						
		f resident property was						
	identified while on							
		5 p.m. an interview was						
		N (licensed practical nurse) #7.						
		they had spoken to R7 on ey reported the watch missing.						
		R7 reported that it was						
		orth a substantial amount of						
		ated that they searched the						
		ved two CNA's. LPN #7 stated						
	that they interview	ed the evening CNA that day						
	and they had not w	vorked with R7 on 2/11/2023						
	1	viewed CNA #7. LPN #7						
		told them that they had taken						
		getting them ready for bed and						
		f and fell on the floor. LPN #7						
		7 told them they had put the						
		ide table. LPN #7 stated that the room and the laundry and						
		vatch so they had reported the						
		ne director of nursing and						

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		495227	B. WING		C 05/10/2023	
	ROVIDER OR SUPPLIER	D 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 600	written the missing wreport. LPN #7 stated the police on 2/12/20 team did the next day The facility policy "Abuse/Neglect/Misal 11/1/19 documented immediately respond reasonable suspicion to patient, and/or visit mistreatment, exploits misappropriation of pagainst a patient" On 5/10/2023 at 4:25 administrator, ASM # #3, regional director of	atch on the supervisor d that they did not contact 23, that the administrative // ppropriation/Crime" dated in part, "A licensed nurse will to all allegations and/or s of staff to patient, patient tor to patient, abuse, neglect, ation or any atient property or crime	F 6	00		
	Past non-compliance Accuracy of Assessm CFR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on staff interv and facility document the facility staff failed MDS (minimum data	n was provided prior to exit. nents	F 6-	The facility sets forth the following pl correction to remain in compliance w federal and state regulations. The fa has taken or will take the actions set in the plan of correction. The following	ith all cility forth	

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NAME OF PI	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	10/2023	
				7	300 FOREST AVE			
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RICHMOND, VA 23226				
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F 641	annual assessment Mesident #2, to include Resident #2 was adm 3/22/23 with diagnose limited to: dementia. The most recent MDS assessment, a quarter ARD (assessment recoded the resident as the BIMS (brief intervindicating the resident impaired. Section P-FP.0200 E. coded the elopement alarm-not A review of the comp 3/22/23, revealed, "Frisk for elopement rel disorientation, exit see Check placement and Elopement risk assessed pement band as mankle." On 5/8/23 at 10:30 Al observed with wande A review of physician revealed the following	d to complete an accurate MDS (minimum data set) for de the use of a wanderguard. Initted to the facility on es that included but were not es that included but were not es that included but were not entry assessment, with an ference date) of 4/10/23, as scoring a 04 out of 15 on item for mental status) score, at was severely cognitively Restraints and Alarms resident as "wander / used." The resident is at ated to confusion and teking. INTERVENTIONS: difunction every shift. It is ment as needed. Replace eeded. Wander guard to left eeded. Wander guard to left enders, dated 3/22/23,	F	541	,	d. sed //e with n ing of		
		system Function Every						

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING		C 05/10/2023		
	DER OR SUPPLIER EHABILITATION AN	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 03/10/2023		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETION		
F 641 Co	ntinued From pag	e 7	F 6	41			
Cor ME the P f on an it c gua Wh cor (re On (ac add AS and we No F 656 SS=E CF §44 §44 imp car res §44 obj me ner ass des	anducted with OSM DS coordinator. Of coding Resident or the 4/10/23. 5/9/23 at 12:40 P agency MDS coordinator. The resident asked what standed asked asked what standed asked was a standed asked with a sked wi	mately 4:00 PM, ASM member) #1, the #2, the director of nursing, I director of clinical services sistant director of nursing the findings. In was provided prior to exit. Comprehensive Care Plan (3) Idensive Care Plans (cility must develop and thensive person-centered tesident, consistent with the erth at §483.10(c)(2) and fincludes measurable frames to meet a resident's did mental and psychosocial fied in the comprehensive mprehensive care plan must	F 6:	56	5/31/23		

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		495227	B. WING _			05/	10/2023
NAME OF PR	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AN	ND NURSING CENTER		73	00 FOREST AVE		
WESTFOR	T INCHABILITATION A	NORSING CENTER		RI	CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	or maintain the resident's highest practicable		F	656			
	required under §483 (ii) Any services that under §483.24, §483	d psychosocial well-being as .24, §483.25 or §483.40; and would otherwise be required 3.25 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 representa (A) The resident's go desired outcomes.	ative(s)- oals for admission and					
	future discharge. Fa	reference and potential for cilities must document 's desire to return to the					
	community was asset	essed and any referrals to es and/or other appropriate					
	` '	in the comprehensive care , in accordance with the					
	section.	th in paragraph (c) of this ervices provided or arranged					
		clined by the comprehensive					
	(iii) Be culturally-com	npetent and trauma-informed. T is not met as evidenced					
	Based on resident in review, staff interview review it was determ failed to develop and				F656 Develop/Implement Comprehent Care Plan 1. Resident #3 no longer resides in the facility.		
	comprehensive care	plan for seven of ten			Resdient#8 no longer resides in the		

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				MINIO			С	
		495227	B. WING _			05	5/10/2023	
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE			
				7	300 FOREST AVE			
WESTPOR	RI REHABILITATION /	AND NURSING CENTER		F	RICHMOND, VA 23226			
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					DEFICIENCY)			
F 656	Continued From page 9		F 6	656				
	residents in the sui #6, #9, #1, #2, and	rvey sample, Residents #3, #8, l #4.			facility. Resident# 6 care plan was revised on			
	The findings include	e:			5/12/23 to reflect current wounds. Resident #9 care plan was revised on			
		3 (R3), the facility staff failed to			5/10/23 to current IV access intervention Resident # 1 no longer resides in the	ons.		
		e plan to administer pain			facility.			
	medication as orde				Resdient#2. care plan for wanderguard	4		
					with documentation is being followed.	-		
	On the most recen	t MDS (minimum data set), a			Resident #4 care plan for ADL			
		ent with an ARD (assessment			interventions for incontinent care,			
	reference date) of	6/29/2022, the resident scored			personal hygiene and dressing is being	g		
	15 out of 15 on the	BIMS (brief interview for			followed with documentation.			
	mental status) asse	essment, indicating the			2. Current residents in the facility ha	ve		
		tively intact for making daily			the potential to be affected. An audit w	as		
		J documented R3 having pain			conducted by the DON or designee to			
	frequently.				verify current residents care plan reflec			
					wounds, IV accesses, inotropic therap	y,		
		e care plan for R3 documented			and verify residents care plan			
		me of R3] has potential for Pain			interventions for ADLs incontinent care	÷,		
		process, impaired mobility.			personal hygiene and dressing and			
	03/30/2022." Unde	2022, Revision on:			residents with wander guard and pain			
		t, "Administered [sic] pain			management was followed with documentation.			
		/sician orders Created on:			3. The Regional Director of MDS or			
		care plan further documented,			designee will educate the MDS staff ar	nd		
		lame of R3] has the following			nursing management (DON, ADON, U			
	_	al spinal cord injury,			Managers and Supervisors) on the	11110		
		na, fall and posthemorrhagic			process for resident □s care plan are			
		n: 03/30/2022." Under			initiated and implemented to reflect an	d		
		ocumented in part, "Administer			meet the needs of the resident⊡s			
		r treatments as ordered.			condition and care and followed and			
	Created on: 03/30/				documentation is complete. The Staff			
					Development Coordinator or designee			
	The physician orde	ers for R3 documented in part,			educate all the licensed nurses on the			
		let 10 MG (milligram) Give 3			process for resident⊡s care plan are			
		ur times a day for Muscle			initiated and implemented to reflect an	d		
	Spasms. May caus	se drowsiness, avoid alcohol.			meet the needs of the resident□s			
	Order Date: 03/28/	2022."			condition and care and followed and			

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	ROVIDER OR SUPPLIER	AND NURSING CENTER	,	73	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE ICHMOND, VA 23226		10,2020
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	mouth three times a 03/28/2022." - "tizanidine HCI (3 mouth three times a Order Date: 04/13/2 Meview of the eMA administration recodocumented the Bate 9:00 a.m., 1:00 p.m. tizanidine HCL 4 ma.m., 2:00 p.m., an Review of the Media Audit report dated documented: The Baclofen 10 madministered late of 7/5/2022 at 11:06 pp.m., on 7/8/2022 at 1:15 a.m., on 7/12/7/13/2022 at 10:32 a.m., and on 7/16/2 Baclofen 10 mg scladministered late of The Gabapentin 60 was administered late of The Gabapentin 60 was administered late on 7/3/2022 at 2.36 p.m., on 7/17/2022 at 3.36 p.m., on 7/17/2022 at 5.36 p.m., on 7/17/2022 at 5.36 p.m., on 7/17/2022 at 5.36 p.m., on 7/27/7/29/2022 at 6:25 p.m.	ablet 600 MG Give 1 tablet by a day for Pain. Order Date: Tablet 4 MG Give 1 tablet by a day for muscle spasms. 2022." R (electronic medication and dated 7/1/2022-7/31/2022 aclofen 10 mg scheduled daily one, 5:00 p.m., and 9:00 p.m. one mg was scheduled daily at and 5:00 p.m. the g was scheduled daily at 6:00 and 10:00 p.m. dated at 9:00 p.m. fication admin (administration) f/1/2022-7/31/2022 g scheduled at 9:00 p.m. n 7/3/2022 at 11:45 p.m., on p.m., on 7/7/2022 at 10:53 at 11:59 p.m., on 7/10/2022 at 2022 at 11:19 p.m., on p.m., on 7/14/2022 at 12:02 2022 at 10:41 p.m. The neduled at 5:00 p.m. was an 7/16/2022 at 8:14 p.m. on mg scheduled at 9:00 a.m. ate on 7/16/2022 at 1:27 p.m. on mg scheduled at 1:00 p.m. ate on 7/10/2022 at 2:37 p.m. ate on 7/10/2022 at 2:37 p.m. at 2:44 p.m. The Gabapentin at 5:00 p.m. was administered 6:34 p.m., on 7/5/2022 at 6:29 at 6:29 p.m., on 7/18/2022 at 2:022 at 10:14 p.m., and on	F	656	documentation is complete. 4. The MDS staff or designee will aud weekly x 4 weeks then monthly x 2 months to verify 10 residents have a caplan initiated and implemented interventions for IV access, wounds/pressure ulcers, inotropic there. The UM or designee will audit weekly x weeks then monthly x 2 months resider care plans for ADL incontinent care, personal hygiene and dressing, wande guards and pain management were followed with documentation in the climitecord. Results of the review will be presented to the QAPI committee for review and recommendation. Once the committee determines the problem no longer exists, the review will be conduct on a random basis. 5. Date of compliance 5/31/2023.	apy. c 4 nts r	

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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		J3/10/2023		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE		
F 656	7/10/2022 at 7:53 a.r. a.m., on 7/20/2022 at 7:52 a.r scheduled at 2:00 p.r. 7/16/2022 at 5:36 p.r scheduled at 10:00 p. 7/3/2022 at 11:46 p.r. 7/9/2022 at 1:15 a.m at 11:46 p.m., on 7/10 (7/15/2022), on 7/20 (7/21/2022), on 7/20 (7/21/2022), on 7/20 (7/21/2022), on 7/20 (7/23/2022), on 7/20 (7/24/2022), on 7/24 (7/28/2022), on 7/24 (7/28/2022	7/4/2022 at 7:30 a.m., on m., on 7/19/2022 at 7:34 tt 7:19 a.m., and on m. The Tizanidine 4 mg m. was administered late on m. The Tizanidine 4 mg m. was administered late on m. The Tizanidine 4 mg m. was administered late on m., 7/8/2022 at 11:59 p.m., . (7/10/2022), on 7/13/2022 4/2022 at 12:02 a.m. 12022 at 12:44 a.m. 12022 at 12:45 a.m. 12022 at 12:51 a.m. 12022 at 1:21 p.m., on m., and on 7/29/2022 at 1:2	F6	56				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495227	B. WING				C 10/2023
	ROVIDER OR SUPPLIER	ID NURSING CENTER	,	730	REET ADDRESS, CITY, STATE, ZIP CODE 10 FOREST AVE CHMOND, VA 23226	<u>, </u>	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From pag		F	556			
	that they implements admission and adder triggered. ASM #4 s not being implement being followed per the On 5/10/2023 at 2:26 conducted with LPN LPN #3 stated that madministered an househeduled time. LPN administered in this on a schedule and be medications work. Let medications were adshould notify the phyprogress notes. LPN the care plan was to resident's care and we LPN #3 stated that the director of nursing an stated that the director.	tated that the care plan was ed if the treatments were not ee doctors orders. 6 p.m., an interview was (licensed practical nurse) #3. nedications were r before to an hour after the N #3 stated that they were window to keep the resident					
	documented in part, coordination with the develops and implen plan for each patient person-centered care a maintain the highest	are Planning" dated 11/01/19 "A licensed nurse, in interdisciplinary team, nents an individualized care in order to provide effective, e, and the necessary nd services to attain or practical physical, mental ill-being of the patient"					
		5 p.m., ASM #1, \$2, director of nursing, ASM of clinical services, ASM #4,					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY
		495227	B. WING _			l	C 10/2023
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	ODE	1 00,	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCE	ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE
F 656	assistant director of r director of operations findings. No further information. 2. For Resident #8 (develop a comprehend plan regarding a commedication infusion. On the most recent Madmission assessmenterence date) of 12 scored 15 out of 15 of for mental status) assinguished the resident was cognitive decisions. Section Coxygen, dialysis and medications. The comprehensive of the director of the comprehensive of the comp	nursing and ASM #8, regional is were made aware of the in was provided prior to exit. R8), the facility staff failed to ensive resident centered care tinuous intravenous cardiac MDS (minimum data set), an ent with an ARD (assessment in the BIMS (brief interview desessment, indicating the rely intact for making daily of documented R8 receiving IV (intravenous) care plan for R8 failed to are plan related to the	Fé	356			
	- "DOBUTamine HCI (milliliter per hour) into as needed for Chang PRN related to UNSI (CONGESTIVE) HEA ****RN ONLY**** Con Progress Note when 82.05 kg (kilogram) I (microgram per kilog Date: 12/13/2022."	for R8 documented in part, Solution Use 6.2 ml/hr travenously every 40 hours le cassette and batteries PECIFIED SYSTOLIC ART FAILURE (I50.20) Implete Cardiac Assessment changing (Baseline weight: Dose: 2.5 mcg/kg/min ram per minute)). Order					

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 5/10/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		5/10/2023	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	ASM #4 stated that was to get an overal and should tell a sto there. ASM #4 state baseline care plan of things to it as they tr. On 5/26/2023 at 2:2 conducted with LPN LPN #3 stated the p to know the guidelin why they were in the the care plan started and the managers. director of nursing, t all reviewed and revistated that they wou have care plans regithe care they were to Con 5/10/2023 at 4:2 staff member) #1, and of nursing, ASM #3, services, ASM #4, and ASM #8, region made aware of the fill No further information. 3. For Resident #6 implement the compute the	sistant director of nursing. The purpose of the care plan I picture of the patient's care ry of why the resident was ad that they implemented the n admission and added iggered. 6 p.m., an interview was (licensed practical nurse) #3. urpose of the care plan was a of the resident's care and a facility. LPN #3 stated that I with the director of nursing LPN #3 stated that the he managers and the nurses ised the care plans. LPN #3 Id expect to see residents arding cardiac drips to show to receive and monitoring. 5 p.m., ASM (administrative diministrator, ASM #2, director regional director of clinical sesistant director of nursing all director of operations were indings. In was provided prior to exit. In (R6), the facility staff failed to rehensive care plan for a to the penis and a pressure	F 65				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING			1	C 10/2023
	ROVIDER OR SUPPLIER			7300 F	T ADDRESS, CITY, STATE, ZIP CODE FOREST AVE MOND, VA 23226	1 03/	10/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	Continued From page	e 15	F	656			
F 030	mental status), indicated cognitively intact for its Section M documents pressure ulcers. On 5/8/2023 at 3:00 proconducted with R6 in they had an area on a from the urinary cathest sometimes the nurse and sometimes the nurse and sometimes they doctor looked at the curologist. A urinary cattached to the bed find bed. The bag was obtained to the bed find they were not sure withought the catheter at the cause the injury. From their foot and the other than the comprehensive of the comprehen	ating the resident was making daily decisions. The Red Red having two Stage 3 co.m., an interview was their room. Red stated that their foot and another area eter. Red stated that is put a dressing on their foot did not and they wound other area and they saw the atheter bag was observed rame on the right side of the observed to be empty with the tubing. Red stated that that had happened but tubing had rubbed the area Red stated that the wound st every day and took care of the eneeds: osteoarthritis to left ochronic obstructive obesity, HTN (hypertension), ageal reflux disease), the eneeds in the red in the re		556			
	d/o (disorder), mood behavior, vitamin D d heart failure, wounds Revision on: 03/20/20	constipation, neurocognitive disorder w/ assaultive leficiency, elevated D-Dimer, . Created on: 06/23/2021, 023." Under "Interventions" , "Administer medications					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 05/10/2023	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	30.10.2020	
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 656	nurse practitioner d part, "Wound Evalu Location: Left latera 1.60 cm (centimete 1.60 cm (squared), I cmStage/Severity Stable; 100% epithof frequently: TID (throwith: Cleanse with seprimary Treatment: Leave open to air report further docur Date: 05/01/2023; Leave open to air report further docur Date: 05/01/2023; Leave open to air report further docur Date: 05/01/2023; Leave open to air The progress in the progress notes "Skin/Wound Note: "Ski	ment Report from the wound ated 5/1/2023 documented in ation Date: 05/01/2023; all foot; Measurements: Length: r), Width: 1.00 cm, L x W: Depth: 0.10: Stage 3 Wound Status: elialDressing change et times a day), Clean wound soap and water, pat dry; Skin prep, Other dressings: The wound assessment mented, ""Wound Evaluation cocation: Penis; agth: 1.50 cm (centimeter), W: 0.90 cm(squared), Depth: Trauma; Stage/Severity: Full Status: Stable; 100% ang change frequently: BID a wound with: Cleanse with imary Treatment: Calcium ointment, Other dressings: " documented in part, 5/4/2023 12:22 Resident seen (nurse practitioner) 5/3/23 for a Residents wound to L (left) and to penis remains present tening noted. Resident ies of daily living) care often educated on importance of the healing. Resident verbalized commendations: Cleanse and saline) or wound cleanser. ate. L foot: apply skin prep doctor) made aware. Wound	F	356			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	100221	1	STREET ADDRESS, CITY, STATE, ZIP COD	•	05/10/2023
				7300 FOREST AVE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		RICHMOND, VA 23226		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 656	Continued From pag	e 17	F6	656		
	"Cleanse left foot with medihoney and bord as needed every day 03/28/2023. Start Day physician orders failed orders from the 5/1/2 wound assessment. documented, "Cleans and apply xeroform to needed. Order Date 03/28/2023." The phevidence the treatmenurse practitioners where the treatmenurse practitioners with the treatmenurse practitioners and be blank. The eTAR "Cleanse penis with the various penis with the treatmenurse practitioners with the trea	ate: 03/29/2023." The ed to evidence the treatment rough nurse practitioners. The physician orders further see penis with wound cleanser wice daily and as needed as e: 03/28/2023. Start Date: pysician orders failed to ent orders from the 5/1/2023 round assessment. The treatment record) dated for R6 documented in part, the wound cleanser and apply er gauze dressing daily and exhiftOrder Date-139 p.m.)." The eTAR trent completed on and 5/7/23. The for 5/5/23 was observed to further documented, wound cleanser and apply and as needed every day rider Date- 03/28/2023 1933				
	observed to be blank evidence treatment the and the wound to the wound nurse practition On 5/9/2023 at 12:50	for 5/5/23 day shift was The eTAR failed to he left foot pressure ulcer penis according to the peners 5/1/2023 assessment. p.m., an interview was				
	conducted with LPN	(licensed practical nurse) #4,				

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 05/10/2023	
	ROVIDER OR SUPPLIER	AND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		33/10/2023	
(X4) ID PREFIX TAG	(EACH DEFIC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 656	nurse practitioner of the residents in LPN #4 stated that practitioner when that the nurse practitioner when as needed. LPN were recommend they notified the practitioner in hou changes the same orders. LPN #4 sonurse practitioners recommend they notified the practitioner in hou changes the same orders. LPN #4 sonurse practitioners recommend they were in LPN practitioner note of the progress note data sometimes they go put the orders in the conducted with AS member) #4, the and SM #4 stated the was to get an overand should tell as there. ASM #4 stated the was to get an overand should tell as there. ASM #4 stated the care plan was treatments were redoctors orders. On 5/10/2023 at 4 staff member) #1,	page 18 a. LPN #4 stated that the wound came in weekly and saw most at the building who had wounds. At they rounded with the nurse they came in. LPN #4 stated ctitioner assessed the wounds, and made changes to treatments #4 stated that when changes ed from the nurse practitioner obysician or the nurse use that day to approve the eday and entered the new tated that the physician and the swent with the wound nurse mmendations because they LPN #4 stated that R6 often use and it depended on the mood N #4 reviewed the wound nurse dated 5/1/2023 and stated that not busy and they may not have the purpose of the care plan used the purpose of the care plan used that they implemented the non admission and added to triggered. ASM #4 stated that the not being implemented if the not being implemented if the not being followed per the decrease and the core of clinical director of clinical	F	656			

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		ELE CONSTRUCTION	· ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C	
	ROVIDER OR SUPPLIER	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		05/10/2023 DE		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	and ASM #8, region made aware of the second ma	assistant director of nursing hal director of operations were findings. on was provided prior to exit. (R9), the facility staff failed to ensive patient centered care peripherally inserted central ravenous access. MDS (minimum data set), an ent with an ARD (assessment st/20/2023, the resident scored BIMS (brief interview for ssment, indicating the rately impaired for making ction O documented R9	F 65				
	plan failed to evider regarding care of th	on: 03/14/2023." The care nce any interventions e PICC line.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C 5/10/2023	
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		5/10/2023	
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	LPN #3 stated that P changed weekly and #3 stated the purpos know the guideline of they were in the facilicare plan started with the managers. LPN nursing, the manage the care plans as nearesident with a PICC that addressed why foften they needed to changes and care of On 5/10/2023 at 12:0 conducted with ASM member) #4, assista #4 stated that the puget an overall picture should tell a story of ASM #4 stated that the baseline care plan of things to it as they tria resident with a PICC the flushes, dressing monitoring the site of On 5/10/2023 at 4:25 staff member) #1, and of nursing, ASM #3, services, ASM #4, as and ASM #8, regional made aware of the fill No further information.	(licensed practical nurse) #3. ICC line dressings were assessed every shift. LPN e of the care plan was to f the resident's care and why ity. LPN #3 stated that the in the director of nursing and #3 stated that the director of rs and the nurses all updated eded. LPN #3 stated that a line should have a care plan they had the PICC line, how flush the PICC line, dressing the PICC line. 109 p.m., an interview was (administrative staff int director of nursing. ASM rpose of the care plan was to e of the patient's care and why the resident was there, they implemented the in admission and added ggered. ASM #4 stated that C line would have the site, change schedule and ocumented in their care plan. 5 p.m., ASM (administrative liministrator, ASM #2, director regional director of clinical seistant director of operations were	F 68	56			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 05/10/2023
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		03/10/2023
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 656	called a central venintravenous (IV) line regular IV and goes the heart or just ins the PICC line stays where the arm bend than one line. The ewith a cap. This infi the website: https://kidshealth.or. 5. The facility staff comprehensive candaily living) care for Resident #1 was ad 3/20/23 with diagnor limited to: CHF (cordiabetes mellitus, a pulmonary edema. The most recent MI assessment, a fivewith an ARD (asses 3/25/23, coded the 15 on the BIMS (bri	tral line. A central line (also ous catheter) is like an a. But it is much longer than a stall the way up to a vein near ide the heart. The other end of outside of the body, usually districted in the second of each line is covered formation was obtained from a reg/en/parents/picc-lines.html failed to implement the explan for ADL (activities of resident #1. Idmitted to the facility on uses that included but were not negestive heart failure), cute respiratory failure, and DS (minimum data set) day Medicare assessment, as ment reference date) of resident as scoring a 13 out of ef interview for mental status) as resident was not cognitively	F 6			
	requiring extensive transfer, locomotion and hygiene; super A review of the com 3/20/23 revealed, "I risk for pain related resident requires as	assistance for bed mobility, n, walking, dressing, bathing vision for eating. aprehensive care plan dated FOCUS: The resident has a to bilateral leg wounds. The essistance with their activities of hronic health conditions and				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		495227	B. WING			1	C 10/2023
	ROVIDER OR SUPPLIER	ND NURSING CENTER		7300	EET ADDRESS, CITY, STATE, ZIP CODE FOREST AVE HMOND, VA 23226	1 00/	10/2020
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656	of bladder and contiveakness INTERVE medications as order interview as indicated Observe for physical assist transfer. Skill therapy/physical the toileting." A review of the Manadministration record documentation miss (3/27), 1 of 12 even night shifts (3/20, 3/4). A review of the Manadressing documentation shifts (3/27) and 1 of A review of the Manadressing documentation shifts (3/27) and 1 of 3 day shifts (4/1). A review of the Apriliancontinence care of 3 day shifts (4/1). A review of the Apriliancontinence care of 3 day shifts (4/1). A review of the Apriliancontinence care of 3 day shifts (4/1). A review of the Apriliancontinence care of 3 day shifts (4/1). A review of the Apriliancontinence care of 3 day shifts (4/1) and 1 of 4 ninterview was considered as a co	on. The resident is incontinent nent of bowels due to ENTIONS: Administer ered. Administer pain ed. Notify MD as indicated. Il indicators of pain. 2 persons led OT/PT (occupational erapy). 1 person assist with example of the series of the s	F	656			

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 05/10/2023	
	ROVIDER OR SUPPLIER	D NURSING CENTER	,	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 00/10/2020	
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION	
F 656	the resident needs fo functioning. When as documentation, is the LPN #6 stated no, it is An interview was conwith CNA (certified not asked if the care plantif there are holes in the #3 stated, no, if it was done, so the care plandirector of nursing, As of clinical services, As of nursing and ASM # operations was made No further information 6. The facility staff fair comprehensive care Resident #2. Resident #2 was adm 3/22/23 with diagnose limited to: dementia. The most recent MDS assessment reficeded the resident as the BIMS (brief intervindicating the resident resident resident resident resident as the BIMS (brief intervindicating the resident resid	goals and interventions that r care and to improve their sked if there are holes in a care plan being followed, is not being followed. ducted on 5/9/23 at 1:50 PM arsing assistant) #3. When a for ADL's is being followed, he ADL documentation, CNA is not documented, it was not in is not being followed. M, ASM (administrative staff ainistrator, ASM #2, the SM #3, the regional director for aware of the findings. In was provided prior to exit. Iled to implement the plan for a wander guard for a wander guard for the staff included but were not set that included but were not set that included but of 15 on iew for mental status) score, it was severely cognitively	F 65	66		
	impaired. A review of G-functional status co requiring limited assis					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	PLE CONSTRUCTION IG	(>	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 05/10/2023	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226	DE	03/10/2023	
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 656	transfers, walking, an P-Restraints and Alaresident as "wander A review of the comp 3/22/23, which revea at risk for elopement disorientation, exit see Check placement an Elopement risk asser elopement band as rankle." On 5/8/23 at 10:30 A observed with wander A review of physiciar revealed the followin Prevention Band ever Prevention System F Sunday. A review of Resident (treatment administration "Check Wander Prevention System F Sunday. A review of Resident (treatment administration "Check Wander Prevention System F Sunday. A review of Resident (treatment administration "Check Wander Prevention System F Sunday. A review of Resident (treatment administration "Check Wander Prevention System F Sunday. A review of Resident "Check Wander Prevention System F Sunday. A review of Resident "Check Wander Prevention System F Sunday. A review of Resident "Check Wander Prevention System F Sunday. A review of Resident "Check Wander Prevention System F Sunday. A review of Resident "Check Wander Prevention System F Sunday. A review of Resident "Check Wander Prevention System F Sunday. A review of Resident "Check Wander Prevention System F Sunday. A review of Resident "Check Wander Prevention System F Sunday. A review of Resident "Check Wander Prevention System F Sunday. A review of Resident (treatment administration System F Sunday.) A review of Resident (treatment administration System F Sunday.) A review of Resident (treatment administration System F Sunday.) A review of Resident (treatment administration System F Sunday.) A review of Resident (treatment administration System F Sunday.) A review of Resident (treatment administration System F Sunday.) A review of Resident (treatment administration System F Sunday.) A review of Resident (treatment administration System F Sunday.) A review of Resident (treatment administration System F Sunday.)	and locomotion. Section rms P.0200 E. coded the / elopement alarm-not used". prehensive care plan dated aled, "FOCUS: The resident is related to confusion and beeking. INTERVENTIONS: d function every shift. ssment as needed. Replace needed. Wander guard to left a.M., Resident #2 was er guard to left ankle. a.M. orders, dated 3/22/23, g, "Check Wander ery shift. Check Wander function Every Week-every #2's April 2023 TAR ation record) revealed: rention System Function ght shifts every Sun for ing." On 1 of 5 Sunday's	F 6	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 10/2023
	ROVIDER OR SUPPLIER	D NURSING CENTER	1	STREET ADDRESS, CITY, STATE, ZIP COE 7300 FOREST AVE RICHMOND, VA 23226)E	,	10/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIA		(X5) COMPLETION DATE
F 656	the resident needs for functioning. When as [blanks] in documents followed, LPN #6 star followed. On 5/10/23 at 4:00 P member) #1, the adm director of nursing, A of clinical services, A of nursing and ASM # operations was made. No further information. 7. The facility staff fair comprehensive care Resident #4. Resident #4 was adm 1/17/23 with diagnost limited to: pericardial kidney disease) and I have most recent MDS assessment, a quarte with an ARD (assess 4/25/23, coded the resident #15 on the BIMS (bries score, indicating the impaired. A review of G-functional status corequiring extensive a transfer, walking, dre supervision for eating	goals and interventions that r care and to improve their sked if there are holes ation, is the care plan being and no, it is not being M, ASM (administrative staff ministrator, ASM #2, the SM #3, the regional director sM #4, the assistant director sM #4, the assistant director sM aware of the findings. In was provided prior to exit. Iled to implement the plan for ADL care for Initted to the facility on the sthat included but were not effusion, CHF, CKD (chronic DM (diabetes mellitus). So (minimum data set) the regional status of the interview for mental status) the MDS Section and the resident as sesistance for bed mobility, assing, bathing and hygiene; and locomotion.	F	556			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZI 7300 FOREST AVE RICHMOND, VA 23226	IP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIAT	(X5) COMPLETION DATE		
F 656	requires assistance their activities of dail conditions, recent he CHF. INTERVENTIONS: Fincontinent episodes as needed for incontassist with bed mobile. A review of the Aprile administration record documentation miss 4/22 and 4/23), 3 of and 4/27) and 3 of 2 4/19). A review of the Aprile documentation miss 4/22 and 4/23) and 3 and 4/27). A review of the Aprile hygiene documentation shifts (4/1, 4/22 and shifts (4/4, 4/7 and 4/27). A review of the May incontinence care do 9 day shifts (5/6 and 5/1). A review of the May documentation miss and 5/8) and 5 of 9 of 5/7 and 5/8). A review of the May	with y living due to chronic health popitalization, weakness and Provide peri-care with Provide toileting hygiene inent episodes. 1 person lity." 2023 TAR (treatment d) revealed incontinence care ing for 3 of 20 day shifts (4/1, 21 evening shifts (4/5, 4/7 and 2023 TAR revealed dressing ing on 3 of 20-day shifts (4/1, 3 of 21 evening shifts (4/4, 4/7) and 2023 TAR revealed personal ion missing on 3 of 20 day 4/23) and 3 of 21 evening 1/27).	F	356				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		/10/2023	
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F 656	shifts (5/6 and 5/8) ar 5/3, 5/6, 5/7 and 5/8). An interview was conwith LPN #6. When a care plan, LPN #6 staplan is to include the the resident needs for functioning. When as	ducted on 5/9/23 at 1:30 PM asked the purpose of the ted, the purpose of the care goals and interventions that r care and to improve their	F 65	56			
	followed, LPN #6 state followed. An interview was conswith CNA (certified nuasked if the care plan if there are holes in the #3 stated, no, if it was done, so the care plan On 5/10/23 at 4:00 Pl member) #1, the admidirector of nursing, AS of clinical services, AS of nursing and ASM # operations was made	ducted on 5/9/23 at 1:50 PM arsing assistant) #3. When for ADL's is being followed, the ADL documentation, CNA is not documented, it was not in is not being followed. M, ASM (administrative staff inistrator, ASM #2, the SM #3, the regional director SM #4, the assistant director 18, the regional director of aware of the findings.					
F 657 SS=D	Care Plan Timing and CFR(s): 483.21(b)(2)(§483.21(b) Comprehe §483.21(b)(2) A complete (i) Developed within 7 the comprehensive as	ci)-(iii) ensive Care Plans brehensive care plan must days after completion of seessment. derdisciplinary team, that	F 65	57		5/31/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BU		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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F 657	resident. (C) A nurse aide wi resident. (D) A member of fo (E) To the extent pr the resident and the An explanation must medical record if the and their resident root practicable for tresident's care plar (F) Other appropria disciplines as deter or as requested by (iii)Reviewed and roteam after each assessments. This REQUIREMED by: Based on staff inte and facility docume that the facility staff the care plan for or survey sample, Resident.	hysician. rse with responsibility for the th responsibility for the od and nutrition services staff. acticable, the participation of e resident's representative(s). st be included in a resident's e participation of the resident epresentative is determined he development of the te staff or professionals in mined by the resident's needs the resident. evised by the interdisciplinary sessment, including both the d quarterly review NT is not met as evidenced rview, clinical record review, nt review it was determined failed to review and/or revise le of ten residents in the sident #8.	F	F657 Care Plan Timing and 1. Resident # 8 no longer r facility. 2. Current residents have t be affected. 3. The Regional Director of designee will educate MDS s nursing management (DON,	Revision esides in the he potential to f MDS or staff and ADON, Unit		
	review and/or revis 1/20/2023. The progress notes - "1/20/2023 5:37 a evaluationUnwith go to the bathroom	8), the facility staff failed to e the care plan after a fall on for R8 documented in part, .m. fall essed fall. She was trying to unassisted; she lost her ther head on her whe [sic] she		Managers and Supervisors) of process for reviewing, updating to reflect the current intervent resident after a fall and/or change condition and followed. The Superpose condition are conditioned to be process for care plans with ingreviewing, revising/ updating	ng care plans tions for the ange in Staff designee will on the nitiating		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
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			7300 FOREST AVE			
WESTPORT REHABILITATION A	ND NURSING CENTER		RICHMOND, VA 23226			
PREFIX (EACH DEFICIEN	STATEMENT 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)	SHOULD BE	DATE	
scalp. Now with a method possible 10) headact pain. Not on anticoal overt physical signs syncope, chest pain Neuro (neurological per protocol. Vital sit is requesting to got which I agree is reasond new-onset head falls due to the follow The patient's condition transferred to the Elepathology" - "1/20/2023 14:15 (form [sic] her ER vist pleasant & happy to & 3 person assist bath to a sperson assist bath to a sperson after the fall. On 5/10/2023 at 2:2 conducted with LPN #3 stated that we assessment was cound treated as need responsible party are of the fall. LPN #3 stated that the state of the fall is care and the fall is care and the managers and the manage	e now has a large latoma on the top of her lew 7/10 (pain level 7 out of liche. No skin tears or acute ligulation. On exam, no other of trauma. No reports of ligulation, or altered mental status.) checks are being performed gns are unremarkableshe line ER (emergency room), lisonable given the hematoma lachePatient is at risk for living Loss of balance lighter of the trace of the trace of lighter of the trace of the trace of lighter of the trace of li	F 6	to reflect the current intervent resident after a fall and/or charcondition and followed. 4. The MDS staff or designed weekly x4 then monthly x 2 modernical records for falls and/or clinical condition to verify 10 modernical condition to verif	ee will audinonths the rehange in residents sed, and eview will be reviews wasis. The sing is on of the plant audinos th	it n e ne vill	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) I IDENTIFICATION NUMBER: A. BL		TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226	E	00.10.2020	
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F 658 SS=E	fall. The facility policy "C documented in part, will be updated by e basis as changes in reviewed quarterly wassessment" On 5/10/2023 at 4:2 staff member) #1, ac of nursing, ASM #3, services, ASM #4, a and ASM #8, regions made aware of the f No further informatic Services Provided M CFR(s): 483.21(b)(3) Comp The services provide as outlined by the comust- (i) Meet professional	are Planning" dated 11/01/19 "Computerized care plans ach discipline on an ongoing the patient occur, and vith the quarterly 5 p.m., ASM (administrative dministrator, ASM #2, director regional director of clinical ssistant director of nursing al director of operations were indings. on was provided prior to exit. leet Professional Standards		657		5/31/23	
	by: Based on resident i review, staff intervie review it was determ failed to follow profe three of ten resident Residents #3, #8, an The findings include	nterview, clinical record w and facility document lined that the facility staff ssional standards of care for s in the survey sample, and #6.		F 658 Services Provided Mer Professional Standards 1. Resident #3 no longer re facility. Resident #8 no longer resides facility. Resident #6 treatment order to per physician order on 5/8/20 2. Current residents in the of the potential to be affected. To	rsides in the s in the transcribed 3. center have		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONST G		(X3) DATE SURVEY COMPLETED	
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NAME OF PR	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	1 00/10/2020	┪
				7300 FOF	REST AVE		
WESTPOR	RT REHABILITATION A	ND NURSING CENTER		RICHMO	OND, VA 23226		
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F 658	Continued From pag	ge 31	F6	58			
F 658	administer medication On the most recent quarterly assessment reference date) of 6, 15 out of 15 on the limental status) assess resident was cognitify decisions. Section of frequently. The physician order - "Baclofen (1) Table tablet by mouth four Spasms. May cause Order Date: 03/28/2 - "Gabapentin (2) Tamouth three times a 03/28/2022." - "tizanidine HCI (3) mouth three times a Order Date: 04/13/2 The comprehensive in part, "PAIN: [Namelated to disease physical Computation of the empty of th	MDS (minimum data set), a not with an ARD (assessment 1/29/2022, the resident scored BIMS (brief interview for assment, indicating the vely intact for making daily documented R3 having pain of the standard set of the set	F 6	designessic physical admires in the North Application with application with a processic admires in the Processic admires in the Application and Application admires in the Application and Application admires in the Application and Applicati	gnee conducted audit to verify dents with inotropic therapy had sician order for monitoring the inistration rate, an audit on current dent that have recommendations havound NP has physician notification transcription of new orders if licable and an audit on current dents to identify medications not inistered or not administered time physician notification of findings. The SDC or designee will educate icensed nursed on the process are dures for medication administratician notification with documental lications not administered or not inistered timely within the 2-hour frame, documentation of monitorina diministration rate for residents siving inotropic therapy and secribing wound NP recommendation seribing wound NP recommendation. The Unit Manager or designee will plete weekly audits x 4 weeks the other weekly audits x 5 weeks the other weekly audits x 6 weeks the other weekly audits x 8 weeks the other weekly audits x 9 weeks the other weekly a	by bon by bon by bon by bon by by bon by	
	9:00 a.m., 1:00 p.m.) mg was scheduled daily at , and 5:00 p.m. The , was scheduled daily at 6:00		prob	Once the committee determines the lem to no longer exist, the review conducted on a		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED		
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ATION AN	D NURSING CENTER					
DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI) TAG	X	· ·		(X5) COMPLETION DATE
rom page	e 32	F 6	358			
				random basis. 5. Date of compliance 5/31/2023.		
dated 7/1 the Back ministere (2022 at on 7/8/20 c 1:15 a.n (3/2022 at and on 7/ mg sche d late on ontin 600 tered late (2022 at 6: (7/2022 at on 7/27/20 c 6:25 p.n on 2/3 a.n (3/2022 at on 7/52 a.n on 7/52 a.n on 7/14 on 7/19/ on 7/20/ on 7/21/	ofen 10 mg scheduled at ed late on 7/3/2022 at 11:45 at 11:06 p.m., on 7/7/2022 at 22 at 11:59 p.m., on n., on 7/12/2022 at 11:19 at 10:32 p.m., on 7/14/2022 at 16/2022 at 10:41 p.m. The duled at 5:00 p.m. was 7/16/2022 at 8:14 p.m. mg scheduled at 9:00 a.m. as on 7/16/2022 at 1:27 p.m. mg scheduled at 1:00 p.m. as on 7/10/2022 at 2:37 p.m. at 10:10 p.m. at 10:11 p.m., and on n. at 10:11					
in e J / I i i i i i i i i i i i i i i i i i i	irom page .m., and ine Medica dated 7/1 I the Bacl diministere /2022 at and on 7/8/20 at 1:15 a.n. 3/2022 at and on 7/ mg sched late on attended at attend	IDENTIFICATION NUMBER: 495227	### ATION AND NURSING CENTER ### ATION AND AND NURSING CENTER ### ATION AND AND NURSING CENTER ### ATION AND AND AND AND AND AND AND AND AND AN	### ATION AND NURSING CENTER ### ATION AND NURSEA ### ATION AND	A BUILDING 495227 ASTON AND NURSING CENTER MATON AND NURSING CENTER MATON AND NURSING CENTER MATON AND NURSING CENTER MANARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) Tom page 32 .m., and 10:00 p.m. Be Medication admin (administration) dated 71/12022-1731/2022 Ithe Baclofen 10 mg scheduled at Iministered late on 7/3/2022 at 11:45 2022 at 11:59 p.m., on 7/17/2022 at 10:30 p.m., on 7/16/2022 at 12:41 p.m. The mg scheduled at 5:00 p.m. was di late on 7/16/2022 at 12:37 p.m. ettered late on 7/16/2022 at 17:30 a.m., on 7/18/2022 at 17:30 p.m., on 7/18/2022 at 17:34 p.m. ettered late on 7/10/2022 at 7:34 0/2022 at 7:34 0/2022 at 7:34 0/2022 at 7:34 0/2022 at 17:39 p.m., on 7/18/2022 at 17:45 1/2022 at 17:45 p.m., and on 1/2022 at 7:34 1/2022 at 17:45 p.m., 1/2022 at 17:40 p.m. 1/2022 at 17:40 p.m. 1/2022 at 17:40 p.m., 1/2022	A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA. 23226 MIMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST BE PRECEDED BY FULL ATORY OR LSC IDENTIFYING INFORMATION) TORY OR LSC IDENTIFYING INFORMATION TORY OR LSC IDENTIFY AND INFORMATION TORY O

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F 658	7/28/2022 at 11:34 pt 11:40 p.m. The progress notes documentation regal of the medications d On 5/8/2023 at 11:33 conducted with OSN LTC (long term care stated that they had and they had attempregarding late medications. OSM acconsistently receive and muscle spasms appointments and doparticipate fully. OS particularly an issue the resident was on On 5/10/2023 at 12:3 conducted with ASM member) #4, the ass ASM #4 stated that the brought up concerns medications in the Dhad wanted to know after the scheduled the ASM #4 stated that the residents that the properties of the properties	for R3 failed to evidence rding the late administration ocumented above. 3 a.m., an interview was (other staff member) #2, ombudsman. OSM #2 worked with R3 at the facility stated to resolve concerns ations, in particular the pain which delayed therapy ecreased their ability to M #2 stated that R3 did not their medications for pain which delayed therapy ecreased their ability to M #2 stated that this was the month of July 2022 when a particular unit. 35 p.m., an interview was (administrative staff sistant director of nursing, he resident council had about timeliness of ecember meeting and they the timeframe before and ime to get their medications, hey had discussed with the actice of an hour before and reduled time was within the if any audits were performed histration timeliness, ASM #4	F	558			
		6 p.m., an interview was (licensed practical nurse) #3.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION G	\ , ,	(X3) DATE SURVEY COMPLETED	
		495227	B. WING			C 5/10/2023	
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F 658	scheduled time. LPN administered in this on a schedule and be medications work. Let medications were adshould notify the phyprogress notes. The facility policy "M Management/Medications were adshould notify the phyprogress notes. The facility policy "M Management/Medications of the times administration of medication, 2005: Patrice Perry; Mosby, Inc., pordered medications minutes of the times On 5/10/2023 at 4:28 administrator, ASM ##3, regional director assistant director assistant director of director of operations findings. No further information Reference: (1) Baclofen is used types of spasticity (mightness) from multinguries, or other spir in a class of medicat relaxants. Baclofen and decreases the nine medications and decreases the nine medications.	nedications were r before to an hour after the N #3 stated that they were window to keep the resident ecause of how the PN #3 stated that when the ministered late the nurse sician and document it in the edication ation Unavailability" dated vidence guidance on dication in a timely manner. nentals of Nursing 6th cia A. Potter and Anne Griffin age 843, "All routinely should be given within 60 ordered." 5 p.m., ASM #1, #2, director of nursing, ASM of clinical services, ASM #4, nursing and ASM #8, regional is were made aware of the In was provided prior to exit.	F 68	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTI IDENTIFICATION NUMBER: A. BUILDIN		TIPLE CONSTRUCTION NG	, ,	(X3) DATE SURVEY COMPLETED	
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F 658	Continued From pa spinal cord conditio improves muscle m was obtained from thttps://medlineplus.tml (2) Gabapentin cap solution are used all help control certain who have epilepsy, and oral solution are of postherpetic neu stabbing pain or act or years after an att extended-release to treat restless legs so that causes discomurge to move the le when sitting or lying class of medication. Gabapentin treats abnormal excitement relieves the pain of body senses pain. It gabapentin works to This information was	ge 35 ns. It also relieves pain and ovement. This information					
	increased muscle to sclerosis (MS, a dis not function properl weakness, numbne coordination and pr and bladder control injury. Tizanidine is called skeletal musc	ed to relieve the spasms and one caused by multiple ease in which the nerves do y and patients may experience ess, loss of muscle oblems with vision, speech,), stroke, or brain or spinal in a class of medications cle relaxants. It works by the brain and nervous system to					

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 05/10/2023			
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C	ODE	1 00/10	72020		
WESTPOR	RT REHABILITATION AN	D 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) BY THE PROVIDER'S PLAN OF CORRECTION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		_	(X5) COMPLETION DATE					
F 658	F 658 Continued From page 36		F6	658					
	obtained from the we https://medlineplus.go ml	relax. This information was bsite: ov/druginfo/meds/a601121.ht R8), the facility staff failed to							
	evidence monitoring of the administration rate of intravenous Dobutamine (1).								
	admission assessme reference date) of 12 scored 15 out of 15 o for mental status) ass resident was cognitiv	MDS (minimum data set), an and with an ARD (assessment /19/2022, the resident on the BIMS (brief interview sessment, indicating the ely intact for making daily documented R8 receiving IV (intravenous)							
	- "Cardiac Monitoring &O (intake and output O= output), Labs revilabs not reviews), me confused), Chest pair Peripheral Pulse (Y= Edema (Y= Yes, N= I (CDI= catheter site of s/sx of infection, O= i provider) every shift for 12/13/2022." - "Monitor pump and shift for Monitoring Nappropriately, note N and follow up with products of the provider of th	yes present, N= no pulses), No), Catheter assessment ean, dry and intact with no ssue noted- follow up with for Monitoring. Order Date: cassette every shift every ote Y if functioning if not functioning properly ovider. Order Date:							

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495227		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 05/10/2023	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	.	00,10,2020	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	Continued From pag		F 6	58			
	(milliliter per hour) ir as needed for Chan PRN related to UNS (CONGESTIVE) HE ****RN ONLY**** Corogress Note wher 82.05 kg (kilogram) (microgram per kilog Date: 12/13/2022." - "DOBUTamine HC intravenously every Change cassette an UNSPECIFIED SYSHEART FAILURE (Is Complete Cardiac Awhen changing (Bas 2.5 mcg/kg/min). Or - "DOBUTamine HC intravenously every Change cassette an UNSPECIFIED SYSHEART FAILURE (Is Complete Cardiac Awhen changing (Bas 2.5 mcg/kg/min). Or - "DOBUTamine HC intravenously every Change cassette an UNSPECIFIED SYSHEART FAILURE (Is Complete Cardiac Awhen changing (Bas 2.5 mcg/kg/min). Or Review of the eMAF administration recor 12/1/2022-12/31/20; above. The eMAR fimonitoring on the da 12/17/2022 and 12/23/2022 and 12/16/2022, 12/17/2 and 12/21/2022. The	I Solution Use 6.2 ml/hr intravenously every 40 hours ge cassette and batteries in PECIFIED SYSTOLIC ART FAILURE (I50.20) complete Cardiac Assessment in changing (Baseline weight: Dose: 2.5 mcg/kg/min gram per minute)). Order I Solution Use 6.6 ml/hr 40 hours as needed for d batteries PRN related to iTOLIC (CONGESTIVE) 50.20) ****RN ONLY**** ssessment Progress Note seline weight:82.05 kg Dose: der Date: 12/21/2022." I Solution Use 6.4 ml/hr 40 hours as needed for d batteries PRN related to iTOLIC (CONGESTIVE) 50.20) ****RN ONLY**** ssessment Progress Note seline weight:82.05 kg Dose: der Date: 12/30/2022." R (electronic medication d) for R8 dated 22 documented the orders failed to evidence cardiac any shift on 12/15/2022, 31/2022, on the evening shift the night shift on 12/14/2022, 022, 12/18/2022, 12/20/2022, the eMAR failed to evidence intery changes completed for					

495227 B. WING	С	
	05/10/2023	
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	0.10.2020	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 658 Continued From page 38 Dobutamine 6.2 ml/hr dosage ordered between 12/13/2022 and 12/21/2022. The eMAR failed to evidence staff monitoring the rate of the Dobutamine infusing via the pump each shift between 12/13/2022-12/31/2022. Review of the eMAR for R8 dated 1/1/2023-1/31/2023 documented the orders above. The eMAR failed to evidence cardiac monitoring on the day shift on 1/1/2023, 1/14/2023, and 1/30/2023 and the night shift on 1/17/2023, 1/18/2023 and 1/31/2023. The eMAR failed to evidence staff monitoring the rate of the Dobutamine infusing via the pump each shift between 1/1/2023-1/31/2023. Review of the eMAR for R8 dated 2/1/2023-2/28/2023 documented the orders above. The eMAR failed to evidence staff monitoring the rate of the Dobutamine infusing via the pump each shift between 2/1/2023-2/28/2023. The progress notes for R8 failed to evidence a nursing assessment on 12/17/2022, 12/18/2022, 12/31/2022, and 1/14/2023. The comprehensive care plan for R8 failed to evidence a nursing assessment on 12/17/2022, 12/18/2022, 12/31/2022, and 1/14/2023. The comprehensive care plan related to the Dobutamine IV medication. On 5/10/2023 at 9:30 a.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated that the RN's were called to come when the Dobutamine cassette and the tubing they wrote a		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 05/10/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		13/10/2023		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE		
F 658	checking the amoun cassette at the beging RN #1 stated that the should complete the eMAR, document the infusing on the eMA write a skilled note of the RN's documented change as needed of reviewed R8's eMAF be a place where the medication infusing shift. RN #1 stated of first resident and the conducted with LPN LPN #3 stated that the drip cassettes and put they monitored resident and the conducted with LPN LPN #3 stated that the drip cassettes and put they monitored resident and medication in the put of their shift. LPN #4 documented on the was infusing, that the cardiac monitoring, completed a skilled thours for residents of the medication was medication administ medication administration and medication administration and medication administration and medication administration administration administration and medication administration and medication administration administration and medication administration administration and medication administration adm	nitored the medication by t of medication in the nning and end of their shift. e assigned nurse each day cardiac monitoring on the at the medication was R, enter the vital signs and every shift. RN #1 stated that d the cassette and battery on the eMAR. RN #1 R and stated that there should e staff were documenting the at the prescribed rate every that R8 may have been their ere was some trial and error. 6 p.m., an interview was (licensed practical nurse) #3. the RN's changed the cardiac tumps. LPN #3 stated that lents receiving the cardiac re by monitoring the pumps to on was infusing at the observed the amount of mp at the beginning and end 3 stated that they eMAR that the correct rate the pump was functioning and LPN #3 stated that they also note in the computer every 12 on cardiac drips. Administration of Inotropic 14/2022 documented in part,	F 6	58				

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		495227	B. WING _			C 05/10/2023	
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		03/10/2023	
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 658	On 5/10/2023 at 4:2 staff member) #1, a of nursing, ASM #3 services, ASM #4, a and ASM #8, region made aware of the No further information Reference: (1) Dobutamine stin improves blood flow better. Dobutamine cardiac decompens muscle. Dobutamine heart medicines had This information was https://www.drugs.cd 3. For Resident #6 transcribe recommenurse practitioner of wound on the resident of 15 out of 15 on the mental status), indiccognitively intact for Section H document catheter. On 5/8/2023 at 3:00 conducted with R6 they had a urinary of the services and the status and the services are services at the services	the rate of administration" 25 p.m., ASM (administrative dministrator, ASM #2, director regional director of clinical assistant director of nursing all director of operations were findings. On was provided prior to exit. Inulates heart muscle and y by helping the heart pump is used short-term to treat ation due to weakened heart he is usually given after other ye been tried without success. Is obtained from the website: from/mtm/dobutamine.html (R6), the facility staff failed to endations made by the wound in 5/1/2023 for treatment to a	F 6	58			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
49522		495227	B. WING			C 05/10/2023		
	NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226	ODE	, 00		
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F 658	were not sure what he catheter tubing had reinjury. On 5/9/2023 at approattempt was made to treatment to the wour refused the care. The Wound Assessmurse practitioner dat part, "Wound Evaluat Location: Penis; Mea (centimeter), Width: Com(squared), Depth: Stage/Severity: Full Totale; 100% granula frequently: BID (twice Cleanse with wound Calcium alginate, Baddressings: Leave open The progress notes of "Skin/Wound Note 5/by wound care NP (note that wound assessment, foot is healed. Woun with 0 signs of worse refuses ADL (activities per staff. Resident experi care to promote lunderstanding. Recopenis with NS (normate).	and they also saw a ea. R6 stated that they ad happened but thought the abbed the area to cause the ximately 9:05 a.m., an observe staff providing ad to the penis however R6 ent Report from the wound ed 5/1/2023 documented in ion Date: 05/01/2023; surements: Length: 1.50 cm 0.60 cm, L x W: 0.90 0.20 cmEtiology: Trauma; ThicknessWound Status: ationDressing change a day), Clean wound with: cleanser; Primary Treatment: citracin ointment, Other an to air" ocumented in part, 4/2023 12:22 Resident seen urse practitioner) 5/3/23 for Residents wound to L (left) d to penis remains present ning noted. Resident s of daily living) care often ducated on importance of nealing. Resident verbalized ammendations: Cleanse al saline) or wound cleanser. e. L foot: apply skin prep ctor) made aware. Wound	F	558				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION	. ,	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 5/40/2022		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF 7300 FOREST AVE RICHMOND, VA 23226		5/10/2023		
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN (((EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE		
F 658	The physician orders "Cleanse penis with v xeroform twice daily a Order Date: 03/28/20 The physician orders treatment orders from practitioners wound a The eTAR (electronic 5/1/2023-5/31/2023 fo "Cleanse penis with v xeroform twice daily a and evening shift -Order (7:33 p.m.)." The eTA treatment completed once on 5/6/23 and o documentation area fobserved to be blank evidence treatment a practitioners 5/1/2023 The comprehensive of in part, "Immunologic infection of the Balan lower extremities. Cr Revision on: 03/20/20 documented, "FOLE's requires urinary cathe uropathy/bladder nec 12/02/2022 Revision plan further documen of R6] has the potenti behaviors; itching, pic care, aggression, rest trays, emptying urine floor. Refusing meds on: 05/18/2022 Revision plan further documen floor. Refusing meds on: 05/18/2022 Revision plan further documen floor. Refusing meds on: 05/18/2022 Revision	for R6 documented in part, wound cleanser and apply and as needed as needed. 23. Start Date: 03/28/2023." failed to evidence the in the 5/1/2023 nurse assessment. Treatment record) dated for R6 documented in part, wound cleanser and apply and as needed every day der Date- 03/28/2023 1933 AR documented the on 5/1/23-5/4/23, 5/6/23, in 5/7/23. The for 5/5/23 day shift was assessment. The eTAR failed to ccording to the wound nurse assessment. The are plan for R6 documented al: [Name of R6] has it and recent cellulitis to eated on: 11/23/2022, it and recent cellulitis to eated on: 11/23/20	F	658				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 05/10/2023	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226			
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F 658	wound care nurse. In urse practitioner care of the residents in the LPN #4 stated that the practitioner when the that the nurse practitioner when the that the nurse practitioner and as needed. LPN #4 were recommended they notified the phy practitioner in house changes the same dorders. LPN #4 state nurse practitioners were an expert. LPN refused wound care they were in. LPN # practitioner note date progress note dated sometimes they get put the order in. The facility policy "P Documentation" date evidence guidance of treatment orders for On 5/10/2023 at 4:25 staff member) #1, and of nursing, ASM #3, services, ASM #4, and ASM #8, regional made aware of the file.	(licensed practical nurse) #4, LPN #4 stated that the wound me in weekly and saw most e building who had wounds. The provided with the nurse ey came in. LPN #4 stated dioner assessed the wounds, made changes to treatments stated that when changes from the nurse practitioner sician or the nurse that day to approve the ay and entered the new end that the physician and the vent with the wound nurse mendations because they will also will be wound to the wound the wo	F	558			
F 676 SS=E		n was provided prior to exit. g (ADLs)/Mntn Abilities	F 6	576		5/31/23	

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		495227	B. WING			C 05/10/2023		
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP COI 7300 FOREST AVE RICHMOND, VA 23226		3/10/2023		
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F 676	resident's needs and provide the necessar ensure that a resident daily living do not dim of the individual's clin that such diminution includes the facility e §483.24(a)(1) A resident reatment and service or her ability to carry living, including those of this section §483.24(b) Activities The facility must provaccordance with para activities of daily livin §483.24(b)(1) Hygier grooming, and oral cases \$483.24(b)(2) Mobilit including walking, §483.24(b)(3) Eliminal §483.24(b)(4) Diningsnacks, §483.24(b)(5) Comm (i) Speech, (ii) Language,	the comprehensive dent and consistent with the choices, the facility must y care and services to t's abilities in activities of ninish unless circumstances ical condition demonstrate was unavoidable. This insuring that: Lent is given the appropriate es to maintain or improve his out the activities of daily especified in paragraph (b) of daily living. Inde care and services in agraph (a) for the following g: Le -bathing, dressing, are, y-transfer and ambulation, ation-toileting, reating, including meals and	F 6	76				

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 05/10/2023		
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	10/2023	
					300 FOREST AVE			
WESTPOR	RT REHABILITATION AN	D NURSING CENTER			RICHMOND, VA 23226			
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
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F 676	Continued From page	e 45	F 6	676				
	This REQUIREMENT by:	is not met as evidenced						
	Based on staff interv and facility document the facility staff failed providing ADLs (activ	iew, clinical record review review, it was determined to provide evidence of ities of daily living) for two of nt #1 and Resident #4.			F676 Activities of Daily Living (ADLs) /Maintain Abilities 1. Resident # 1 no longer resides in facility. Resident # 4 timeframe has passed to	the		
	The findings include:				correct. Resident #4 current ADL is complete. 2. Current residents in the facility have	ve		
	The facility staff failed to provide evidence of incontinence care, dressing and personal hygiene care for Resident #1. Resident #1 was admitted to the facility on 3/20/23 with diagnosis that included but were not limited to: CHF (congestive heart failure), diabetes mellitus, acute respiratory failure,				the potential to be affected. 3. The SDC or designee will educate CNAs on providing ADL care with documentation in the clinical record for	e all		
					validation and verification services and care were provided for incontinent care dressing and personal hygiene. 4. The UM or designee assess 10	9,		
	The most recent MDS assessment, a five-da with an ARD (assess 3/25/23, coded the re 15 on the BIMS (brief score, indicating the rimpaired. A review of G-functional status corequiring extensive as transfer, locomotion, and hygiene; supervision A review of the composition.	ay Medicare assessment, ment reference date) of esident as scoring a 13 out of interview for mental status) resident was not cognitively the MDS Section oded the resident as esistance for bed mobility, walking, dressing, bathing sion for eating.			residents weekly x 4 weeks the monthl 2 months to verify ADL provided and documentation fir incontinent care, dressing and personal hygiene is complete in the clinical record. Once the QAPI committee determines the problem to longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the professional of the professional complexity. 5. Date of compliance 5/31/2023.	ne em		
	3/20/23, which reveal has a risk for pain relative resident requires activities of daily living conditions and recent	led, "FOCUS: The resident ated to bilateral leg wounds. assistance with their g due to chronic health						

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		495227	B. WING _			C 05/10/2023		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE 00 FOREST AVE CHMOND, VA 23226	1 00	10/2020	
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F 676	Administer medicati pain interview as indicated. Observe 2 persons assist tra (occupational thera assist with toileting. A review of the Maradministration record documentation miss (3/27), 1 of 12 even night shifts (3/20, 3/4). A review of the Mardressing documentation shifts (3/27) and 1 of A review of the Marpersonal hygiene do 11 day shifts (3/27) (3/30). A review of the Apriliancontinence care do 3 day shifts (4/1). A review of the Apriliancontinence care do 3 day shifts (4/1). A review of the Apriliancontinence care do 3 day shifts (4/1). A review of the Apriliancontinence care do 3 day shifts (4/1). A review of the Apriliancontinence care do 3 day shifts (4/1). A review of the Apriliancontinence care do 3 day shifts (4/1). A review of the Apriliancontinence care do 3 day shifts (4/1) and 1 of 4 day shifts (4/1) and 1 of 5 days for the care documentation missing the residents, CNA	chess INTERVENTIONS: cons as ordered. Administer dicated. Notify MD as for physical indicators of pain. nsfer. Skilled OT/PT py/physical therapy). 1 person ch 2023 TAR (treatment rd) revealed incontinence care sing in 1 of 11 day shifts ing shifts (3/30) and 5 of 12 rd, 3/25, 3/28 and 3/31). ch 2023 TAR revealed ation missing in 1 of 11-day of 12 evening shifts (3/30). ch 2023 TAR revealed becomentation missing in 1 of and 1 of 12 evening shifts I 2023 TAR revealed ocumentation missing in 1 of and 1 of 3 day shifts (4/1). I 2023 TAR revealed personal tion missing in 1 of 3-day 3 evening shifts. I 2023 TAR revealed personal tion missing in 1 of 3-day 3 evening shifts.	F	676				

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F 676	I am assigned to this residents may need to frequently." When as documented, CNA #1 the ADL-CNA form. To under section of bown bathing is documented grooming is part of personal perso	unit so I know which to be changed more sked where all of this care is a stated, it is documented on the incontinence care is tel/bladder elimination, and under bathing and tersonal hygiene. When tots in the documentation ated, "If it is not documented tred to be done." When time for call bells, CNA #1 timmediately, it is usually aducted on 5/9/23 at 1:15 PM tesident #4 scored a 14 out of a interview for mental status) tresident was not cognitively the is coded as always and bladder. When asked tinence care is provided, that is the only thing that is the sthem awhile when you the sonly changed 1-2 times aducted on 5/9/23 at 1:50 PM	F	576				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		(2) MULTIPLE CONSTRUCTION . BUILDING			(X3) DATE SURVEY COMPLETED	
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F 676	incontinence care is bowel/bladder eliminunder bathing and gr hygiene. When aske documentation indicate blanks then the control to have blanks in can see where there specifics." On 5/10/23 at 4:00 Pmember) #1, the addirector of nursing, A of clinical services, A of nursing and ASM apperations was made. A review of the facility dated 11/1/19, revea provide basic nursing accepted standards or recognized by state to informed by national nurse aide curriculum. No further information. 2. The facility staff faincontinence care, dreare for Resident #4. Resident #4 was adm 1/17/232 with diagnonot limited to: pericar (chronic kidney diseatmellitus). The most recent MD:	under section of ation, bathing is documented coming is part of personal and what blank spots in the lates, CNA #3 stated, "If there have was not given. We are our documentation. You are codes to document the are codes to document the lates, CNA #3, the regional director and the lates, and the lates was not given. We are our documentation. You are codes to document the lates was not given. We are our documentation. You are codes to document the lates was not given. We are lates was followed as a surface was followed by the lates was lates w	F6	376				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		495227	B. WING _				C 10/2023	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP C 7300 FOREST AVE RICHMOND, VA 23226	ODE	, 33	10,2020	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BI HE APPROPRIA		(X5) COMPLETION DATE	
F 676	4/25/23, coded the real 15 on the BIMS (brief score, indicating the impaired. A review of G-functional status or requiring extensive a transfer, walking, dresupervision for eating A review of the compaires assistance was their activities of daily conditions, recent hoo CHF. INTERVENTIONS: Princontinent episodes as needed for incontinent episodes as needed for incontinent assist with bed mobil A review of the April 2 administration record documentation missing 4/22 and 4/23), and 3 of 21 4/19). A review of the April 2 documentation missing 4/22 and 4/23) and 3 and 4/27). A review of the April 2 administration missing 4/22 and 4/23) and 3 and 4/27).	ment reference date) of resident as scoring a 14 out of a finterview for mental status) resident was not cognitively the MDS Section coded the resident as sesistance for bed mobility, ssing, bathing and hygiene; and locomotion. The resident with a living due to chronic health spitalization, weakness and rovide peri-care with Provide toileting hygiene nent episodes. 1 person ity." 2023 TAR (treatment and incontinence care for 3 of 20 day shifts (4/1, 21 evening shifts (4/5, 4/7) and	F	676				

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 _			05/10/2023		
	ROVIDER OR SUPPLIER	ND NURSING CENTER		730	REET ADDRESS, CITY, STATE, ZIP CODE O FOREST AVE CHMOND, VA 23226	1 00.		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 676	F 676 Continued From page 50		F	676				
	9 day shifts (5/6 and	ocumentation missing on 2 of 15/8), 5 of 9 evening shifts and 5/8) and 2 of 9-night shifts						
	documentation miss	2023 TAR revealed dressing ing on 2 of 9 day shifts (5/6 evening shifts (5/1, 5/3, 5/6,						
	hygiene documenta	2023 TAR revealed personal tion missing on 2 of 9 day and 5 of 9 evening shifts (5/1, s).						
	with CNA (certified rasked to describe in the residents, CNA; incontinence care et am assigned to this residents may need frequently." When a documented, CNA the ADL-CNA form. under section of box bathing is document grooming is part of pasked what blank spindicates, CNA #1 sthen it is not considerasked the response	nducted on 5/8/23 at 9:20 AM hursing assistant) #1. When continence care process for #1 stated, "We do very two hours or more often. Is unit so I know which to be changed more asked where all of this care is #1 stated, it is documented on The incontinence care is very loader elimination, and the dered to be done." When cots in the documentation tated, "If it is not documented ered to be done." When time for call bells, CNA #1 is immediately, it is usually						
	with CNA #3. When incontinence care p	nducted on 5/9/23 at 1:50 PM asked to describe rocess for the residents, CNA acontinence care every two						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED			
		495227	B. WING			C 05/10/2023	
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		03/10/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTIC REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO TH		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 676	they sometimes call hours. Personally, I shours. Personally, I shoushing their teeth a putting them in new of showers or they gwhere all of this care stated, it is documer incontinence care is bowel/bladder eliminunder bathing and ghygiene. When asked documentation indicare blanks then the cont to have blanks in can see where there specifics." On 5/10/23 at 4:00 Fmember) #1, the addirector of nursing, A of clinical services, A of nursing and ASM operations was mad A review of the facility dated 11/1/19, reveal provide basic nursing accepted standards recognized by state informed by national nurse aide curriculur	If they can use their call bell, us if it is in between the 2 start by washing them and and hair. Washing them up. clothes. There is a schedule et a bed bath." When asked is documented, CNA #3 sted on the ADL form. The under section of ation, bathing is documented rooming is part of personal ed what blank spots in the ates, CNA #3 stated, "If there eare was not given. We are our documentation. You are codes to document the ASM #3, the regional director as M #4, the assistant director #8, the regional director of a ware of the findings. Let's "General Care" policy led, "Nursing personnel will go care and services following of practice guidelines boards of nursing as nursing organizations and/or in."	F 6	76			
F 677 SS=E	ADL Care Provided to CFR(s): 483.24(a)(2	n was provided prior to exit. for Dependent Residents) dent who is unable to carry	F 6	777		5/31/23	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER			ICHMOND, VA 23226		
	OLUMBA A DV OT	TATEMENT OF DEFICIENCIES			·		0.4=)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 677	Continued From page	e 52	F	677			
	out activities of daily services to maintain personal and oral hyd	living receives the necessary good nutrition, grooming, and					
	Based on clinical red and facility document that the facility staff fa (activities of daily living	ng) care for dependent en residents in the survey			F677 ADL Care Provided for Depende Residents 1. Resident #3 no longer resides in the facility. Resident #8 no longer resides in the		
	The findings include: 1. For Resident #3 (R3), the facility staff failed to provide incontinence care. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 6/29/2022, the resident scored 15 out of 15 on the BIMS (brief interview for mental status) assessment, indicating the resident was cognitively intact for making daily decisions. Section G documented R3 being totally dependent on one staff member for personal hygiene and totally dependent on two or more persons for toileting. Section H documented R3 having an external catheter, receiving intermittent catheterization and being frequently incontinent of bowel.				facility. 2. Current residents in the facility have the potential to be affected. 3. The SDC or designee will educate CNAs on providing incontinent care and toileting assistance for the resident and	all d/or	
					personal hygiene with documentation in the clinical record for validation and verification care and services were provided. 4. The UM or designee will assess 10 residents weekly x 4 weeks then month x 2 months to verify incontinent care and/or toileting assistance and personal hygiene was provided with documentate in the clinical record. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are	n O nly al ion	
	in part, "INCONTINE Bowel/Urinary incont mobility, quadriplegia Revision on: 03/30/20 documented, "ADLs: care deficit related to	care plan for R3 documented NCE: [Name of R3] has inence related to impaired a. Created on: 03/30/2022, 022." The care plan further [Name of R3] has ADL Self physical limitations, d on: 03/30/2022, Revision			responsible for implementation of the p of correction. 5. Date of compliance 5/31/2023.	lan	

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 _				0 10/2023
	ROVIDER OR SUPPLIER	ND NURSING CENTER	•	STREET ADDRESS, CITY 7300 FOREST AVE RICHMOND, VA 232		, 00.	10,2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COF	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE
F 677	7/1/2022-7/31/2022 and Toilet Use" faile care provided on da 7/6-7/8/2022, 7/19/2 7/27-7/28/2022, and shift on 7/3/2022, 7/7/23/2022 and 7/27/7/5/2022, 7/16/2022, 7/22-7/24/2022, and On 5/8/2023 at 11:3 conducted with OSN long term care ombut they worked with R3 concerns of not receitmely from staff at the that they had resolve with care but inconticisue until they were OSM #2 stated that and witnessed the sonot provide care for that R3 was a difficula appeared scared of 7/19/2022 they with room for over two hong getting changed until On 5/9/2023 at 1:06 conducted with LPN wound care nurse. Worked with R3 at they did find R3 in fewould tell them that for a while so they would so	locumentation for R3 dated under "Bowel Continence d to evidence incontinence y shift on 7/1/2022, 7/3/2022, 17/30-7/31/2022, on evening 5/2022, 7/17-7/18/2022, 2022, on night shift on , 7/18/2022, 7/18/2022, 7/20/2022,	F	577			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 05/10/2023		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		J3/10/2023		
(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 CC ((EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE		
F 677	staff would leave the On 5/9/2023 at 1:39 conducted with CNA #3. CNA #3 stated in provided every two leaves the stated that blank spameant that you did resupposed to be any The facility policy "A Services" dated 11/0 "Nursing personnel and services following practice guidelines resurring as informed organizations and as individuals who grade nursing school and/on have successfully practification examinates. The facility provided Chapter 22 pg. 324" "Incontinence is en wet and odors devel uncomfortable. Skir pressure ulcers are self-esteem are affer.	p.m., an interview was a (certified nursing assistant) what incontinence care was a computer every shift. CNA #3 aces under incontinence care not do it and there were not blanks there. Incillary Nursing Care and continence care not do it and there were not blanks there. Incillary Nursing Care and continence care not do it and there were not blanks there. Incillary Nursing Care and continence care not do it and there were not blanks there. Incillary Nursing Care and continence care not do it and there were not blanks there. Incillary Nursing Care and continence care not documented in part, mbarrassing. Garments get	F6					
	staff member) #1, ad of nursing, ASM #3, services, ASM #4, a	5 p.m., ASM (administrative dministrator, ASM #2, director regional director of clinical ssistant director of nursing al director of operations were						

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 05/10/2023		
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIF 7300 FOREST AVE RICHMOND, VA 23226	P CODE	00/10/2020		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TI DEFICIE	ACTION SHOULD BE O THE APPROPRIAT	DATE.		
F 677	2. For Resident #8 (I provide toileting assis care, and personal hyoccasions from Dece February 2023. On the most recent Madmission assessme reference date) of 12 scored 15 out of 15 of for mental status) assistance hygiene and toileting being frequently inco Review of the ADL do 12/1/2022-12/31/202 and "Bowel/Bladder E evidence toileting assistance toileting assistance and 12/17/2022, 12/25/20 evening shift on 12/1 12/15/2022, 12/20-12 and 12/28-12/29/202 failed to evidence car 12/14/2022, 12/25/20	n was provided prior to exit. R8), the facility staff failed to stance and/or incontinence regione on numerous mber 2022 through MDS (minimum data set), an exit with an ARD (assessment regional for making daily documented R8 requiring of one person for personal for Section H documented R8 exit exit in the BIMS (brief interview for making daily documented R8 requiring for one person for personal for pers	Fé	577	in (T)			
	1/1/2023-1/31/2023 เ "Bowel/Bladder Elimi	ocumentation for R8 dated inder "ADL-Toilet Use" and nation" failed to evidence nd/or incontinence care						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRE 7300 FOREST A		1 00/	10/2020
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F 677	1/27/2023 and 1/30/2 1/7/2023, 1/11/2023, 1/23/2023 and 1/28- 1/2-1/5/2023, 1/8-1/9 1/18-1/24/2023 and "ADL-Personal Hygie provided on day shift 1/27/2023 and 1/30/2 1/7/2023, 1/11/2023, 1/11/2023, 1/23/2023, and 1/28- observed to be blank Review of the ADL d 2/1/2023-2/28/2023 "Bowel/Bladder Elim toileting assistance a provided on day shift and on night shift 2/5 Hygiene" failed to ev shift on 2/2/2023 and observed to be blank On 5/9/2023 at 1:39 conducted with CNA #3. CNA #3 stated the provided every two h documented in the costated that blank spameant that you did n supposed to be any On 5/10/2023 at 10:5 conducted with CNA worked with R8 in the R8 was alert and original their call bell when the stated that R8 was alert and original to the stated that R8 was alert and the stated that R8 was alert and the stated that R8 was alert R8 was	ton 1/6/2023, 1/8-1/9/2023, 2023, on evening shift 1/19/2023, 1/21/2023, 1/29/2023 and on night shift 1/29/2023 and on night shift 1/28-1/29/2023. The failed to evidence care to on 1/6/2023, 1/8-1/9/2023, 2023 and on evening shift on 1/19/2023, 1/21/2023, 2023 and on evening shift on 1/19/2023, 1/21/2023, 2023. The areas were to occumentation for R8 dated ander "ADL-Toilet Use" and ination" failed to evidence and/or incontinence care to on 2/2/2023 and 2/5/2023, 1/2023. "ADL-Personal idence care provided on day 1/2/5/2023. The areas were to occumentation for R8 dated and on the provided on day 1/2/5/2023. The areas were to occumentation for R8 dated and on the provided on day 1/2/5/2023. The areas were to occumentation for R8 dated and on the provided on day 1/2/5/2023. The areas were to occumentation for R8 dated and on the provided on day 1/2/5/2023. The areas were to occumentation for R8 dated and on the provided on day 1/2/5/2023. The areas were to occumentation for R8 dated and on the provided on day 1/2/5/2023. The areas were to occumentation for R8 dated and on the provided on day 1/2/5/2023. The areas were to occumentation for R8 dated and on the provided on day 1/2/5/2023. The areas were to occumentation for R8 dated and occumentation for R8	F	577			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		495227	B. WING _		C 05/10/2023
	ROVIDER OR SUPPLIER	ID NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	, 33/10/222
(X4) ID PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETION
F 686 SS=D	residents were bather personal hygiene even the ADL documentated in the ADL do	do. CNA #6 stated that ed daily and received ery shift. CNA #6 reviewed ion for R8 and stated that it hey received a bath on 5 p.m., ASM (administrative diministrator, ASM #2, director regional director of clinical essistant director of nursing all director of operations were oncern. In was provided prior to exit. revent/Heal Pressure Ulcer ()(i)(ii)	F 6		5/31/23
	resident, the facility (i) A resident received professional standar pressure ulcers and ulcers unless the indicated demonstrates that the (ii) A resident with professional standard promote healing, present ulcers from device This REQUIREMENT by: Based on resident in clinical record review review it was determined to the clinical record review review it was determined to the clinical record review review it was determined as a clinical record review review it was determined as a clinical record review review it was determined as a clinical record review review it was determined as a clinical record review review it was determined as a clinical record review review it was determined as a clinical record review review it was determined as a clinical record review review it was determined as a clinical record rec	ehensive assessment of a must ensure that- es care, consistent with es of practice, to prevent does not develop pressure lividual's clinical condition ey were unavoidable; and ressure ulcers receives and services, consistent ndards of practice, to event infection and prevent		F686 *Treatment/Svcs to Prevent/H Pressure Ulcers 1. Resident # 6 has treatment order	

STATEMENT OF DEFIC AND PLAN OF CORRE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
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		495227	B. WING			05/	10/2023
WESTPORT REH		D NURSING CENTER		73	TREET ADDRESS, CITY, STATE, ZIP CODE 800 FOREST AVE ICHMOND, VA 23226		
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ress the su The file For R transcription for R	ndings include: esident #6 (R6) cribe recommen practitioner on ure ulcer/injury e most recent M erly assessment ence date) of 3/1 t of 15 on the B al status), indicatively intact for r on M documente ure ulcers. 8/2023 at 3:00 p ucted with R6 in had an area on t times the nurse ometimes they of doctor came in of their foot. 9/2023 at appro pt was made to left foot pressu are. Vound Assessm practitioner dat 'Wound Evaluat ion: Left lateral cm (centimeter), cm(squared), De	for one of ten residents in esident #6. In the facility staff failed to dations made by the wound 5/1/2023 for treatment to the (1) on the left lateral foot. IDS (minimum data set), a set with an ARD (assessment 3/2023, the resident scored limbs (brief interview for ting the resident was making daily decisions. End R6 having two Stage 3 and their foot. R6 stated that their foot. R6 stated that their foot. R6 stated that their almost every day and took with their foot staff providing care refulcer however R6 refused ent Report from the wound foot; Measurements: Length: Width: 1.00 cm, L x W:	F	686	physician order on 5/8/2023 and is beir performed and documented. The physician was notified Resident #6 did receive wound treatment on 5/5/2023. 2. Current residents in the facility have the potential to be affected. The DON of designee conducted an audit on reside with pressure wound treatment recommendations by the wound NP to verify were transcribed per physician order and performed per physician order and performed per physician order and performed per physician order and tocumentation in the clinical record and physician notification of wound NP recommendations and transcribed in the clinical record per physician order. 4. The UM or designee will assess weekly x 4 weeks then monthly x 2 months to verify residents with pressure wound treatment recommendations by wound NP were transcribed per physicion order. Observation audits weekly x 4 weeks then monthly x 2 months on 5 residents with pressure wound care treatments to verify wound treatment performed and documented in the clinic record. Once the QAPI committee determines the problem no longer exist the reviews will be completed on a random basis. The Administrator or Director of Nursing is responsible for implementation of the plan of correction 5. Date of compliance 5/31/2023.	not ve or onts er. or d ee ethe ian	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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F 686	Continued From pa	_	F	586				
	frequently: TID (three with: Cleanse with s	elialDressing change be times a day), Clean wound soap and water, pat dry; Skin prep, Other dressings:						
	"Skin/Wound Note is by wound assessment foot is healed. Wou with 0 signs of wors refuses ADL (activit per staff. Resident peri care to promote understanding. Repenis with NS (norm Apply calcium algin TID. MD (medical care will continue to	documented in part, 5/4/2023 12:22 Resident seen (nurse practitioner) 5/3/23 for . Residents wound to L (left) and to penis remains present lening noted. Resident lies of daily living) care often educated on importance of the healing. Resident verbalized commendations: Cleanse hal saline) or wound cleanser. Late. L foot: apply skin prep doctor) made aware. Wound of monitor and treat."						
	"Cleanse left foot w medihoney and bor as needed every da 03/28/2023. Start I physician orders fai	ith wound cleanser and apply der gauze dressing daily and by shift. Order Date: Date: 03/29/2023." The led to evidence the treatment 2023 nurse practitioners						
	record) dated 5/1/20 documented in part cleanser and apply dressing daily and a -Order Date- 03/28/ eTAR documented 5/1/23-5/4/23, 5/6/2	ic treatment administration 023-5/31/2023 for R6, "Cleanse left foot with wound medihoney and border gauze as needed every day shift. 2023 1939 (7:39 p.m.)." The the treatment completed on 3 and 5/7/23. The						

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F 686	according to the vision of the residents in LPN #4 stated the practitioner when that the nurse pramasured them as needed. LPN were recommend they notified the practitioner in hou changes the sam orders. LPN #4 snurse practitioner in hou changes the sam orders. LPN #4 snurse practitioner practitioner recommend they notified the practitioner in hou changes the sam orders. LPN #4 snurse practitioner recommend they were in. LPI practitioner note of the progress note day sometimes they go put the order in.	AR failed to evidence treatment wound nurse practitioners nent. Ve care plan for R6 documented f R6) is alert and verbal. He has ge due to pressure ulcer 4/2021. Revision on: 2:50 p.m., an interview was PN (licensed practical nurse) #4, e. LPN #4 stated that the wound came in weekly and saw most in the building who had wounds. At they rounded with the nurse they came in. LPN #4 stated actitioner assessed the wounds, and made changes to treatments #4 stated that when changes ed from the nurse practitioner obysician or the nurse use that day to approve the e day and entered the new stated that the physician and the se went with the wound nurse mmendations because they LPN #4 stated that R6 often are and it depended on the mood N #4 reviewed the wound nurse dated 5/1/2023 and stated that get busy and they may not have	F	586		
		und care was evidenced by he eTAR. LPN #5 stated that if				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 5/10/2023
	ROVIDER OR SUPPLIER	ND NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	1 0	3/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 686	The facility policy "F Documentation" date evidence guidance treatment orders for On 5/10/2023 at 4:2 staff member) #1, a of nursing, ASM #3, services, ASM #4, a and ASM #8, region No further information (1) Pressure Ulcer A pressure sore is a down when someth against the skin. Proceedings of the severity of sympostage. Stage IV is the painful area on the swhen pressed. This is forming. The skin soft. Stage II: The sore. The area arou irritated. Stage III: open, sunken hole of the severity of symposium of the stage of t	c they could not evidence that ed. Pressure Ulcer Monitoring & ded 11/01/2019 failed to on following the current pressure ulcers. Pressure ulcers. Sp.m., ASM (administrative dministrator, ASM #2, director of regional director of clinical assistant director of nursing hal director of operations. In area of the skin that breaks ing keeps rubbing or pressing ressure sores are grouped by botoms. Stage I is the mildest ne worst. Stage I: A reddened, skin that does not turn white is a sign that a pressure ulcer may be warm or cool, firm or skin blisters or forms an open and the sore may be red and The skin now develops an called a crater. The tissue	F 68	36		
F 689 SS=D	see body fat in the operation of the must be tendons and joint obtained from the whttps://medlineplus.00740.htm.	maged. You may be able to crater. Stage IV: The become so deep that there is cle and bone, and sometimes is. This information was rebsite: gov/ency/patientinstructions/0 uzards/Supervision/Devices	F 68	39		5/31/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		ATE SURVEY MPLETED
		495227	B. WING _			C 05/10/2023
	ROVIDER OR SUPPLIER	ND NURSING CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		1 03/10/2023	
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F 689	as free of accident h §483.25(d)(2)Each r supervision and ass accidents. This REQUIREMEN by: Based on staff inter and facility documer the facility staff failed for one of 10 resider Residents #2. The findings include Resident #2 did not implemented to mor monitoring device th activates an alarm w leave a safe/secured	s. sure that - esident environment remains azards as is possible; and esident receives adequate istance devices to prevent T is not met as evidenced view, clinical record review at review, it was determined d to monitor a safety device ats in the survey sample,	F 6	F689 *Free of Accident Hazards/Supervision/Devices 1. Resident #2 current wander monitored with documentation. 2. Current residents in the facil the potential to be affected. An a conducted by the DON or design current residents with wandergua documentation for monitoring co 3. The SDC or designee will ed licensed nurses on the process f residents with wanderguards are	lity have audit nee on ard have mpleted. ducate all for	
	3/22/23 with diagnost limited to: dementia. The most recent MD assessment, a quark ARD (assessment recoded the resident at the BIMS (brief interindicating the reside impaired. A review of	es (minimum data set) derly assessment, with an eference date) of 4/10/23, des scoring a 04 out of 15 on view for mental status) score, nt was severely cognitively		monitored, on and functional with verification of documentation cor the clinical record. 4. The UM or designee will aud x 4 weeks then monthly x 2 moniverify residents with wanderguar monitored, on and functional with verification of documentation cor the clinical record. Once the QAI committee determines the proble longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nurs responsible for implementation or	mpleted in dit weekly ths to ds are n mpleted in Pl em no The ing are	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		495227	B. WING _			C 05/10/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226	I	03/10/2023
(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	transfers, walking, locand bathing; supervise P-Restraints and Alar resident as "wander / A review of the compression of the co	stance for bed mobility, comotion, dressing, hygiene ion for eating. Section ms P.0200 E. coded the elopement alarm-not used". The elopement alarm-not used". The resident is at risk to confusion and eking. INTERVENTIONS: If function every shift. Is ment as needed. Replace eleded. Wander guard to left M, Resident #2 was lerguard worn on the left orders, dated 3/22/23, pricheck Wander y shift. Check Wander y shift. Check Wander unction Every Week-every g note dated 3/22/23 at Cognitive state on arrival: Infused." g note dated 3/22/23 at 4:22 ent eloped and was ext to facility after "Code staff member brought lity. Wander guard was eft ankle. RP (responsible practitioner) made aware of	F 6	of correction. 5. Date of compliance 5/3	.1/2023.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		495227	B. WING _			C 05/10/2023	
	ROVIDER OR SUPPLIER	D NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 7300 FOREST AVE RICHMOND, VA 23226		10/10/2020	
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 689	dated 3/23/23, reveal for elopement. Elope for elopement. Elope A review of Resident Wander Prevention Severy night shifts every night shifts ever	ed, "Resident is at high risk ed 3/22/23." #2's April TAR: "Check ystem Function Every Week ry Sun for Wandering/exit: 1 of 5 Sunday's missing #2's April 2023 TAR tion record): "Check and every shift" revealed on for day shift: 1 of 30 days sing shifts (4/17, 4/26 and nt shifts (4/8 and 4/9). ducted on 5/9/23 at 1:30 d practical nurse) #6. When es [blanks] in the here evidence that the pencked. LPN #6 stated, so, we cannot validate that it mately 4:00 PM, ASM nember) #1, the 2, the director of nursing, director of clinical services stant director of nursing was	F 6	89			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X	(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 05/10/2023	
NAME OF P	ROVIDER OR SUPPLIER		<u>'</u>	STREET ADDRESS, CITY, STATE, ZIP C	ODE	00/10/2020	
WESTBOR	T DELIA DII ITATIONI AL	UD NUIDEING CENTER		7300 FOREST AVE			
WESTPOR	RT REHABILITATION A	ND NORSING CENTER		RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 689	Continued From pag	ge 65 on was provided prior to exit.	F 6	889			
F 694 SS=E	Parenteral/IV Fluids CFR(s): 483.25(h)		F 6	594		5/31/23	
	with professional state accordance with phy comprehensive persisted the resident's goals. This REQUIREMEN by: Based on resident is review, staff interview review it was determ failed to provide care peripherally inserted intravenous line for survey sample, Resident #8 evidence dressing or PICC line (1). On the most recent admission assessmenterence date) of 13 scored 15 out of 15 for mental status) as resident was cognitive decisions. Section coxygen, dialysis and medications.	st be administered consistent indards of practice and in visician orders, the on-centered care plan, and and preferences. T is not met as evidenced interview, clinical record w and facility document a services to a central catheter (PICC) and of ten residents in the dents #8 and #9. (R8), the facility staff failed to hanges were performed to a ment with an ARD (assessment 2/19/2022, the resident on the BIMS (brief interview is sessment, indicating the vely intact for making daily of the order of R8 documented in part, in for R8 documented in part, indicating the part, is for R8 documented in part, is for R8 documented in part, is for R8 documented in part, indicating the part, indicating the part is for R8 documented in part, is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part, indicating the part is for R8 documented in part indicating the part is for R8 documented in part indicating the part is for R8 documented in part indicating the part is for R8 documented in part indicating the part indicating t		F694 Parenteral/IV fluids 1. Resident #8 no longer facility. Resident #9 the physician of 5/15/2023 physician order include day for PICC treath dressing changes and are operformed with documentate. 2. Current residents in the the potential to be affected conducted by the DON or current residents with PICC site to verify has physician to complete dressing change performed and has docume completed in clinical record 3. The SDC or designed licensed nurses on the procedure for PICC/IV site dressing changes, docume completed in the clinical record treatment per physician or site dressing change was part of the UM or designed with the UM or designed	was notified or revised to nent for currently being tion. e facility have . An audit designee on C/ IV access order with day ges, verify entation d. will educate all cess and and performing entation cord to verify der for PICC/IV performed.	n g y	

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 _			0.5	C 5/ 10/2023
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				73	00 FOREST AVE		
WESTPOF	RT REHABILITATION	AND NURSING CENTER		RI	CHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIE	' STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 694	Change needleles dressing change a securement device dressing change. a every Thu (Thursd 12/13/2022." Review of the eTA administration reconstruction reconstruction as ordered. Review 1/1/2023-1/31/202 line dressing was 6 1/12/2023. The ef 2/1/2023-2/28/202	eekly and PRN (as needed). s connector with weekly and after blood draw. If e is used, change at time of as needed AND every day shift ay) weekly. Order Date: R (electronic treatment ord) for R8 dated 022 failed to evidence the g was changed on 12/29/2022 ew of the eTAR for R8 dated 3 failed to evidence the PICC changed on 1/5/2023 and IAR for R8 dated 3 failed to evidence the PICC changed on 2/2/2023. The	F	694	verify residents with PICC/IV site have physician orders with day to perform dressing change and documentation in the clinical record to verify treatment w performed. Observation audits of 5 residents with PICC/IV site to verify dressing changed per procedure was followed and documentation completed clinical record weekly x 4 weeks then monthly x 2 months. Once the QAPI committee determines the problem no longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing is responsible for implementation of the pof correction. 5. Date of compliance 5/31/2023.	as d in	
	documentation that changed on 12/29, 2/2/2023. The comprehensive in part, "(Name of access. Created of "Interventions" it dechange per order. On 5/9/2023 at 1:0 conducted with LP LPN #5 stated that signing them off or if the eTAR was blothat the care was properties.						
	On 5/10/2023 at 2	:26 p.m., an interview was					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X:	3) DATE SURVEY COMPLETED
		495227	B. WING _			C 05/10/2023
	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		05/10/2023
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 694	conducted with LPN LPN #3 stated that F changed weekly and #3 stated that PICC documented in the peTAR. On 5/10/2023 at 4:0 conducted with LPN line dressings were stated that the dress computer to let them needed. LPN #9 stated the PICC line dressing the medications for I documented in the peTAR documented in the peTAR dated guidance on PICC line According to Lipping Practice 10th edition Catheter Maintenancin part, "Catheter: catheter, Dressing constinsertion, then were considered at 2 staff member) #1, and for nursing, ASM #3, services, ASM #4, a and ASM #8, regions made aware of the formal processing constinsertion in the percentage of the formal processing constinsertion in part, "Catheter: catheter, Dressing constinsertion, then were constituted to the percentage of the formal processing pro	(licensed practical nurse) #3. PICC line dressings were d assessed every shift. LPN line dressing changes were progress notes and on the 2 p.m., an interview was #9. LPN #9 stated that PICC changed weekly. LPN #9 sing changes came up on the n know when they were ated that they could change ngs but normally the RN ng when they were changing R9 and it would be progress notes. eripheral IV Site 13/13/2023 failed to provide ne dressing care. sott Manual of Nursing n, pg. 94 "Table 6-4 IV ce Guidelines" it documented Peripherally inserted central hange: 24 hours weekly" 5 p.m., ASM (administrative dministrator, ASM #2, director regional director of clinical ssistant director of nursing al director of operations were indings.	F6	94		
	No further information	on was provided prior to exit.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		l	C / 10/2023	
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226		110/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 694	line) is a type of cent called a central veno intravenous (IV) line. regular IV and goes at the heart or just inside the PICC line stays of where the arm bends than one line. The enwith a cap. This infort the website: https://kidshealth.org 2. For Resident #9 (I evidence dressing choose of the contract of the website of 3/2 at 10 out of 15 on the B mental status) assess resident was moderated aily decisions. Seed receiving IV (intravental stays of the website of 5/10/2023 at 8:45 conducted with R9 in observed in bed with right upper arm and at the bedside. Whe PICC line, R9 stated the dressing before bethey had done it. The physician orders order for PICC line did the comprehensive of the co	erted central catheter (PICC ral line. A central line (also us catheter) is like an But it is much longer than a all the way up to a vein near e the heart. The other end of utside of the body, usually It may divide into more d of each line is covered rmation was obtained from len/parents/picc-lines.html R9), the facility staff failed to anges to a PICC line. MDS (minimum data set), an int with an ARD (assessment 20/2023, the resident scored lims (brief interview for sment, indicating the tely impaired for making ion O documented R9 ous) medications. a.m., an interview was their room. R9 was a PICC line in place to the an infusion by portable pump in asked about care of the that the nurses had changed out was not sure of how often	F 69	34			

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 05/10/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226	•	J3/10/2023	
(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 694	on: 03/22/2023." The any interventions regard the eTAR (electronic record) for R9 dated 4/1/2023-4/30/2023 a failed to evidence Plant The progress notes of PICC line dressing of the progress notes of PICC line dressing weekly and #3 stated that PICC documented in the petark. On 5/10/2023 at 4:02 conducted with LPN line dressings were of stated that the dressing the progressing the dressing the dressing the medications for Find the progressing the medications for Find the progressing the p	atted on: 03/14/2023. Revision e care plan failed to evidence farding care of the PICC line. The treatment administration 3/1/2023-3/31/2023, and 5/1/2023-5/31/2023. The dressing changes. Tor R9 failed to evidence frances. Tor R9 failed to evi	F 6	94			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		(X3) DATE COMP	SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER	100221		STREET ADDRES	SS, CITY, STATE, ZIP CODE	05/	/10/2023
				7300 FOREST A	VE		
WESTPO	RT REHABILITATION A	ND NURSING CENTER		RICHMOND, V	/A 23226		
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F 726 SS=E	Competent Nursing CFR(s): 483.35(a)(3) §483.35 Nursing Se The facility must har the appropriate comprovide nursing and practicable physical well-being of each resident assessmer and considering the diagnoses of the factor accordance with the at §483.70(e). §483.35(a)(3) The factor	Staff (3)(4)(c) rvices we sufficient nursing staff with opetencies and skills sets to related services to assure attain or maintain the highest of the mental, and psychosocial esident, as determined by the sand individual plans of care number, acuity and continuous acuity and continuous accordance of the specific competencies are successful to the specific competencies are s		726			5/31/23
	This REQUIREMEN by: Based on staff inter review it was detern failed to evidence tr	IT is not met as evidenced view and facility document nined that the facility staff aining was completed for nursing staff reviewed.		1. Facili	mpetent Nursing Staff ity staff identified # 13, #14 in-service and the agency s #12, #15, #16 will receive		

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 _			l	C 10/2023	
NAME OF P	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 03/	10/2023	
					000 FOREST AVE			
WESTPOF	RT REHABILITATION ANI	D NURSING CENTER			ICHMOND, 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 726	Continued From page	e 71	F 7	26				
F 726	The findings include: The facility staff failed monitoring residents is cardiac drip medication licensed nursing staff nurse) #10, #11, #12, On 5/10/2023 at 8:40 licensed nursing staff training on the monitor receiving continuous medications. The samursing staff document medication administrative receiving Dobutamine by a CADD (portable for congestive heart for the list was provided member) #1, the adm for evidence of training staff. On 5/10/2023 at appropriate (registered nurse) #2, coordinator provided completed on 3/29/2014 nurses participating 6/21/2022 with 20 nurses	I to evidence training for receiving an intravenous on in their care for eight, LPN (licensed practical #13, #14, #15 and #16. a.m., a sample of 20 were chosen to review oring and care of residents intravenous cardiac drip mple was chosen from the nation on an electronic ation record of a resident e solution (1) intravenously intravenous infusion) pump aillure, in December of 2022. to ASM (administrative staff inistrator with the request g provided to the selected oximately 10:00 a.m., RN a staff development evidence of training 122 from the pharmacy with g, training completed on	F 7	26	training prior to assignment of residents with inotropic management. 6. Current residents in the facility have the potential to be affected. There are nother residents currently in the facility receiving inotropic management. 7. The SDC or designee will educate licensed nurses on the process for physician orders, assessing, monitoring and required documentation for resider receiving inotropic management and completion of competency checklist. 8. The UM or designee will assess weekly x 4 weeks then monthly x 2 months to verify residents receiving inotropic management have assigned staff that have completed education and their competency checklist. Once the QAPI committee determines the problem to longer exists, the reviews will be completed on a random basis. The Administrator or Director of Nursing are responsible for implementation of the profice correction. 9. Date of compliance 5/31/2023.	ve no all g nt		
	sheets provided failed LPN #10, #11, #12, # There were no advers the lack of documents On 5/10/2023 at 11:1	se events identified due to ed training. 7 a.m., an interview was						
	conducted with RN #2	2. RN #2 stated that they						

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			05/	10/2023
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				7	TREET ADDRESS, CITY, STATE, ZIP CODE 300 FOREST AVE RICHMOND, VA 23226		
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 726	had arranged a staff cardiac drips and the that they had comple load the cassette int monitor and had rec RN assessed and w #2 stated that the as documented their re hours on skilled note medication administ medication was infurplace. RN #2 stated monitoring vital sign pulse, intake and our assessing the IV site monitoring on the M RN's were trained to pump and the LPN's residual readings froughly. RN #2 stated RN when the cartrid RN #2 stated that the assessment, write a on the MAR in the achanged the cartridomade aware that LP #15 or #16 were not sheets provided. RI sheets and stated the they were able to find they were able to find they were agency staff and were agency staff and were agency staff and they were	sition since July of 2022 and inservice in December on a CADD pump. RN #2 stated ated hands on training, how to to the pump, how to read the eived examples of what the hat the LPN assessed. RN assigned nurse for the day sident assessments every 12 as, documented on the ration record that the that the sing and the pump was in a sing and the pump was in a second that the assigned nurse was a second and a second	F	726			

AND PLAN OF CORRECTION IDENTIFICATION NUI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING		C 05/10/2023		
NAME OF PROVIDER OR SUPPLIER WESTPORT REHABILITATION AND NURSING CENTER				STREET ADDRESS, CITY, STATE, ZIP COD 7300 FOREST AVE RICHMOND, VA 23226		5/10/2025	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD E		(X5) COMPLETION DATE	
F 726	conducted with OSM staffing coordinator. ensured that the nurs residents on cardiac the residents and the stated that admission or the assistant direct when there were resist that they would scheef for back up with the costated that they were CPR certified. The facility policy "Infrevised 02/2019 doct shall be provided with instructions regarding upon initial pump dispured in the facility policy "Active The facility p	dep.m., an interview was (other staff member) #7, When asked how they see assigned to work with drips had training to monitor a cardiac drips, OSM #7 as and the director of nursing tor of nursing let them know dents with cardiac drips so dule an RN around the clock competencies. OSM #7 working to get everyone fusion Devices/Pumps" Jumented in part, "Nurses a verbal and/or written grump operation and care pensing" Idministration of Inotropic 4/2022 documented in part, e responsible for ic therapy shall be indications for use; b. and diluents; c. side effects; d. rs; e. toxicities; f. tability; h. storage potential complications" Japan., ASM (administrative ministrator, ASM #2, director regional director of clinical sistant director of operations were	F 7	26			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495227	B. WING _			C 05/40/2022	
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 PREFIX TAG	(EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 726	Reference: (1) Dobutamine stimulimproves blood flow I better. Dobutamine i cardiac decompensal muscle. Dobutamine heart medicines have This information was	alates heart muscle and by helping the heart pump is used short-term to treat tion due to weakened heart is usually given after other is been tried without success. obtained from the website: m/mtm/dobutamine.html	F7				