STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

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E 000	Initial Comments An unannounced Emergency Preparedness COVID-19 Focused Survey was conducted offsite from 05/21/2020 through 05/28/2020, and onsite on 05/21/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted offsite from 05/21/2020 through 05/28/2020, and onsite on 05/21/2020 and 05 27/2020. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. On 05/21/2020, the census in this 225 certified bed facility was 130. Of the 130 current residents, 81 residents had tested positive for the COVID-19 virus. The survey sample consisted of six current resident reviews (Residents #1 through #6 and nine closed record review [Residents #7 through #15]. On 05/22/2020 at 6:18 p.m., immediate jeopardy was called and the the facility was notified. On 5/27/2020 at 11:59 a.m., immediate jeopardy was abated, and was lowered to a level 2 isolated.	F 000		
F 880 SS=J	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		5/28/20

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

Electronically Signed | 06/18/2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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F 880	Continued From page 1 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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F 880	Continued From page 2 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interviews, interviews with local health-department staff, review of facility documents, and clinical record review, it was determined, that the facility staff failed to ensure the implementation of infection control practices and precautions, to prevent the spread of infection, and communicable disease during an identified outbreak of Coronavirus (COVID 19) for three of 37 residents residing on the 300 Unit, (Residents, #2, #4, and #5). The facility staff failed to implement standard and droplet precautions to prevent the spread of COVID 19* to residents that had tested negative for COVID-19, and who resided in the same room with a COVID 19 positive roommate on the 300 unit. The facility staff failed to pull privacy curtains the full length of the bed in three of three resident rooms in which COVID-19 positive and negative residents resided together in the same room, for	F 880	The filing of the plan of correction does not constitute an admission that the alleged deficiencies did, in fact, exist. This plan of corrections is filed as evidence to comply with requirements of participation and continue to provide high quality resident centered care. F880 1. Corrective Action for those residents found to be affected by the alleged deficient practice. 3 rooms with Covid positive and negative residents had privacy curtains that were not pulled close. Upon notification, privacy curtains of the 3 rooms were pulled closed. Residents that were tested positive were cohorted with positive residents. The residents that had tested negative coming out of a room where the roommate tested	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

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F 880	Continued From page 3 Residents, #1, #2, #3, #4, #5 and #6. Cohorting COVID-19 positive and negative residents together and failing to pull privacy curtains the full length of the bed and to implement droplet precautions created the likelihood of residents being exposed to and contracting COVID-19. At the time of the survey, there had already been nine deaths of residents, who had contracted COVID 19. Review of the facility LTC [Long Term Care] Respiratory Surveillance List" [for COVID-19 Outbreaks], submitted by the facility for review by fax on 5/28/2020, revealed the facility census was 130 current residents, 81 residents had tested positive for the COVID-19 virus and nine had expired, (Residents #7, #8, #9, #10, #11, #12, #13, #14 and # 15). This failure resulted in Immediate Jeopardy. The State Agency informed the facility on 05/22/2020 at 6:18 p.m. of the Immediate Jeopardy situation. On 05/27/2020 at 11:59 a.m., the Immediate Jeopardy was abated and lowered to a level II isolated. The findings include: On 05/21/2020 at 5:08 p.m., the survey team conducted an onsite, abbreviated, remote FICS (focused infection control survey) at the facility. As a part of the survey process, the survey team conducted observations and interviewed facility staff members and staff from the local health department. On 5/21/20 at 5:25 p.m., an observation was conducted of resident rooms on the 300 hall of the facility. Observation of the resident room	F 880	positive, were moved to a private room or cohorted with other like residents. Besides cohorting the residents who tested negative, these residents are routinely monitored for signs and symptoms of COVID-19. 2. Corrective Actions taken for residents with potential to be affected by alleged deficient practice. Audit on current residents that are COVID-19 positive were cohorted with positive residents. The residents that had tested negative coming out of a room where the roommate tested positive, were moved to a private room or cohorted with other like residents. Besides cohorting the residents who tested negative, these residents are routinely monitored for signs and symptoms of COVID-19. Newly admitted and readmitted residents with confirmed COVID-19 who have not met criteria for discontinuation of Transmission-Based Precautions should go to the designated COVID-19 care unit. Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit. 3. Systemic Changes put into place to ensure the alleged deficient practice does not recur. In-service for facility staff that provide direct resident care will be completed by the Director of Nursing or designee on pulling the privacy curtain between the residents on precautions and on confirming Residents that are positive	

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	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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F 880	Continued From page 4 shared by Residents #1 [COVID-19 positive] and #2 [COVID-19 negative] revealed, both residents lying in single beds. The curtain between the two beds was open (drawn back to the wall allowing visualization of both residents from the doorway). Observation of room shared by Residents #3 [COVID-19 positive] and #4 [COVID-19 negative] revealed the two residents lying in single beds. The curtain between the two beds was observed open. An isolation cart containing gloves, gowns and linen bags was observed outside of the doorway of Resident #3 and Resident #4's room. Observation of the room shared by Residents #5 [COVID-19 negative] and #6 [COVID-19 positive] revealed a semi-private room and a resident lying in the bed closest to the doorway, and the second resident sitting in a wheelchair in the center of the room between the two beds wearing a facemask. The curtain between the two beds was observed open behind the resident in the wheelchair. Further observation of the 300 hall revealed seven vacant rooms. On 05/21/2020 at 4:57 p.m. through 6:11 p.m., an onsite visit and observation was completed. The long-term care supervisor was notified of the survey team's observations and a conference call was completed with two additional supervisors and the survey team. On 5/22/20 at 9:11 a.m., a telephone interview was conducted with CNA [certified nursing assistant] # 3 who worked on the 300 hallway. When asked if they were aware of any residents in the same room, where one resident was COVID-19 positive and the other resident COVID-19 negative CNA # 3 stated, "Yes, we do have positive and negative together." When	F 880	for COVID-19 are cohorted with positive residents. The residents that had tested negative coming out of a room where the roommate tested positive, were moved to a private room or cohorted with other like residents for 14 days. Besides cohorting the residents who tested negative, these residents are routinely monitored for signs and symptoms of COVID-19. Newly admitted and readmitted residents with confirmed COVID-19 who have not met criteria for discontinuation of Transmission-Based Precautions should go to the designated COVID-19 care unit. Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of Transmission-Based Precautions can go to a regular unit. 4. Monitoring of corrective action to ensure the alleged deficient practice does not recur. The Director of Nursing or designee will complete an audit of residents on precautions to verify the cohorting of Residents that have tested positive for COVID-19 and Residents that were exposed to COVID-19 Residents are in a private room or cohorted with other exposed residents for 14 days privacy curtains are pulled between residents 3 x weekly x 4 weeks and then monthly x 3 months. The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed. 5. Date of compliance- 5/29/2020	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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F 880	Continued From page 5	F 880		

asked what procedure they follow to prevent the spread of the virus from the COVID-19 positive resident to the COVID-19 negative resident CNA # 3 stated, "I take care of negative resident first, change all of my PPE [personal protective equipment] then do care for the positive resident." When asked about the cubicle curtain CNA # 3 stated that the curtain was to be pulled between the residents.

On 5/22/20 at 9:22 a.m., a telephone interview was conducted with CNA # 4 who worked on the 300 hallway. When asked if they were aware of any residents in the same room, where one resident was COVID-19 positive and the other resident COVID-19 negative CNA # 4 stated, "Yes, we do have positive and negative in the same room." When asked what procedure they follow to prevent the spread of the virus from the COVID-19 positive resident to the COVID-19 negative resident CNA # 4 stated, "Put all of PPE gear on first, then I take care of negative person first, then change PPE gear, wash hands Put on new PPE and poncho." When asked about the cubicle curtain CNA # 4 stated that the curtain was to be pulled between the residents.

On 05/22/2020 at 9:35 a.m., a telephone interview was conducted with OSM # 7, nurse supervisor of [Name of City] health department and OSM # 8, epidemiologist. OSM # 7 and OSM # 8 had been in contact with [name of facility] and OSM # 7 was last on site on 04/09/2020. OSM #7 and #8 were asked about any recommendations they had made to the facility. OSM # 7 and OSM # 8 stated that they made recommendations after recent testing at the facility and finding some residents testing positive for COVID-19 and other resident residing in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

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F 880	Continued From page 6	F 880		

same rooms, who tested negative for COVID-19. OSM #8 and #7 stated they recommended to the facility that the facility shelter the resident's in-place because the roommate who was negative, was already exposed to the COVID-19 virus and moving the residents to separate them could spread the virus.

On 05/22/2020 at 11:00 a.m., a telephone interview was conducted with ASM [administrative staff member] # 1, facility administrator and ASM # 2, interim director of nursing and infection control coordinator. When asked how facility staff knows which residents are COVID-19 positive or negative ASM # 2 stated they notify the staff each morning, there is a list at the units and it is reflected on their 24-hour report. ASM #2 was asked what they were doing to reduce the spread of COVID-19 within the facility when there is COVID-19 positive and negative residing in the same room. ASM # 2 stated the CNAs [certified nursing assistants] provide care to the negative resident first, change their PPE [personal protective equipment], wash their hands, put on new PPE before providing care the COVID-19 positive resident, the resident's beds are six feet apart and the curtain is pulled between the beds. ASM # 1 and ASM # 2 further stated that they had an outbreak on the 300 hall. They stated that 21 of the 37 residents on the 300 hall tested positive for COVID-19, 13 were negative, two test results were pending and one resident refused to be tested. When asked if they had been in contact with OSM # 7 and OSM # 8 and if they had discussed any recommendations ASM # 2 stated yes, that they were in contact with OSM # 7 by telephone and that they recommended the facility shelter the resident's in place. When asked what explanation was provided for not moving a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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F 880	Continued From page 7	F 880		

resident who tested positive for COVID-19 or a resident who tested negative for COVID-19 who were residing in the same room, ASM # 1 and ASM # 2 stated that they were told the more they try to move the residents around the virus will spread. When asked if there was discussion about pulling the privacy curtains to divide the residents in the room ASM # 1 and ASM # 2 stated that OSM # 7 and OSM # 8 did not say anything about it. When asked if they had received written documentation about the sheltering the residents in place ASM # 1 and ASM # 2 stated no.

A remote review of the clinical records for Residents #1, #2, #3, #4, #5, and #6, revealed the following:

Remote review of Resident #1's clinical record revealed, Resident # 1 was admitted to the facility on 01/28/2020 with diagnoses that included but were not limited to: COVID-19 [1], dementia [2] and diabetes [3]. Resident # 1's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 04/30/20, coded Resident # 1 as scoring a four on the brief interview for mental status (BIMS) of a score of 0 - 15, four - being severely impaired of cognition for making daily decisions. Resident # 1 was coded as requiring extensive assistance of one staff member for activities of daily living.

The comprehensive care plan for Resident #1 dated 03/16/2020 documented in part, "Focus. I am at risk for psychosocial well-being concern r/t [related to] medically imposed restrictions r/t COVID-19 precautions. I am at risk for s/sx [signs and symptoms]. Positive for COVID-19 (5/19) [05/19/2020]. Revision on: 05/23/2020."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 8	F 880		

Under "Interventions it documented in part, "Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar [Sic.] throat, respiratory issues. Date Initiated: 03/16/2020."

The nurse's note for Resident # 1 dated 05/19/2020 documented in part, "22:32 [10:32 p.m.] COVID-19 results pending. Remains asymptomatic [4]."

The nurse's note for Resident # 1 dated 05/21/2020 documented in part, "04:41 [4:41 a.m.] Continues on droplet precautions [5] for COVID-19." At 11:48 a.m., the nurse's note documented in part, "COVID test for resident was positive, MD/NP [medical director/Nurse Practitioner] made aware ...RP [responsible party] called made aware of COVID test results ..."

Remote review of Resident #2's clinical record revealed, Resident # 2 was admitted to the facility on 06/26/2018 and a readmission on 05/16/2020 with diagnoses that included but were not limited to: stroke, dementia and congestive heart failure [6]. Resident # 2's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 04/09/2020, coded Resident # 2 as scoring a 10 on the brief interview for mental status (BIMS) of a score of 0 - 15, 10 - being moderately impaired of cognition for making daily decisions. Resident # 2 was coded as requiring extensive assistance of one staff member for activities of daily living.

The comprehensive care plan for Resident #2 dated 03/16/2020 documented in part, "Focus. I am at risk for psychosocial well-being concern r/t [related to] medically imposed restrictions r/t

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

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F 880	Continued From page 9	F 880		

COVID-19 precautions. I am at risk for s/sx [signs and symptoms]. Negative for COVID-19 (5/19) [05/19/2020]. Revision on: 05/23/2020." Under "Interventions it documented in part, "Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar Sic. throat, respiratory issues. Date Initiated: 03/16/2020."
The "Physician/Practitioner Progress Note" note for Resident # 2 dated 05/20/2020 documented in part, "13:07 [1:07 p.m.] COVID-19 test pending. Resident is asymptomatic today."

The "Physician/Practitioner Progress Note" note for Resident # 2 dated 05/21/2020 documented in part, "12:35 p.m., Assessment/Plan: COVID-19 test negative." At 2:46 p.m., the "Physician/Practitioner Progress Note" documented in part, "Telephoned the resident's RP, [Name of RP] to discuss the resident's recent negative COVID-19 test results from 5/19 [05/19/2020]."

Remote review of Resident #3's clinical record revealed, Resident # 3 was admitted to the facility on 03/21/2020 with diagnoses that included but were not limited to: COVID-19, stroke, aphasia [7] and dementia with behavioral disturbance [8]. Resident # 3's most recent MDS (minimum data set), an admission assessment with an ARD (assessment reference date) of 03/27/2020, coded Resident # 3 as scoring a two on the brief interview for mental status (BIMS) of a score of 0 - 15, two - being severely impaired of cognition for making daily decisions. Resident # 3 was coded as requiring extensive assistance of one staff member for activities of daily living.

The comprehensive care plan for Resident #3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

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F 880	Continued From page 10	F 880		

dated 03/21/2020 documented in part, "Focus. I am at risk for psychosocial well-being concern r/t [related to] medically imposed restrictions r/t COVID-19 precautions. I am at risk for s/sx [signs and symptoms]. Positive for COVID-19 (5/19) [05/19/2020]. Revision on: 05/23/2020." Under "Interventions it documented in part, "Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar Sic. throat, respiratory issues. Date Initiated: 03/21/2020."

The nurse's note for Resident # 3 dated 05/19/2020 documented in part, "22:35 [10:35 p.m.] COVID-19 results pending."

The nurse's note for Resident # 3 dated 05/21/2020 documented in part, "15:04 [3:05 p.m.], COVID results positive, resident has not had any sx [symptoms], N/V/D [nausea/vomit/diarrhea], sob [shortness of breath], or cough, MD/NP [medical director/Nurse Practitioner] and RP [responsible party] aware."

Remote review of Resident #4's clinical record revealed, Resident # 4 was admitted to the facility on 10/16/2018 with diagnoses that included but were not limited to: pneumonia, Parkinson's disease [9] and high blood pressure. Resident # 4's most recent MDS (minimum data set), an annual assessment with an ARD (assessment reference date) of 04/16/2020, coded Resident # 4 as scoring a three on the brief interview for mental status (BIMS) of a score of 0 - 15, three - being severely impaired of cognition for making daily decisions. Resident # 4 was coded as requiring extensive assistance of one staff member for activities of daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 11	F 880		

The comprehensive care plan for Resident #4 dated 03/16/2020 documented in part, "Focus. I am at risk for psychosocial well-being concern r/t [related to] medically imposed restrictions r/t COVID-19 precautions. I am at risk for s/sx [signs and symptoms]. Negative for COVID-19 (5/19) [05/19/2020]. Revision on: 05/23/2020." Under "Interventions it documented in part, "Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar Sic. throat, respiratory issues. Date Initiated: 03/16/2020."

The "Physician/Practitioner Progress Note" for Resident # 4 dated 05/20/2020 documented in part, "14:40 [2:40 p.m.] Assessment/Plan: COVID-19 test pending."

The nurse's note for Resident # 4 dated 05/21/2020 documented in part, "00:08 [12:08 a.m.], Remains on droplet precautions related to COVID-19."

The "Physician/Practitioner Progress Note" for Resident # 4 dated 05/21/2020 documented in part, "12:41 [12:41 p.m.], COVID-19 test negative." At 14:55 [2:55 p.m.], the "Physician/Practitioner Progress Note" documented, "Resident's RP [responsible party] [Name of RP-relationship], notified this afternoon of the resident's negative COVID-19 test results.

Remote review of Resident #5's clinical record revealed, Resident # 5 was admitted to the facility on 09/07/2013 with diagnoses that included but were not limited to: hemiplegia [10], aphasia [11], and dysphagia [12]. Resident # 5's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12	F 880		

05/20/2020, coded Resident # 5 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 5 was coded as requiring limited assistance of one staff member for activities of daily living.

The comprehensive care plan for Resident #5 dated 03/16/2020 documented in part, "Focus. I am at risk for psychosocial well-being concern r/t [related to] medically imposed restrictions r/t COVID-19 precautions. I am at risk for s/sx [signs and symptoms]. Negative for COVID-19 (5/19) [05/19/2020]. Revision on: 05/23/2020." Under "Interventions it documented in part, "Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar Sic. throat, respiratory issues. Date Initiated: 03/16/2020."

The "Physician/Practitioner Progress Note" for Resident # 5 dated 05/18/2020 documented in part, "14:30 [2:30 p.m.] Screen for COVID-19."

The nurse's note for Resident # 5 dated 05/19/2020 documented in part, "14:29 [2:49 p.m.] RP [responsible party]: left message in reference to COVID-19 testing, Awaiting return call."
The nurse's note for Resident # 5 dated 05/21/2020 documented in part, "17:17 [5:17 p.m.], COVID results were negative, call placed to RP, message left on answering machine."

Remote review of Resident #6's clinical record revealed, Resident # 6 was admitted to the facility on 04/10/2017 and a readmission on 03/02/2020 with diagnoses that included but were not limited to: COVID-19 [5], cerebral palsy [13], and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 13	F 880		

hemiplegia [10]. Resident # 6's most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 03/08/2020, coded Resident # 6 as scoring a 15 on the brief interview for mental status (BIMS) of a score of 0 - 15, 15 - being cognitively intact for making daily decisions. Resident # 6 was coded as requiring extensive assistance of one staff member for activities of daily living.

The comprehensive care plan for Resident #6 dated 03/16/2020 documented in part, "Focus. I am at risk for psychosocial well-being concern r/t [related to] medically imposed restrictions r/t COVID-19 precautions. I am at risk for s/sx [signs and symptoms]. Positive for COVID-19 (5/19) [05/19/2020]. Revision on: 05/23/2020." Under "Interventions it documented in part, "Observe for s/s of COVID-19/document and promptly report s/sx: fever, coughing, sneezing, soar Sic. throat, respiratory issues. Date Initiated: 03/16/2020."

The nurse's note for Resident # 6 dated 05/19/2020 documented in part, "14:46 [2:46 p.m.] RP [responsible party] notified in reference to COVID-19 testing with consent, MD [medical director] notified."

The nurse's note for Resident # 6 dated 05/21/2020 documented in part, "17:19 [5:19 p.m.], COVID results were positive, resident was made aware, call placed to [Name of Relative], message left on answering machine."

On 5/22/2020 at approximately 11:52 a.m., ASM [administrative staff member] #1, the administrator, was contacted by telephone and asked for the standard used for sheltering

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 14	F 880		

residents in place [COVID 19 positive and negative in the same room].

On 05/22/2020 at 1:05 p.m., ASM # 1 provided this surveyor with the following email, "The conversation was had with the DOH [Department of Health] about sheltering in place on Wing 3 was on Friday May 15, 2020 until all of the Residents were tested and results in. The decision was based on the concerns that there was a widespread outbreak and even those that would be negative would already have been exposed and all would be treated as presumed positive.

[Name of OSM # 7] provided this:
Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive). Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of SARS-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, HCP should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Cloth face coverings are not considered PPE and should only be worn by HCP for source control, not when PPE is indicated.
Have a plan for how roommates, other residents, and HCP who may have been exposed to an individual with COVID-19 will be handled (e.g.,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 15	F 880		

monitor closely, avoid placing unexposed residents into a shared space with them)."

On 05/22/2020 at 1:11 p.m., a telephone conference was conducted with OSM [other staff member] # 9, medical director, deputy director of [Name of City and County] Health District, Long Term Care [LTC] Supervisor and this surveyor. OSM # 9 was asked if they [local health department] talked with or visited the facility. OSM # 9 stated that there were a set of written recommendations provided to the facility. OSM #9 was informed of the observation that was conducted onsite at the facility on 05/21/2020 and of the interview conducted with OSM # 7, nurse supervisor of [Name of City] health department and OSM # 8, epidemiologist on 05/22/2020 at 9:35 a.m., by telephone. OSM #9 was informed of the information the facility provided from the local health department in regards to residents sheltering in place (COVID positive and negative in the same room). OSM # 9 acknowledged this information did not address sheltering in place. OSM #9 stated if there is an even risk of exposure, they [local health department] are on board with putting them [residents] together, i.e. if there are two roommates who have been tested negative but with positive roommates, the two negative roommates can be moved together. OSM # 9 further stated, "We can suggest that they move the exposed residents." OSM # 9 stated that she needed to locate the guidance and would send this to the LTC Supervisor and surveyor.

On 05/22/2020, at 4:55 p.m., a second telephone conference, was conducted with, OSM #9, the LTC [long term care] Supervisor, Director of OLC [Office of licensure and Certification], Assistant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 16	F 880		

Director of OLC and this surveyor, regarding, CMS [Centers for Medicare & Medicaid Services], regulations and the CDC's (Centers for Disease Control and Prevention's] guidance, for cohorting residents who are positive or negative for COVID-19. OSM #9 stated that they were trying to get a feel from the early April 04/04/2020 CDC guidance, "Evaluate and Manage Residents with Symptoms of Respiratory Infection." OSM #9 stated that the 04/30/2020 CDC guidance specifically stated that exposed individuals needed to be moved from the COVID-19 positive residents. OSM #9 stated that because there is an element of judgement involved, that moving the exposed resident out of the room poses more of a danger and more of a shuffling of the residents and could cause more "blenderizing. I would say that is why the guidance doesn't say must or will." OSM #9 informed that facilities must ensure that they are complying with all CMS and CDC guidance related to infection control and the 05/19/2020 CDC's guidance, which documents facilities "Have a plan for how roommates, other residents and HCP [health care providers] who may have been exposed to an individual with COVID-19 will be handled. OSM #9 was informed that the word plan, on the 5/19/2020, CDC guidance links and connects to the 04/30/2020, CDC guidance, titled, "Responding to Coronavirus (COVID-19) in Nursing Homes, Considerations for the Public Health Response to COVID-19 in Nursing Homes". The 04/30/2020, CDC guidance** documents under the header, "Resident with new-onset suspected or confirmed COVID-19", in part the following, "If the resident is confirmed to have COVID-19, regardless of symptoms, they should be transferred to the designated COVID-19 care unit." "Exposed residents may be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 17	F 880		

permitted to room share with other exposed residents if space is not available for them to remain in a single room." OSM #9 then stated now, those seven to ten words, yes.

A remote review of the Line List for COVID-19 Outbreaks, submitted by the facility for review by fax on 5/28/2020, revealed the facility census was 130 current residents, 81 residents had tested positive for the COVID-19 virus and nine had expired. The remote review of the facility's "LTC [Long Term Care] Respiratory Surveillance List" [for COVID-19 Outbreaks], and a remote review of clinical records revealed the following documented entries for Residents #7, #8, #9, #10, #11, #12, #13, #14 and # 15.

On the line list the following was documented, "Name of resident [Resident #7], Unit [number], room[number], Onset Date, 4/4/20, Fever (Y/N),Y, Cough (Y/N),N, Myalgia (Y/N), Y, Shortness of Breath (Y/N), Y, COV-2 test result (+/-), + [positive], Flu Test Result (+/-).-[dash], Chest Xray (+/-),-[dash], Hospitalized (Y/N), Y [yes], Died (Y/N), 4/07." Under the section titled Outcome During Outbreak: a handwritten note beside this documented, "Died in hospital."

Remote review of Resident #7's clinical record revealed, Resident #7 was admitted to the facility on 9/27/18 with diagnoses that include, but are not limited to diabetes mellitus [3] and obsessive compulsive disorder [14]. On the most recent MDS [minimum data set], an quarterly assessment with an assessment reference date of 3/26/2020, Resident #7 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS [brief interview for mental status]. A review

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 18	F 880		

of Resident #7's clinical record revealed a physician note dated 4/5/2020 documenting that the resident had test for COVID-19 and was "Instructed not to leave his room." RP [responsible party] informed of change in condition. Further review revealed a nurse practitioner note dated 4/7/2020 documenting "will transfer resident to hospital for further evaluation and treatment of fevers, diarrhea, hypoxic respiratory failure. Further review revealed a nurse note dated 4/7/2020 documenting the resident was admitted to the hospital and RP called and updated.

On the line list the following was documented, "Name of Resident [Resident #8], Unit [number], room[number], Onset Date, 4/10/20, Fever (Y/N),Y, Cough (Y/N), not noted, Myalgia (Y/N), not noted, Shortness of Breath (Y/N), Y, COV-2 test result (+/-), + [positive], Chest Xray (+/-),- [dash], Hospitalized (Y/N), Y [yes], Died (Y/N), 4/10." Under the section titled Outcome During Outbreak: a handwritten note beside this documented, "Admitted to hospital, expired."

Remote review of Resident #8's clinical record revealed, Resident #8 was admitted to the facility on 3/10/20 with diagnoses that include, but are not limited to chronic obstructive pulmonary disease [15] and chronic respiratory failure [16]. On the most recent MDS, a five [5] day Medicare assessment with an assessment reference date of 3/16/2020, Resident #8 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS. A review of Resident #8's clinical record revealed a nurse's note dated 4/9/2020 documenting that the resident had shortness of breath and oxygen saturations of 85% on 4 liters

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 19	F 880		

of oxygen. Resident's sister informed of his condition. Further review revealed a nurse practitioner note on 4/9/20 "Due to resident intermittent respiratory distress/labored breathing, tachypnea, tachycardia-irregular heart rate, resident will be sent out via 911 to hospital emergency room for further evaluation." Further review revealed a nurse's note dated 4/10/20 "Patient admitted to hospital with diagnosis of hypoxia."

On the line list the following was documented, "Name of Resident [Resident #9], Unit [number], room[number], Onset Date, no notation, Fever (Y/N), no notation, Cough (Y/N), no notation, Myalgia (Y/N), no notation, Shortness of Breath (Y/N), no notation, COV-2 test result (+/-), + [positive], Flu Test Result (+/-). No notation, Chest Xray (+/-), no notation, Hospitalized (Y/N), Y [yes], Died (Y/N), Y (yes)." A handwritten note beside this documented, "Hospital expired of vascular."

Remote review of Resident #9's clinical record revealed, Resident #9 was admitted to the facility on 3/26/20 with diagnoses that include, but are not limited to diabetes mellitus [3] and stroke. On the most recent MDS, a 5 day Medicare assessment with an assessment reference date of 4/1/2020, Resident #9 was coded as having no cognitive impairment for making daily decisions, having scored 14 out of 15 on the BIMS. A review of Resident #9's clinical record revealed a nurse's note dated 4/13/2020 documenting that the resident had a "change in condition with abdominal pain or edema, decrease in fluid/food intake and nausea/vomiting with Temperature of 97.1." Further review revealed a nurse's note dated 4/14/20 documenting "Therapy notified nurse of resident left lower extremity feeling cold

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 20	F 880		

to the touch." Further review revealed an activities aide note dated 4/14/20 documenting "virtual family visit with resident and son, she was actively engaged in video chat with him." Further review revealed a nurse's note dated 4/15/20 documenting "Resident transferred to medical center."

On the line list the following was documented, Name of Resident [Resident #10], Unit [number], room[number], Onset Date, 4/7/20, Fever (Y/N),Y, Cough (Y/N),N, Myalgia (Y/N), Y, Shortness of Breath (Y/N), Y, COV-2 test result (+/-), + [positive], Flu Test Result (+/-).no notation, Chest Xray (+/-), N, Hospitalized (Y/N), N [no], Died (Y/N), 4/07." Under the section titled Outcome During Outbreak: COV test pending, admitted to hospital CVOID +, expired in hospital."

Remote review of Resident #10's clinical record revealed, Resident #10 was admitted to the facility on 3/27/20 with diagnoses that include, but are not limited to partial intestinal obstruction and mild cognitive impairment. On the most recent MDS, a 5-day Medicare assessment with an assessment reference date of 4/1/2020, Resident #10 was coded as having severe cognitive impairment for making daily decisions, having scored 01 out of 15 on the BIMS. A review of Resident #10's clinical record revealed a nurse practitioner note dated 4/10/2020 documenting that the resident had test for COVID-19 with pending results and fever of 102.8 on 4/8/20 afebrile since then. Further review revealed a nurse's note dated 4/10/210 "Resident has a low grade temp 99.6 call placed to on call service, unable to contact RP (responsible party) at this time. Further review revealed a social services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 21	F 880		

note dated 4/13/20 "Contacted RP to clarify resident's code status. RP states resident is to be a FULL CODE. Covid droplet precautions remain." Further review revealed a nurse's note dated 4/16/20 "Resident alert but not responding as usual. Oxygen saturation 89% on two liters of oxygen. Resident transported to the hospital for further evaluation."

On the line list the following was documented, "Name of Resident [Resident #11], Unit [number], room[number], Onset Date, no notation, Fever (Y/N), no notation, Cough (Y/N), no notation, Myalgia (Y/N), no notation, Shortness of Breath (Y/N), no notation, COV-2 test result (+/-), + [positive], Flu Test Result (+/-). No notation, Chest Xray (+/-), no notation, Hospitalized (Y/N), Y [yes], Died (Y/N), Y [yes]." A handwritten note beside this documented, "Died in hospital."

Remote review of Resident #11's clinical record revealed, Resident #11 was admitted to the facility on 4/7/20 with diagnoses that include, but are not limited to sepsis [17] and chronic kidney disease [18]. On the most recent MDS, a 5-day Medicare assessment with an assessment reference date of 4/13/2020, Resident #11 was coded as having moderately impaired cognition for making daily decisions, having scored 9 out of 15 on the BIMS. A review of Resident #11's clinical record revealed a nurse practitioner note dated 4/15/2020 documenting that the resident recently had been hospitalized for severe sepsis [infection] and MSSA [methicillin-susceptible staphylococcus aureus]bacteremia [an infection], amputation and osteomyelitis. Further review revealed a nurse's note dated 4/16/20 documented "Resident in respiratory distress,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 22	F 880		

oxygen saturations at 47% on two liters of oxygen, temp 100.9 BP [blood pressure] 203/106. Oxygen increased to four liters with no increase in oxygen saturation. Nurse Practitioner notified and RP notified. RP wanted resident transferred to the emergency room. Further review revealed a nurse's note dated 4/16/20 documented "Emergency room informed that resident was admitted for COVID 19."

On the line list the following was documented, "Name of Resident [Resident #12], Unit [number], room[number], Onset Date, no notation, Fever (Y/N),Y, Cough (Y/N), no notation, Myalgia (Y/N), no notation, Shortness of Breath (Y/N), no notation, COV-2 test result (+/-), + [positive], Flu Test Result (+/-).-[dash], Chest Xray (+/-),-[dash], Hospitalized (Y/N), Y [yes], Died (Y/N), 4/23." Under the section titled Outcome During Outbreak: a handwritten note beside this documented, "At Home Hospice Care 4/20/20, Home 4/22/20, expired 4/23/20."

Remote review of Resident #12's clinical record revealed, Resident #12 was admitted to the facility on 3/27/20 with diagnoses that include, but are not limited to diabetes mellitus [3] and dementia [2]. On the most recent MDS, a 5-day Medicare assessment with an assessment reference date of 4/3/2020, Resident #12 was coded as having severe cognitive impairment for making daily decisions, having scored 03 out of 15 on the BIMS. A review of Resident #12's clinical record revealed a nurse's note dated 4/19/2020 documenting that the resident remained on droplet precautions maintained for COVID-19 positive results. Further review revealed a nurse's note documented that hospice admitted resident with family approval. Nurse's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 23	F 880		

note on 4/21/20 documented that RP was made aware of Hospice order for scheduled Morphine and Ativan. Further, review revealed nurse's note of 4/22/20 documenting "Reviewed discharge instructions at length with resident's daughter with social services present. No concerns voiced at this time. Belongings packed, bagged and placed into family car. Resident picked up by ambulance and taken home."

On the line list the following was documented, "Name of Resident [Resident #13], Unit [number], room[number], Onset Date, no notation, Fever (Y/N), no notation, Cough (Y/N), no notation, Myalgia (Y/N), no notation, Shortness of Breath (Y/N), no notation, COV-2 test result (+/-), + [positive], Flu Test Result (+/-). No notation, Chest Xray (+/-), no notation, Hospitalized (Y/N), no notation, Died (Y/N), 4/23." A handwritten note beside this documented, "Hospice expired 4/28/20."

Remote review of Resident #13's clinical record revealed, Resident #13 was admitted to the facility on 3/7/20 with diagnoses that include, but are not limited to stroke and heart failure. On the most recent MDS, a 5-day Medicare assessment with an assessment reference date of 3/10/2020, Resident #13 was coded as having severe cognitive impairment for making daily decisions, having scored 6 out of 15 on the BIMS. A review of Resident #13's clinical record revealed a nurse's note dated 4/24/2020 documenting that the resident was been admitted to hospice. Further review revealed a nurse's note dated 4/26/20 documenting "resident's condition continues to decline. Oxygen saturation 85% on two liters. Further review revealed a nurse's note dated 4/27/20 oxygen at three liters with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 24	F 880		

saturation of 94%, family updated. Further review revealed a nurse's note dated 4/28/20 documented "Resident without pulse, respiration or blood pressure. Hospice nurse contacted family. Patient expired at 2:49 PM [p.m.]."

On the line list the following was documented, "Name of Resident #14], Unit [number], room[number], Onset Date, no notation, Fever (Y/N), Y [Yes], Cough (Y/N), no notation, Myalgia (Y/N), no notation, Shortness of Breath (Y/N), no notation, COV-2 test result (+/-), + [positive], Flu Test Result (+/-). No notation, Chest Xray (+/-), no notation, Hospitalized (Y/N), N [yes], Died (Y/N), Y 5/16." Under the section titled Outcome During Outbreak: a handwritten note beside this documented, "Died in hospital."

Remote review of Resident #14's clinical record revealed, Resident #14 was admitted to the facility on 2/7/20 with diagnoses that include, but are not limited to stroke and dementia [2]. On the most recent MDS, a quarterly assessment with an assessment reference date of 5/15/20, Resident #14 was coded as having moderately impaired cognition for making daily decisions, having scored 10 out of 15 on the BIMS. A review of Resident #14's clinical record revealed a nurse's note dated 5/15/2020 documenting that the resident was too lethargic to take medications. Resident in coma like state and is DNR [do not resuscitate]. Family aware. Further review revealed a nurse practitioner's note dated 5/16/20 documenting "Acutely ill with hypoxia, tachycardia, fever. COVID test pending. Resident is DNR, wife agrees to start comfort meds [medications]. Unresponsive, resident appears imminent. Further review revealed a nurse's note dated 5/16/20 documenting "resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 25	F 880		

is without blood pressure, pulse and respirations. Daughter notified of death. Patient expired at 7:59 PM.

On the line list the following was documented, "Name of Resident [Resident #15], Unit [number], room[number], Onset Date, no notation, Fever (Y/N), no notation, Cough (Y/N), no notation, Myalgia (Y/N), no notation, Shortness of Breath (Y/N), no notation, COV-2 test result (+/-), + [positive], Flu Test Result (+/-). No notation, Chest Xray (+/-), no notation, Hospitalized (Y/N), Y [yes], Died (Y/N), 5/16/20.

Remote review of Resident #15's clinical record revealed, Resident #15 was admitted to the facility on 3/31/20 with diagnoses that include, but are not limited to diabetes mellitus [3] and obsessive compulsive disorder [14]. On the most recent MDS, a 5-day Medicare assessment with an assessment reference date of 4/6/2020, Resident #15 was coded as having severe cognitive impairment for making daily decisions, having scored 6 out of 15 on the BIMS. A review of Resident #15's clinical record revealed a nurse practitioner's note dated 5/16/2020 documenting that the resident had a marked decline in functional status. Oxygen saturation 90% on three liters oxygen now increased to 95% on five liters oxygen. Daughter agrees to no hospital admissions, will consult with hospice. COVID test positive on 4/12/20, negative on 5/6/20 and 5/7/20. Further review revealed a nurse's note dated 5/20/20 documenting "Resident exhibiting no signs of life, pulse and breath sounds absent. Time of death 6:25 AM [a.m.]."

A review of the facility policy, "COVID-19 Isolation - Initiating Contact/Droplet Precautions"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 26	F 880		

documented in part, "Droplet Precautions. 2. Residents on droplet precautions will be placed in a private room if possible. a. When a private room is not available, residents may share a room with a resident infected with the same microorganism or with limited risk factors. b. When a private room is not available and cohorting is not achievable, a curtain will be used and a distance of at least 6 feet of space will be maintained between the infected resident [sic] his or her roommate."

On 05/22/2020 at 6:11 p.m., after the completion of the call with the local health department, a conference call was completed with two LTC supervisors and the survey team. It was determined that the facility's failure to implement infection control practices to prevent the spread of a communicable disease (COVID-19), resulted in a situation of IJ (immediate jeopardy).

On 05/22/2020 at 6:18 p.m., the administrator was reached by phone, and was informed of the concern for IJ.

On 05/22/2020 at 7:36 p.m., the surveyor received a call from ASM (administrative staff member) # 5, the regional director of operations. ASM #5 asked how IJ could be called without the surveyors being onsite at the facility and not staying onsite until the IJ was cleared. This surveyor then offered to contact the supervisor to speak with him for further explanation.

On 05/22/2020 at 7:44 p.m., a telephone conference call was conducted with ASM # 5, the Long Term Care Supervisor and this surveyor regarding the IJ. The supervisor explained the process and timeline for reviewing and accepting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 27	F 880		

the facility's plan of correction, review of credible evidence and abatement of the IJ. ASM # 5 stated he did not disagree with the citation, it was warranted. He stated that the curtains should have been pulled [between the residents identified at the time of the onsite observation] but he did not agree with the level.

On 05/26/2020, the facility presented the following plan of correction.

"1. On 5/21/20 at 5:26 PM, surveyors entered the facility and observed COVID-19 positive residents cohorted with COVID-19 negative residents in rooms with cubicle curtains between the beds not pulled. The facility's mitigation plan, in place of cohorting positive with positive residents, is to have the cubicle curtains completely pulled to separate residents; this was observed to be non-compliant in resident rooms with both COVID-19 positive and negative residents.

Three rooms with Covid positive and negative residents had privacy curtains that were not pulled close. Upon notification, privacy curtains of the 3 rooms were pulled closed. Residents that were tested positive were cohorted with positive residents. The residents that had tested negative coming out of a room where the roommate tested positive, were moved to a private room or cohorted with other "like" residents. Besides cohorting the residents who tested negative, these residents are routinely monitored for signs and symptoms of COVID-19.

2. Audit on current residents that are COVID-19 positive were cohorted with positive residents. The residents that had tested negative coming

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 28	F 880		

out of a room where the roommate tested positive, were moved to a private room or cohorted with other "like" residents. Besides cohorting the residents who tested negative, these residents are routinely monitored for signs and symptoms of COVID-19. Newly admitted and readmitted residents with confirmed COVID-19 who have not met criteria for discontinuation of transmission-based precautions should go to the designated COVID-19 care unit. Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of transmission-based precautions can go to a regular unit.

3. In-service for facility staff that provide direct resident care will be completed by the Director of Nursing or designee on pulling the privacy curtain between the residents on precautions and on confirming Residents that are positive for COVID-19 are cohorted with positive residents. The residents that had tested negative coming out of a room where the roommate tested positive, were moved to a private room or cohorted with other "like" residents for 14 days. Besides cohorting the residents who tested negative, these residents are routinely monitored for signs and symptoms of COVID-19. Newly admitted and readmitted residents with confirmed COVID-19 who have not met criteria for discontinuation of transmission-based precautions should go to the designated COVID-19 care unit. Newly admitted and readmitted residents with COVID-19 who have met criteria for discontinuation of transmission-based precautions can go to a regular unit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 29	F 880		

4. Director of Nursing or designee will complete an audit of residents on precautions to verify the cohorting of Residents that have tested positive for COVID-19 and Residents that were exposed to COVID-19 Residents are in a private room or cohorted with other exposed residents for 14 days privacy curtains are pulled between residents 3 x weekly x 4 weeks and then monthly x 3 months. The audits will be reviewed in the quality assurance and performance improvement process for tracking/trending and revisions as needed.
Date of Compliance 5/26/2020."

On 05/26/2020 at 3:55 p.m., the facility's POC (plan of correction) was accepted, and ASM #1 was informed of the acceptance. The facility presented credible evidence that the POC had been implemented, including evidence that employee education regarding staff drawing the privacy curtains between residents and cohorting COVID-19 negative resident together and COVID-19 positive resident together. The survey team remotely reviewed the credible evidence, and completed staff interviews by phone, verifying full implementation of the POC.

On 05/27/2020 at 10:45 a.m., the survey team entered the facility to make observations and observe to verify that POC had been fully implemented. These observations revealed no concerns with the facility's implementation of an infection control program to prevent the spread of communicable disease, COVID-19.

On 05/27/2020 at 11:59 a.m., ASM #1 was notified that the IJ was abated.

References:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 30	F 880		

Information for infection control and COVID in long-term care facilities obtained from the CDC website:
"https://www.cms.gov/files/document/4220-covid-19-long-term-care-facility-guidance.pdf
https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html
https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-recommendations.html#adhere"

* "Coronaviruses are a large family of viruses found in many different species of animals, including camels, cattle, and bats. The new strain of coronavirus identified as the cause of the outbreak of respiratory illness in people first detected in Wuhan, China, has been named SARSCoV-2. (Formerly, it was referred to as 2019-nCoV.) The disease caused by SARS-CoV-2 has been named COVID-19." This information was obtained from the website: https://www.nccih.nih.gov/health/in-the-news-coronavirus-and-alternative-treatments

[1] A general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis." Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.

[2] A loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior. This information was obtained from the website: https://medlineplus.gov/ency/article/000739.htm.

[3] A chronic disease in which the body cannot regulate the amount of sugar in the blood. This information was obtained from the website:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 31	F 880		

https://www.nlm.nih.gov/medlineplus/ency/article/001214.htm.

[4] Means there are no symptoms. This information was obtained from the website: https://medlineplus.gov/ency/article/002217.htm

[5] For patients known or suspected to be infected with pathogens transmitted by respiratory droplets that are generated by a patient who is coughing, sneezing, or talking ..." This information is taken from the website https://www.cdc.gov/infectioncontrol/basics/transmission-based-precautions.html.

[6] A condition in which the heart can't pump enough blood to meet the body's needs. It means that your heart is not able to pump blood the way it should. It can affect one or both sides of the heart. This information was obtained from the website: https://medlineplus.gov/heartfailure.html.

[7] A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html

[8] Psychological symptoms and behavioral abnormalities are common and prominent characteristics of dementia. This information was obtained from the website: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3181717/.

[9] A type of movement disorder. This information was obtained from the website:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 32	F 880		

https://www.nlm.nih.gov/medlineplus/parkinsonsdisease.html.

[10] Loss of muscle function in part of your body. It happens when something goes wrong with the way messages pass between your brain and muscles. This information was obtained from the website: https://medlineplus.gov/paralysis.html.

[11] A disorder caused by damage to the parts of the brain that control language. It can make it hard for you to read, write, and say what you mean to say). This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/aphasia.html.

[12] A swallowing disorder. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/swallowingdisorders.html.

[13] A group of disorders that affect a person's ability to move and to maintain balance and posture. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/cerebralpalsy.html.

[14] A common, chronic and long-lasting disorder in which a person has uncontrollable, reoccurring thoughts (obsessions) and behaviors (compulsions) that he or she feels the urge to repeat over and over. This information was obtained from the website: http://www.nimh.nih.gov/health/topics/obsessive-compulsive-disorder-ocd/index.shtml.

[15] Disease that makes it difficult to breath that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495227	A. BUILDING _____ B. WING _____	C 05/28/2020

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33	F 880		

can lead to shortness of breath. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/copd.html.

[16] When not enough oxygen passes from your lungs into your blood. This information was obtained from the website: https://www.nlm.nih.gov/medlineplus/respiratoryfailure.html.

[17] An illness in which the body has a severe, inflammatory response to bacteria or other germs. This information was obtained from the website: https://medlineplus.gov/ency/article/000666.htm.

[18] Kidneys are damaged and can't filter blood as they should. This information was obtained from the website: https://medlineplus.gov/chronickidneydisease.html.