Printed: 04/30/2025
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495096	A. Building B. Wing	10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westminster-Canterbury of Richmond	1600 Westbrook Ave Richmond, VA 23227

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow professional standards of practice for documentation for one of four residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed to document assessments, interventions, and vital signs in the clinical record on 10/19/24. A review of R1's nurses' progress notes revealed the following: 10/19/24 19:44 (7:44 p.m.) Resident remains lethargic. BP remains low 88/43. Resident responds to tactile and verbal stimuli. Has declined PO (by mouth) this evening. [Name of attending physician] updated. No new orders. 10/19/24 19:57 (7:57 p.m.) Per [name of attending physician] change Morphine to 15 mg (milligrams) every 8 hours and hold Metoprolol tonight. 10/20/24 01:15 (1:15 a.m.) Resident continues with lethargy, night medications of Morphine, Metoprolol held. Resident blood pressure decline 70/56 and repeat was 56/31. On call NP (nurse practitioner) notified. Gave order for transfer. This note was written by RN (registered nurse) #1. (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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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 1:57 p.m., RN (registered nurse) #1 was interviewed. She was caring for R1 at the time of her transfer to the hospital. She stated this was her first time of taking care of R1. The day nurse told her that R1 had been responsive but lethargic, and that Morphine and Metoprolol should be held until the morning. R1 produced a notebook with her notes regarding R1 from the night shift of 10/19/24. She stated her notes indicated that around 9:00 p.m., the resident's blood pressure was 95/57, and that her O2 (blood oxygen saturations) were fluctuation in the low 80s. She applied oxygen at 2 liters per minute, and R1's O2 increased to 95%, She stated at around 10:10 p.m., R1's O2 was still 95%. She stated she looked in on the resident frequently, called her, name, and rubbed her face. She stated the resident always responded to her. She stated around 11:30 p.m., R1's blood pressure was 70/56, She rechecked it and it was 70/40. She notified her supervisor, who rechecked the blood pressure manually, and it was 56/31. At this time, she called the on-call nurse practitioner, who gave the order to send R1 to the hospital. RN #1 stated none of this information could be found in the resident's clinical record because she had not transcribed it from her personal notebook to the facility's electronic medical record. She said if she had it to do over again, she would have recorded this information in R1's clinical record. She stated it is important for the resident's continuation of care for all care that is given to be documented in the clinical record. On 10/30/24 at 2:58 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. ASM #2 stated RN #1 did not follow accepted nursing standards of practice for documentation when she did not include all of her assessments and interventions in R1's medical record for 10/19/24. She stated the clinical record is a primary method of relaying information from one nurse to another, and for providers to see what has and has not worked. A review of the facility policy, Charting and Documentation, revealed, in part: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record .All observations, medications administered, services performed, etc., must be documented in the resident's electronic medical record or progress notes as indicated. No additional information was provided prior to exit.

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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 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 32642 Based on staff interview, facility document review, and clinical record review, the facility staff failed to maintain a complete, accurate clinical record for one of four residents in the survey sample, Resident #1. The findings include: For Resident #1 (R1), the facility staff failed maintain a complete, accurate medical record by documenting assessments, interventions, and vital signs in the clinical record on 10/19/24. A review of R1's nurses' progress notes revealed the following: 10/19/24 19:44 (7:44 p.m.) Resident remains lethargic. BP remains low 88/43. Resident responds to tactile and verbal stimuli. Has declined PO (by mouth) this evening. [Name of attending physician] updated. No new orders. 10/19/24 19:57 (7:57 p.m.) Per [name of attending physician] change Morphine to 15 mg (milligrams) every 8 hours and hold Metoprolol tonight. 10/20/24 01:15 (1:15 a.m.) Resident continues with lethargy, night medications of Morphine, Metoprolol held. Resident blood pressure decline 70/56 and repeat was 56/31. On call NP (nurse practitioner) notified. Gave order for transfer. This note was written by RN (registered nurse) #1. On 10/30/24 at 1:57 p.m., RN (registered nurse) #1 was interviewed. She was caring for R1 at the time of her transfer to the hospital. She stated this was her first time of taking care of R1. The day nurse told her that R1 had been responsive but lethargic, and that Morphine and Metoprolol should be held until the morning. R1 produced a notebook with her notes regarding R1 from the night shift of 10/19/24. She stated her notes indicated that around 9:00 p.m., the resident's blood pressure was 95/57, and that her O2 (blood oxygen saturations) were fluctuation in the low 80s. She applied oxygen at 2 liters per minute, and R1's O2 increased to 95%, She stated at around 10:10 p.m., R1's O2 was still 95%. She stated she looked in on the resident frequently, called her, name, and rubbed her face. She stated the resident always responded to her. She stated around 11:30 p.m., R1's blood pressure was 70/56, She rechecked it and it was 70/40. She notified her supervisor, who rechecked the blood pressure manually, and it was 56/31. At this time, she called the on-call nurse practitioner, who gave the order to send R1 to the hospital. RN #1 stated none of this information could be found in the resident's clinical record because she had not transcribed it from her personal notebook to the facility's electronic medical record. She said if she had it to do over again, she would have recorded this information in R1's clinical record. She stated it is important for the resident's continuation of care for all care that is given to be documented in the clinical record. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/30/24 at 2:58 p.m., ASM (administrative staff member) #1, the administrator, and ASM #2, the director of nursing, were informed of these concerns. ASM #2 stated RN #1 did not follow accepted nursing standards of practice for documentation when she did not include all of her assessments and interventions in R1's medical record for 10/19/24, and that R1's clinical record was not complete. She stated the clinical record is a primary method of relaying information from one nurse to another, and for providers to see what has and has not worked. A review of the facility policy, Charting and Documentation, revealed, in part: All services provided to the resident, or any changes in the resident's medical or mental condition, shall be documented in the resident's medical record .All observations, medications administered, services performed, etc., must be documented in the resident's electronic medical record or progress notes as indicated. No additional information was provided prior to exit.