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	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Rehabilitation and Nursing Center	7300 Forest Ave Richmond, VA 23226

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Let each resident or the resident's legal representative access or purchase copies of all the resident's records. 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to evidence the provision of medical records to a discharged resident for one of 24 residents in the survey sample, Resident #6. The findings include: For Resident #6 (R6), the facility staff failed to provide the resident with requested medical records after the resident was discharged . A review of R6's clinical record revealed the resident was discharged from the facility on 8/6/24. On 9/27/24 at 10:32 a.m., OSM (other staff member) #5, the clinical liaison, was interviewed. She stated she was the former discharge planner, and was working in that capacity when R6 was at the facility. She stated she has heard from R6 many times since his discharge, and the resident is requesting a copy of all of his discharge documentation. She admitted she did not know exactly what information the resident was trying to obtain from the discharge paperwork, and that she does not have access in the EMR (electronic medical record) to a discharged resident's clinical information. She added: I don't have access to the same things the nursing team has access to. Because of this, she stated she has elevated this request to the former administrator and to ASM (administrative staff member) #2, the director of nursing, many times. She added: This is why I have asked multiple people to get the information to [R6]. She stated the last conversation about this concern was with ASM #2 on 9/10/24. She stated she does not know whether or not R6 ever received the information he requested. On 9/30/24 at 4:03 p.m., ASM #2 was interviewed. She stated she was of the understanding that R6 had received the information he had requested. She stated she thought the former administrator had sent the information to R6 by mail. ASM #2 was asked to provided evidence that the records had been sent to R6. On 9/30/24 at 5:22 p.m., ASM #2 and ASM #1, the acting administrator, were informed of these concerns. They stated they could not locate any evidence that the requested records had been mailed to R6. On 9/30/24 at 5:40 p.m., ASM #2 stated the facility did not have a policy regarding providing records to discharged residents. (continued on next page)

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.

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to notify the provider (physician and/or nurse practitioner) of missed doses of medication for one of 24 residents in the survey sample, Resident #24. The findings include: For Resident #24 (R24), the facility staff failed to notify the provider of multiple missed doses of Azithromycin (1) and Triumeq (2) in August and September 2024. A review of R24's clinical record revealed the following orders: 8/22/24 Azithromycin Oral Tablet 500 mg (milligrams) Give 1 tablet by mouth one time a day related to Disseminated Mycobacterium Avium-Intracellulare Complex (DMAC) (3). 8/22/24 Triumeq Oral Tablet (3) 600-50-300 mg .Give 1 tablet by mouth one time a day related to Human Immunodeficiency Virus (HIV) disease. A review of R24's September 2024 MAR (medication administration records) and pharmacy manifests revealed the Azithromycin was not available from the pharmacy between 9/1/24 and 9/5/24, and was not administered to R24 on those dates. Further review of R24's August and September 2024 MARs and pharmacy manifests revealed the Triumeq was not available from the pharmacy from 8/23/24 through 9/14/24, and was not administered during this time. A review of R24's progress notes revealed no notification of the missed doses to the provider on all dates in between 8/23/14 through 9/14/24 except 8/26/24, 9/1/24, 9/2/24, and 9/7/24. On 9/30/24 at 2:14 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She verified that the Azithromycin and Triumeq were not administered to R24 on the dates indicated above. She stated when a dose is missed, the provider should be notified, and new orders given. She stated she was not aware of any response from the provider about the missing doses. On 9/30/24 at 3:13 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated if a dose of a medication is missed, the provider (either physician or nurse practitioner) should be notified so that an alternate plan can be made for the resident. She stated the provider's response should be documented in the clinical record. On 9/30/24 at 5:22 p.m., ASM #2 and ASM #1, the acting administrator, were informed of these concerns. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24 at 5:30 p.m., ASM #1 and ASM #2 presented a plan of correction dated 9/24/24. A review of this plan revealed, in part: An audit by DON or designee to verify residents with HIV medications have available. An Audit by the DON or designee to verify medications ordered are available for the resident, Findings will be corrected with medication process followed. Education by the SDC (staff development coordinator) or designee to the Licensed Nurses on following the processes for medication unavailability, obtaining resident medications for administration per physician order, use of Omnicell, MD notification with consideration for alternative med if able, pharmacy notification to use back up pharmacy and/or alternative to inform MD if applicable, if no alternative obtain MD order to hold and give when available, if prior authorization /approval is required by DON or Administrator, pharmacy will send limited quantity until approved by DON or Administrator, medication administration with professional standards of documentation accurate to administration. Audits by the Unit Manager or designee weekly x 4 weeks to verify new admits residents or changes in residents' medications are available as ordered with accurate documentation of administration of the medication. Findings will be corrected. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. Date of complaince 9/25/24. The facility provided credible evidence the education had been provided prior to entrance, as alleged. A review of the facility policy, General Guidelines for Medication Administration, revealed, in part: If 3 consecutive doses, or in accordance with facility policy, of a vital medication are withheld, refused, or not available, the physician is notified. Nursing documents the notification and physician response. No further information was provided prior to exit. References (1) Azithromycin is used to treat certain bacterial infections, such as bronchitis; pneumonia; sexually transmitted diseases (STD); and infections of the ears, lungs, sinuses, skin, throat, and reproductive organs. Azithromycin also is used to treat or prevent disseminated Mycobacterium avium complex (MAC) infection [a type of lung infection that often affects people with human immunodeficiency virus (HIV)]. Azithromycin is in a class of medications called macrolide antibiotics. It works by stopping the growth of bacteria. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697037.html. (2) The combination of abacavir, dolutegravir, and lamivudine is used alone or along with other medications to treat HIV infection in certain adults and children 3 months or older. Although abacavir, dolutegravir, and lamivudine will not cure HIV, these medications may decrease your chance of developing acquired immunodeficiency syndrome (AIDS) and HIV-related illnesses such as serious infections or cancer. This information is taken from the website https://medlineplus.gov/druginfo/meds/a617015.html. (3) Disseminated Mycobacterium avium-intracellulare complex (MAC) infection is one of the relatively common opportunistic infections seen in severely immunocompromised AIDS patients. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5692144/.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 32642 Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide a resident with a written summary of the baseline care plan for one of 24 residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), who was admitted on [DATE], the facility failed to provide evidence that the resident and RP (responsible party) received a written copy of the baseline care plan goals. A review of R1's clinical record revealed a care plan that was initiated at the time of R1's admission to the facility on [DATE]. Further review of the clinical record failed to reveal evidence that a written summary of the baseline care plan was ever provided to the resident or his RP. On 9/27/24 at 10:32 a.m., OSM (other staff member) #5, the former admissions director and current clinical liaison, was interviewed. She stated she is aware that a baseline care plan is initiated on admission by nursing staff, but she was not aware or a part of any process to provide the residents/RPs with a written summary of the baseline care plan. On 9/30/24 at 1:12 p.m., OSM #2, the social worker, was interviewed. She stated the interdisciplinary team participates in a jumpstart meeting to go over the plan of care for each resident according to disciplines, including nursing, dining, therapy, social services, and activities. She stated she is not sure whose responsibility it is to provide the written summary to the resident/RP, but she has never been instructed to do so. On 9/30/24 at 5:22 p.m., ASM (administrative staff member) #1, the acting administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policies, Admission Assessment, and Admitting a Patient, revealed no information related to a written summary of the baseline care plan being given to residents/RPs. No further information was provided prior to exit.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 32642 Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to develop and/or implement the comprehensive care plan for two of 24 residents in the survey sample, Residents #24 and #20. The findings include: 1. For Resident #24 (R24), the facility staff failed to implement the comprehensive care plan to administer medications to treat advanced HIV (human immunodeficiency virus). A review of R24's comprehensive care plan updated 9/28/24 revealed, in part: The resident has an infection, HIV .medications as ordered. A review of R24's clinical record revealed the following orders: 8/22/24 Azithromycin Oral Tablet 500 mg (milligrams) (1) Give 1 tablet by mouth one time a day related to Disseminated Mycobacterium Avium-Intracellulare Complex (DMAC) (2). 8/22/24 Triumeq Oral Tablet (3) 600-50-300 mg .Give 1 tablet by mouth one time a day related to Human Immunodeficiency Virus (HIV) disease. A review of R24's September 2024 MAR (medication administration records) and pharmacy manifests revealed the Azithromycin was not available from the pharmacy between 9/1/24 and 9/5/24, and was not administered to R24 on those dates. Further review of R24's August and September 2024 MARs and pharmacy manifests revealed the Triumeq was not available from the pharmacy from 8/23/24 through 9/14/24, and was not administered during this time. On 9/30/24 at 2:14 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She verified that the Azithromycin and Triumeq were not administered to R24 on the dates indicated above. On 9/30/24 at 3:19 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated the purpose of a care plan is for everyone to know what is going on with a resident, and if there have been any changes in the resident's needs. She stated the unit manager is responsible for making sure the staff know what is included on the care plan, and it is up to everyone on the care team to implement it. On 9/30/24 at 5:22 p.m., ASM #2 and ASM #1, the acting administrator, were informed of these concerns. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of the facility policy, Care Planning, revealed, in part: A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. No further information was provided prior to exit. (1) Azithromycin is used to treat certain bacterial infections, such as bronchitis; pneumonia; sexually transmitted diseases (STD); and infections of the ears, lungs, sinuses, skin, throat, and reproductive organs. Azithromycin also is used to treat or prevent disseminated Mycobacterium avium complex (MAC) infection [a type of lung infection that often affects people with human immunodeficiency virus (HIV)]. Azithromycin is in a class of medications called macrolide antibiotics. It works by stopping the growth of bacteria. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697037.html. (2) Disseminated Mycobacterium avium-intracellulare complex (MAC) infection is one of the relatively common opportunistic infections seen in severely immunocompromised AIDS patients. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5692144/. (3) The combination of abacavir, dolutegravir, and lamivudine is used alone or along with other medications to treat HIV infection in certain adults and children 3 months or older. Although abacavir, dolutegravir, and lamivudine will not cure HIV, these medications may decrease your chance of developing acquired immunodeficiency syndrome (AIDS) and HIV-related illnesses such as serious infections or cancer. This information is taken from the website https://medlineplus.gov/druginfo/meds/a617015.html. 2. For Resident #20, the facility staff failed to develop a care plan for sleep apnea and the use of a CPAP (continuous positive air pressure) (1) machine. On 9/26/24 at 4:35 p.m., R20 was interviewed. She stated has sleep apnea and uses a CPAP at night for sleeping. A review of R20's physician orders revealed the following orders dated 8/28/22: CPAP Pressure: 12 Humidity: 4 Pressure Relief . *Use sterile water only* at bedtime related to OBSTRUCTIVE SLEEP APNEA (ADULT) .Apply CPAP. CPAP Pressure: 12 Humidity: 4 Pressure Relief .*Use sterile water only* every day and evening shift. for napping related to OBSTRUCTIVE SLEEP APNEA (ADULT). A review of R20's comprehensive care plan dated 2/13/21 and most recently updated 9/19/24 revealed no information related to the resident's obstructive sleep apnea or CPAP use. On 9/27/24 at 1:05 p.m., LPN (licensed practical nurse) #5, a unit manager, was interviewed. She stated a CPAP should be included on a resident's care plan because it is necessary information to provide the best possible care for the resident. On 9/30/24 at 4:03 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She stated the care plan shows what care should be given for each resident. She stated sleep apnea and the use of a CPAP should be included on the resident's care plan. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24 at 5:22 p.m., ASM #2 and ASM #1, the acting administrator, were informed of these concerns. No further information was provided prior to exit. Reference (1) CPAP (Continuous Positive Airway Pressure) is a treatment that uses mild air pressure to keep your breathing airways open .It involves using a CPAP machine that includes a mask or other device that fits over your nose or your nose and mouth, straps to position the mask, a tube that connects the mask to the machine's motor, and a motor that blows air into the tube. CPAP is used to treat sleep-related breathing disorders including sleep apnea. This information is taken from the website https://www.nhlbi.nih.gov/health-topics/cpap.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure services provided by the nursing facility meet professional standards of quality. 32642 Based on staff interview, clinical record review, and facility document review, the facility staff failed to follow professional standards of practice for the administration of medications for one of 24 residents in the survey sample, Resident #24. The findings include: For Resident #24 (R24), the facility inaccurately documented a medication was given when it was not on hand to be administered. A review of R24's clinical record revealed the following orders: 8/22/24 Azithromycin Oral Tablet (1) 500 mg (milligrams) Give 1 tablet by mouth one time a day related to Disseminated Mycobacterium Avium-Intracellulare Complex (DMAC) (2). 8/22/24 Triumeq Oral Tablet (3) 600-50-300 mg .Give 1 tablet by mouth one time a day related to Human Immunodeficiency Virus (HIV) disease. A review of R24's September 2024 MAR (medication administration records) revealed the Azithromycin was not available from the pharmacy between 9/2/24 and 9/5/24. However, on 9/2/24 and 9/3/24, the facility staff documented on the MAR that the medication had been administered to R24. Further review of R24's August and September 2024 MARs revealed the Triumeq was not available from the pharmacy from 8/23/24 through 9/14/24. However, on 8/25/24, 8/27/24, 8/28/24, 8/30/24, 8/31/24, 9/1/24, 9/6/24, 9/9/24, 9/10/24, 9/11/24, and 9/12/24, the facility staff documented on the MAR that the medication had been administered to R24. On 9/30/24 at 2:14 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She verified that the Azithromycin and Triumeq were not available for administration to R24 on the dates indicated above. She stated she became aware of the medication availability concerns when one of the nurses brought it to her attention. She agreed the Triumeq was not administered between 8/23/24 and 9/13/24 on those dates when the MAR was signed to indicate it had been administered. She also agreed the Azithromycin was not administered on 9/2/24 and 9/3/24, despite the MAR documentation otherwise. On 9/30/24 at 3:13 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated if a medication is not available for administration to a resident, the nurse should follow the facility's protocol of checking the Omnicell (common medications available for residents), and then calling the pharmacy. She stated it is against professional nursing standards to document that a nurse has administered a medication when he/she has actually not administered it. On 9/30/24 at 5:22 p.m., ASM #2 and ASM #1, the acting administrator, were informed of these concerns. A review of the policy, General Guidelines for Medication Administration, failed to reveal any information related to inaccurate documentation of medications that were not given. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	No further information was provided prior to exit. References (1) Azithromycin is used to treat certain bacterial infections, such as bronchitis; pneumonia; sexually transmitted diseases (STD); and infections of the ears, lungs, sinuses, skin, throat, and reproductive organs. Azithromycin also is used to treat or prevent disseminated Mycobacterium avium complex (MAC) infection [a type of lung infection that often affects people with human immunodeficiency virus (HIV)]. Azithromycin is in a class of medications called macrolide antibiotics. It works by stopping the growth of bacteria. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697037.html. (2) Disseminated Mycobacterium avium-intracellulare complex (MAC) infection is one of the relatively common opportunistic infections seen in severely immunocompromised AIDS patients. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5692144/. (3) The combination of abacavir, dolutegravir, and lamivudine is used alone or along with other medications to treat HIV infection in certain adults and children 3 months or older. Although abacavir, dolutegravir, and lamivudine will not cure HIV, these medications may decrease your chance of developing acquired immunodeficiency syndrome (AIDS) and HIV-related illnesses such as serious infections or cancer. This information is taken from the website https://medlineplus.gov/druginfo/meds/a617015.html.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 32642 Based on staff interview, facility document review, and clinical record review, the facility pharmacy failed to provide medication for administration to one of 24 residents in the survey sample, Resident #24. The findings include: For Resident #24 (R24), the facility pharmacy failed to provide Azithromycin (1) and Triumeq (2) for administration in August and September 2024. A review of R24's clinical record revealed the following orders: 8/22/24 Azithromycin Oral Tablet 500 mg (milligrams) Give 1 tablet by mouth one time a day related to Disseminated Mycobacterium Avium-Intracellulare Complex (DMAC) (3). 8/22/24 Triumeq Oral Tablet (3) 600-50-300 mg .Give 1 tablet by mouth one time a day related to Human Immunodeficiency Virus (HIV) disease. A review of R24's September 2024 MAR (medication administration records) and pharmacy manifests revealed the Azithromycin was not available from the pharmacy between 9/1/24 and 9/5/24. Further review of R24's August and September 2024 MARs and pharmacy manifests revealed the Triumeq was not available from the pharmacy from 8/23/24 through 9/14/24. On 9/30/24 at 2:14 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She verified that the Azithromycin and Triumeq were not available for administration to R24 on the dates indicated above. She stated she became aware of the medication availability concerns when one of the nurses brought it to her attention. She added: The process to obtain the medication was not followed. She stated if a resident is being admitted with any medications that are unusual, the admissions staff member and/or nurses should notify management. She stated the pharmacy is also responsible for notifying management if an unusual and/or expensive medication is order. She stated that, at some point, there was some understanding by some staff members that the family would be providing the medication; however, the family did not do this. She stated both pharmacy and facility staff dropped the ball. On 9/30/24 at 3:13 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated if a medication is not available for administration to a resident, the nurse should follow the facility's protocol of checking the Omnicell (common medications available for residents), and then calling the pharmacy. She stated the provider (either physician or nurse practitioner) should be notified so that an alternate plan can be made for the resident. On 9/30/24 at 5:22 p.m., ASM #2 and ASM #1, the acting administrator, were informed of these concerns. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24 at 5:30 p.m., ASM #1 and ASM #2 presented a plan of correction dated 9/24/24. A review of this plan revealed, in part: An audit by DON or designee to verify residents with HIV medications have available. An Audit by the DON or designee to verify medications ordered are available for the resident, Findings will be corrected with medication process followed. Education by the SDC (staff development coordinator) or designee to the Licensed Nurses on following the processes for medication unavailability, obtaining resident medications for administration per physician order, use of Omnicell, MD notification with consideration for alternative med if able, pharmacy notification to use back up pharmacy and/or alternative to inform MD if applicable, if no alternative obtain MD order to hold and give when available, if prior authorization /approval is required by DON or Administrator, pharmacy will send limited quantity until approved by DON or Administrator, medication administration with professional standards of documentation accurate to administration. Audits by the Unit Manager or designee weekly x 4 weeks to verify new admits residents or changes in residents' medications are available as ordered with accurate documentation of administration of the medication. Findings will be corrected. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. Date of complaince 9/25/24. The facility provided credible evidence the education had been provided prior to entrance, as alleged. A review of the facility policy, General Guidelines for Medication Administration, revealed, in part: If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit. No further information was provided prior to exit. References (1) Azithromycin is used to treat certain bacterial infections, such as bronchitis; pneumonia; sexually transmitted diseases (STD); and infections of the ears, lungs, sinuses, skin, throat, and reproductive organs. Azithromycin also is used to treat or prevent disseminated Mycobacterium avium complex (MAC) infection [a type of lung infection that often affects people with human immunodeficiency virus (HIV)]. Azithromycin is in a class of medications called macrolide antibiotics. It works by stopping the growth of bacteria. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697037.html. (2) The combination of abacavir, dolutegravir, and lamivudine is used alone or along with other medications to treat HIV infection in certain adults and children 3 months or older. Although abacavir, dolutegravir, and lamivudine will not cure HIV, these medications may decrease your chance of developing acquired immunodeficiency syndrome (AIDS) and HIV-related illnesses such as serious infections or cancer. This information is taken from the website https://medlineplus.gov/druginfo/meds/a617015.html. (3) Disseminated Mycobacterium avium-intracellulare complex (MAC) infection is one of the relatively common opportunistic infections seen in severely immunocompromised AIDS patients. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5692144/.

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	495227	A. Building B. Wing	09/30/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure medication error rates are not 5 percent or greater. 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to administer medications as ordered, resulting in significant medication errors, to one of 24 residents in the survey sample, Resident #24. The findings include: For Resident #24 (R24), the facility pharmacy failed to administer Azithromycin (1) and Triumeq (2) on multiple dates in August and September 2024, resulting in multiple significant medication errors. A review of R24's clinical record revealed the following orders: 8/22/24 Azithromycin Oral Tablet 500 mg (milligrams) Give 1 tablet by mouth one time a day related to Disseminated Mycobacterium Avium-Intracellulare Complex (DMAC) (3). 8/22/24 Triumeq Oral Tablet (3) 600-50-300 mg .Give 1 tablet by mouth one time a day related to Human Immunodeficiency Virus (HIV) disease. A review of R24's September 2024 MAR (medication administration records) and pharmacy manifests revealed the Azithromycin was not available from the pharmacy between 9/1/24 and 9/5/24, and was not administered to R24 on those dates. Further review of R24's August and September 2024 MARs and pharmacy manifests revealed the Triumeq was not available from the pharmacy from 8/23/24 through 9/14/24, and was not administered during this time. On 9/30/24 at 2:14 p.m., ASM (administrative staff member) #2, the director of nursing, was interviewed. She verified that the Azithromycin and Triumeq were not administered to R24 on the dates indicated above. She stated she became aware of the medication availability concerns when one of the nurses brought it to her attention. She added: The process to obtain the medication was not followed. She stated if a resident is being admitted with any medications that are unusual, the admissions staff member and/or nurses should notify management. She stated the pharmacy is also responsible for notifying management if an unusual and/or expensive medication is order. She stated that, at some point, there was some understanding by some staff members that the family would be providing the medication; however, the family did not do this. She stated both pharmacy and facility staff dropped the ball. On 9/30/24 at 3:13 p.m., LPN (licensed practical nurse) #1 was interviewed. She stated if a medication is not available for administration to a resident, the nurse should follow the facility's protocol of checking the Omnicell (common medications available for residents), and then calling the pharmacy. She stated the provider (either physician or nurse practitioner) should be notified so that an alternate plan can be made for the resident. On 9/30/24 at 5:22 p.m., ASM #2 and ASM #1, the acting administrator, were informed of these concerns. (continued on next page)

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 9/30/24 at 5:30 p.m., ASM #1 and ASM #2 presented a plan of correction dated 9/24/24. A review of this plan revealed, in part: An audit by DON or designee to verify residents with HIV medications have available. An Audit by the DON or designee to verify medications ordered are available for the resident, Findings will be corrected with medication process followed. Education by the SDC (staff development coordinator) or designee to the Licensed Nurses on following the processes for medication unavailability, obtaining resident medications for administration per physician order, use of Omnicell, MD notification with consideration for alternative med if able, pharmacy notification to use back up pharmacy and/or alternative to inform MD if applicable, if no alternative obtain MD order to hold and give when available, if prior authorization /approval is required by DON or Administrator, pharmacy will send limited quantity until approved by DON or Administrator, medication administration with professional standards of documentation accurate to administration. Audits by the Unit Manager or designee weekly x 4 weeks to verify new admits residents or changes in residents' medications are available as ordered with accurate documentation of administration of the medication. Findings will be corrected. The results will be reported to the monthly Quality Committee for review and discussion to ensure substantial compliance. Once the QA Committee determines the problem no longer exists, then review will be completed on a random basis. Date of complaince 9/25/24. The facility provided credible evidence the education had been provided prior to entrance, as alleged. A review of the facility policy, General Guidelines for Medication Administration, revealed, in part: If a medication with a current, active order cannot be located in the medication cart/drawer, other areas of the medication cart, medication room, and facility (e.g. other units) are searched, if possible. If the medication cannot be located after further investigation, the pharmacy is contacted or medication removed from the emergency kit. No further information was provided prior to exit. References (1) Azithromycin is used to treat certain bacterial infections, such as bronchitis; pneumonia; sexually transmitted diseases (STD); and infections of the ears, lungs, sinuses, skin, throat, and reproductive organs. Azithromycin also is used to treat or prevent disseminated Mycobacterium avium complex (MAC) infection [a type of lung infection that often affects people with human immunodeficiency virus (HIV)]. Azithromycin is in a class of medications called macrolide antibiotics. It works by stopping the growth of bacteria. This information is taken from the website https://medlineplus.gov/druginfo/meds/a697037.html. (2) The combination of abacavir, dolutegravir, and lamivudine is used alone or along with other medications to treat HIV infection in certain adults and children 3 months or older. Although abacavir, dolutegravir, and lamivudine will not cure HIV, these medications may decrease your chance of developing acquired immunodeficiency syndrome (AIDS) and HIV-related illnesses such as serious infections or cancer. This information is taken from the website https://medlineplus.gov/druginfo/meds/a617015.html. (3) Disseminated Mycobacterium avium-intracellulare complex (MAC) infection is one of the relatively common opportunistic infections seen in severely immunocompromised AIDS patients. This information is taken from the website https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5692144/.

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure menus must meet the nutritional needs of residents, be prepared in advance, be followed, be updated, be reviewed by dietician, and meet the needs of the resident. 32642 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to serve food according to the menu for three of 24 residents in the survey sample, Residents #21, #22, and #23. The findings include: 1. For Resident #21 (R21), the facility staff failed to serve food according to the established menu at dinner on 9/26/24 and breakfast on 9/27/24. On 9/26/24 at 5:04 p.m., R21 was observed sitting in bed. CNA (certified nursing assistant) #2 was feeding the resident. The resident's meal tray contained chicken and carrots. The posted menu for dinner on 9/26/24 was honey mustard chicken, orzo, and California blend vegetables. No California blend vegetables or orzo were visible on the plate. On 9/27/24 at 8:33 a.m., R21 was observed sitting up in her bed. CNA #4 was preparing to feed R21 breakfast. The resident's plate contained mechanically chopped sausage, pancakes, and oatmeal. The posted menu for breakfast on 9/27/24 was Belgian waffle with topping and bacon strips. On 9/27/24 at 10:07 a.m., OSM (other staff member) #3, a dietary director at a sister facility, was interviewed. She stated: We have a menu in place. Meal tickets should match the menu, and the food on the tray should match the menu. She stated if a resident wants an alternate from what is listed on the menu, the resident or staff may contact the kitchen and make a request. She stated she was not sure what process the facility was following for preparing food according to the established menu at dinner on 9/26/24 or breakfast on 9/27/24. She added: The food on the tray did not match the menu. On 9/30/24 at 5:22 p.m., ASM (administrative staff member) #1, the acting administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy, Select Menus, revealed, in part: Select menus will be provided to all individuals who choose to make their own menu selections. Assistance from family or staff is encouraged for those who cannot make their own choices. 1. Food and nutrition services staff will label menus with the individual's name, room number and diet, and deliver the menus. 2. Nursing and/or other facility staff may assist in the delivery of menus and in menu selection as deemed necessary. Family members will be encouraged to assist when needed. Menus will be returned to the department of food and nutrition services when complete. 3. The director of food and nutrition services or designee will review menu selections for individuals on therapeutic diets, and refer to the registered dietitian nutritionist (RDN) or designee if there are concerns. a. The RDN or designee will counsel individuals, if needed, on appropriate choices for their therapeutic diets to encourage a nutritionally adequate diet and will document accordingly in the medical record. The RDN or designee will interview the individual regarding nutritional interventions that are acceptable (i.e. milkshake, fortified cereal, etc.) for those needing high calorie/protein supplements or other nutrition interventions. No further information was provided prior to exit. (continued on next page)

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F 0803 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #22 (R22), the facility staff failed to serve food according to the established menu at dinner on 9/26/24 and breakfast on 9/27/24. On 9/26/24 at 5:06 p.m., R22 was observed sitting in bed eating dinner. The resident's meal tray contained chicken and carrots. The posted menu for dinner on 9/26/24 was honey mustard chicken, orzo, and California blend vegetables. No California blend vegetables or orzo were visible on the plate. On 9/27/24 at 8:18 a.m., R22 was observed sitting up in her bed. The resident's plate contained toast and eggs. The posted menu for breakfast on 9/27/24 was Belgian waffle with topping and bacon strips. On 9/27/24 at 10:07 a.m., OSM (other staff member) #3, a dietary director at a sister facility, was interviewed. She stated: We have a menu in place. Meal tickets should match the menu, and the food on the tray should match the menu. She stated if a resident wants an alternate from what is listed on the menu, the resident or staff may contact the kitchen and make a request. She stated she was not sure what process the facility was following for preparing food according to the established menu at dinner on 9/26/24 or breakfast on 9/27/24. She added: The food on the tray did not match the menu. On 9/30/24 at 5:22 p.m., ASM (administrative staff member) #1, the acting administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit. 3. For Resident #23 (R23), the facility staff failed to serve food according to the established menu at breakfast on 9/27/24. On 9/27/24 at 8:44 a.m., R23 was observed sitting up in her bed. CNA #3 was feeding the resident breakfast. The resident's plate contained eggs and bacon. The posted menu for breakfast on 9/27/24 was Belgian waffle with topping and bacon strips. On 9/27/24 at 10:07 a.m., OSM (other staff member) #3, a dietary director at a sister facility, was interviewed. She stated: We have a menu in place. Meal tickets should match the menu, and the food on the tray should match the menu. She stated if a resident wants an alternate from what is listed on the menu, the resident or staff may contact the kitchen and make a request. She stated she was not sure what process the facility was following for preparing food according to the established menu at dinner on 9/26/24 or breakfast on 9/27/24. She added: The food on the tray did not match the menu. On 9/30/24 at 5:22 p.m., ASM (administrative staff member) #1, the acting administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. 32642 Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to serve palatable food for three of 24 residents in the survey sample, Residents #21, #22, and #23. The findings include: 1. For Resident #21 (R21), the facility staff failed to serve carrots at a palatable texture and temperature at dinner on 9/26/24, and failed to serve toast and oatmeal at a palatable texture and temperature at breakfast on 9/27/24. On 9/26/24 at 5:04 p.m., R21 was observed sitting in bed. CNA (certified nursing assistant) #2 was feeding the resident. The resident's meal tray contained chicken and carrots. CNA #2 was observed to attempt to cut the resident's carrots into smaller pieces before feeding them to her. CNA #2 was unable to cut the carrots with a fork or knife. CNA #2 said: These carrots are so hard I can't cut them. CNA #2 stated the carrots were cold to her touch. On 9/27/24 at 8:33 a.m., R21 was observed sitting up in her bed. CNA #4 was preparing to feed R21 breakfast. The resident's plate contained pancakes and oatmeal. CNA #4 stated: These pancakes are hard; they are hard to cut with a knife. She also reported that the pancakes and oatmeal were both cool to her touch. She added: The food comes like this all the time. On 9/27/24 at 10:07 a.m., OSM (other staff member) #3, a dietary director at a sister facility, was interviewed. She stated the cooks and dietary managers should always taste food before it leaves the kitchen to go out on resident trays. She said: When I check a meal, I taste it. All cooks should be tasting their cooking. She stated she was not certain of this facility's process for making sure the food was served at a palatable taste, and she did not know how long the food sat in the dining carts on the units before staff had the opportunity to distribute the meal trays to the residents. On 9/30/24 at 5:22 p.m., ASM (administrative staff member) #1, the acting administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy, Timely Meal Service, revealed, in part: Food will be delivered promptly to assure safe, palatable, and high quality food served at the proper temperature .Food and nutrition services staff will notify the appropriate staff as each cart is ready for delivery. Food and nutrition services staff will deliver the carts to the wings. Nursing or food and nutrition services staff will return the carts to the kitchen after meal service per facility policy .Food will be served at preferable temperatures (hot food hot and cold foods cold) as discerned by the patients/residents and customary practice. No further information was provided prior to exit. (continued on next page)

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #22 (R22), the facility staff failed to serve carrots at a palatable texture and temperature at dinner on 9/26/24, and failed to serve toast at a palatable texture and temperature at breakfast on 9/27/24. On 9/26/24 at 5:06 p.m., R22 was observed sitting in bed eating dinner. The resident's meal tray contained carrots. R22 was observed to have difficulty biting the carrots. CNA (certified nursing assistant) #2, who was feeding R22's roommate, said: These carrots are so hard, I can't cut them. CNA #2 stated the carrots were cold to her touch. On 9/27/24 at 8:18 a.m., R22 was observed sitting up in her bed. The resident's plate contained toast and eggs. CNA #3 was assisting the resident by setting up her breakfast tray. CNA #3 stated: This toast is hard as a brick. It is cold. On 9/27/24 at 10:07 a.m., OSM (other staff member) #3, a dietary director at a sister facility, was interviewed. She stated the cooks and dietary managers should always taste food before it leaves the kitchen to go out on resident trays. She said: When I check a meal, I taste it. All cooks should be tasting their cooking. She stated she was not certain of this facility's process for making sure the food was served at a palatable taste, and she did not know how long the food sat in the dining carts on the units before staff had the opportunity to distribute the meal trays to the residents. On 9/30/24 at 5:22 p.m., ASM (administrative staff member) #1, the acting administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit. 3. For Resident #23 (R23), the facility staff failed to serve oatmeal at a palatable temperature at breakfast on 9/27/24. On 9/27/24 at 8:44 a.m., R23 was observed sitting up in her bed. CNA #3 was feeding the resident breakfast. The resident's tray contained oatmeal. CNA #3 stated: She doesn't have milk in this oatmeal, and it is still cold. CNA #3 poured a small amount of oatmeal into an empty nearby cup, and the oatmeal was verified to be cold to the touch. On 9/27/24 at 10:07 a.m., OSM (other staff member) #3, a dietary director at a sister facility, was interviewed. She stated the cooks and dietary managers should always taste food before it leaves the kitchen to go out on resident trays. She said: When I check a meal, I taste it. All cooks should be tasting their cooking. She stated she was not certain of this facility's process for making sure the food was served at a palatable taste, and she did not know how long the food sat in the dining carts on the units before staff had the opportunity to distribute the meal trays to the residents. On 9/30/24 at 5:22 p.m., ASM (administrative staff member) #1, the acting administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit.

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F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. 32642 Based on observation, staff interview, and facility document review, the facility staff failed to serve food according to the residents' preferences for three of 24 residents in the survey sample, Residents #21, #22, and #23. The findings include: 1. For Resident #21 (R21), the facility staff failed to serve food according to the resident's preferences at dinner on 9/26/24 and at breakfast on 9/27/24. On 9/26/24 at 5:04 p.m., R21 was observed sitting in bed. CNA (certified nursing assistant) #2 was feeding the resident. R21's dinner meal ticket listed tea and apple juice as preferences. R21's dinner tray contained neither of these items. On 9/27/24 at 8:33 a.m., R21 was observed sitting up in her bed. CNA #4 was preparing to feed R21 breakfast. R21's breakfast meal ticket listed fresh fruit as a preference. The breakfast tray contained no fresh fruit. On 9/27/24 at 10:07 a.m., OSM (other staff member) #3, a dietary director at a sister facility, was interviewed. She stated: We have a menu in place, and I give the residents the menu for a whole day so they can choose. She stated the menus she gives the residents in her facility contain all the options for the whole day, all three meals. She stated the residents circle what they want, or write their preferences on the menus. She stated the staff help residents who are unable to write or communicate their preferences independently to the kitchen staff. She stated meal tickets should match the tray, and the dietary aides are responsible for making sure the resident receives everything that is listed on the meal ticket as a preference. She stated she was not present in the facility for dinner or 9/26/24 or for breakfast on 9/27/24. On 9/30/24 at 5:22 p.m., ASM (administrative staff member) #1, the acting administrator, and ASM #2, the director of nursing, were informed of these concerns. A review of the facility policy, Select Menus, revealed, in part: Select menus will be provided to all individuals who choose to make their own menu selections. Assistance from family or staff is encouraged for those who cannot make their own choices. a. Food and nutrition services staff will label menus with the individual's name, room number and diet, and deliver the menus. 2. Nursing and/or other facility staff may assist in the delivery of menus and in menu selection as deemed necessary. Family members will be encouraged to assist when needed. Menus will be returned to the department of food and nutrition services when complete. 3. The director of food and nutrition services or designee will review menu selections for individuals on therapeutic diets, and refer to the registered dietitian nutritionist (RDN) or designee if there are concerns. a. The RDN or designee will counsel individuals, if needed, on appropriate choices for their therapeutic diets to encourage a nutritionally adequate diet and will document accordingly in the medical record. The RDN or designee will interview the individual regarding nutritional interventions that are acceptable (i.e. milkshake, fortified cereal, etc.) for those needing high calorie/protein supplements or other nutrition interventions. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit. 2. For Resident #22 (R22), the facility staff failed to serve food according to the resident's preferences at dinner on 9/26/24 and at breakfast on 9/27/24. On 9/26/24 at 5:06 p.m., R22 was observed sitting in bed eating dinner. R22's dinner meal ticket listed fresh fruit, cottage cheese, ginger ale, and decaffeinated coffee as preferences. The dinner tray contained none of these items. On 9/27/24 at 8:18 a.m., R22 was observed sitting up in her bed. R22's breakfast meal ticket listed fresh fruit as a preference. The breakfast tray contained no fresh fruit. On 9/27/24 at 10:07 a.m., OSM (other staff member) #3, a dietary director at a sister facility, was interviewed. She stated: We have a menu in place, and I give the residents the menu for a whole day so they can choose. She stated the menus she gives the residents in her facility contain all the options for the whole day, all three meals. She stated the residents circle what they want, or write their preferences on the menus. She stated the staff help residents who are unable to write or communicate their preferences independently to the kitchen staff. She stated meal tickets should match the tray, and the dietary aides are responsible for making sure the resident receives everything that is listed on the meal ticket as a preference. She stated she was not present in the facility for dinner or 9/26/24 or for breakfast on 9/27/24. On 9/30/24 at 5:22 p.m., ASM (administrative staff member) #1, the acting administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit. 3. For Resident #23 (R23), the facility staff failed to serve food according to the resident's preferences at breakfast on 9/27/24. On 9/27/24 at 8:44 a.m., R23 was observed sitting up in her bed. CNA #3 was feeding the resident breakfast. R23's breakfast meal ticket listed fresh fruit and orange juice as preferences. The breakfast tray contained no fresh fruit or orange juice. While CNA #3 was feeding the resident her eggs, R23 asked for ketchup for her eggs. Without checking for ketchup availability, CNA #3 stated: We don't have ketchup here. On 9/27/24 at 10:07 a.m., OSM (other staff member) #3, a dietary director at a sister facility, was interviewed. She stated: We have a menu in place, and I give the residents the menu for a whole day so they can choose. She stated the menus she gives the residents in her facility contain all the options for the whole day, all three meals. She stated the residents circle what they want, or write their preferences on the menus. She stated the staff help residents who are unable to write or communicate their preferences independently to the kitchen staff. She stated meal tickets should match the tray, and the dietary aides are responsible for making sure the resident receives everything that is listed on the meal ticket as a preference. She stated she was not present in the facility for dinner or 9/26/24 or for breakfast on 9/27/24, but she was certain there was ketchup available for residents at all times. (continued on next page)

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	09/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westport Rehabilitation and Nursing Center	7300 Forest Ave Richmond, VA 23226

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 9/30/24 at 5:22 p.m., ASM (administrative staff member) #1, the acting administrator, and ASM #2, the director of nursing, were informed of these concerns. No further information was provided prior to exit.