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	06/12/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42183 Based on staff interview, resident interview, facility document review and clinical record review, it was determined the facility staff failed to ensure an assessment was completed for medication self-administration for one of 20 residents, Resident #30. The findings include: The facility staff failed to ensure Resident #30 was assessed for self-administration of medication. Resident #30 was admitted to the facility on [DATE] with diagnosis that included but were not limited to: osteoarthritis, spondylosis and bipolar disorder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 4/21/24, coded the resident as scoring a 15 out of 15 on the BIMS (brief interview for mental status) score, indicating the resident was not cognitively impaired. A review of the comprehensive care plan dated 7/19/23, which revealed, FOCUS: The resident has pain due to osteoarthritis and gout. INTERVENTIONS: Assess need for pain medication on each contact. Assess effectiveness of pain medication. A review of the physician orders dated 6/4/23 revealed, Tylenol Extra Strength 500 mg tablet. 1000 mg by mouth every 8 hours as needed (may self-medicate Tylenol per physician). On 6/11/24 at 10:23 AM, in Resident #30's room, observation of one bottle of 500 milligram Tylenol caplets. Bottle had cap on with approximately one half full of the 100-caplet bottle. Resident was not in their room. On 6/11/24 at 11:30 AM, Resident #30 was in their room. A Tylenol bottle was still on bedside cabinet unsecured. When asked about the Tylenol, Resident #30 stated, yes, that is my Tylenol and the facility said I could have it but should keep it in the top drawer, I forgot to put it back in the drawer before I went to art class. Tylenol bottle still on bedside cabinet. (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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 6/12/24 at 8:00 AM, an interview was conducted with ASM (administrative staff member) #2, the director of nursing. ASM #2 stated, we realized that when the resident was readmitted a self-administration of medication evaluation was not done. We did it last night and made sure that the resident knew how to lock the Tylenol up. I have provided you a copy of the evaluation dated 6/11/24at 4:05 PM. On 6/12/24 at 9:05 AM an interview was conducted with LPN (licensed practical nurse) #2 when asked about Resident #30's Tylenol, LPN #2 stated, yes, we did not have the Tylenol locked up and yes, we should have done a self-administration of medication evaluation prior to her having it at the bedside. On 6/12/24 at 11:50 AM, ASM #1, the administrator, ASM #2, the director of nursing and ASM #3 the assistant director of nursing was made aware of the findings. On 6/12/24 at 12:00 PM, ASM #1 stated, we have no further evidence for the finding. A review of the facility's Self-administration of Medication policy revealed, Each resident desiring to self-administer medication is permitted to do so if the facility has determined that the practice would be clinically appropriate for the resident. The ability to self-administer medications will be documented in the physician's orders. The assessment will be completed by the nurse. No further 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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to implement the comprehensive care plan for one of 20 residents in the survey sample, Resident #76. The findings include: For Resident #76, (R76), the facility staff failed to implement the resident's comprehensive care plan for diabetic medication administration. A review of R76's clinical record revealed a physician's order dated 1/31/24 for Basaglar KwikPen U-100 insulin, 100 units/milliliter- 10 units once daily for diabetes. The order further documented to hold the insulin if the resident's blood sugar was less than 100. R76's comprehensive care plan dated 4/5/24 documented, (Name) is at risk for hypo/hyperglycemia and complications of diabetes will be minimized. Administer diabetic meds per MD (medical doctor) order. A review of R76's June medication administration record revealed that on 6/1/24, the insulin was administered although the resident's blood sugar was 94. On 6/12/24 at 10:07 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated the care plan is an action plan and includes the things staff sets in place for residents' care. LPN #1 stated the staff individualizes care for each resident and the nurses have to review the care plan monthly. LPN #1 stated that if a resident has a physician's order to hold insulin for a blood sugar less than 100 and the resident's blood sugar is 94 then the resident's insulin should be held because that is the physician's order. On 6/12/24 at 11:49 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Person-Centered Care Plans documented, (Name of facility) Nursing Staff will develop a person-centered comprehensive plan of care to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of the resident.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38615 Based on record review and staff interviews, the facility failed to monitor the neurological status post unwitnessed falls putting the residents at risk for undetected neurological deterioration. This failure affected 2 of 6 residents reviewed for falls (Residents (R) #50 and #68). This deficient practice was evidenced by the following: 1. A review of the medical record revealed, R#50 was originally admitted to the facility on [DATE] with a current admitted [DATE]. The diagnoses including but not limited to fractured shaft of right fibula, pain in right ankle and joints of right foot, Parkinson's Disease, unspecified dementia with unspecified severity, history of repeated falls, unspecified cerebral infarction (stroke) and abnormal posture. R#50's Minimum Data Set (MDS), Brief Interview for Mental Status (BIMS) score was 4 (The BIMS test presents a scoring scale that guides the interpretation: 0 to 7 points indicates severe cognitive impairment, 8 to 12 points indicates moderate cognitive impairment, 13 to 15 points indicates that cognition is intact). A report dated 10/16/2023 at 03:00 PM indicated R#50 was found in the room on the floor next to a wheelchair on their knees. A nurses note dated 10/16/2023, indicated R#50 had an unwitnessed fall in room around 03:00 PM. The Neurological Assessment Flowsheet dated 06/12/2024 indicated neurological assessments were started at 10/16/2023 at 03:00 PM. The neurological assessments for 10/16/2023 at 03:15 PM, 03:30 PM, and 10/17/2023 at 12:00 PM were omitted. 2. R#68 was originally admitted to the facility on [DATE] with the current admitted [DATE]. The diagnoses including but not limited to unspecified Alzheimer's disease and muscle weakness (generalized). R#68's Minimum Data Set (MDS), Brief Interview for Mental Status (BIMS) score was 4 (The BIMS test presents a scoring scale that guides the interpretation: 0 to 7 points indicates severe cognitive impairment, 8 to 12 points indicates moderate cognitive impairment, 13 to 15 points indicates that cognition is intact). - A report dated 03/30/2024 at 04:50 PM indicated, CNA stated #### witness resident losing her balance after bumping into a piece of furniture in another resident room but was unable to brace resident's fall in time and witnessed resident falling onto floor bracing fall with #### left arm and hitting #### head. Per report, the R#68 stated, I hurt my head. The report further stated, nurse assessed resident noted 5.5cm (centimeter) x 4. 5cm (centimeter) raised bump on forehead. The Neurological Assessment Flowsheet dated 03/30/2024 indicated neurological assessments were started at 03/30/2024 at 04:50 PM. The neurological assessments for 03/30/2024 at 05:17 PM, 05:35 PM, 06:20 PM, 06:50 PM, 09:50 PM, 03/31/2024 at 01:50 AM, 05:50 AM, 01:50 PM, 09:50 PM, and 04/01/2024 at 05:50 AM were omitted. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A report dated 04/02/2024 at 06:10 AM, staff heard a loud noise and entered the resident's room and resident was lying in front of #### recliner on #### right shoulder. Resident assessed for injuries no new ones were noted. Resident helped into #### bed and neuro checks (neurological assessment) were initiated. The Neurological Assessment Flowsheet dated 04/02/2024 indicated neurological assessments were started at 04/02/2024 at 06:10 AM. The neurological assessments, specifically, motor functions were omitted for 04/02/2024 at 06:25 AM, 06:55 AM, 07:40 AM, and 08:10 AM. Review of facility policy titled, Fall Prevention and Management Program dated 02/08/2022. Under Post Fall Management and Reporting, Section C. Post Fall Management, 3. Unwitnessed falls with unverifiable head trauma by resident and those with head trauma will have a neurological assessment according to Post-Fall management protocol. (Utilize the Post Fall management protocol under attachment A.) Under attachment A Section B Minor Head Trauma, 1. Use the same protocol outlined above and perform neurological assessments as followed: Q (every) 15 minutes x4 Q30 minutes x2 Q1 hour x1 Q2 hours x1 Q4 hours x2 Q8 hours x3 On 06/12/2024 at 03:42 PM, the administrative staff member (ASM)#2 and registered nurse (RN) #1 were interviewed. RN#1 stated that if a resident has experienced an unwitnessed fall or hits head neurological checks must be done. ASM#2 stated the expectation for nursing staff is fully complete neurological checks as prescribed in the facility policy.

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. 31753 Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure a resident was free from an unnecessary medication for one of 20 residents in the survey sample, Resident #76. The findings include: For Resident #76, (R76), the facility staff failed to hold the resident's insulin on 6/1/24, per a physician's order. A review of R76's clinical record revealed a physician's order dated 1/31/24 for Basaglar KwikPen U-100 insulin, 100 units/milliliter- 10 units once daily for diabetes. The order further documented to hold the insulin if the resident's blood sugar was less than 100. A review of R76's June medication administration record revealed that on 6/1/24, the insulin was administered although the resident's blood sugar was 94. On 6/12/24 at 10:07 a.m., an interview was conducted with LPN (licensed practical nurse) #1. LPN #1 stated that if a resident has a physician's order to hold insulin for a blood sugar less than 100 and the resident's blood sugar is 94 then the resident's insulin should be held because that is the physician's order. On 6/12/24 at 11:49 a.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of nursing) were made aware of the above concern. The facility policy titled, Medication Administration, Including Administration Times documented, Medication will be administered according to best nursing practice for accuracy, timeliness, effectiveness and according to physician's order.