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	12/04/2024

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 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to prevent an avoidable accident for one of six residents in the survey sample, Resident #1. This accident resulted in a fractured pelvis and intractable pain for Resident #1, constituting harm. The facility presented a plan of correction with an allegation of compliance date prior to survey entrance. The facility presented credible evidence that the plan of correction had been implemented, resulting in a finding of past noncompliance. The findings include: For Resident #1 (R1), the facility staff failed to correctly use the mechanical lift, resulting in a fall with a fractured pelvis for R1. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/14/24, R1 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as being completely dependent on facility staff for transfers from bed to chair. A review of R1's clinical record revealed the following Fall Note dated 11/29/24: Description of the fall . Resident was found on floor next to bed. CNA's (certified nursing assistants) present. Per Unit Manager writer was told to go call 911. Writer did as instructed and printed paperwork and met EMS (emergency medical services) at nursing station. Writer was told that Resident slid out of Hoyer lift to the floor. What interventions were in place at the time of the fall: CNAs instructed on proper use of lift equipment .What new interventions were implemented in response to the fall: Instructing CNAs to always have two aides that have been properly trained on of lift equipment when transferring residents. This fall note was written by RN (registered nurse) #1, who was unavailable for interview during the survey. Further review of R1's clinical record revealed the following progress notes: 11/29/2024 20:51(8:51 p.m.) Resident returned from emergency room via stretcher .She has a Sacral Fracture. (continued on next page)

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

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F 0689 Level of Harm - Actual harm Residents Affected - Few	11/29/24 21:45 (9:45 p.m.) Nursing observations, evaluation, and recommendations are: Resident - post fall this morning. She returned from ER (emergency room) with Sacral Fracture per hospital discharge paper work. Resident is grimacing and moaning when transferred and turned in bed from Transport Stretcher. Oxycodone medication is given by mouth. Resident is to be sent to emergency room for Sacral Fracture and unmanaged pain per provider. On 12/3/23 at 2:04 p.m., ASM (administrative staff member) #2, the director of nursing, and ASM #3, the assistant administrator, were interviewed. ASM #2 stated the facility had a plan of correction related to this incident. ASM #2 stated two CNAs were present in the room when R1 fell from the Hoyer lift. ASM #2 stated: They were using the sling correctly when the resident slid out. When asked why a plan of correction was needed if the Hoyer lift had been used correctly, ASM #2 stated she always does a plan of correction for a resident fall with fracture. She stated the plan of correction centered around re-education of the staff on how to correctly use a Hoyer mechanical lift. ASM #2 stated the CNAs in the room at the time of R1's fall were CNA #1 and CNA #2. On 12/3/24 at 2:35 p.m., LPN (licensed practical nurse) #1was interviewed. She stated she was the charge nurse when R1 experienced a fall on 11/29/24. She stated she was not in the room when the fall happened. She stated she heard screaming as she was leaving the supervisor's (RN #1's) office, and she ran to R1's room. She realized R1 was on the floor and crying hysterically. She stated the Hoyer lift was elevated to a level where the sling seat was just above her head. She stated RN #1 entered the room after she did, and immediately instructed her to call EMS. She stated she never went back in the room until EMS arrived because she was busy preparing paperwork for the EMS staff. She stated she did not know what transpired prior to the resident falling out of the Hoyer lift. She stated she was sure that one of the CNAs in the room at the time of R1's fall was on orientation, and had not yet been trained on the use of the Hoyer lift. On 12/3/24 at 3:01 p.m., CNA #1 was interviewed. She stated she and CNA #2 worked together to place R1 in the sling for the Hoyer lift. She stated she helped CNA #2 secure a couple of the sling straps to the lift frame, but could not remember exactly how this worked. CNA #1 stated she was in control of the lift remote, and asked R1 if she was ready. She began to lift the sling using the remote, and noticed the resident was looking contracted in the sling. She stated: I wasn't sure if that's how she usually looked. She stated the resident then just slid out. She stated she does not think the sling was positioned correctly under the resident's lower body, possibly causing the fall. She added: I think [CNA #2] just didn't notice. CNA #1 stated she is still in orientation, and has not yet been checked off in safe use of the lift. On 12/3/24 at 3:20 p.m., CNA #2 was interviewed. She stated R1 had asked to be moved from the wheelchair to her bed. She stated she does not normally care for R1, so was not sure how the Hoyer lift normally functioned for R1. She stated she tugged on all the connections to make sure they were secure, and attached the sling to the lift frame. She stated she CNA #1 began to lift the resident using the sling. As CNA #2 was attempting to make her way around the resident to guide her into the bed, the resident fell out. She stated R1 fell and hit her buttocks hard on the floor. She stated the resident fell from a level just below her (CNA #2's) chest. She stated the resident did not hit her head on the floor. When asked what went wrong, she stated she is still trying to figure out what happened. When asked if she was aware at the time that CNA #1 had not been signed off on the use of Hoyer lifts, she stated she had not worked with CNA #1 before, but she asked her about her Hoyer lift experience. CNA #1 told her she had used the lift in previous facilities. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 12/3/24 at 3:32 p.m., Resident # 4 (R4), R1's roommate, was interviewed. She stated she was awake and aware at the time of the fall, but was not able to see how the resident was positioned in the mechanical lift. On 12/4/24 at 9:41 a.m., R1 was interviewed. She stated she returned from the hospital after supper on 12/3/24. She stated she fell out of the sling because the sling was not positioned correctly. She stated the sling was not positioned all the way down to her knees, but was only positioned just a little below her buttocks. She stated she has no feeling on the left side of her body, so she was unaware of the sling positioning. She said she did not think either CNA was paying very close attention when the accident happened. She stated CNA #1 jerked the lift twice in an effort to move it from over the wheelchair towards the bed, and these jerking motions caused her to slip out of the sling. On 12/4/24 at 11:13 a.m., ASM #2 was interviewed. She agreed that if the Hoyer lift had been used correctly, the resident should not have sustained a fall. On 12/4/24 at 2:00 p.m., ASM #1, the administrator, ASM #2, and ASM #3 were informed of these concerns. A review of the facility's plan of correction revealed, in part: Problem: Fall with major injury/Transfer - Mechanical Lift .Problem: Resident sustained a fall with a major injury during a 2 person assist with mechanical lift. Immediate Response - what was done at the time: Fall assessment and sent to ER for evaluation. IDT (interdisciplinary team)/DON (director of nursing) Risk meeting to discuss and review the facility fall prevention program and a 4-point plan initiated on 2 person assist/mechanical lift to maintain safety while transfer to reduce falls or major injury. How to Identify other residents that might be impacted: Audit by DON or designee on residents to verify with 2 person assist/mechanical lift. What Measures were put in place to prevent reoccurrence: The DON or designee will educate the licensed nurses and CNAs on approaches to managing residents with 2 person assist/transfer - mechanical lift to maintain safety such as adjusting Hoyer lift pad and maintain contact guard and prevent falls with or without injury. How to monitor to ensure the problem does not reoccur: The UM (unit manager) or designee will audit weekly X 4 on resident with change of condition or new admitted residents who are identified as 2 person assist for mechanical lift. 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 Compliance: 12/2/24. The facility presented credible evidence, including audits and staff education, that this plan was implemented as described and completed by 12/2/24. No further information was provided prior to exit.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on resident interview, staff interview, facility document review, and clinical record review, the facility staff failed to prevent an unevaluated CNA (certified nursing assistant) from operating a mechanical lift for one of three CNA (certified nursing assistant) records reviewed, CNA #1. The findings include: CNA #1 was allowed to operate a Hoyer lift while caring for Resident #1 (R1) prior to having her competency to do so reviewed by facility staff. On the most recent MDS (minimum data set), a quarterly assessment with an ARD (assessment reference date) of 11/14/24, R1 was coded as having no cognitive impairment for making daily decisions, having scored 15 out of 15 on the BIMS (brief interview for mental status). She was coded as being completely dependent on facility staff for transfers from bed to chair. A review of R1's clinical record revealed the following Fall Note dated 11/29/24: Description of the fall . Resident was found on floor next to bed. CNA's (certified nursing assistants) present. Per Unit Manager writer was told to go call 911. Writer did as instructed and printed paperwork and met EMS (emergency medical services) at nursing station. Writer was told that Resident slid out of Hoyer lift to the floor. What interventions were in place at the time of the fall: CNAs instructed on proper use of lift equipment .What new interventions were implemented in response to the fall: Instructing CNAs to always have two aides that have been properly trained on of lift equipment when transferring residents. This fall note was written by RN (registered nurse) #1, who was unavailable for interview during the survey. On 12/3/23 at 2:04 p.m., ASM (administrative staff member) #2, the director of nursing, and ASM #3, the assistant administrator, were interviewed. ASM #2 stated the facility had a plan of correction related to this incident. ASM #2 stated two CNAs were present in the room when R1 fell from the Hoyer lift. ASM #2 stated: They were using the sling correctly when the resident slid out. When asked why a plan of correction was needed if the Hoyer lift had been used correctly, ASM #2 stated she always does a plan of correction for a resident fall with fracture. She stated the plan of correction centered around re-education of the staff on how to correctly use a Hoyer mechanical lift. ASM #2 stated the CNAs in the room at the time of R1's fall were CNA #1 and CNA #2. On 12/3/24 at 2:35 p.m., LPN (licensed practical nurse) #1was interviewed. She stated she was the charge nurse when R1 experienced a fall on 11/29/24. She stated she was not in the room when the fall happened. She stated she heard screaming as she was leaving the supervisor's (RN #1's) office, and she ran to R1's room. She realized R1 was on the floor and crying hysterically. She stated the Hoyer lift was elevated to a level where the sling seat was just above her head. She stated RN #1 entered the room after she did, and immediately instructed her to call EMS. She stated she never went back in the room until EMS arrived because she was busy preparing paperwork for the EMS staff. She stated she did not know what transpired prior to the resident falling out of the Hoyer lift. She stated she was sure that one of the CNAs in the room at the time of R1's fall was on orientation, and had not yet been trained on the use of the Hoyer lift. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 12/3/24 at 3:01 p.m., CNA #1 was interviewed. She stated she and CNA #2 worked together to place R1 in the sling for the Hoyer lift. She stated she helped CNA #2 secure a couple of the sling straps to the lift frame, but could not remember exactly how this worked. CNA #1 stated she was in control of the lift remote, and asked R1 if she was ready. She began to lift the sling using the remote, and noticed the resident was looking contracted in the sling. She stated: I wasn't sure if that's how she usually looked. She stated the resident then just slid out. She stated she does not think the sling was positioned correctly under the resident's lower body, possibly causing the fall. She added: I think [CNA #2] just didn't notice. CNA #1 stated she is still in orientation, and has not yet been checked off in safe use of the lift. On 12/3/24 at 3:20 p.m., CNA #2 was interviewed. She stated R1 had asked to be moved from the wheelchair to her bed. She stated she does not normally care for R1, so was not sure how the Hoyer lift normally functioned for R1. She stated she tugged on all the connections to make sure they were secure, and attached the sling to the lift frame. She stated she CNA #1 began to lift the resident using the sling. As CNA #2 was attempting to make her way around the resident to guide her into the bed, the resident fell out. She stated R1 fell and hit her buttocks hard on the floor. She stated the resident fell from a level just below her (CNA #2's) chest. She stated the resident did not hit her head on the floor. When asked what went wrong, she stated she is still trying to figure out what happened. When asked if she was aware at the time that CNA #1 had not been signed off on the use of Hoyer lifts, she stated she had not worked with CNA #1 before, but she asked her about her Hoyer lift experience. CNA #1 told her she had used the lift in previous facilities. On 12/4/24 at 9:12 a.m., RN (registered nurse) #2, the staff development director, was interviewed. She stated CNA orientation includes the use of mechanical lifts. She stated each CNA must demonstrate their ability to safely use the mechanical lift and be checked off by either a seasoned CNA, a supervisor, or a nursing management team member. She stated CNA #1 has not yet been checked off for the safe use of a Hoyer lift. She stated CNA #1 cannot function as a second staff member for the safe use of a Hoyer lift because she has not been checked off. On 12/4/24 at 9:41 a.m., R1 was interviewed. She stated she returned from the hospital after supper on 12/3/24. She stated she fell out of the sling because the sling was not positioned correctly. She stated the sling was not positioned all the way down to her knees, but was only positioned just a little below her buttocks. She stated she has no feeling on the left side of her body, so she was unaware of the sling positioning. She said she did not think either CNA was paying very close attention when the accident happened. She stated CNA #1 jerked the lift twice in an effort to move it from over the wheelchair towards the bed, and these jerking motions caused her to slip out of the sling. On 12/4/24 at 11:13 a.m., ASM #2 was interviewed. She stated CNA #1 had received some instruction in use of the Hoyer lift, but she had not yet been signed off to function independently. She stated that according to the facility's policy, CNA #1 was not qualified to be operating a Hoyer lift. On 12/4/24 at 2:00 p.m., ASM #1, the administrator, ASM #2, and ASM #3 were informed of these concerns. A review of the facility policy, Orientation, revealed, in part: Successful verbal, written, and/or return demonstration of knowledge, skills/competencies will be documented utilizing the Skills Validation Record . Skills/competencies are signed and dated by a nursing trainer and validated by the Staff Development Coordinator or designee. (continued on next page)

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information was provided prior to exit.