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	10/22/2025

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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. (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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on staff interview, facility document review, and clinical record review, the facility staff failed to protect a resident's right to consent to receiving a psychoactive medication for one of 17 residents in the survey sample, Resident #14.The findings include:For Resident #14 (R14), the facility staff failed to obtain consent from the resident prior to administering Ativan (1) on 3/1/25.A review of the MDS (minimum data set) immediately prior to 3/1/25, an annual assessment with an ARD (assessment reference date) of 2-15-25, revealed R14 was coded as having no cognitive impairment, having scored 15 out of 15 on the BIMS (brief interview for mental status).A review of R15's clinical record between 2/15/25 and 3/1/25 revealed no evidence of a change in R14's cognitive status. Multiple entries in the record named R14 as her own RP (responsible party).Further review of R15's clinical record revealed the following progress notes: 3/1/2025 15:05 (3:05 p.m.) Behavior Note.Type of Behavior: Agitation, outward expressions of anger, Striking staff with room phone x 2, attempting to strike staff with fists. Threatening roommate.Non-pharmacological intervention: redirection, removing pt to quiet area, Effect: Pt (patient) continued to scream, yell, attempt to strike staff. Social worker present, called daughter.PRN (as-needed) Medication: Order obtained for PRN Ativan [tablet], pt refused to accept. 3/1/25 14:51 (4:51 p.m. Note Text: Writer reached out to [name of nurse practitioner] for patients (sic) continued aggression/agitation and continued physical strikes to staff members despite all intervention and redirection. Provider prescribed Ativan Injection Solution 2 MG/ML (Lorazepam) stat (immediate) dose one time. Writer attempted to call daughter as well as son again. VM (voicemail) left for both x 2. Ativan IM (intramuscular injections) administered as ordered and effective.A review of R15's clinical record revealed no evidence that R14 was given the opportunity to consent to the Ativan injection she received on 3/1/25.On 10/21/25 at 1:25 p.m., LPN (licensed practical nurse) #3, a unit manager, was interviewed. She stated any medication that is administered to a resident must first be ordered by a provider. She explained that once the provider writes and signs the order, the resident (if the resident is named as their own responsible party) and/or the RP are notified prior to administering the medication. She stated every resident has the right to refuse any medication or treatment. She stated that even is a resident is exhibiting behaviors, there is always an alternative to administering a medication without the resident's consent. These include non-pharmacological interventions and sending the resident to the hospital as a last resort. She added that even if a resident is confused, if the resident does not agree to receiving a medication, the facility can not administer it.On 10/21/25 at 2:07 p.m., ASM (administrative staff member) #1, the director of nursing and RN (registered nurse) #1, the assistant director of nursing, were interviewed. ASM #1 stated that a resident has a right to refuse a medication unless the resident is posing a risk to themselves or to other residents. RN #1 stated the purpose of administering Ativan to R14 was to calm the resident down, and that non-pharmacological interventions were attempted prior to the resident's receiving the Ativan injection. She stated the resident was offered the opportunity to refuse the Ativan by mouth, and when the resident refused, the facility staff administered the Ativan by injection. She stated there was no evidence that the resident was given the opportunity to refuse the injection.On 10/22/25 at 10:10 a.m., ASM #1, ASM #2, the administrator, and RN #1 were informed of these concerns.A review of the facility policy, Refusal of Medication/Treatment/Care, revealed, in part: All patients have the right to refuse medication(s) and/or care; however, a licensed nurse is responsible for providing education to patient and/or the responsible party regarding the risk for negative outcomes.No additional information was provided prior to exit.Reference(1) Lorazepam (brand name Ativan) is used to relieve anxiety. Lorazepam is in a class of medications called benzodiazepines. It works by slowing activity in the brain to allow for relaxation. This information is taken from the website https://medlineplus.gov/druginfo/meds/a682053.html.

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. Based on observation and staff interview, the facility staff failed to accommodate a resident's need by placing the call bell within reach for one of 12 residents in the survey sample, Resident #103. The findings include:For Resident #103 (R103), the facility staff failed to place the call bell (a device with a button that can be pushed to alert staff when assistance is needed) within reach. R103 was admitted to the facility with a diagnosis that included by not limited to difficulty walking. The most recent comprehensive MDS (minimum data set) was not due at the time of the survey. The facility's admission Assessment for R103 dated 12/10/2025 documented in part, 1. Cognitive State. a) cognitively impaired. 16. admission Narrative Note: resident presents to facility by medical transport is a manual wheelchair. alert and oriented to self with confusion to time, place, and situation. pleasant affect. On 12/16/2025 at approximately 10:40 a.m. an observation of R103 in his room revealed he was sitting in his wheelchair next to the right side of the bed. When asked if he was able to locate the call bell, R103 looked around his bed and stated he did not know where it was. Observation of the call bell revealed it was draped over the left side of the headboard. After pointing out the location of the call bell to R103, he was asked if he was able to access it. Observations revealed R103 propelling his wheelchair to the opposite of the bed but unable to mauver the wheelchair alongside the left side of the bed to reach the call bell. R103 stated that he could not reach the call bell. On 12/16/2025 at approximately 10:55 a.m. an observation revealed LPN (licensed practical nurse) #5 enter R103's room, remove the call bell from the head of the bed and clip it to R103's shirt while he was sitting in his wheelchair. On 12/16/2025 at approximately 10:57 a.m. an interview was conducted with LPN # 5. When asked about the purpose of a call bell for residents she stated that it was used to call for assistance. She further stated that R103's call bell was not within his reach and should have been where R103 could access it. On 12/17/2025 at approximately 2:00 p.m. ASM (administrative staff member) # 1, administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interview, facility staff failed to maintain a clean environment for one of 12 resident rooms observed, resident room [ROOM NUMBER]. The findings include:For resident room [ROOM NUMBER], facility staff failed to maintain the PTAC (packaged terminal air conditioner) unit vents in a clean manner. On 12/16/2025 at approximately 12:45 p.m. an observation of the PTAC in resident room [ROOM NUMBER] revealed the vents to have a black, greasy substance coating them. On 12/16/2025 at approximately 3:36 p.m. an observation of the PTAC unit in resident room [ROOM NUMBER] and interview with OSM (other staff member) #7 was conducted. After observing the vents on the PTAC unit he agreed that they were not clean. When asked about maintaining the vents in a clean manner he stated that PTAC units are checked every two weeks and that this one was overlooked. On 12/17/2025 at approximately 2:00 p.m. ASM (administrative staff member) # 1, administrator, and ASM #2, director of nursing, were made aware of the above findings. No further information was provided prior to exit.

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to implement their abuse policy to report an allegation of abuse in the required timeframe for one of 17 residents in the survey sample, Resident #4.The findings include: The facility policy Reporting Requirements/Investigations effective 2/5/2023 documented in part, .Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury .Review of the facility synopsis of events documented an event for Resident #4 (R4) dated 1/27/2025 which documented in part, .Report Date: 1/27/2025. Incident Date: 1/27/2025. Resident alleged that his nurse hit him on his arm today in his room, nurse denied hitting him but that the resident attempted to strike at her and there was a witness to collaborate he attempted to strike at the nurse. Upon notification of the allegation the nurse was suspended. The Administrator interviewed the resident, assessed the skin area where he stated he was hit, there were no obvious bruises, swelling, abrasions or reddened areas. Resident was transferred to the hospital for AMS (altered mental status) today around 1:45 pm . Review of the fax transmittal confirmation of the event to the state agency documented the report sent 1/28/2025 at 10:54 AM.The progress notes for R4 documented in part, 01/27/2025 13:12 (1:12 p.m.) Note Text: Resident has been yelling throughout the shift today related to roommates' mats on floor and bedside table. Writer arranged room to accommodate resident's needs, but resident was still yelling. Writer went to check resident's BS (blood sugar) and explained to resident that he will be getting 10 units of Humalog (insulin). Resident started yelling at nurse that he is allergic to Humalog. Nurse apologized to resident and stated that I did not mean Humalog but Admelog (another brand of insulin). Resident started cursing and yelling I'm allergic to Humalog. Writer attempted to show Insulin pen to resident, when writer showed insulin pen to resident, resident attempted to grab pen from writer and then attempted to hit resident (sic). Writer backed up and walked out of room. After leaving resident's room he came out of his room and stated that nurse hit me twice. Writer went to inform ADON (assistant director of nursing) of situation.On 10/21/2025 at 2:24 PM, an interview was conducted with administrative staff member (ASM) #1, the director of nursing, who stated that R4 had alleged that the nurse had hit them. She stated that the former administrator had taken over the investigation due to her personal relationship with the accused nurse. ASM #1 stated that when there was any allegation of abuse the staff member is suspended, a pain and skin assessment is completed, a trauma screening is completed by social services, and they notified the physician and responsible party. She stated that abuse allegations were reported within two hours and the event for R4 would qualify as required to report in two hours because it was an allegation of abuse. On 10/22/2025 at 10:09 AM, ASM #1 and ASM #2, the administrator were made aware of the concern.No further information was provided prior to exit.

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. Based on staff interview, facility document review, and clinical record review, it was determined that the facility staff failed to report an allegation of abuse in the required timeframe for one of 17 residents in the survey sample, Resident #4.The findings include: Review of the facility synopsis of events documented an event for Resident #4 (R4) dated 1/27/2025 which documented in part, .Report Date: 1/27/2025. Incident Date: 1/27/2025. Resident alleged that his nurse hit him on his arm today in his room, nurse denied hitting him but that the resident attempted to strike at her and there was a witness to collaborate he attempted to strike at the nurse. Upon notification of the allegation the nurse was suspended. The Administrator interviewed the resident, assessed the skin area where he stated he was hit, there were no obvious bruises, swelling, abrasions or reddened areas. Resident was transferred to the hospital for AMS (altered mental status) today around 1:45 pm . Review of the fax transmittal confirmation of the event to the state agency documented the report sent 1/28/2025 at 10:54 AM.The progress notes for R4 documented in part, 01/27/2025 13:12 (1:12 p.m.) Note Text: Resident has been yelling throughout the shift today related to roommates' mats on floor and bedside table. Writer arranged room to accommodate resident's needs, but resident was still yelling. Writer went to check resident's BS (blood sugar) and explained to resident that he will be getting 10 units of Humalog (insulin). Resident started yelling at nurse that he is allergic to Humalog. Nurse apologized to resident and stated that I did not mean Humalog but Admelog (another brand of insulin). Resident started cursing and yelling I'm allergic to Humalog. Writer attempted to show Insulin pen to resident, when writer showed insulin pen to resident, resident attempted to grab pen from writer and then attempted to hit resident(sic). Writer backed up and walked out of room. After leaving resident's room he came out of his room and stated that nurse hit me twice. Writer went to inform ADON (assistant director of nursing) of situation.On 10/21/2025 at 2:24 PM, an interview was conducted with administrative staff member (ASM) #1, the director of nursing, who stated that R4 had alleged that the nurse had hit them. She stated that the former administrator had taken over the investigation due to her personal relationship with the nurse. ASM #1 stated that when there was any allegation of abuse the staff member is suspended, a pain and skin assessment is completed, a trauma screening is completed by social services, and they notified the physician. She stated that abuse allegations were reported within two hours and the event for R4 would qualify as required to report in two hours because it was an allegation of abuse. The facility policy Reporting Requirements/Investigations effective 2/5/2023 documented in part, .Immediately upon notification of any alleged violations involving abuse, neglect, exploitation, or mistreatment, including injuries of unknown source and misappropriation of resident property, the Administrator will immediately report to the State Agency, but not later than 2 hours after the allegation is made, if the events that caused the allegation involves abuse or results in serious bodily injury .On 10/22/2025 at 10:09 AM, ASM #1 and ASM #2, the administrator were made aware of the concern.No further information was provided prior to exit.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, the facility staff failed to complete an accurate MDS assessment for one of 17 residents in the survey sample, Resident # 1. The findings include: For Resident #1, the facility staff failed to complete an accurate quarterly MDS (minimum data set) assessment. R1 was admitted to the facility on [DATE] with diagnosis that included but were not limited to paraplegia, ASCVD (atherosclerosis cardiovascular disease) and neuromuscular dysfunction of bladder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 9/27/25, 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 MDS Section GG-functional abilities and goals coded the resident as being dependent for bed mobility, transfer, hygiene and supervision for eating. A review of MDS Section: GG0115. Functional Limitation in Range of Motion- B. Lower extremity coded 0 = no impairment. MDS Section: GG0170. Mobility: I. Walk 10 feet: coded as 88 = not attempted due to medical condition or safety concerns. A review of the comprehensive care plan dated 1/13/25 and revised 9/27/25 revealed, FOCUS: Resident is at risk for falls related to muscle weakness, related to poor balance, related to psychoactive medications. INTERVENTIONS: ensure the resident wears shoes when ambulating, place common items within reach of the resident, remind the resident to use their call light to ask for assistance with ADLS (activities of daily living).R1 had been transferred to hospital on [DATE] and was not in facility during the survey. On 10/21/25 at 7:14 AM, an interview was conducted with LPN (licensed practical nurse) #2. When asked what she remembered about R1, LPN #2 stated he could not walk and used a wheelchair. On 10/21/25 at 7:25 AM, an interview was conducted with LPN #10, the MDS coordinator. When asked to review R1's, 9/27/25 MDS functional limitations in range of motion and mobility sections and asked if there was an error in what was coded, LPN #10 stated yes, there is. When asked what standard is followed to complete the MDS, LPN #10 stated the RAI (resident assessment instrument) manual. On 10/22/25 at 10:15 AM, ASM (administrative staff member) #1, the director of nursing, ASM #2, the administrator and RN (registered nurse) #1, the assistant director of nursing, were made aware of the findings. According to the RAI (resident assessment instrument) MDS Section GG0170: Code based on the resident's performance.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 - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview facility document review and clinical record review, it was determined the facility staff failed to develop/implement the care plan for one of twelve residents in the survey sample, Resident #112 (R112).The findings include: The facility staff failed to develop the comprehensive care plan for sexual / inappropriate behavior monitoring for R112.R112 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ischemic cardiomyopathy, CHF (congestive heart failure), atrial fibrillation and LVAD (left ventricular assist device).The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 11/8/25, 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 MDS Section GG-functional abilities and goals coded the resident as requiring supervision for bathing/transfer/dressing/toileting and independent for eating.A review of the comprehensive care plan dated 10/3/24 revealed, FOCUS: Resident has behaviors refuses cardiac clinic appointments. Resident refuses daily weights. Encourage compliance with routine weight monitoring. INTERVENTIONS: assure the resident they are safe if they become distressed. Contact clinic and see if can do facility visit.During a complaint investigation regarding admission of residents on the VSP (Virginia State Police) Sex Offender Registry, R112 was found to be on the registry.On 12/17/25 at 10:45 AM, an interview was conducted with ASM (administrative staff member) #2, the DON (director of nursing). Asked if monitoring sexual / inappropriate behaviors should be on the care plan for a resident who is listed on the sex offender registry, ASM #2 stated, It should be on the care plan. I would expect it to be there.On 12/17/25 at 2:00 PM ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #3, the assistant director of nursing, RN #4, the assistant director of nursing was made aware of the concerns.According to the facility's Care Planning policy, which revealed, 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.According to the facility's Behavioral Assessment/Behavior Monitoring policy, which revealed, Behaviors will be assessed and monitored. Factors influencing behaviors, as well as management interventions will be evaluated and care planned.No further information was provided prior to exit.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, facility document review, and clinical record review, the facility staff failed to review and revise the care plan for two of 17 residents in the survey sample, Residents #5 and #1.The findings include:1. For Resident #5 (R5), the facility staff failed to review and revise the care plan after a fall. On the following dates and times, R5 was observed lying on his back in bed; there were no fall mats to either side of the bed: 10/20/25 at 2:26 p.m. and 3:48 p.m.; 10/21/25 at 9:26 a.m. A review of R5's care plan dated 4/26/25 and most recently revised on 8/22/25 revealed no information regarding the implementation of fall mats to prevent injury to R5 in case of a fall. A review of R5's clinical record revealed the following progress note dated 3/30/2025: 03:38 (3:38 a.m.) Fall Note Description of the fall.Writer was called to Resident's room because CNA (certified nursing assistant) found the resident on the floor. Resident was laying (sic) on the floor on the right side of the bed. He has a small skin tear on the left side of his forehead. Resident is suspected to have had a seizure prior to fall. Resident still showed on and off jerking spells/seizure-like movements. What interventions were in place at the time of the fall? Bed in low position, call light within reach.What are the risk factors that could have contributed to the fall? History of seizures, nonverbal -- unable to call for help.What new interventions were implemented in response to the fall? Fall mat placed, neurochecks initiated, sent to ER (emergency room). On 10/21/25 at 12:02 p.m., ASM (administrative staff member) #1, the director of nursing, stated she could not find any evidence that the facility staff reviewed or revised R5's care plan following the fall on 3/29/25. She admitted that the care plan should have been reviewed, as the care plan gives the staff directions about how to care for the resident. She added: He had a fall so it should have been reviewed. On 10/21/25 at 12:37 p.m., CNA #4 was interviewed. He stated when he arrives at work, he receives report from the nurse. If there have been changes to a resident's care plan, including interventions to prevent injuries from falls, the nurse will usually tell him. He stated he also has access to the Kardex, which takes interventions from the care plan and puts them in a format that CNAs can see on the computer kiosk. He stated he was not aware that R5 needed floor mats, although he could see how they would be helpful for the resident. On 10/21/25 at 2:42 p.m., LPN (licensed practical nurse) #4, a unit manager, was interviewed. She stated if a floor nurse determines floor mats are needed as an intervention following a resident's fall, the nurse should update the care plan, alert all the staff, and place the mats by the resident's bed. She stated that any floor nurse has the ability to update a resident's care plan at any time. On 10/22/25 at 10:10 a.m., ASM #1, ASM #2, the administrator, and RN #1 were informed of these concerns. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the facility policy, Care Planning, revealed, in part: Care plans will be updated on an ongoing basis as changes in the patient occur, and reviewed quarterly with the quarterly assessment. No additional information was provided prior to exit. 2. The facility failed to revise the comprehensive care plan for fall interventions for R1. R1 was admitted to the facility on [DATE] with diagnosis that included but were not limited to paraplegia, ASCVD (atherosclerosis cardiovascular disease) and neuromuscular dysfunction of bladder. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 9/27/25, 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 MDS Section GG-functional abilities and goals coded the resident as being dependent for bed mobility, transfer, hygiene and supervision for eating. A review of MDS Section: GG0115. Functional Limitation in Range of Motion- B. Lower extremity coded 0 = no impairment. MDS Section: GG0170. Mobility: I. Walk 10 feet: coded as 88 = not attempted due to medical condition or safety concerns. A review of the comprehensive care plan dated 1/13/25 and revised 9/27/25 revealed, FOCUS: Resident is at risk for falls related to muscle weakness, related to poor balance, related to psychoactive medications. INTERVENTIONS: ensure the resident wears shoes when ambulating, place common items within reach of the resident, remind the resident to use their call light to ask for assistance with ADLS (activities of daily living). R1 had been transferred to hospital on [DATE] and was not in facility during the survey. On 10/20/25 at 2:35 PM, an interview was conducted with LPN (licensed practical nurse) #1. When asked if she remembered R1, LPN #1 stated, yes, he could not walk and he had a foley. I changed his foley and foley bag when the NP (nurse practitioner asked me to, it was before he went to the hospital. His sister was visiting that day. When asked the purpose of the care plan, LPN #1 stated, it is to describe the care each resident needs and what interventions we are to implement to meet those needs. When asked if the care plan for R1 included an intervention of ensure the resident wears shoes when ambulating was the care plan correct, LPN #1 stated, no, because he did not walk. When asked if the care plan should be revised, LPN #1 stated, yes. On 10/21/25 at 7:14 AM, an interview was conducted with LPN #2. When asked what she remembered about R1, LPN #2 stated he could not walk and used a wheelchair. On 10/22/25 at 10:15 AM, ASM (administrative staff member) #1, the director of nursing, ASM #2, the administrator and (registered nurse) #1, the assistant director of nursing, were made aware of the findings. No further information was provided prior to exit.

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Westport Rehabilitation and Nursing Center	7300 Forest Ave Richmond, VA 23226

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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. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff interview, clinical record review and facility document review, it was determined that the facility staff failed to follow professional standards of practice to promote residents highest level of well-being for two of 17 residents in the survey sample, Resident #10 and Resident #4.The findings include: 1. For Resident #10 (R10), the facility staff failed to follow professional standards of practice during medication administration.On 10/20/2025 at 10:19 AM, an observation was made of licensed practical nurse (LPN) #5 preparing medication for R10. LPN #5 was observed removing one tablet of Folic Acid from a house stock bottle that was labeled Folic Acid 400mcg (microgram) and placing it in a medication cup and administered it to R10.Review of the physician orders for R10 documented in part, Folic Acid Oral Tablet 1 MG (milligram) (Folic Acid) Give 1 tablet by mouth one time a day for supplement. Order Date: 04/03/2025. Start Date: 04/04/2025.On 10/20/2025 at 2:15 PM, an interview was conducted with LPN #5 who stated that during medication administration she verified the resident, right medication, right dosage, right quantity, right time, and right preferences for taking the medication. She retrieved the bottle of Folic Acid 400mcg from the medication cart and reviewed the physicians order and stated that she administers one-quarter of the tablet to R10 to equal the 1mg dosage. LPN #5 stated that it was not the correct dosage and it was hard using the stock medications when the nurses had to calculate the dosages.The facility policy General Guidelines for Medication Administration revised 08/2020, documented in part, Medications are administered as prescribed in accordance with good nursing principles and practices and only by persons legally authorized to administer . Check #1: Select the medication, check the label, container, and contents for integrity, and compare the medication against the Medication Administration Record (MAR) by reviewing the 5 Rights. Check #2: Prepare the dose by removing the dose from the container and verifying it against the label and the MAR by reviewing the 5 Rights. c. Check #3: Complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights .On 10/22/2025 at 10:09 AM, administrative staff member (ASM) #1, the director of nursing and ASM #2, the administrator were made aware of the concern.No further information was provided prior to exit.2. For Resident #4 (R4), the facility staff failed to A) document behaviors, a change in condition and resident-initiated hospital transfer and B) clarify physician orders for insulin.A) Document behaviors/change in condition and resident-initiated hospital transfer:The progress notes for R4 documented in part,- 01/27/2025 13:12 (1:12 p.m.) Note Text: Resident has been yelling throughout the shift today related to roommates' mats on floor and bedside table. Writer arranged room to accommodate resident's needs, but resident was still yelling. Writer went to check resident's BS (blood sugar) and explained to resident that he will be getting 10 units of Humalog (insulin). Resident started yelling at nurse that he is allergic to Humalog. Nurse apologized to resident and stated that I did not mean Humalog but Admelog (another brand of insulin). Resident started cursing and yelling I'm allergic to Humalog. Writer attempted to show Insulin pen to resident, when writer showed insulin pen to resident, resident attempted to grab pen from writer and then attempted to hit resident. Writer backed up and walked out of room. After leaving resident's room he came out of his room and stated that nurse hit me twice. Writer went to inform ADON (assistant director of nursing) of situation.- 01/27/2025 23:13 (11:13 p.m.) Note Text: Resident returned to facility from [Name of hospital]. No new orders noted at this. No new areas noted to skin. Will continue with plan of care.Review of the facility synopsis of events documented an event dated 1/27/25 which documented in part, Resident alleged that his nurse hit him on his arm today in his room, nurse denied hitting him but that the resident attempted to strike at her and there was a witness to collaborate he attempted to strike at the nurse. Upon notification of the allegation the nurse was suspended. The Administrator interviewed the resident, assessed the skin area where he stated he was hit, there were no obvious bruises, swelling, abrasions or reddened areas. Resident was transferred to the hospital for AMS (altered mental status) today around 1:45 pm . On 10/21/2025 at 11:55 AM, administrative staff member (ASM) #1, the director of nursing stated that the former unit manager had taken over for the nurse who was suspended on 1/27/25 and she no longer worked at the facility. She stated that she had been informed that R4 went outside and called 911 themselves and initiated the hospital transfer themselves. On 10/21/2025 at 1:26 PM, an interview was conducted with licensed practical nurse (LPN) #3 who stated that she was called to go check on R4 because the other unit manager had taken over for the nurse sent home. She stated that she was told that R4 had been having behaviors and had gone outside to the edge of the road. LPN #3

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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 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident/staff interview, facility document review and clinical record review, it was determined that the facility staff failed to provide ADL (activities of daily living) care for dependent residents for one of twelve residents, Resident #104 (R104).The findings include: The facility staff failed to provide ADL (activities of daily living) specifically turning/repositioning, incontinence care and feeding R104.R104 was admitted to the facility on [DATE] with diagnosis that included but were not limited to quadriplegia, spinal stenosis and TIA (transient ischemic attack).The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/9/25, 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 MDS Section GG-functional abilities and goals coded the resident as dependent for bathing/transfer/dressing/toileting and eating; Section H-Bladder and Bowel coded the resident as bowel always incontinent, urinary indwelling catheter. A review of the comprehensive care plan dated 8/1/24 revealed, FOCUS: LONG TERM CARE: the resident requires assistance with ADLS relate to weakness, Quadriplegic and hand contractures. FOLEY CATHETER: resident requires a urinary 18 FR Coude' catheter 10cc balloon related to: obstructive neurogenic bladder. INTERVENTIONS: Assist of one with ADLS, resident dependent with feeding for meals, 2 person assist with bed mobility. Observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated. Provide catheter care Q shift.A review of the October, November and December 2025 ADL forms reveal missing documentation on the following dates and shifts:-Turning/repositioning: Day shift: 11/28, 12/3 and Night shift: 10/29, 10/31, 11/25, 11/30 and 12/11.-Incontinence care: Day shift: 11/28, 12/3, 12/4 12/14 and Night shift: 10/26, 10/29, 10/31,11/25, 11/30 and 12/12.-Feeding: Day shift (breakfast/lunch): 11/28, 12/3 and Night shift (supper) 10/29, 10/31, 11/25, 11/30 and 12/12.On 12/15/25 at 2:00 PM an interview was conducted with CNA (certified nursing assistant) #1. When asked where documentation of specifically turning/repositioning, incontinence care and feeding would be located, CNA #1 stated, we document it in PCC (point click care) on the ADL form. When asked if the documentation is not present, would there be evidence of the care, CNA #1 stated, no, there would not be any evidence of the care. They are to document all care given in the ADL form. On 12/17/25 at 2:00 PM ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #3, the assistant director of nursing, RN #4, the assistant director of nursing was made aware of the concerns.According to the facility's Nursing Care and Services policy, which revealed, The center will utilize Mosby's Textbook for Long-Term Care Assistants by Kostelnick and/or Clinical Nursing Skills & Techniques by [NAME], [NAME] and Ostendorff, as a reference for nursing services and skills not otherwise provided in the Policies and Procedures Manuals. Turning and repositioning the person- record and document your observations.No further information was provided prior to exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident’s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide care and services to promote a resident's highest level of wellbeing for one of twelve residents, Resident #112 (R112).The findings include: The facility failed to monitor sexual / inappropriate behaviors for a resident who is listed on the sex offender registry. R112 was admitted to the facility on [DATE] with diagnosis that included but were not limited to ischemic cardiomyopathy, CHF (congestive heart failure), atrial fibrillation and LVAD (left ventricular assist device).The most recent MDS (minimum data set) assessment, an annual assessment, with an ARD (assessment reference date) of 11/8/25, 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 MDS Section GG-functional abilities and goals coded the resident as requiring supervision for bathing/transfer/dressing/toileting and independent for eating.A review of the comprehensive care plan dated 10/3/24 revealed, FOCUS: Resident has behaviors refuses cardiac clinic appointments. Resident refuses daily weights. Encourage compliance with routine weight monitoring. INTERVENTIONS: assure the resident they are safe if they become distressed. Contact clinic and see if can do facility visit.During a complaint investigation regarding admission of residents on the VSP (Virginia State Police) Sex Offender Registry, R112 was found to be on the registry, dated 8/21/24.An interview was conducted on 12/17/25 at 10:45 AM with ASM (administrative staff member) #2, the DON (director of nursing). When asked the admissions process, ASM #2 stated, they do a sex offender check. The facility administrators until 4/21/25 allowed sex offenders in the facility. Asked the process for admitting sex offenders, ASM #2 stated, we find out if the resident is mobile, is the offense recent, nature of offense (virtual or physical). Asked how staff and residents are protected, ASM #2 stated, we would monitor behavior, and if there is an incident- separation of resident, investigation, if sexual in nature- evaluation in ED (emergency department) and call the police. When asked where this would be monitored, ASM #2 stated, on the MAR-TAR (medication administration record, treatment administration record). Asked for evidence of this monitoring for R112, ASM #2 stated, there is no monitoring. On 12/17/25 at 11:50 AM, an interview was conducted with OSM (other staff member) #1, the social worker. Asked, what is the process for residents on the sex offender registry, OSM #1 stated, We previously had accepted these residents, we do not anymore. I'll pass information along to case worker or parole officer. Asked if sexual / inappropriate behaviors should be monitored, OSM #1 stated, Yes, his behaviors should be monitored. On 12/17/25 at 2:00 PM ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #3, the assistant director of nursing, RN #4, the assistant director of nursing, were made aware of the concerns.According to the facility's Behavioral Assessment/Behavior Monitoring policy, which revealed, Behaviors will be assessed and monitored. Factors influencing behaviors, as well as management interventions will be evaluated and care planned.No further information was provided prior to exit.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff interview, resident interview, clinical document and facility document review, it was determined that the facility staff failed to provide a safe environment for two of 17 residents in the survey sample, Resident #9 (R9) and Resident #5 (R5). For Resident #9, the facility staff left the resident unattended, in an unsafe position, with the bed in the high position on 3/24/25. R9 rolled off the bed and suffered a hematoma. The resident was sent to the emergency room and found to have an occipital condyle fracture (1) thus causing harm to the resident.The findings include: 1. For R9, the facility staff left the resident, unattended, in an unsafe position, with the bed in the high position, causing the resident to fall out of the bed, which resulted in an occipital condyle fracture thus causing harm to the resident on 3/24/25. R9 was admitted to the facility on [DATE] with diagnosis that included but were not limited to CVA (cerebrovascular accident – stroke), hemiplegia and hemiparesis. The most recent MDS (minimum data set) assessment, an admission assessment, with an ARD (assessment reference date) of 6/28/25, 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 MDS Section GG-functional abilities and goals coded the resident as being partial to moderate assist for bathing/transfer/dressing/toileting and set up for eating. A review of the 2/24/25 Medicare 5-day MDS GG0170. Mobility: A. Roll left and right: The ability to roll from lying on back to left and right side, return to lying on back on the bed. Coded as substantial/max assist. Fall occurred on 3/24/25 and on 3/28/25 MDS GG0170. Mobility: A. Roll left and right: was coded as dependent. A review of the baseline care plan dated 2/20/25 revealed, FOCUS: FALLS: resident is at risk for falls related to muscle weakness related to poor balance, related to psychoactive medications, related to recent hospitalization and high-risk medication use. INTERVENTIONS: place common items within reach of the resident. remind the resident to use their call light to ask for assistance with ADLS (activities of daily living). Care plan was revised on 4/9/25 with added intervention of 1 person assists with bed mobility, assistance may vary. A review of RN (registered nurse) #3's progress note dated 3/24/25 at 7:48 AM revealed, Description of the fall/V/S (vital signs)/injuries if any: Writer heard a loud noise from resident room and upon entering room resident was found on the floor with the face down. Hematoma and bleeding noted on the resident's forehead. Complete head to assessment conducted, V/S at baseline, ROM (range of motion) WNL (within normal limits). Oxycodone (2) 5mg (milligrams) and Tylenol (2) 650mg administered for c/o pain. Site cleansed with normal saline, ice cube applied to site, and compression bandage in place. RP (responsible party)/NP (nurse practitioner) notified. What Interventions were in place at the time of the fall? Fall mats, Staff education on calling for assistance when changing resident, gather supplies before changing resident. What are the risk factors that could have contributed to the fall? Staff education on calling for assistance. A review of the progress note dated 3/24/25 at 9:00 AM revealed, Resident out at hospital, NP aware, RP aware. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	A review of the progress note dated 3/24/25 at 1:00 PM revealed, Resident returned to facility from hospital with documentation, discharge paperwork, states resident has unspecified occipital condyle fracture, paperwork states he does not recommend a C- collar or any surgical interventions and will be supportive care with pain management and outpatient follow-up PCP (primary care practitioner). Resident has laceration to left forehead and left check. Treatment orders in place, pain regimen reviewed and updated by NP. NP visited resident during shift. Resident accompanied by brother. Resident noted resting in bed, bed in lowest position. A review of the progress note dated 3/24/25 at 9:15 PM revealed, Skilled Nursing Focus: Resident alert and verbal, resident skilled for PT(physical therapy)-OT(occupational therapy), resident c/o (complained of) back neck pain, medicated with PRN (as needed) meds (medications) with positive effect, resident verbalizes needs to staff, resident tolerates whole meds in apple sauce, resident x2 person assist with ADL care, day 1/3 post fall on the floor, ROM WNL, discoloration remains to forehead, bed in lowest position, call bell, within reach. A review of the progress note dated 3/24/25 10:21 PM revealed, LATE ENTRY: Situation: Date and time the fall occurred: 03/24/2025 6:30 AM. Background: Circumstances of the fall: Resident rolled off the bed and landed face down on the floor. Assessment (RN)/Appearance (LPN): Current status of the resident's injuries or reports of pain from the fall: Sustained a bleeding hematoma & discoloration to his face. Recommendation: Interventions currently in place to prevent additional falls: common items within reach, use call bell, 2 person (sic) with bed mobility, use pillows for parameters. Resident's response to new interventions: accepting. A review of the 3/24/25 NP note revealed, Fall: Provider in morning received a call from nursing staff, that patient had a fall and was facedown (sic) on floor with a hematoma and forehead was bleeding. Resident sent to the ER. Resident states he was rolled onto his side and being changed when he rolled out of bed, did not lose consciousness. Seen by neurosurgeon in the emergency room. Recommend by neurosurgeon that he does not need any C-collar or any surgical treatment at this time. He will need pain management and supportive care at this time. Posttraumatic changes involving soft tissue overlying the left frontal bone. A review of the facility's Employee Corrective Action form for CNA (certified nursing assistant) #3, dated 3/26/25 and signed by the Director of Nursing, revealed Describe specific facts: Staff failed to verify bed mobility for Resident. Resident states staff member left the room to get more supplies and that resulted in resident falling. Staff member called on 3/25/25 and made them aware of suspension pending investigation. CNA #3 resigned from facility on 4/26/25 and was not available to be interviewed. A review of the March 2025 ADL record for R9 revealed bed mobility coded as dependent 36 out of 62 shifts. On 3/23/25 day shift coded as dependent on 3/23/25 night shift (till 7AM 3/24/25) coded as partial/moderate assist. On 10/21/25 at 11:00 AM an interview was conducted with R9. When asked if he remembered the fall, R9 stated, Oh yes, the aide turned me on my side to clean me up and left the room to get more supplies, I fell off of the bed and broke my glasses. When asked if there were fall mats, R9 stated yes, there were. When asked what position the bed was in, R9 stated, It was raised, but I could not tell you exactly how high. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 10/21/25 at 12:00 PM an interview was conducted with ASM (administrative staff member) #1, the director of nursing. When asked what substantial / max assist (assistance) means, ASM #1 stated, it means a minimum of two staff. If the care plan does not identify number of staff to care for the resident, the CNAs (certified nursing assistants) use the Kardex and the number of staff should be designated on the Kardex. ASM #1 stated, they should ask and not do care until they have an answer as to how many staff are needed. ASM #1 was asked for the Kardex for March 2025, ASM #1 stated that facility if unable to pull Kardex past 30 days. On 10/22/25 at 7:15 AM an interview was conducted with RN (registered nurse) #3. When asked to describe the R9's fall on 3/24/25, RN #3 stated, I was out in the hall and doing meds, heard a loud sound in the room and rushed in. The resident mentioned that the aide was trying to clean him up and turned him on his side, the resident stated that the aide had stepped out of the room to get some supplies, the aide was not in the room when I entered. The resident had fall mats on both sides and the bed was not in the lowest position. I am not sure how high the bed was. The resident was partially on the floor mat and partially on the floor, he was angled on the floor mat. I had told the CNA to ask for help as she floats for the most part and did not work on that unit all the time After the fall, when I was talking with the CNA, I told her again that she could have yelled for help or to get supplies. I really saw there was remorse in the aide after the fall but the harm had happened at that point. I believe the resident was substantial / max assist. On 10/22/25 at 8:20 AM an interview was conducted with ASM #1, the director of nursing. RELIAS online education was provided for CNA #3. Fall education was documented. ASM #1 provided the Therapy notes for R9 and stated, it is documented on the OT Discharge summary dated [DATE] Patient is maintaining sit-stand-transfer at Min-Mod A with no further progress this reporting period. Goal met to highest practical level. When asked what the baseline dated 4/1/25 substantial/maximal assistance indicates, ASM (administrative staff member) #1, the DON (director of nursing) was not sure, but I will have OT or PT come talk with you. On 10/22/25 at 9:00 AM an interview was conducted with OSM (other staff member) #5, the physical therapy assistant. When shown R9's OT/PT discharge summary and asked to describe it, OSM #5 stated, we generate the STG (short term goals) and LTG (long term goals). Baseline heading and date underneath reflects the status that the resident was on the evaluation date of 4/1/25. He was substantial / max assistance. It is implied as a 1 person assist. Min-Mod A designation means varied assistance from minimum to moderate. We had not seen him before 4/1/25. On 10/22/25 at 2:55 PM, ASM (administrative staff member) #1, the director of nursing, ASM #2, the administrator and (registered nurse) #1, the assistant director of nursing, were made aware of the concern for harm for R9. According to the facility's Fall Management Program policy which revealed, The center considers all patients to be at risk for falls and provides an environment as safe as practicable for all patients. The center utilizes a systematic approach to a falls management program that facilitates an interdisciplinary approach with evidence-based interventions to develop individual care strategies. Discuss fall risks and interventions with patient and/or responsible party. Incorporate any identified interventions into the care plan as applicable. (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 0689 Level of Harm - Actual harm Residents Affected - Few	No further information was provided prior to exit. References: 1. Occipital condylar fractures are uncommon injuries usually resulting from high-energy blunt trauma. They are considered a specific type of basilar skull fracture. mostly occur in the setting of high-energy trauma fall from a significant height: This information was obtained from the following website: Occipital condyle fracture | Radiology Reference Article | Radiopaedia.org. 2. Oxycodone is used to relieve severe pain. Oxycodone is in a class of medications called opiate (narcotic) analgesics. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682132.html. 3. Tylenol (acetaminophen) Acetaminophen is used to relieve mild to moderate pain from headaches, muscle aches, menstrual periods, colds and sore throats, toothaches, backaches, reactions to vaccinations (shots), and to reduce fever. This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a681004.html

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	10/22/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff/resident interview, facility document review and clinical record review, it was determined that the facility staff failed to provide treatment and services for an indwelling catheter for one of twelve residents in the survey sample, Resident #104 (R104).The findings include: The facility failed to evidence treatment and services for Resident 104's (R105's) indwelling catheter.R104 was admitted to the facility on [DATE] with diagnosis that included but were not limited to quadriplegia, spinal stenosis and TIA (transient ischemic attack).The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/9/25, 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 MDS Section GG-functional abilities and goals coded the resident as dependent for bathing/transfer/dressing/toileting and eating; Section H-Bladder and Bowel coded the resident as bowel always incontinent, urinary indwelling catheter. A review of the comprehensive care plan dated 8/1/24 revealed, FOCUS: LONG TERM CARE: the resident requires assistance with ADLS relate to weakness, Quadriplegic and hand contractures. FOLEY CATHETER: resident requires a urinary 18 FR Coude' catheter 10cc balloon related to: obstructive neurogenic bladder. INTERVENTIONS: Assist of one with ADLS, resident dependent with feeding for meals, 2 person assist with bed mobility. Observe for signs and symptoms of infection such as dark or cloudy urine or blockage and notify md as indicated. Provide catheter care Q shift.A review of the physician orders dated 6/20/25 revealed, FOLEY CATH : Catheter Output every day and night shift for foley monitoring.A review of the physician orders dated 11/6/25 revealed, Foley catheter and Suprapubic catheter: Flush with 60ml of Normal Saline 1x/daily while patient is lying in bed. one time a day for UTI prophylaxis. Suprapubic catheter: Provide foley catheter care every day and night shift for Obstructive Neurogenic bladder.A review of the physician orders dated 11/10/25 revealed, Suprapubic catheter: Flush with 10cc NS (normal saline) as needed for sluggish urine AND every day and night shift.A review of the October, November and December 2025 MAR-TAR (medication administration record-treatment administration record) revealed missing evidence of treatment provided:-Catheter Output every day and night shift for foley monitoring: Day shift: 10/21, 10/24 and Night shift: 10/24, 10/25, 11/9, 11/19.-Flush with 60ml of Normal Saline 1x/daily: Day shift: 11/11.-Suprapubic catheter: Provide foley catheter care every day and night shift: Day shift: 10/24, 11/24 and Night shift: 10/24, 11/9, 11/24.-Flush with 10cc NS (normal saline) as needed for sluggish urine AND every day and night shift: Day shift: 11/11.On 12/16/25 at 1:05 PM an interview was conducted with LPN (licensed practical nurse) #4, asked where evidence of catheter care would be documented, LPN #4 stated, it would be documented on the MAR-TAR. When asked if there is no evidence of care being documented- the care been done, LPN #4 stated, no, if it is not documented it was not done. On 12/17/25 at 2:00 PM ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #3, the assistant director of nursing, RN #4, the assistant director of nursing was made aware of the concerns.According to the facility's Urinary Catheterization policy, which revealed, Licensed nurses will irrigate catheter, if indicated, per provider's order. Perform catheter care every shift and document in the medical record.No further information was provided prior to exit.

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	495227	A. Building B. Wing	10/22/2025

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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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview and clinical record review, it was determined that the facility staff failed to provide food at a palatable temperature for one of twelve residents, Resident #104 (R104).The findings include: The facility staff failed to provide food at a palatable temperature for R104 during lunch on 12/15/25. R104 was admitted to the facility on [DATE] with diagnosis that included but were not limited to quadriplegia, spinal stenosis and TIA (transient ischemic attack).The most recent MDS (minimum data set) assessment, a quarterly assessment, with an ARD (assessment reference date) of 10/9/25, 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 MDS Section GG-functional abilities and goals coded the resident as dependent for bathing/transfer/dressing/toileting and eating. A review of the comprehensive care plan dated 8/1/24 revealed, FOCUS: LONG TERM CARE: the resident requires assistance with ADLS relate to weakness, Quadriplegic and hand contractures. INTERVENTIONS: Assist of one with ADLS, resident dependent with feeding for meals.A test tray was done on Unit 1 for lunch on 12/15/25. 12:10 PM lunch trays arrived in cart on Unit 1, 12:14 PM, first tray taken off of cart. R104 was in the last room on the right of Unit 1 Hall. R104 received his tray at 12:43 PM. Temperatures of test tray: fish 118.6 degrees, noodles 122.8 degrees, zucchini and tomatoes 120.0.An interview was conducted on 12/15/25 at 12:52 PM with OSM (other staff member) #3, the dietary manager. When asked about the temperatures on the lunch test tray, OSM #3 stated, No, the food should be warmer. I get a lot of complaints about food temperatures. The staff do not deliver them to residents quickly enough. On 12/15/25 at 1:10 PM an interview was conducted with R104, when asked about his lunch food temperatures, R104 stated, it was warm at best, but it was not good to eat at that temperature.On 12/17/25 at 2:00 PM ASM (administrative staff member) #1, the administrator, ASM #2, the director of nursing, RN (registered nurse) #3, the assistant director of nursing, RN #4, the assistant director of nursing was made aware of the concerns.According to the facility's Timely Meal Service policy, which revealed, Food will be delivered promptly to assure safe, palatable and high-quality food served at the proper temperature. Food will be served at preferable temperatures as discerned by the patients/residents and customary practice.No further information was provided prior to exit.