	-	ID HUMAN SERVICES			FOI	RM APPROVED
STATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DA	IO. 0938-0391 TE SURVEY MPLETED
		495227	B. WING		0	C 5/28/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	0		
F 000	COVID-19 Focused S from 05/21/2020 thro on 05/21/2020. The fa compliance with 42 C	g-Term Care Facilities.	F 00	0		
	was conducted offsite 05/28/2020, and onsi 27/2020. Significant	VID-19 Focused Survey e from 05/21/2020 through te on 05/21/2020 and 05 corrections are required for FR Part 483 Federal Long nts.				
F 880 SS=J	bed facility was 130. 81 residents had test virus. The survey sal resident reviews (Res nine closed record re #15]. On 05/22/2020 jeopardy was called a notified. On 5/27/2021 jeopardy was abated 2 isolated. Infection Prevention 8		F 88	0		5/28/20
	infection prevention a designed to provide a comfortable environm	blish and maintain an Ind control program I safe, sanitary and Inent and to help prevent the Insmission of communicable				
ABORATORY	 DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE		(X6) DATE
Electroni	cally Signed					06/18/2020

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.

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		495227	B. WING				_ 28/2020	
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
WESTPOR	RT REHABILITATION AN	D NURSING CENTER			00 FOREST AVE ICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 880	 §483.80(a) Infection program. The facility must esta and control program (a minimum, the follow §483.80(a)(1) A system reporting, investigating and communicable distaff, volunteers, visite providing services unarrangement based unconducted according accepted national states §483.80(a)(2) Written procedures for the probut are not limited to: (i) A system of surveil possible communicable diseases reported; (iii) Standard and trant to be followed to preview (iv) When and how isor resident; including but (A) The type and durate depending upon the init involved, and (B) A requirement that least restrictive possible communicable (b) and (b) A requirement that least restrictive possible (c) and (c) and	brevention and control blish an infection prevention (IPCP) that must include, at ving elements: em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following ndards; e standards, policies, and ogram, which must include, lance designed to identify ble diseases or can spread to other can spread to other can spread to other can spread to other can spread of infections; blation should be used for a t not limited to: ation of the isolation, infectious agent or organism t the isolation should be the ble for the resident under the s under which the facility ees with a communicable	F	880				

Facility ID: VA0270

If continuation sheet Page 2 of 34

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/23/202 FORM APPROVE OMB NO. 0938-039			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED				
		495227	B. WING		C 05/28/2020			
	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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETION			
F 880	contact will transmit t (vi)The hand hygiene by staff involved in di §483.80(a)(4) A syste identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update the This REQUIREMENT by: Based on observation with local health-depa facility documents, ar was determined, that ensure the implement practices and precau of infection, and com identified outbreak of three of 37 residents (Residents, #2, #4, al The facility staff failed droplet precautions to COVID 19* to resider for COVID-19, and w with a COVID 19 pos unit. The facility staff the full length of the b	s or their food, if direct he disease; and procedures to be followed rect resident contact. em for recording incidents acility's IPCP and the ten by the facility. Ile, store, process, and s to prevent the spread of view. Int an annual review of its ir program, as necessary. T is not met as evidenced on, staff interviews, interviews artment staff, review of nd clinical record review, it the facility staff failed to tation of infection control tions, to prevent the spread municable disease during an Coronavirus (COVID 19) for residing on the 300 Unit,	F 880	The filing of the plan of correction not constitute an admission that the alleged deficiencies did, in fact, exi- plan of corrections is filed as evide comply with requirements of partici- and continue to provide high qualit resident centered care. F880 1. Corrective Action for those res- found to be affected by the alleged deficient practice. 3 rooms with Co- positive and negative residents had privacy curtains that were not pulle close. Upon notification, privacy cu- of the 3 rooms were pulled closed. Residents that were tested positive cohorted with positive residents. T residents that had tested negative out of a room where the roommate	e sist. This nce to ipation y sidents vid durtains e were che coming			

Facility ID: VA0270

		MEDICAID SERVICES				<u>O. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		495227	B. WING			С
	ROVIDER OR SUPPLIER	495221		STREET ADDRESS, CITY, STATE, Z		/28/2020
NAIVIE OF Pr	COUDER OR SUPPLIER			7300 FOREST AVE		
WESTPOR	T REHABILITATION ANI	D NURSING CENTER		RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED		(X5) COMPLETIC DATE
F 880	Continued From page	2	F 88	0		
1 000			F 00		a privata raam ar	
	Residents, #1, #2, #3	, #4, #5 anu #0.		positive, were moved to cohorted with other like	-	
	Cohorting COVID-19	positive and negative		Besides cohorting the r		
		d failing to pull privacy		tested negative, these r		
	curtains the full length			routinely monitored for		
	implement droplet pre	ecautions created the		symptoms of COVID-19).	
		s being exposed to and				
	•	9. At the time of the survey,				
	•	en nine deaths of residents,		2. Corrective Actions		
		COVID 19. Review of the		with potential to be affe		
	facility LTC [Long Ter	COVID-19 Outbreaks],		deficient practice. Audit		
		ity for review by fax on		residents that are COVI cohorted with positive re		
		he facility census was 130		residents that had teste		
		residents had tested positive		out of a room where the		
		is and nine had expired,		positive, were moved to		
	(Residents #7, #8, #9	, #10, #11, #12, #13, #14		cohorted with other like	residents.	
	and # 15).			Besides cohorting the re	esidents who	
	This failure resulted in	n Immediate Jeopardy.		tested negative, these r		
				routinely monitored for	-	
	The State Agency info			symptoms of COVID-19	-	
	05/22/2020 at 6:18 p.			and readmitted resident		
		On 05/27/2020 at 11:59 a.m.,		COVID-19 who have no		
	to a level II isolated.	rdy was abated and lowered		discontinuation of Trans Precautions should go t		
				COVID-19 care unit. Ne	•	
	The findings include:			readmitted residents wi		
				have met criteria for dis		
	On 05/21/2020 at 5:0	8 p.m., the survey team		Transmission-Based Pr	ecautions can go	
		abbreviated, remote FICS		to a regular unit.	-	
		ntrol survey) at the facility.				
		y process, the survey team		3. Systemic Changes	· ·	
		ons and interviewed facility		ensure the alleged defic		
		aff from the local health		not recur. In-service for		
	department.			provide direct resident of		
	On 5/21/20 at 5:25 a	m., an observation was		completed by the Direct designee on pulling the		
	-	m., an observation was trooms on the 300 hall of		between the residents of		
	the facility. Observation				n precautions and	1

Facility ID: VA0270

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							<u>O. 0938-03</u>
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ° ′		CONSTRUCTION		E SURVEY PLETED
			A. DOILDING				С
		495227	B. WING				5/28/2020
IAME OF PF	ROVIDER OR SUPPLIER	L	I	STI	REET ADDRESS, CITY, STATE, ZIP CODE	1 00	
				730	00 FOREST AVE		
VESTPOR	T REHABILITATION AN	D NURSING CENTER		RI	CHMOND, VA 23226		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETIC
F 880	Continued From page	e 4	F 88	30			
		#1 [COVID-19 positive] and			for COVID-19 are cohorted with positiv	/e	
	#2 [COVID-19 negati				residents. The residents that had test		
	residents lying in sing				negative coming out of a room where		
		s was open (drawn back to alization of both residents			roommate tested positive, were moved a private room or cohorted with other I		
	•	Dbservation of room shared			residents for 14 days. Besides cohorti		
		VID-19 positive] and #4			the residents who tested negative, the		
	[COVID-19 negative]			residents are routinely monitored for s			
	lying in single beds.	The curtain between the two			and symptoms of COVID-19. Newly	-	
		open. An isolation cart			admitted and readmitted residents with		
		wns and linen bags was			confirmed COVID-19 who have not me	et	
		he doorway of Resident #3 om. Observation of the			criteria for discontinuation of Transmission-Based Precautions shou	uld	
	room shared by Resi				go to the designated COVID-19 care u		
		DVID-19 positive] revealed a			Newly admitted and readmitted reside		
		d a resident lying in the bed			with COVID-19 who have met criteria		
		y, and the second resident			discontinuation of Transmission-Based	b	
		r in the center of the room			Precautions can go to a regular unit.		
		s wearing a facemask. The					
		wo beds was observed open			4. Monitoring of corrective action to		
		n the wheelchair. Further 0 hall revealed seven vacant			ensure the alleged deficient practice d not recur. The Director of Nursing or	oes	
	rooms.				designee will complete an audit of		
					residents on precautions to verify the		
	On 05/21/2020 at 4:5	57 p.m. through 6:11 p.m., an			cohorting of Residents that have teste	d	
		vation was completed. The			positive for COVID-19 and Residents t		
	-	visor was notified of the			were exposed to COVID-19 Residents		
		vations and a conference call			in a private room or cohorted with othe		
	•	wo additional supervisors			exposed residents for 14 days privacy		
	and the survey team.				curtains are pulled between residents weekly x 4 weeks and then monthly x		
	On 5/22/20 at 9.11 a	m., a telephone interview			months. The audits will be reviewed in		
	was conducted with (quality assurance and performance		
		orked on the 300 hallway.			improvement process for tracking/tren	ding	
	-	vere aware of any residents			and revisions as needed.	-	
	in the same room, wh	nere one resident was					
	COVID-19 positive ar						
	COVID-19 negative C have positive and neg	CNA # 3 stated, "Yes, we do			5. Date of compliance- 5/29/2020		

Facility ID: VA0270

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 01/23/2021 FORM APPROVED MB NO. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION		3) DATE SURVEY COMPLETED	
		495227	B. WING			C 05/28/2020		
NAME OF P	ROVIDER OR SUPPLIER		•	STR	EET ADDRESS, CITY, STATE, ZIP COE)E		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER) FOREST AVE HMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETION DATE	
F 880	asked what procedur spread of the virus for resident to the COVIE # 3 stated, "I take car change all of my PPE equipment] then do c When asked about th stated that the curtain the residents. On 5/22/20 at 9:22 a. was conducted with 0 300 hallway. When a any residents in the s resident was COVID- resident COVID-19 n "Yes, we do have pos same room." When a follow to prevent the COVID-19 positive re negative resident CN gear on first, then I ta first, then change PP new PPE and poncho cubicle curtain CNA # was to be pulled betw On 05/22/2020 at 9:3 interview was conduc supervisor of [Name of and OSM # 8, epiden # 8 had been in conta OSM # 7 was last on #7 and #8 were aske recommendations aft facility and finding so	e they follow to prevent the om the COVID-19 positive D-19 negative resident CNA e of negative resident first, E [personal protective are for the positive resident." e cubicle curtain CNA # 3 h was to be pulled between m., a telephone interview CNA # 4 who worked on the tasked if they were aware of ame room, where one 19 positive and the other egative CNA # 4 stated, sitive and negative in the asked what procedure they spread of the virus from the sident to the COVID-19 A # 4 stated, "Put all of PPE ake care of negative person E gear, wash hands Put on D." When asked about the # 4 stated that the curtain veen the residents. 5 a.m., a telephone ted with OSM # 7, nurse of City] health department hiologist. OSM # 7 and OSM act with [name of facility] and site on 04/09/2020. OSM	F	880				

Facility ID: VA0270

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					<u>10. 0938-039</u>
		· · ·			TE SURVEY MPLETED
		A. BUILDING	3		
	105007	D WING			С
	495227	B. WING			5/28/2020
OVIDER OR SUPPLIER				DE	
T REHABILITATION AN	D NURSING CENTER				
			,		(XE)
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETIOI DATE
Continued From page	e 6	E 88	30		
		1.00			
	-				
•					
On 05/22/2020 at 11.	00 a m a telephone				
	-				
	•				
	-				
	-				
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	-				
same room. ASM # 2	stated the CNAs [certified				
nursing assistants] pr	ovide care to the negative				
protective equipment], wash their hands, put on				
	•				
	-				
	-				
	-				
-					
	-				
-					
sneiter the resident's	in place. When asked what				
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page same rooms, who test OSM #8 and #7 state facility that the facility in-place because the negative, was already virus and moving the could spread the viru On 05/22/2020 at 11: interview was conduct staff member] # 1, fac # 2, interim director of control coordinator. I knows which resident negative ASM # 2 state morning, there is a lis reflected on their 24-1 asked what they were of COVID-19 within th COVID-19 positive at same room. ASM # 2 nursing assistants] pr resident first, change protective equipment new PPE before prov positive resident, the apart and the curtain ASM # 1 and ASM # an outbreak on the 30 of the 37 residents or for COVID-19, 13 we were pending and on tested. When asked with OSM # 7 and OS discussed any recom yes, that they were in telephone and that the	CORRECTION IDENTIFICATION NUMBER: 495227 COVIDER OR SUPPLIER T REHABILITATION AND NURSING CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 6 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 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	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495227 B. WING	CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495227 B. WING COVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP COL 7300 FOREST AVE RICHMOND, VA 23226 IDENTIFICATION AND NURSING CENTER STREET ADDRESS, CITY, STATE, ZIP COL 7300 FOREST AVE RICHMOND, VA 23226 IDENTIFICATION OF DEFICIENCIES (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSCIDENTIFIVING INFORMATION) PREFIX TAG PREFIX (EACH CORRECTIVE ACTIO CROSS-REFERENCED OT HIP (EACH CORRECTIVE ACTIO CROSS-REFERENCED OT HIP REGULATORY OR LSCIDENTIFIVING INFORMATION) F 880 Continued From page 6 same rooms, who tested negative for COVID-19. OSM #8 and #7 stated they recommended to the facility that the facility sheller 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. F 880 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 ther sidents 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 uport. ASM #2 was asked what they were doing to reduce the spread of 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 residents on the 300 hall. They stated that 21 of the 37 residents on the 300 hall. They stated the 21 positive residen	CORRECTION IDENTIFICATION NUMBER: A BUILDING Conversion 495227 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 700 FOREST AVE STREET ADDRESS, CITY, STATE, ZIP CODE 1200 FOREST AVE RCHMOND, VA 32226 SUMMARY STREMENT OF DEFICIENCES ID PECHADISTICATION AND NURSING CENTER ID RECHADREST AVE STREET RCHMOND, VA 32226 Continued From page 6 ID Same rooms, who tested negative for COVID-19. Preserve OSM #8 and #7 stated they recommended to the facility that the facility shelter the resident's in-place because the roommande who was negative, was already exposed to the COVID-19. Virus and moving the residents to separate them could spread the virus. F 880 On 05/22/202 at 11:00 a.m., a telephone interview was conducted with ASM (administrative staff member) 1, facility administrative staff member) 1, facility administrative staff member 1, facility administrative staff member 1, facility advective residing in the saked 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 need on the 300 hall. They stated that 21 of the ASM #2 further stated that they head an outbrack on the 300 hall. They stated that 21 of the 37 resident frust, change their PPE [personal protective equipment], wash their hands, put on new PPE before providing care the COVID-19 positive resident frust be beds. ASM #1 and ASM # 2 further stated that they had an outbrack on the 3

Facility ID: VA0270

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED C	
	IRS FOR MEDICARE & MEDICAID SERVICES T OF DEFICIENCIES OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING 495227 B. WING PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZI 7300 FOREST AVE RICHMOND, VA 23226 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED DEFICIE			/28/2020			
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
WESTPO	RT REHABILITATION ANI	D NURSING CENTER					
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	resident who tested p resident who tested n were residing in the s ASM # 2 stated that the try to move the resider spread. When asked about pulling the priva- residents in the room stated that OSM # 7 a anything about it. Wh received written docu sheltering the residen ASM # 2 stated no. A remote review of the Residents #1, #2, #3, the following: Remote review of Re- revealed, Resident # on 01/28/2020 with di- were not limited to: C and diabetes [3]. Ress (minimum data set), a an ARD (assessment coded Resident # 1 a interview for mental s - 15, four - being sever for making daily decis coded as requiring ex staff member for active The comprehensive of dated 03/16/2020 doc am at risk for psychos [related to] medically COVID-19 precaution [signs and symptoms]	ositive for COVID-19 or a egative for COVID-19 who ame room, ASM # 1 and hey were told the more they ents around the virus will if there was discussion acy curtains to divide the ASM # 1 and ASM # 2 and OSM # 8 did not say hen asked if they had mentation about the its in place ASM # 1 and e clinical records for #4, #5, and #6, revealed sident #1's clinical record 1 was admitted to the facility agnoses that included but OVID-19 [1], dementia [2] ident # 1's most recent MDS a quarterly assessment with reference date) of 04/30/20, s scoring a four on the brief tatus (BIMS) of a score of 0 erely impaired of cognition sions. Resident # 1 was itensive assistance of one	F	880			

Facility ID: VA0270

If continuation sheet Page 8 of 34

		ND HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/23/202 RM APPROVEI	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495227	B. WING			C 05/28/2020		
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE			
WESTPOF	RT REHABILITATION AN	D NURSING CENTER						
04015		TATEMENT OF DEFICIENCIES		RIC	HMOND, VA 23226 PROVIDER'S PLAN OF CORREC		()(5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE	
F 880	Continued From page	e 8	F 8	80				
1 000		it documented in part,	FO	000				
		OVID-19/document and						
		fever, coughing, sneezing,						
	soar [Sic.] throat, res Initiated: 03/16/2020	piratory issues. Date "						
	The numeric mate for	Decident # 4 dated						
	The nurse's note for	nted in part, "22:32 [10:32						
		Ilts pending. Remains						
	asymptomatic [4]."							
		Resident # 1 dated hted in part, "04:41 [4:41 roplet precautions [5] for						
	-	3 a.m., the nurse's note						
		"COVID test for resident was						
	positive, MD/NP [me							
	-	wareRP [responsible party]						
	called made aware o	f COVID test results"						
		esident #2's clinical record						
		2 was admitted to the facility						
		readmission on 05/16/2020						
	÷	ncluded but were not limited and congestive heart failure						
		ost recent MDS (minimum						
		assessment with an ARD						
	(assessment referen	ce date) of 04/09/2020,						
		as scoring a 10 on the brief						
		status (BIMS) of a score of 0						
	÷	erately impaired of cognition sions. Resident # 2 was						
	÷ .	xtensive assistance of one						
	staff member for activ							
	-	care plan for Resident #2						
		cumented in part, "Focus. I						
		social well-being concern r/t						
	Irelated to Imedically	imposed restrictions r/t						

Facility ID: VA0270

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 01/23/2021 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495227	B. WING		_		C 28/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
WESTPOR	RT REHABILITATION AND	D NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	COVID-19 precaution [signs and symptoms] (5/19) [05/19/2020]. If Under "Interventions if "Observe for s/s of CO promptly report s/sx: f soar Sic. throat, respi Initiated: 03/16/2020.' The "Physician/Practif for Resident # 2 dated part, "13:07 [1:07 p.m Resident is asymptom The "Physician/Practif for Resident # 2 dated part, "12:35 p.m., Ass test negative." At 2:4 "Physician/Practitione documented in part, " RP, [Name of RP] to on negative COVID-19 te [05/19/2020]." Remote review of Rest revealed, Resident # on 03/21/2020 with di were not limited to: Co and dementia with be Resident # 3's most re- set), an admission as (assessment reference coded Resident # 3 at interview for mental si - 15, two - being sever for making daily deciss coded as requiring ex- staff member for activ	s. I am at risk for s/sx J. Negative for COVID-19 Revision on: 05/23/2020." it documented in part, DVID-19/document and fever, coughing, sneezing, ratory issues. Date ' tioner Progress Note" note d 05/20/2020 documented in D. COVID-19 test pending. hatic today." tioner Progress Note" note d 05/21/2020 documented in sessment/Plan: COVID-19 6 p.m., the er Progress Note" Telephoned the resident's discuss the resident's recent est results from 5/19 sident #3's clinical record 3 was admitted to the facility agnoses that included but OVID-19, stroke, aphasia [7] havioral disturbance [8]. ecent MDS (minimum data sessment with an ARD te date) of 03/27/2020, s scoring a two on the brief tatus (BIMS) of a score of 0 rely impaired of cognition tions. Resident # 3 was tensive assistance of one	F 880				

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 01/23/2021 APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	i í		CONSTRUCTION		(X3) DATE COMP	SURVEY LETED
		495227	B. WING			_		C 28/2020
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, ST	ATE, ZIP CODE	-	
WESTPOR	RT REHABILITATION ANI	D NURSING CENTER			300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORRE) CROSS-REFERE	EPLAN OF CORRECTION CTIVE ACTION SHOULD B NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	am at risk for psychos [related to] medically COVID-19 precaution [signs and symptoms] (5/19) [05/19/2020]. I Under "Interventions i "Observe for s/s of CO promptly report s/sx: 1 soar Sic. throat, respi Initiated: 03/21/2020." The nurse's note for F 05/19/2020 document p.m.] COVID-19 results had any sx [symptom [nausea/vomit/diarrhe breath], or cough, MD Practitioner] and RP [Remote review of Res revealed, Resident # on 10/16/2018 with di were not limited to: pr disease [9] and high t 4's most recent MDS annual assessment w reference date) of 04/ 4 as scoring a three of mental status (BIMS) being severely impair	aumented in part, "Focus. I social well-being concern r/t imposed restrictions r/t s. I am at risk for s/sx J. Positive for COVID-19 Revision on: 05/23/2020." t documented in part, DVID-19/document and rever, coughing, sneezing, ratory issues. Date Resident # 3 dated red in part, "22:35 [10:35 ts pending." Resident # 3 dated red in part, "15:04 [3:05 positive, resident has not s], N/V/D a], sob [shortness of /NP [medical director/Nurse responsible party] aware." sident #4's clinical record 4 was admitted to the facility agnoses that included but neumonia, Parkinson's blood pressure. Resident # (minimum data set), an ith an ARD (assessment 16/2020, coded Resident # n the brief interview for of a score of 0 - 15, three - ed of cognition for making dent # 4 was coded as assistance of one staff	F	880				

Facility ID: VA0270

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	-	ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 01/23/2021 ORM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		ONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495227	B. WING				C 05/28/2020
	ROVIDER OR SUPPLIER	D NURSING CENTER		730	EET ADDRESS, CITY, STATE, ZIP COE 0 FOREST AVE CHMOND, VA 23226	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	The comprehensive of dated 03/16/2020 doc am at risk for psychos [related to] medically COVID-19 precaution [signs and symptoms (5/19) [05/19/2020]. Under "Interventions "Observe for s/s of Co promptly report s/sx: soar Sic. throat, respi Initiated: 03/16/2020. The "Physician/Practi Resident # 4 dated 00 part, "14:40 [2:40 p.m COVID-19 test pendin The nurse's note for F 05/21/2020 documenta a.m.], Remains on dr COVID-19." The "Physician/Practi Resident # 4 dated 00 part, "12:41 [12:41 p. negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation of the resident's negative." At 14:55 [2 "Physician/Practitioned documented, "Residee [Name of RP-relation]	care plan for Resident #4 cumented in part, "Focus. I social well-being concern r/t imposed restrictions r/t ns. I am at risk for s/sx]. Negative for COVID-19 Revision on: 05/23/2020." it documented in part, OVID-19/document and fever, coughing, sneezing, iratory issues. Date " itioner Progress Note" for 5/20/2020 documented in n.] Assessment/Plan: ng." Resident # 4 dated ted in part, "00:08 [12:08 oplet precautions related to itioner Progress Note" for 5/21/2020 documented in m.], COVID-19 test 2:55 p.m.], the	F	880			

Facility ID: VA0270

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED
STATEMENT (OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			PLETED
		495227	B. WING				C 28/2020
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WESTRO	RT REHABILITATION AN				7300 FOREST AVE		
WESTFOR	T REHABILITATION AN	D NORSING CENTER			RICHMOND, VA 23226		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5) COMPLETION
PREFIX TAG		Y MUST BE PRECEDED BY FULL _SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		DATE
					DEFICIENCY)		
E 000		10	_				
F 880	Continued From page		F	880	0		
		esident # 5 as scoring a 15 for mental status (BIMS) of					
		being cognitively intact for					
		s. Resident # 5 was coded					
	as requiring limited as						
	member for activities	of daily living.					
	The comprehensive of	are plan for Resident #5					
		cumented in part, "Focus. I					
		social well-being concern r/t					
		imposed restrictions r/t					
	-	is. I am at risk for s/sx]. Negative for COVID-19					
		Revision on: 05/23/2020."					
	Under "Interventions						
		OVID-19/document and					
		fever, coughing, sneezing,					
	soar Sic. throat, respi Initiated: 03/16/2020.						
	initiatioa. 00, 10,2020.						
		tioner Progress Note" for					
		5/18/2020 documented in					
	part, "14:30 [2:30 p.m	n.] Screen for COVID-19."					
	The nurse's note for F	Resident # 5 dated					
	05/19/2020 documen	ted in part, "14:29 [2:49					
		e party]: left message in					
		19 testing, Awaiting return					
	call." The nurse's note for I	Resident # 5 dated					
		ted in part, "17:17 [5:17					
		were negative, call placed to					
	RP, message left on a	answering machine."					
	Remote review of Re	sident #6's clinical record					
		6 was admitted to the facility					
		readmission on 03/02/2020					
		ncluded but were not limited					
	to: COVID-19 [5], cer	ebral palsy [13], and					

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		ID HUMAN SERVICES MEDICAID SERVICES			F	NTED: 01/23/2021 ORM APPROVED 3 NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	TIPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495227	B. WING			C 05/28/2020
NAME OF P	ROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE,	ZIP CODE	
WESTPOR	RT REHABILITATION AN	D NURSING CENTER		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 PREFI TAG	PROVIDER'S PLA X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 880	hemiplegia [10]. Resi (minimum data set), a an ARD (assessment 03/08/2020, coded R on the brief interview a score of 0 - 15, 15 - making daily decision as requiring extensive member for activities The comprehensive of dated 03/16/2020 doo am at risk for psychol [related to] medically COVID-19 precaution [signs and symptoms (5/19) [05/19/2020]. Under "Interventions "Observe for s/s of C promptly report s/sx: soar Sic. throat, respi Initiated: 03/16/2020. The nurse's note for R 05/19/2020 documen p.m.] RP [responsible to COVID-19 testing of director] notified." The nurse's note for R 05/21/2020 documen p.m.], COVID results made aware, call plac message left on answ On 5/22/2020 at appr [administrative staff n	dent # 6's most recent MDS a quarterly assessment with reference date) of esident # 6 as scoring a 15 for mental status (BIMS) of being cognitively intact for as. Resident # 6 was coded e assistance of one staff of daily living. care plan for Resident #6 cumented in part, "Focus. I social well-being concern r/t imposed restrictions r/t as. I am at risk for s/sx]. Positive for COVID-19 Revision on: 05/23/2020." it documented in part, OVID-19/document and fever, coughing, sneezing, tratory issues. Date " Resident # 6 dated ted in part, "14:46 [2:46 e party] notified in reference with consent, MD [medical Resident # 6 dated ted in part, "17:19 [5:19 were positive, resident was ced to [Name of Relative], vering machine."	F	880		

Facility ID: VA0270

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<u>OEITER</u>	3 FOR MEDICARE &	MEDICAID SERVICES				O. 0938-039
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	· · · ·	E SURVEY IPLETED
		495227	B. WING			С
		493227	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	05	5/28/2020
NAME OF PI	ROVIDER OR SUPPLIER					
WESTPOF	RT REHABILITATION AN	ID NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 880	Continued From pag	e 14	F 88	30		
		OVID 19 positive and	1.00			
	negative in the same	roomj.				
		05 p.m., ASM # 1 provided				
	-	e following email, "The				
		d with the DOH [Department tering in place on Wing 3				
		5, 2020 until all of the				
		ed and results in. The				
	decision was based of	on the concerns that there				
		utbreak and even those that				
	-	ould already have been				
	exposed and all wou positive.	ld be treated as presumed				
	[Name of OSM # 7] p	provided this:				
		residents in the facility who				
		vill be handled (e.g., transfer				
	to single room, imple					
		Precautions, prioritize for				
		OVID-19 unit if positive).				
		lity who develop symptoms ID-19 could be moved to a				
		results of SARS-CoV-2				
		not be placed in a room with				
		should they be moved to the				
		unless they are confirmed to				
		esting. While awaiting				
	-	P should wear an N95 or				
		or (or facemask if a respirator protection (i.e., goggles or a				
		Id that covers the front and				
		oves, and gown when caring				
		Cloth face coverings are not				
		should only be worn by HCP				
		ot when PPE is indicated.				
	-	roommates, other residents,				
		ave been exposed to an				
	Individual with COVII	D-19 will be handled (e.g.,				

Facility ID: VA0270

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			0.0			O. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
			A. DOILDING			С
		495227	B. WING		0	5/28/2020
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		
WESTPOF	RT REHABILITATION AN	D NURSING CENTER		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 CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 880	Continued From page	e 15	F 88	0		
	monitor closely, avoid residents into a share					
	On 05/22/2020 at 1:1	1 p.m., a telephone lucted with OSM [other staff				
	member] # 9, medica	I director, deputy director of bunty] Health District, Long				
		ervisor and this surveyor.				
	department] talked w	ith or visited the facility.				
		there were a set of written ovided to the facility. OSM				
	#9 was informed of th	ne observation that was				
		he facility on 05/21/2020 and ucted with OSM # 7, nurse				
		of City] health department				
		niologist on 05/22/2020 at ne. OSM #9 was informed				
		facility provided from the				
	•	ent in regards to residents				
		OVID positive and negative SM # 9 acknowledged this				
		dress sheltering in place.				
	OSM #9 stated if ther					
		health department] are on em [residents] together, i.e. if				
		ates who have been tested				
		itive roommates, the two				
	-	can be moved together. ed, "We can suggest that				
		ed residents." OSM # 9				
		ed to locate the guidance				
	and would send this t surveyor.	o the LTC Supervisor and				
		55 p.m., a second telephone				
		ducted with, OSM <i>#</i> 9, the Supervisor, Director of OLC				
		nd Certification], Assistant				

Facility ID: VA0270

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 01/23/2021 FORM APPROVED MB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ONSTRUCTION		3) DATE SURVEY COMPLETED
		495227	B. WING				C 05/28/2020
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP COD	DE	
				730	0 FOREST AVE		
WESTPO	RT REHABILITATION AN	D NURSING CENTER		RIC	HMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	Director of OLC and the CMS [Centers for Me regulations and the C Control and Prevention residents who are post of COVID-19. OSM #9 to get a feel from the guidance, "Evaluate a Symptoms of Respiral stated that the 04/30/specifically stated that the 04/30/specifically stated that needed to be moved residents. OSM #9 stant element of judger the exposed resident of a danger and more residents and could c would say that is why must or will." OSM # must ensure that they and CDC guidance residents facilities " roommates, other resproviders] who may h individual with COVIE #9 was informed that 5/19/2020, CDC guid the 04/30/2020, CDC guid the 04/30/2020, CDC guid the 04/30/2020, CDC "Responding to Coron Nursing Homes, Coron Health Response to C Homes". The 04/30/2 documents under the new-onset suspected part the following, "If have COVID-19, regarshould be transferred."	his surveyor, regarding, dicare & Medicaid Services], iDC's (Centers for Disease on's] guidance, for cohorting sitive or negative for stated that they were trying early April 04/04/2020 CDC and Manage Residents with atory Infection." OSM #9 2020 CDC guidance t exposed individuals from the COVID-19 positive tated that because there is nent involved, that moving out of the room poses more e of a shuffling of the ause more "blenderizing. I the guidance doesn't say 9 informed that facilities 7 are complying with all CMS elated to infection control CDC's guidance, which Have a plan for how idents and HCP [health care ave been exposed to an 0-19 will be handled. OSM the word plan, on the ance links and connects to guidance, titled, navirus (COVID-19) in siderations for the Public COVID-19 in Nursing 2020, CDC guidance** header, "Resident with or confirmed COVID-19", in the resident is confirmed to ardless of symptoms, they	F	880			

Facility ID: VA0270

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495227	B. WING				C / 28/2020
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WESTPOR	RT REHABILITATION ANI	D NURSING CENTER			7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	permitted to room sharesidents if space is normalities if space is normalities in a single room now, those seven to the A remote review of the Outbreaks, submitted fax on 5/28/2020, reverside the coversident of the Coverside t	are with other exposed not available for them to om." OSM #9 then stated en words, yes. e Line List for COVID-19 by the facility for review by ealed the facility census was , 81 residents had tested D-19 virus and nine had review of the facility's "LTC spiratory Surveillance List" eaks], and a remote review ealed the following or Residents #7, #8, #9, 14 and # 15. lowing was documented, esident #7], Unit [number], Date, 4/4/20, Fever ,N, Myalgia (Y/N), Y, Y/N), Y, COV-2 test result Test Result (+/-)[dash], sh], Hospitalized (Y/N), Y 7." Under the section titled oreak: a handwritten note ed, "Died in hospital." sident #7's clinical record 7 was admitted to the facility oses that include, but are s mellitus [3] and obsessive 14]. On the most recent set], an quarterly assessment reference date in #7 was coded as having	F	880			

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		ID HUMAN SERVICES MEDICAID SERVICES				FO	ED: 01/23/2021 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED
		495227	B. WING				C 05/28/2020
NAME OF P	ROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION AN	D NURSING CENTER			800 FOREST AVE ICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 880	of Resident #7's clinic physician note dated the resident had test "Instructed not to leav [responsible party] inf condition. Further rev practitioner note date "will transfer resident evaluation and treatm hypoxic respiratory fa revealed a nurse note documenting the resid hospital and RP calle On the line list the fol "Name of Resident [F room[number], Onset (Y/N),Y, Cough (Y/N) not noted, Shortness test result (+/-), + [pos [dash], Hospitalized (4/10." Under the sect Outbreak: a handwritt documented, "Admitter Remote review of Re revealed, Resident #8 on 3/10/20 with diagn not limited to chronic disease [15] and chro On the most recent M assessment with an a of 3/16/2020, Residen no cognitive impairmed decisions, having sco BIMS. A review of Re revealed a nurse's no documenting that the	cal record revealed a 4/5/2020 documenting that for COVID-19 and was /e his room." RP formed of change in view revealed a nurse d 4/7/2020 documenting to hospital for further hent of fevers, diarrhea, illure. Further review e dated 4/7/2020 dent was admitted to the d and updated. dowing was documented, Resident #8], Unit [number], Date, 4/10/20, Fever , not noted, Myalgia (Y/N), of Breath (Y/N), Y, COV-2 sitive], Chest Xray (+/-),- Y/N), Y [yes], Died (Y/N), ion titled Outcome During ten note beside this ed to hospital, expired." sident #8's clinical record 8 was admitted to the facility noses that include, but are obstructive pulmonary onic respiratory failure [16]. IDS, a five [5] day Medicare assessment reference date in #8 was coded as having ent for making daily ored 15 out of 15 on the sident #8's clinical record	F	880			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 01/23/2021 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495227	B. WING				C / 28/2020
NAME OF PI	ROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTRO	RT REHABILITATION AN				7300 FOREST AVE		
WESTFOR				1	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	Continued From page of oxygen. Resident's	e 19 s sister informed of his	F	880			
	condition. Further rev practitioner note on 4 intermittent respirator tachypnea, tachycard resident will be sent c emergency room for t review revealed a num	iew revealed a nurse /9/20 "Due to resident y distress/labored breathing, lia-irregular heart rate,					
	"Name of Resident [F room[number], Onset (Y/N), no notation, Co Myalgia (Y/N), no not (Y/N), no notation, Co [positive], Flu Test Re Xray (+/-), no notation Died (Y/N), Y (yes)."	lowing was documented, Resident #9], Unit [number], Date, no notation, Fever ough (Y/N), no notation, ation, Shortness of Breath DV-2 test result (+/-), + esult (+/-). No notation, Chest n, Hospitalized (Y/N), Y [yes], A handwritten note beside ospital expired of vascular."					
	revealed, Resident #8 on 3/26/20 with diagn not limited to diabetes the most recent MDS assessment with an a of 4/1/2020, Resident cognitive impairment having scored 14 out of Resident #9's clinic note dated 4/13/2020 resident had a "chang abdominal pain or ed intake and nausea/vo 97.1." Further review	assessment reference date #9 was coded as having no for making daily decisions, of 15 on the BIMS. A review cal record revealed a nurse's documenting that the					
		lower extremity feeling cold					

Facility ID: VA0270

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		MEDICAID SERVICES				<u>IO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>			TE SURVEY MPLETED
			A. BUILDING	3		
		495227	B. WING			С
		455227	B. WING			5/28/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COE)E	
WESTPO	RT REHABILITATION AN	ID NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226		
(V4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	COMPLETIO DATE
F 880	Continued From pag	e 20	F 88	30		
	to the touch." Furthe		1.00			
		ated 4/14/20 documenting				
		th resident and son, she was				
		/ideo chat with him." Further				
		irse's note dated 4/15/20				
	documenting "Reside	ent transferred to medical				
	center."					
		llowing was documented,				
	-	Resident #10], Unit [number],				
		t Date, 4/7/20, Fever),N, Myalgia (Y/N), Y,				
		(Y/N), Y, COV-2 test result				
		Test Result (+/-).no notation,				
		Hospitalized (Y/N), N [no],				
	Died (Y/N), 4/07." Ur					
		break: COV test pending,				
	admitted to hospital	CVOID +, expired in				
	hospital."					
	Romoto roviow of Ro	esident #10's clinical record				
		10 was admitted to the				
		th diagnoses that include, but				
	-	tial intestinal obstruction and				
		ment. On the most recent				
	MDS, a 5-day Medic	are assessment with an				
		ce date of 4/1/2020, Resident				
		aving severe cognitive				
	-	ng daily decisions, having				
		on the BIMS. A review of				
		al record revealed a nurse ed 4/10/2020 documenting				
		test for COVID-19 with				
		fever of 102.8 on 4/8/20				
		Further review revealed a				
		/10/210 "Resident has a low				
		placed to on call service,				
	-	(responsible party) at this				
		revealed a social services				

Facility ID: VA0270

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				PLE CONSTRUCTION		10.0938-039
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	G		TE SURVEY MPLETED
			A. BUILDING			С
		495227	B. WING			5/28/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		5/20/2020
				7300 FOREST AVE		
WESTPO	RT REHABILITATION AN	ID NURSING CENTER		RICHMOND, VA 23226		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	RRECTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	COMPLETION DATE
F 880	Continued From pag	e 21	F 88	30		
		Contacted RP to clarify				
		is. RP states resident is to				
	be a FULL CODE.	Covid droplet precautions				
		iew revealed a nurse's note				
	dated 4/16/20 "Resid	lent alert but not responding				
		aturation 89% on two liters of				
		ansported to the hospital for				
	further evaluation."					
	On the line list the fo	llowing was documented,				
	"Name of Resident [I	-				
	[number], room[num	-				
), no notation, Cough (Y/N),				
	no notation, Myalgia					
		(Y/N), no notation, COV-2				
		ositive], Flu Test Result (+/-). (ray (+/-), no notation,				
		(fyes], Died (Y/N), Y [yes]." A				
		side this documented, "Died				
	in hospital."					
	Remote review of Re	esident #11's clinical record				
	revealed, Resident #	11 was admitted to the				
		n diagnoses that include, but				
		osis [17] and chronic kidney				
		most recent MDS, a 5-day				
		nt with an assessment				
		3/2020, Resident #11 was derately impaired cognition				
		sions, having scored 9 out of				
	•••	eview of Resident #11's				
		ed a nurse practitioner note				
		umenting that the resident				
		ospitalized for severe sepsis				
	[infection] and MSSA	A [methicillin-susceptible				
		us]bacteremia [an infection],				
	-	omyelitis. Further review				
	revealed a nurse's no					
	I documented "Reside	ent in respiratory distress,				1

Facility ID: VA0270

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 01/23/202 DRM APPROVE NO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION		ATE SURVEY
		495227	B. WING				C 05/28/2020
NAME OF P	ROVIDER OR SUPPLIER		•	STR	REET ADDRESS, CITY, STATE, ZIP CODE	•	
WESTPOR	RT REHABILITATION AN	D NURSING CENTER					
					CHMOND, VA 23226	FOTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 880	Continued From pag	e 22	F	880			
		t 47% on two liters of					
		BP [blood pressure] 203/106.					
		four liters with no increase					
		Nurse Practitioner notified					
		wanted resident transferred om. Further review revealed					
	a nurse's note dated						
		formed that resident was					
	admitted for COVID	19."					
	On the line list the fo	llowing was documented,					
	"Name of Resident [F	Resident #12], Unit					
	[number], room[num]	-					
),Y, Cough (Y/N), no notation, tation, Shortness of Breath					
		OV-2 test result (+/-), +					
		esult (+/-)[dash], Chest Xray					
		lized (Y/N), Y [yes], Died					
		he section titled Outcome					
	•	andwritten note beside this ne Hospice Care 4/20/20,					
	Home 4/22/20, expire						
	Remote review of Re	sident #12's clinical record					
	,	12 was admitted to the					
	· ·	th diagnoses that include, but					
		betes mellitus [3] and most recent MDS, a 5-day					
		nt with an assessment					
		/2020, Resident #12 was					
		ere cognitive impairment for					
		ns, having scored 03 out of					
		eview of Resident #12's ed a nurse's note dated					
	4/19/2020 document						
		precautions maintained for					
	COVID-19 positive re	esults. Further review					
		ote documented that hospice					
	admitted resident wit	h family approval. Nurse's					

Facility ID: VA0270

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	E SURVEY PLETED C //28/2020 (X5) COMPLETIC DATE
NAME OF PROVIDER OR SUPPLIER 95227 STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE RICHMOND, VA 23226 (X4)ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 23 note on 4/21/20 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." F 880 On the line list the following was documented, "Name of Resident [Resident #13], Unit [number], room[number], Onset Date, no notation, Rever (Y/N), no notation, COU-2 test result (+/-), * [positive], Flu Test Result (+/-). No notation, Chest Xray (+/-), no notation, Hospitalized (V/N), no notation, Died (V/N), 4/23." A handwritten note beside this documented, "Hospice expired 4/28/20."	C 5/28/2020
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WESTPORT REHABILITATION AND NURSING CENTER WESTPORT REHABILITATION AND NURSING CENTER DROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG VMID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 880 Continued From page 23 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 [Resident #13], Unit [number], room[number], Onset Date, no notation, Fever (Y/N), no notation, Cough (Y/N), no notation, Myajaja (Y/N), no notation, Shortness of Breath (Y/N), no notation, No notation, Chest Xray (Y-1), no notation, Hospitalized (Y/N), no notation, Died (Y/N), 4/23." A handwritten note beside this documented, "Hospice expired 4/28/20." Struct Structure Apprecession (Y/N), no notation, Multion, Hospitalized (Y/N), no notation, Died (Y/N), 4/23." A handwritten note beside this documented, "Hospice expired 4/28/20."	(X5) COMPLETIC
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[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."	
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."	
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."	
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."	
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."	
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."	
Hospitalized (Y/N), no notation, Died (Y/N), 4/23." A handwritten note beside this documented, "Hospice expired 4/28/20."	
A handwritten note beside this documented, "Hospice expired 4/28/20."	
"Hospice expired 4/28/20."	
Remote review of Resident #13's clinical record	
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	

Facility ID: VA0270

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CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING NAME OF PROVIDER OR SUPPLIER 495227 B. WING 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 REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WESTPORT REHABILITATION AND NURSING CENTER 7300 FOREST AVE RICHMOND, VA 23226 RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	05/28/2020
WESTPORT REHABILITATION AND NURSING CENTER 7300 FOREST AVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	N (X5) BE COMPLETION
WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
(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 I TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR	BE COMPLETION
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD I TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
	,,,,,,,
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	

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		ID HUMAN SERVICES MEDICAID SERVICES					RINTED: 01/23/202 FORM APPROVEI MB NO: 0938-039
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		ONSTRUCTION	(X	3) DATE SURVEY COMPLETED
		495227	B. WING				C 05/28/2020
NAME OF P	ROVIDER OR SUPPLIER	1		STR	EET ADDRESS, CITY, STATE, ZIP CO	DE	
WESTRO	T REHABILITATION AN			730	0 FOREST AVE		
WEON OF				RIC	HMOND, VA 23226		
(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 C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 880	Continued From page	e 25	F	380			
	is without blood press	sure, pulse and respirations. leath. Patient expired at					
	"Name of Resident [F room[number], Onset (Y/N), no notation, Co Myalgia (Y/N), no not (Y/N), no notation, Co [positive], Flu Test Re	lowing was documented, Resident #15], Unit [number], t Date, no notation, Fever ough (Y/N), no notation, ration, Shortness of Breath OV-2 test result (+/-), + esult (+/-). No notation, Chest ion, Hospitalized (Y/N), Y 6/20.					
	revealed, Resident # facility on 3/31/20 wit are not limited to dial obsessive compulsive recent MDS, a 5-day an assessment refere Resident #15 was co- cognitive impairment having scored 6 out co of Resident #15's clin practitioner's note dat that the resident had functional status. Ox three liters oxygen no liters oxygen. Daugh admissions, will cons positive on 4/12/20, m 5/7/20. Further reviet dated 5/20/20 docum	e disorder [14]. On the most Medicare assessment with ence date of 4/6/2020, ded as having severe for making daily decisions, of 15 on the BIMS. A review hical record revealed a nurse ted 5/16/2020 documenting a marked decline in ygen saturation 90% on ow increased to 95% on five ter agrees to no hospital ult with hospice. COVID test negative on 5/6/20 and w revealed a nurse's note enting "Resident exhibiting and breath sounds absent.					
		y policy, "COVID-19 Isolation					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 01/23/2021 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>'</i>		E CONSTRUCTION	(X3) DATE	
		495227	B. WING				C 28/2020
NAME OF PI	ROVIDER OR SUPPLIER			s	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPORT REHABILITATION AND NURSING CENTER			7	7300 FOREST AVE			
WEOTION				F	RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	Residents on droplet a private room if poss room is not available, room with a resident i microorganism or with When a private room cohorting is not achie and a distance of at le maintained between t or her roommate." On 05/22/2020 at 6:1 of the call with the loc conference call was of supervisors and the s determined that the fa- infection control pract of a communicable di in a situation of IJ (im On 05/22/2020 at 6:1 was reached by phon concern for IJ. On 05/22/2020 at 7:3 received a call from A member) # 5, the regi ASM #5 asked how I. surveyors being onsit staying onsite until the surveyor then offered speak with him for fur On 05/22/2020 at 7:4 conference call was of Long Term Care Super regarding the IJ. The	Droplet Precautions. 2. precautions will be placed in ible. a. When a private residents may share a nfected with the same n limited risk factors. b. is not available and vable, a curtain will be used east 6 feet of space will be he infected resident [sic] his 1 p.m., after the completion al health department, a completed with two LTC urvey team. It was acility's failure to implement ices to prevent the spread sease (COVID-19), resulted mediate jeopardy). 8 p.m., the administrator e, and was informed of the 6 p.m., the surveyor SM (administrative staff onal director of operations. I could be called without the e at the facility and not e IJ was cleared. This to contact the supervisor to ther explanation.	F	880			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		495227	B. WING				C 28/2020
NAME OF PROVIDER OR SUPPLIER					TREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOF	RT REHABILITATION ANI	D NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	evidence and abatem stated he did not disa warranted. He stated have been pulled [bet identified at the time of he did not agree with	prrection, review of credible ent of the IJ. ASM # 5 gree with the citation, it was that the curtains should ween the residents of the onsite observation] but the level.	F	380			
	facility and observed cohorted with COVID- rooms with cubicle cu pulled. The facility's r cohorting positive with have the cubicle curta separate residents; th non-compliant in resid COVID-19 positive ar Three rooms with Cov residents had privacy pulled close. Upon no of the 3 rooms were p were tested positive v residents. The reside coming out of a room positive, were moved cohorted with other "li cohorting the resident these residents are ro and symptoms of CO	ection. 5 PM, surveyors entered the COVID-19 positive residents -19 negative residents in rtains between the beds not mitigation plan, in place of n positive residents, is to ains completely pulled to bis was observed to be dent rooms with both ad negative residents. vid positive and negative curtains that were not obtification, privacy curtains bulled closed. Residents that vere cohorted with positive ents that had tested negative where the roommate tested to a private room or ike" residents. Besides ts who tested negative, putinely monitored for signs VID-19.					
	positive were cohorte	sidents that are COVID-19 d with positive residents. d tested negative coming					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		495227	B. WING				/28/2020
NAME OF P	ROVIDER OR SUPPLIER		•	5	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOR	RT REHABILITATION ANI	D NURSING CENTER			7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	cohorting the resident these residents are ro and symptoms of CO and readmitted reside COVID-19 who have discontinuation of tran precautions should go COVID-19 care unit. I readmitted residents met criteria for discon- transmission-based p regular unit. 3. In-service for facilit resident care will be o Nursing or designee o between the residents COVID-19 are cohort The residents that havout of a room where t positive, were moved cohorted with other "II Besides cohorting the negative, these reside for signs and symptor admitted and readmit COVID-19 care unit. I readmitted residents y met criteria for discon-	he roommate tested to a private room or ike" residents. Besides ts who tested negative, butinely monitored for signs VID-19. Newly admitted ents with confirmed not met criteria for hsmission-based to to the designated Newly admitted and with COVID-19 who have tinuation of recautions can go to a y staff that provide direct completed by the Director of on pulling the privacy curtain is on precautions and on that are positive for ed with positive residents. d tested negative coming he roommate tested to a private room or ike" residents for 14 days. e residents who tested ents are routinely monitored ns of COVID-19. Newly ted residents with confirmed not met criteria for hemission-based to to the designated Newly admitted and with COVID-19 who have	F	880			

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP		TMENT OF HEALTH AN RS FOR MEDICARE &					FORM	APPROVED 0. 0938-0391
495227 B. WING 05/28/20 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7300 FOREST AVE WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 7300 FOREST AVE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (COMPRESENT) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPRESENCE	STATEMENT (T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WESTPORT REHABILITATION AND NURSING CENTER 7300 FOREST AVE RICHMOND, VA 23226 RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (COMPREFIX) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE D			495227	B. WING				-
WESTPORT REHABILITATION AND NURSING CENTER RICHMOND, VA 23226 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (COMPRETIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPRETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE D	NAME OF PROVIDER OR SUPPLIER			·			-	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE D	WESTPOR	ORT REHABILITATION AN	D NURSING CENTER					
	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		(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 that were exposed to COVID-19 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 x4 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 employee education regarding staff drawing the privacy curtains between residents and cohorting COVID-19 positive resident together and COVID-19 positive resident together. The survey team remotely reviewed the credible evidence, and completed staff interviews by phone, verifying full implemented. The Boc beservations and observe to verify that POC had beser fully implemented. These observations and observe to verify that POC had beservations and observe to verify that POC had beservations communicable disease,	F 880	 4. Director of Nursing an audit of residents of cohorting of Resident for COVID-19 and Resident for COVID-19 Resident cohorted with other e days privacy curtains residents 3 x weekly x x 3 months. The audit quality assurance and process for tracking/th needed. Date of Compliance 5 On 05/26/2020 at 3:5 (plan of correction) w was informed of the a presented credible ev been implemented, in employee education in privacy curtains betw COVID-19 negative re team remotely review and completed staff in full implementation of On 05/27/2020 at 10: entered the facility to observe to verify that implemented. These concerns with the fac infection control progic communicable disease On 05/27/2020 at 11: notified that the IJ was 	or designee will complete on precautions to verify the is that have tested positive esidents that were exposed ints are in a private room or xposed residents for 14 are pulled between x 4 weeks and then monthly ts will be reviewed in the d performance improvement rending and revisions as 5/26/2020." 5 p.m., the facility's POC as accepted, and ASM #1 acceptance. The facility vidence that the POC had neluding evidence that regarding staff drawing the een residents and cohorting esident together and esident together. The survey ved the credible evidence, interviews by phone, verifying f the POC. 45 a.m., the survey team make observations and POC had been fully observations revealed no ility's implementation of an ram to prevent the spread of se, COVID-19. 59 a.m., ASM #1 was	F	880			

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		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/23/203 FORM APPROVE OMB NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		495227	B. WING		C 05/28/2020
NAME OF PI	ROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CC	
WESTPOF	RT REHABILITATION AN	D NURSING CENTER		0 FOREST AVE CHMOND, 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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	DN SHOULD BE COMPLETIO IE APPROPRIATE DATE
F 880	long-term care facilitie website: "https://www.cms.gov/ 19-long-term-care-face https://www.cdc.gov/ ursing-homes-respon https://www.cdc.gov/ nfection-control-recor * "Coronaviruses are found in many differe including camels, cat of coronavirus identifi outbreak of respirator detected in Wuhan, C SARSCoV-2. (Forme 2019-nCoV.) The disc SARS-CoV-2 has bee information was obtai https://www.nccih.nih navirus-and-alternativ [1] A general term fo disease that is usually emphysema and chro Dictionary of Medical Reader, 5th edition, F page 124. [2] A loss of brain fun diseases. It affects m judgment, and behav obtained from the we https://medlineplus.go	on control and COVID in es obtained from the CDC //files/document/4220-covid- cility-guidance.pdf coronavirus/2019-ncov/hcp/n nding.html coronavirus/2019-ncov/hcp/i mmendations.html#adhere" a large family of viruses nt species of animals, tle, and bats. The new strain ied as the cause of the ry illness in people first China, has been named rly, it was referred to as ease caused by en named COVID-19." This ined from the website: gov/health/in-the-news-coro ve-treatments r chronic, nonreversible lung y a combination of onic bronchitis." Barron's Terms for the Non-Medical Rothenberg and Chapman, ction that occurs with certain nemory, thinking, language, ior. This information was	F 880		

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		495227	B. WING				C / 28/2020
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTPOF	RT REHABILITATION ANI	D NURSING CENTER			7300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	001214.htm. [4] Means there are n information was obtai https://medlineplus.go [5] For patients known infected with pathoge droplets that are gene coughing, sneezing, o information is taken fr https://www.cdc.gov/i mission-based-precat [6] A condition in whice enough blood to mee that your heart is not it should. It can affect heart. This information website: https://medlin [7] A disorder caused the brain that control hard for you to read, y mean to say. This information the website: https://www.nlm.nih.g I [8] Psychological sym- abnormalities are con- characteristics of dem- obtained from the web-	ov/medlineplus/ency/article/ o symptoms. This ned from the website: ov/ency/article/002217.htm n or suspected to be ns transmitted by respiratory erated by a patient who is or talking" This rom the website nfectioncontrol/basics/trans utions.html. ch the heart can't pump t the body's needs. It means able to pump blood the way cone or both sides of the on was obtained from the neplus.gov/heartfailure.html. d by damage to the parts of language. It can make it write, and say what you ormation was obtained from tov/medlineplus/aphasia.htm	F	880			
	81717/. [9] A type of moveme information was obtai	ent disorder. This ned from the website:					

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	-	ID HUMAN SERVICES				FORM	M APPROVED
	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED
		495227	B. WING				C 28/2020
NAME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00		
WESTPOF	RT REHABILITATION ANI	D NURSING CENTER			300 FOREST AVE RICHMOND, VA 23226		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 880	sease.html. [10] Loss of muscle fu It happens when som way messages pass I muscles. This informa website: https://medlin [11] A disorder caused the brain that control hard for you to read, w mean to say). This information the website: https://www.nlm.nih.g I. [12] A swallowing disc obtained from the well https://www.nlm.nih.g sorders.html. [13] A group of disord ability to move and to posture. This information website: https://www.nlm.nih.g y.html. [14] A common, chror in which a person has thoughts (obsessions (compulsions) that here repeat over and over. obtained from the well	ov/medlineplus/parkinsonsdi unction in part of your body. ething goes wrong with the between your brain and ation was obtained from the neplus.gov/paralysis.html. d by damage to the parts of language. It can make it write, and say what you formation was obtained from ov/medlineplus/aphasia.htm order. This information was bsite: ov/medlineplus/swallowingdi ers that affect a person's maintain balance and ation was obtained from the ov/medlineplus/cerebralpals hic and long-lasting disorder s uncontrollable, reoccurring) and behaviors e or she feels the urge to This information was bsite: jov/health/topics/obsessive-c	F	380			
		kes it difficult to breath that					

Facility ID: VA0270

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	: 01/23/2021 APPROVED . 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		(X3) DATE S COMPL	SURVEY ETED
		495227	B. WING		_	C 05/2	8/2020
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
WESTPOR	RT REHABILITATION ANI	D NURSING CENTER		7300 FOREST AVE RICHMOND, VA 23226			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE ICED TO THE APPROPRIA EFICIENCY)		(X5) COMPLETION DATE
F 880	was obtained from the https://www.nlm.nih.g [16] When not enougl lungs into your blood. obtained from the wel https://www.nlm.nih.g ilure.html. [17] An illness in whice inflammatory respons germs. This informati website: https://medlineplus.go [18] Kidneys are dam as they should. This in from the website:	of breath. This information e website: ov/medlineplus/copd.html. n oxygen passes from your This information was bsite: ov/medlineplus/respiratoryfa	F 88(

Facility ID: VA0270

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