PRINTED: 09/29/2016 FORM APPROVED

CLNILIVO	TON MILDICANL	& MILDICAID SERVICES			MB NO. 0938-0391	
STATEMENT OF C		[(· ·) · · · · · · · · · · · · · · · ·		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495200	B __ WING		C 09715/2016	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTWOO	D CENTER			WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPOLICIENCY)	BE COMPLETION	

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 9/13/16 through 9/15/16. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. Complaints were investigated during the course of the survey. The Life Safety Code survey/report will follow.

The census in this 65 certified bed facility was 57 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents 1 through 16) and 2 closed record reviews (Residents 17 through 18).

F 241 483.15(a) DIGNITY AND RESPECT OF SS=D INDIVIDUALITY

> The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility document review and clinical record review, the facility staff failed to promote and enhance the dignity for 1 of 18 residents (Resident #2). Resident #2 was originally admitted to the facility on 12/10/13 and was readmitted on 8/24/16. His diagnoses included, but were not limited to: high blood pressure, depression, schizophrenia, anemia, anxiety, diabetes and dementia.

The current minimum data set assessment (MDS) with an assessment reference date (ARD) completed on 8/24/16 for Resident #2 was a

The statements made on this Plan of F 000 Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.

> To remain in compliance with all Federal and State regulations, the Center has taken or will take the actions set forth in the following Plan of Correction constitutes the Center's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.

F 241

RECEIVED OCT 11 2016 VDH/OLC

BORATORY	DIRECTOR'S C	OR PROVIDER	SUPPLIER	REPRESENT	ATIVE'S SIGNATUR	₹E

Sichard

(X6) DATE

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 ollowing 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2016

DEPAR	INCNI OF HEALIN	AND HUMAN SERVICES			FORM APPROVED			
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO. 0938-0391			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		495200	B WING		09/15/2016			
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03/13/2010			
MECTIAN	OOD CENTED			WESTWOOD MEDICAL PARK				
WESIW	OOD CENTER			BLUEFIELD, VA 24605				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION			
F 241	Continued From pa	ge 1	F 2	241				
		essment. Resident #2 in		Resident #2's allowed nursing staff	to 10/15/16			
	section C, had a co short time memory	gnitive score of 1/1 (long and problem) and he scored a 2		trim/cut his fingernails on 9/15/16.	10 10/13/10			
		indicating he was moderately		Current residents were checked for				
	impaired. His MDS also coded the resident to need the assistance of one person for activities of			nails needing to be clipped and				
	daily living (ADL)			clipped as needed or refusals				
				documented and care planned.				
On 9/14/16 Resident #2 was observed in the dining room eating his breakfast. He spoke with the surveyor and responded to questions that were asked him. The surveyor noticed he had long ragged dirty finger nails. The surveyor asked him about his long nails, he looked at them and said "they need to be clipped."			Nursing staff will be re-educated on before 10/15/16 by the Nurse Practic Educator (NPE) and/or designee on trimming fingernails, as needed, documenting and care planning					
		plan indicated he did resist		refusals.				
	care. However, it did not say he refused to have his nails clipped. Review of the nurse's notes did not reveal documentation that the resident was refusing any care. On 9/14/16 at approximately 4:30 during a meeting with the administrator and the director of nurses Resident #2's dirty long nails were discussed.			Unit manager (UM) and/or designee will monitor residents' fingernails to ensure they are trimmed appropriate)			
				or refusals are documented or care planned with corrective action upon discovery. Findings will be reported to the Director of Nursing (DON).				
	nurses note to the s 9/15/16 08:13 after encouragement, res	ctor of nurses brought a surveyor that read as follows: a great deal of sident allowed night shift e nurse) to trim/cut his finger		Any trends identified will be reported to the Quality Improvement Committee for further evaluation an recommendations.				

FORM CMS-2567(02-99) Previous Versions Obsolete

F 252 483.15(h)(1)

resident's finger nails.

Prior to exit no further discussion related to the

SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE

Event ID I7L211

Facility ID: VA0271

F 252

If continuation sheet Page 2 of 45



PRINTFD: 09/29/2016

DEPAR	IMENT OF HEALTH	AND HUMAN SERVICES		,	FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			MB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495200	B WING		C 09/15/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTW	OOD CENTER			WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 252	Continued From pa	ge 2	F 25	1. On the evening of 9/14/16, nur	se 10/15/16
	the resident to use I	melike environment, allowing his or her personal belongings		management removed the calend wipes, tissues & foot rest from th floor in Resident #10's room.	ar,
	by: Based on observat record review, facilit clean and homelike	ite. IT is not met as evidenced ion, staff interview, and clinical ty staff failed to maintain a environment for 1 of 18 yey sample (Resident #10)		Resident rooms were checked by department managers to ensure fl were free of trash and equipment corrections made upon discovery. Environmental Services will be reconstructed and the formula for the formul	with
	and in the hallway o room.	outside the resident dining		NPE and/or designee on keeping floor in the residents' rooms free	the of
), facility staff failed to retrieve nt care equipment from the		trash & equipment. Findings will reported to the Administrator. Department managers and/or desi	gnee
	3/8/16 with diagnose hypertension, heart reflux disease, end shemodialysis, neuro mellitus, anxiety, ast On the annual minim	dmitted to the facility on es including atrial fibrillation, failure, gastroesophageal stage renal disease with genic bladder, diabetes thma, and respiratory failure. num data set assessment		will make room rounds to ensure floors in resident's rooms are free trash & equipment daily X 2 week then conduct random observations with corrective action upon discovering findings will be reported to the Administrator.	of ss

Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.

times from 9/13 to 9/15/15; talking with the ORM CMS-2567(02-99) Previous Versions Obsolete

was not documented).

with assessment reference date 7/19/16, the resident was scored 15/15 on the brief interview

for mental status, and was assessed as without delirium, psychosis, or behaviors affecting others.

The resident was assessed with pain (J0300= 1

not documented. Hemodialysis (SectionO0100)

The surveyor was in the resident's room several

Yes), but its characteristics and frequently was

Event ID 17L211

Facility ID: VA0271

If continuation sheet Page 3 of 45



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495200	' '	(X2) MULTIPLE CONSTRUCTION A BUILDING B. WING		
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER			\	STREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	

F 252 Continued From page 3

resident and the resident's room mate about their care and the condition of the facility.

On 9/14/16 at 8:30 AM, the resident was in bed with a an IV pump alarm ringing. She asked the surveyor to find the call bell so she could ring it for help. A nurse answered the bell, flushed the IV, washed her hands, and left. The surveyor saw a calendar, a package of bath cloths, a wrapper were in the floor near the foot of the bed. On the floor between the bed and the window were two large wipes, a tissue, and a wheelchair footrest. On 9/14 at 3 PM, the package of bath wipes were on the wheelchair, but the calendar, wipes, tissues, and footrest were still on the floor. At 4 PM, the surveyor reported the concern to the administrative team. The chief nursing officer stated that the resident dropped tissues in the floor and they would be there no matter how often someone picked them up off the floor.

The concern was reported to the administrator and director of nursing during a summary meeting on 9/15/16.

2. On 9/13/16 at approximately 12:50 pm., during initial tour of the facility the dark green carpet in the hallway outside of the dining room had a white stain/spot on it.

As the tour continued another white stain/spot was noted between room 226 and 227. Against the wall across from room 230, a white stain /spot was observed. Paper was also noted to be on the carpet in different places. As the surveyor came closer to the south hall nurses station food particles that had the appearance of cookie crumbs were also noted to be on the carpet. At approximately 1:10 the surveyor ask housekeeper #1 what the white spots on the carpet were. She looked and said I don't know.

F 252

2. The crumbs and paper were removed from the carpet on 9/13/16 by housekeeping. Carpets were cleaned by housekeeping on 9/13/16. The white stains on the carpets have been cleaned multiple times since 9/13/16 and although the carpets are clean, the stains remain.

Housekeeping will sweep/vacuum the carpets daily and will continue to extract carpets on weekly basis. Environmental Services Director and/or designee will ensure carpets are cleaned per schedule. Findings will be reported to the Administrator.

Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I7L211

Facility ID: VA0271

If continuation sheet Page 4 of 45



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	OMB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		495200	B WING		nc	C 715/2016	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		71372010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 253	unit and said he is a housekeeper was a On 9/14/16 the survival stains on the carper aforementioned. On 9/15/16 at approstains/spots on the the administrator ar Prior to exit on 9/15 provided to the survival stains. 483.15(h)(2) HOUS MAINTENANCE SE	own the hall toward the north cleaning stains now. A male leaning the carpet. The same white in the same place as eximately 4:00 pm, the carpet were discussed with and the director of nurses of the first of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the carpet were discussed with the director of nurses of the directo		On 9/15/16, the rusted sho North shower room was re		10/15/16	
	sanitary, orderly, and the shower room. In shower chairs and the rest and trusted arm rest and the rest and t			properly disposed of. The were returned to the prope 9/15/16. On 9/15/16, the beat was repaired in North show the Maintenance Director. stain in the stall in North si is a discoloration of the flocannot be removed. On 9/Unit manager removed all in South shower room and them appropriately. The carelocked. The Maintenance removed the broken file he the South shower room was 9/15/16.	black shoes or resident on broken tile wer room by The dark shower room bor and 15/16, the of the items disposed of abinet was be Director older from		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I7L211

Facility ID VA0271

If continuation sheet Page 5 of 45



PRINTED: 09/29/2016

		AND HUMAN SERVICES			FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495200	BWING		C
NAME OF I	PROVIDER OR SUPPLIER	+33230	1	STREET ADDRESS, CITY, STATE, ZIP CODE	09/15/2016
TW KINE OF	NOVIDEN ON OUT FIELD			WESTWOOD MEDICAL PARK	
WESTWO	OOD CENTER			BLUEFIELD, VA 24605	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLÉTION
F 253	Continued From pa	_	F 2	53	
	floor and a dark stathat was used to give Two surveyors obsessouth unit on 9/15/11 the shower room was lock present. The catowel covering the stowel covering the stowel covering the stowel covering the stower not labeled with 2 used tubes of Colligioves. One used to bottle of no-rinse shoutle of the unit manager with shower room and he the issues. At 1:30 pm, the surved director the above lift one had reported it chair should be remidirector also informed of the busted and be of the south unit shoutle shoutl	erved the shower room on the 16 at 9:15 am. The cabinet in as found unlocked with the abinet had a stained and dirty shelf. On the towel was the cans of shaving cream that the aresidents name; 5 razors, gate tooth paste and box of par of soap in the box and one nampoo, and an empty bottle e wall of the shower room was dibusted file holder. Was asked to come into the e said he would take care of exercised concerns. He stated no to him. He also said the rusty loved. The maintenance ed the surveyor of the removal roken file holder from the wall ower room. We administrator and in 9/15/16 the above findings with the environment issues.		Nursing staff will be reeducated by NPE and/or designee on or before 10/15/16 on keeping the shower refree of resident's personal belonging keeping the cabinet locked and reporting any problems with equipment or repairs needed. Findings will be reported to the Administrator. The Maintenance Director and/or designee will monitor the shower rooms on an ongoing weekly basis Findings will be reported to the Administrator. Any trends identified will be reported to the Quality Improvement Committee for further evaluation a recommendations.	oom ngs,
	483.20(g) - (j) ASSE ACCURACY/COOR	SSMENT DINATION/CERTIFIED	F 2	/ 8	

FORM CMS-2567(02-99) Previous Versions Obsolete

The assessment must accurately reflect the

Event ID: I7L211

Facility ID: VA0271

If continuation sheet Page 6 of 45



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		C	OMB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		495200	B. WING		C 09/15/2016	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
WESTWO	OOD CENTER			WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROFICIENCY)	D BE COMPLETION	
F 278	Continued From page	ge 6	F 2	78		
	each assessment we participation of heal A registered nurse in assessment is completed. Each individual who assessment must is that portion of the assessment must is that portion of the assessment in a subject to a civil mo \$1,000 for each assessment willfully and knowing to certify a material resident assessment penalty of not more assessment. Clinical disagreeme material and false is this REQUIREMENT by: Based on staff interreview, the facility stomplete and accurrent.	must sign and certify that the pleted. completes a portion of the sign and certify the accuracy of ssessment. d Medicaid, an individual who gly certifies a material and a resident assessment is eney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a ent is subject to a civil money than \$5,000 for each		Resident #9 no longer resides in the facility. Resident #1 no longer resident the facility. Resident #2 will be reassessed for pain and a MDS with completed with ARD on or before 10/15/16. Resident #4's MDS was corrected on 9/15/16 to accurately code oxygen therapy on the MDS. The Director of Nursing will condan audit of current residents' most recent MDS to verify completion the pain assessment and accurate coding for pain by 10/6/16. The CRCs will correct any inaccurate RUG based MDS's with their next scheduled MDS. Other payor sout inaccurate MDS's will be corrected with an ARD on or before 10/29/10. The Director of Nursing will condan audit of current residents' most recent MDS to verify accurate coor of oxygen by 10/9/16. The CRCs correct any inaccurate MDS's by 10/15/16.	sides e ill be e as / . duct t of att arces ed 16. duct t ding	
	The findings include	E				

1. The facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) regarding



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

					11D 110. 0000 000
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
		495200	B-WING	-	C 09/15/2016
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTWO	OD CENTER			WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION

F 278 Continued From page 7 pain for Resident #9.

Resident #9 was admitted to the facility on 6/29/16 with diagnoses of coronary artery disease, hypertension, pneumonia, septicemia, stroke, paraplegia, and dysphagia.

The current quarterly MDS with a reference date of 8/24/16 assessed the resident with a cognitive score of "4" of "15". The resident was assessed requiring extensive to total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene.

The current MDS was reviewed. Section "J" for "Health Condition" contained documentation that a pain assessment should be conducted. The pain assessment was blank and contained dashes instead of responses.

The MDS co-ordinator (RN#1) was interviewed regarding the pain assessment on 9/13/16 at 4:05 p.m. RN#1 stated she reviews the pain assessment report performed by the nursing staff and uses the information to complete the MDS. RN#1 showed the report to the surveyor and the report was blank. RN#1 stated if the report was blank, she puts dashes in the MDS because the pain assessment was incomplete. When asked if she asked the staff or the resident about the pain assessment, RN#1 stated she looked at the report only.

The administrator and director of nursing were informed of the findings during a meeting with the survey team on 9/14/16 at 4:00 p.m.

2. For Resident #1, the facility staff failed to code section J (Pain) on the resident's annual MDS assessment with an ARD (assessment reference

F 278

Nursing staff will be reeducated by the NPE and/or designee on or before 10/15/16 on completion of pain assessments and the need for oxygen therapy to be on the MAR so that an accurate MDS can be completed. The Clinical Reimbursement Coordinators (CRC) were reeducated on 10/6//16 by the Director of Nursing to interview the nursing staff for completion of the pain assessment and for resident use of oxygen therapy so that an accurate MDS can be completed.

The Unit managers and/or designee will review 100% of the MDS' prior to transmission with October 2016 ARDs to ensure the pain assessments were completed and coded on the MDS, with corrective action upon discovery. Findings will be reported to the Director of Nursing.

Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I7L211

Facility ID: VA0271

If continuation sheet Page 8 of 45 RECEIVED



OCT 11 2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2016 FORM APPROVED

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	_				O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
		495200	B. WING	·		0	C 9/15/2016
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
WESTW	OOD CENTER				STWOOD MEDICAL PARK UEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	ΊΧ	PROVIDER'S PLAN OF CORREC- (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 278	Continued From pa date) of 2/13/16.	ge 8	F	278			
	on 1/17/06 and was diagnoses included	iginally admitted to the facility readmitted on 2/8/15. Her , but were not limited to: high pression, stroke, anemia, tes and dementia.		7	This page was intentionally les	t blank.	
	(MDS) with an assection C, had a conshort time memory for decision making impaired.	m data set assessment essment reference date (ARD) 16 for Resident #1 was a essment. Resident #1 in gnitive score of 1/1 (long and problem) and she scored a 3 indicating she was severely ved in section J dash (-) tain assessment area. The ot done.					s
	On 9/14/16 at 2:45, the MDS nurse RN #1, was asked why the pain assessment was marked with a dash. She looked at the MDS and said " it is not assessed; if the nurse does not have the assessment done we mark it that way." The surveyor asked the MDS nurse if she went in and talked to the resident. She said, " No that 's not our policy."						
		om, the administrator, and there informed of the					
	related to the inacci	/16 no further information urate MDS. the facility staff failed to code					

section J (Pain) on the resident's annual MDS assessment with an ARD (assessment reference





PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES						0. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1		CONSTRUCTION		ATE SURVEY OMPLETED
		495200	B. WING			0	C 9 i 15/2016
	PROVIDER OR SUPPLIER OOD CENTER			WE	REET ADDRESS, CITY, STATE, ZIP CODE STWOOD MEDICAL PARK UEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 278	Continued From page 9		F	278			
	Resident #2 was originally admitted to the facility on 12/10/13 and was readmitted on 8/24/16. His diagnoses included, but were not limited to: high blood pressure, depression, schizophrenia, anemia, anxiety, diabetes and dementia. The current minimum data set assessment (MDS) with an assessment reference date (ARD) completed on 8/24/16 for Resident #2 was a quarterly MDS assessment. Resident #2 in section C, had a cognitive score of 1/1 (long and short time memory problem) and he scored a 2 for decision making indicating he was moderately impaired. The surveyor observed in section J dash (-)			Т	his page was intentionally lef	t blank.	
	assessment was no On 9/14/16 at 2:45,	marks were in the pain assessment area. The assessment was not done. On 9/14/16 at 2:45, the MDS nurse RN #1, was					8
	asked why the pain assessment was marked with a dash. She looked at the MDS and said " it is not assessed; if the nurse does not have the assessment done we mark it that way." The surveyor asked the MDS nurse if she went in and talked to the resident. She said, " No that 's not our policy."						
		veyor interviewed Resident #2. red without difficulty and					
		om, the administrator, and where informed of the					

Prior to exit on 9/15/16 no further information

4. For Resident #4, facility staff failed to ensure

related to the inaccurate MDS.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2016

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				O		D. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	, ,		PLE CONSTRUCTION G		(X3) DA	ATE SURVEY OMPLETED
		495200	B. WING	;		-	08	C 9/15/2016
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STAT	ΓΕ, ZIP CODE		
WESTWO	OOD CENTER			1	WESTWOOD MEDICAL PAR BLUEFIELD, VA 24605	₹K		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD	BE	(X5) COMPLETION DATE
F 278	Continued From page	ge 10	F 2	278	3			
	that the minimum data set assessment reflected							
	oxygen therapy.			This page was intenti	ionally left bl	ank.		
	including coronary a heart failure, hypert insufficiency. On th assessment 7/20/16 on the brief interview resident was assess psychosis, or behave 00100 Respiratory oxygen.	ne quarterly minimum data set 6, the resident scored 15/15 w fro mental status. The sed without signs of delirium, vioral symptoms. Section Treatment was not coded for						
	on 9/14/16. The res nasal cannula at 4 L resident's oxygen co tape on it which app	e with the resident in the room sident was wearing oxygen via L/minute flow rate. The concentrator had a piece of peared to have 9/15/16 written nk with a finer line than the						8
	Clinical record review on 9/14/16 revealed an order dated 7/13/16 for O2 4L / NC (oxygen at a rate of 4 liters per minute via a nasal cannula). Oxygen therapy did not appear on the resident's treatment administration record and there was no order to clean the equipment or change the tubing on the resident's clinical record.							
	notified of the conce on 9/15/16. The sur corrected minimum	nd chief nursing officer were ern during a summary meeting rveyor was offered a data set assessment which erapy at Section O0100.						

5. For Resident #10, facility staff failed to ensure the minimum data set assessment reflected pain



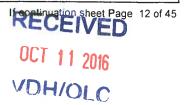
DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2016

		AND HUMAN SERVICES			FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495200	B_WING_		C 09715/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	00/10/2010
MESTA	OOD CENTED			WESTWOOD MEDICAL PARK	
WESIW	OOD CENTER			BLUEFIELD, VA 24605	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 278	Continued From pa status.	ge 11	F 2	78	
	3/8/16 with diagnos hypertension, heart reflux disease, end hemodialysis, neuro mellitus, anxiety, as On the annual minir with assessment reresident was scored for mental status, at delirium, psychosis, The resident was as Yes), but its charact	idmitted to the facility on es including atrial fibrillation, failure, gastroesophageal stage renal disease with ogenic bladder, diabetes thma, and respiratory failure. In mum data set assessment ference date 7/19/16, the diabete 15/15 on the brief interview and was assessed as without or behaviors affecting others. It is sessed with pain (J0300= 1 teristics and frequently was emodialysis (SectionO0100) diabete in the serior of the facility of the serior of th		This page was intentionally left	blank.
	surveyor noted an o hemodialysis 3 X we	d review on 9/15/16, the order initiated 8/4/14 for eek Tuesday, Thursday, as no order for assessment or site.			
	addressing hemodia The surveyor reques	nable to locate a care plan alysis in the resident's record. sted a copy of the resident's of receive one prior to exiting			
	6/27/16 for oxycodo order dated 6/27/16 of pain or hurting? e medication administ	w revealed an order dated ne 5 mg twice per day and an for "Pain monitor Are you free very night shift". Pain ration and the pain monitor ented as administered per			

orders on the medication administration record.

The MDS co-ordinator (RN#1) was interviewed



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

OLIVILI	TO TOTAL MEDICATE	WINDOWN OF WAR			CIVID IV	<u>O. 0330-039 I</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ILTIPLE CONSTRUCTION DING		OATE SURVEY OMPLETED
		495200	B. WING		C	C 9/15/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTW	OOD CENTER			WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	TIX (EACH CORRECTIVE ACTION SHO	ULD BE	(X5) COMPLETION DATE
F 278	p.m. RN#1 stated sassessment report and uses the inform	assessment on 9/13/16 at 4:05 she reviews the pain performed by the nursing staff nation to complete the MDS.	Fí	278		
	report was blank. R blank, she puts das pain assessment w she asked the staff	eport to the surveyor and the N#1 stated if the report was hes in the MDS because the as incomplete. When asked if or the resident about the pain stated she looked at the				
	administrator and commany meeting of annual minimum da 7/19/16 was not coopain assessment was 483.20(d)(3), 483.1		Fí	280 Resident #9 no longer resides in		10/15/16
	incompetent or othe incapacitated under	the laws of the State, to ng care and treatment or		facility. A plan of correction was initiate 9/13/16 regarding the plan of car Resident #9 not containing any	ed on	10/13/16
	within 7 days after t comprehensive ass interdisciplinary teal physician, a register for the resident, and disciplines as detern and, to the extent pothe the resident, the resident representative	are plan must be developed the completion of the essment; prepared by an m, that includes the attending red nurse with responsibility. I other appropriate staff in mined by the resident's needs, racticable, the participation of ident's family or the resident's; and periodically reviewed am of qualified persons after		problems listed for pain. The pl was further discussed, reviewed approved during an Adhoc meet 9/14/16 by Administrator, Direc Nursing, Manager of Clinical Operations and Medical Directo plan was completed & presented surveyors on 9/15/16.	& ing on stor of	





Facility ID: VA0271

If continuation sheet Page 13 of 45



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
		495200	B. WING		C 09 715/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
\A/EQT\A/	OOD CENTER			WESTWOOD MEDICAL PARK	
WESTWO	DOD CENTER			BLUEFIELD, VA 24605	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE COMPLETION
	by: Based on staff intereview, the facility sthe comprehensive (Resident #9). The findings include The facility staff faile comprehensive care in the area for pain. Resident #9 was ad 6/29/16 with diagnodisease, hypertensistroke, paraplegia, at The current quarter of 8/24/16 assessed score of "4" of "15". requiring extensive persons for bed modeating, toileting, bat The current MDS will the current MDS	NT is not met as evidenced rview and clinical record taff failed review and revise care plan for 1 of 19 residents e: ed to review and revise the e plan (CCP) for Resident #9 Imitted to the facility on ses of coronary artery on, pneumonia, septicemia, and dysphagia. Ity MDS with a reference date of the resident with a cognitive The resident was assessed to total assistance of 1-2 billity, transfers, dressing,	F	Pain care plan was initiated for Resident #9 on 9/13/16 by nursi administration. Re-education we completed with the staff respons for care plans on 9/15/16 by the Director of Nursing. A 100% at current resident charts was compon 9/13/16 to ensure all resident pain care plans in place. No other residents had pain care plans mistrated a monthly audit of admission care plans to ensure a pain care plans present with corrective actions mas needed. Findings will be report to the Administrator. Any trends identified will be report to the Quality Improvement Committee for further evaluation recommendations.	ras sible udit of pleted s had her ssing. mplete re is made, orted
	dashes instead of re				

contained a nursing assessmnet for pain

completed by one of the nursing staff on 8/24/16.



PRINTED: 09/29/2016 FORM APPROVED OMB NO 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	' '	FIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		495200	B WING		_	C 09/15/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA		
MESTA	OOD CENTER		İ	WESTWOOD MEDICAL PAI	RK	
WESTW	JOD CENTER			BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTIVI CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 280	Continued From pa	ge 14	F 2	80		
	•	oted Resident #9 had frequent				
		level in the last 5 days.				
	The CCP was revie problems listed for	wed and did not contain any pain.				
	regarding the pain a p.m. RN#1 stated s assessment report and uses the inform RN#1 showed the rreport was blank. R blank, she puts das pain assessment w she asked the staff	attor (RN#1) was interviewed assessment on 9/13/16 at 4:05 whe reviews the pain performed by the nursing staff nation to complete the MDS, eport to the surveyor and the N#1 stated if the report was hes in the MDS because the as incomplete. When asked if or the resident about the pain stated she looked at the				8
	informed of the find survey team on 9/1- 483.20(k)(3)(i) SER PROFESSIONAL S The services provide	VICES PROVIDED MEET TANDARDS ed or arranged by the facility	F 2	RN #2 was re-educate medication administra	ation policy	10/15/16
4	must meet profession	onal standards of quality.		regarding medications borrowed from another		
	by: Based on observat record review, the fa	·		Nursing staff will be a before 10/15/16 by the designee on facility per medications will not be from another resident action upon discovery	e NPE and/or olicy that be borrowed with corrective	



PRINTED: 09/29/2016 FORM APPROVED OMB NO 0938-0391

E & MEDIO, ND CERTIFICE		<u> </u>	1VID 140. 0000 000
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X3) DATE SURVEY COMPLETED
495200	B WING		C
100200			09/15/2016
		STREET ADDRESS, CITY, STATE, ZIP CODE	
		WESTWOOD MEDICAL PARK	
		BLUEFIELD, VA 24605	
Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
	(X1) PROVIDER/SUPPLIER/CLIA	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495200 B WING ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL (X2) MULT A BUILDIN B WING PREFIX	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495200 B WING STREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605 ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A BUILDING BY WING STREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIATE CONSTRUCTION A BUILDING BY WING STREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605 ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL TAG CROSS-REFERENCED TO THE APPROPRIATE CONSTRUCTION A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

F 281 Continued From page 15

A medication pass and pour observation was conducted on 9/14/16 at 7:40 a.m. and included Resident #14.

Resident #14 was admitted to the facility on 7/1/16 and re-admitted on 8/16/16 with diagnoses of anxiety, depression, diabetes, hypertension, arthritis, bipolar disease, dementia, peptic ulcer disease, urinary tract infection and a recent cough with shortness of breath.

The admission Minimum Data Set (MDS) with a reference date of 7/1/16 assessed the resident with a cognitive score of "14" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene.

RN#2 was observed administering medications to Resident #14. RN#2 stated the resident needed her nebulizer treatment of Duoneb 3 mg. RN #2 was observed to search the medication cart for the medication and was unable to locate the Duoneb. RN#2 stated the order was new, so she reached in the cart and stated she would borrow the Duoneb from another resident and repay that resident when Resident #14's medication came from the pharmacy. RN#2 entered the room and found there was no nebulizer machine for the resident and left the room to obtain the machine. RN#2 set up the nebulizer and applied the mask for the resident and administered the Duoneb.

The administrator and director of nursing were informed on 9/14/16 at 4:30 p.m. of the borrowed medication observation and asked for the standard of practice the facility used for borrowed medications. The director of nursing provided the facility policy for medication administration. The

F 281

RN #2 will be observed administering medications by NPE and/or designee on or before 10/15/16 to ensure medications are not borrowed from another resident. NPE and/or designee will observe nursing staff administering medications 2 times per week X 4 weeks to ensure medications are not borrowed from another resident with correction action upon discovery. Findings will be reported to the Director of Nursing.

Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 17L211

Facility ID: VA0271

If continuation sheet Page 16 of 45



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			O	MB NO). 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		DNSTRUCTION		TE SURVEY MPLETED
		495200	B WING				C 715/2016
NAME OF F	PROVIDER OR SUPPLIER		1	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	.'	
· · · · · · · · · · · · · · · · · · ·	OOD OFWED		1	WEST	TWOOD MEDICAL PARK		
WESING	OOD CENTER			BLU	EFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 281	Continued From pa	ine 16	F 2	Ω1			
1 =0.	,	ications will not be borrowed	1 4	0 1			!
		ent". The facility offered no					
	further information						
	483.20(k)(3)(ii) SEF	RVICES BY QUALIFIED	F 2	82			
SS=D	PERSONS/PER CA	ARE PLAN		A late	e entry note on Resident #10 w	/as	171271
	The services provid	ded or arranged by the facility			leted on 10/6/16 to indicate that		10/15/16
		y qualified persons in		-	amedic, not employed by the	ELE.	
		ach resident's written plan of		-	ty, had been called to start the	137	-
	care.	, , , , , , , , , , , , , , , , , , ,		lacin	y, had been caned to start the	1 V .	
				Murci	ng staff will be re-educated by	,	
	This DECHIDEMEN	NT is not met as evidenced			PE and/or designee on or before		
	by:	11 IS HOLITIEL AS EVIGENCEG			6/16 regarding only qualified	10	
		vation, interview and record			ty staff to attempt IV access or	n	
	review, the facility fa	ailed to provide or arrange			ents in our care. If unable to	1	
,		ided by a qualified person in				1:4.	
		written plan of care for 1 of 19			n IV access with qualified facil	-	8
	residents (Resident	. #10).		-	nursing will notify physician t		
	Resident #10 was a	admitted to the facility on		_	est resident be sent to the ER of	ſ	
		ses including atrial fibrillation,		otner	appropriate orders.		
	hypertension, heart	failure, gastroesophageal					
1		stage renal disease with					
		ogenic bladder, diabetes					
	-	sthma, and respiratory failure. mum data set assessment					
		eference date 7/19/16, the					
		d 15/15 on the brief interview					
		nd was assessed as without					
		, or behaviors affecting others.					
1		ssessed with pain (J0300= 1					
		teristics and frequently was lemodialysis (SectionO0100)					!
	was not documente						
		•					
		n the resident's room several 9/15/15, talking with the					
		77 TO TO, talking with the					I

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2016 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	O. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	' '	TIPLE CONSTRUCTION		ATE SURVEY OMPLETED
		495200	B WING			C 9/15/2016
	PROVIDER OR SUPPLIER DOD CENTER			STREET ADDRESS, CITY, STATE, ZIP C WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
	care and the conditi surveyor did not observed that a hemocare during these via to be. The surveyor officer who the man thought he was an ewith the local rescue for a policy governing non-employees who facility and concernious. On 9/14, the chat the man was a of the license walle manager knew the period to try to save the resident and concernious. During clinical reconsurveyor was unable progress note in the a paramedic not embeen called to start.	sident's room mate about their ion of the facility. The serve any indication that the odialysis access that required isits. veyor observed a man in the o stated he was truing to start teter (IV) access. He was not is facility employees appeared in asked the chief nursing in was. She stated that she emergency medical technician is esquad. The surveyor asked ing credentialing in operform procedures in the ing skills testing for starting international paramedic and offered a copy it card. She stated that a unit paramedic and had called him is ident a trip to the emergency are to locate an order or a calcinical record indicating that inployed by the facility had	F 2	The Unit managers will revie documentation for the next 3 with orders for IV access to obtained to ensure qualified staff attempted the IV access unsuccessful the resident wathe ER or other orders obtain corrective action upon disco Findings will be reported to Director of Nursing. Any trends identified will be to the Quality Improvement Committee for further evaluate recommendations.	B residents be facility s and if us sent to ned with very. the	
	administrator and cl summary meeting o	nief nursing officer during a on 9/15/16. ARE/SERVICES FOR	F 3	09		

Each resident must receive and the facility must provide the necessary care and services to attain





OCT 11 2016

PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		O ¹	MB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	i,	495200	B. WING		C 09/15/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
'A/FOTIA/	AAD AENTED			WESTWOOD MEDICAL PARK	
WESIW	OOD CENTER			BLUEFIELD, VA 24605	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE COMPLETION
F 309	Continued From pa	age 18	F 30	09	_
		hest practicable physical,			1045 I46
		osocial well-being, in		Resident #10 is currently out of the	1015/16
	accordance with the	e comprehensive assessment		facility.	ļ
	and plan of care.				
				The forms for communication with	
				Dialysis were ordered on 9/15/16 and	nd
	This REQUIREMEN	NT is not met as evidenced		will be initiated on receipt. The	
	by:			hemodialysis site assessment was	
	Based on observat	tion, staff interview, and clinical		initiated on 10/3/16. Hemodialysis	
		ity staff failed to ensure		care plan was initiated on 9/4/14 an	
		he resident's condition with the		last revised on 9/13/16. The annua	ıl
		modialysis and to ensure staff care of the dialysis shunt for 1		minimum data set with assessment	
		ne survey sample (Resident		reference date 7/19/16 did have	
į	#10).	le survey sample (1.00.00		Hemodialysis Section O-0100	
	н 107.			documented.	
	Resident #10 was a	admitted to the facility on		WOOD WALLAND WITH	8
		ses including atrial fibrillation,		Nursing staff will be re-educated by	
		failure, gastroesophageal		NPE and/or designee on or before	′
		stage renal disease with			
		ogenic bladder, diabetes sthma, and respiratory failure.		10/15/16 on the policy regarding	
		mum data set assessment		communication with Dialysis,	
		eference date 7/19/16, the		Hemodialysis site assessment, and	
		d 15/15 on the brief interview		Hemodialysis care plan.	
		ind was assessed as without			
		, or behaviors affecting others.			
		ssessed with pain (J0300= 1			
		teristics and frequently was lemodialysis (SectionO0100)			
	was not documente				
	Was not accuments				
	The surveyor was i	n the resident's room several			
		9/15/15, talking with the			
		sident's room mate about their			
		ion of the facility. The			
	surveyor did not ob	serve any indication that the			

FORM CMS-2567(02-99) Previous Versions Obsolete

resident had a hemodialysis access that required

Event ID: 17L211

Facility ID: VA0271

If continuation sheet Page 19 of 45



		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 09/29/2016 RM APPROVED NO: 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	' '	TIPLE CONSTRUCTION ING	(X3)	DATE SURVEY COMPLETED
		495200	B. WING			C 09i̇15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		00/10/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CORREST TO THE APPOPER OF T	OULD BE	(X5) COMPLETION DATE
F 309	During clinical reco surveyor noted and hemodialysis 3 X w Saturday. There we care of the access: The surveyor was a addressing hemodial. The surveyor requestance plan, but did not the facility. Review, on 9/15/16 August and Septemaddressing hemodial	rd review on 9/15/16, the order initiated 8/4/14 for eek Tuesday, Thursday, as no order for assessment or site. unable to locate a care plan alysis in the resident's record. ested a copy of the resident's or receive one prior to exiting , of nursing progress notes for other 2016 revealed one note alysis on 9/28/16: Resident	F3	We currently have no residents dialysis. Monitoring will be initiafter admission of any resident receiving dialysis with correctivaction upon discovery. Unit mawill monitor residents receiving dialysis for completion of Hemodialysis site assessments, hemodialysis care plans and Hemodialysis communication for weekly with corrective action up discovery. Findings will be report to the Director of Nursing.	e nagers orms oon	
ì	OOF to dialysis. Th	ere was no documentation of		A next than do idantified will be well	1	70477

the resident's condition before leaving or on her return.

The surveyor asked the two nurses working day shift on the resident's nursing unit on 9/15/16 where to find the assessments and documentation of communication of assessments with the dialysis center. The surveyor also asked the nurses where the dialysis access was. Neither nurse was able to state the type or location of the dialysis access. The nurses stated that they sometimes made a push to get communication from the dialysis center. It would get better for a while then get worse again. The chief nursing officer stated that the dialysis centered did not send information about the resident's condition and also that facility staff do not do a regular assessment before or after dialysis.

The surveyor reported the concern to the facility

Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I7L211

Facility ID VA0271

If continuation sheet Page 20 of 45



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES		·	JMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495200	B WING		C 09/15/2016
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
				WESTWOOD MEDICAL PARK	
WESTWO	OOD CENTER			BLUEFIELD, VA 24605	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETION
	summary meeting of considered this to be failures and multiple evidence of a nursing to address the reside with hemodialysis, rewith the dialysis cer received treatment hemodialysis did not set assessment.	hief nursing officer during a on 9/15/16. The surveyor be a pattern with multiple be occurrences: There was not not assessment, no care plant dent's end stage renal disease no interchange of information atter where the resident at times per week, and of appear on the minimum data thank that a stage of the stage of t	F3	.12	
	daily living receives maintain good nutrit and oral hygiene. This REQUIREMEN by:	nable to carry out activities of the necessary services to tion, grooming, and personal IT is not met as evidenced		Resident #3 receives bed baths a minimum of 2 times per week, per preference due to refusal to get out bed. Resident #5 has received 2 showers per week since 9/13/16 except 9/27/16 & 9/30/16 when shrefused to shower. Resident #11 libeen acutely ill since 9/16/16. Resident has been out to the hospi	ne nas
Children maken (1988-198	clinical record revier personal hygiene set two showers per we survey sample (Res 1. For Resident #1 2 showers per week Resident #11 was re 1/23/16 with diagno disease, end stage	interview, staff interview, and w, facility staff failed to provide ervices, to include the required eek, to 4 of 18 residents in the sidents # 3, 5, 11, and 13). 1, facility staff failed to provide c. e-admitted to the facility on ses including coronary artery renal disease, asthma, post order, anxiety, depression,		several times and at times too sick go to the shower room but has received either a bed bath or show least 2 days every week. Resident no longer resides in the facility.	to er at

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:17L211

Facility ID: VA0271

If continuation sheet Page 21 of 45





PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT O	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495200	B. WING		C 09/15/2016
		l			1 03/13/2010
NAME OF PRO	OVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	
				WESTWOOD MEDICAL PARK	
WESTWOO	DD CENTER				
				BLUEFIELD, VA 24605	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFI)	(EACH CORRECTIVE ACTION SHOULD	
TAG	V	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
17.0				DEFICIENCY)	
				·	

F 312 Continued From page 21

On the annual minimum data set assessment with assessment reference date 8/15/16, the resident scored 14/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others. The resident was assessed asrequiring supervision of staff for bathing (G0120 A=1, B=0).

During a group interview on 9/14/16 at 11 AM with 10 residents capable of answering questions, Resident #11 and four others reported that they frequently did not receive two showers per week because there were not enough staff to take residents to the shower. Several residents stated they would be told staff would try to get them in the next day, but there is not enough staff to do extra showers, either.

A resident who does not receive 2 showers per week must receive daily bed baths.

During clinical record review on 9/15/16, the surveyor noted that one shower was documented for Resident #11on September 1 2016. Bed baths were not documented for September 6, 9, or 15. The surveyor did not receive requested documents containing August 2016 shower recirds prior to exit from the facility.

The administrator and director of nursing were notified of the concern during a summary interview on 9/14/15.

2. For Resident #3, facility staff failed to provide 2 showers per week.

Resident #3 was re-admitted to the facility on 2/19/16 with diagnoses including hypertension, congestive heart failure, neurogenic bladder,

F 312

Director of Nursing met with the Resident Council on 9/28/16 to discuss their concerns with not receiving 2 showers per week. Ideas were discussed to improve the number of showers and/or bed baths being given. The residents agreed to a revision of the shower schedule and agreed to provide feedback and give the new plan an opportunity to be successful.

Nursing staff was re-educated by the NPE and/or designee on or before 10/15/16 regarding the revision of the shower schedule and the requirement the residents receive their appropriate number of showers and/or bed baths per week with refusals appropriately documented.

The Unit managers will monitor the CNA ADL books to ensure showers and/or bed baths are given appropriately with corrective action upon discovery. Findings will be reported to the Director of Nursing.

Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I7L211

Facility ID: VA0271

If continuation sheet Page 22 of 45



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION ING		ATE SURVEY MPLETED
		495200	B WING		05	С 9 715/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	 	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 312	Continued From pa diabetes, anxiety, d	ge 22 epression, and asthma.	F 3	12		
The second of the control of the con	with assessment re resident scored 9/1 mental status and v of delirium, psychos others. The resident dependent on staff During a group inte 10 residents capable residents reported to receive two shower were not enough st shower. Several restold staff would try to there is not enough either.	nimum data set assessment ference date 8/30/16, the 5 on the brief interview for was assessed as without signs sis, or behaviors affecting at was assessed as totally for bathing (G0120 A=4, B=2). Tryiew on 9/14/16 at 11 AM with the of answering questions, that they frequently did not as per week because there aff to take residents to the sidents stated they would be on get them in the next day, but staff to do extra showers,		This page was intentionall	ly left blank.	in the second se
The second secon	week must receive During clinical record surveyor noted that documented for Res September 2016. Edocumented for Aug September 7 and 1. The administrator a notified of the conceinterview on 9/14/18	rd review on 9/14/16, the no showers were sident #3 in August or 3ed baths were not gust 10, 11, and 29, or for 3. Ind director of nursing were ern during a summary 5. In facility staff failed to provide				

Resident #5 was re-admitted to the facility on 5/23/15 with diagnoses including hypertension,



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB N	<u>O. 0938-0391</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTRUCTION ING		ATE SURVEY OMPLETED
		495200	B. WING		0	C 9/15/2016
	PROVIDER OR SUPPLIER OOD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC	OULD BE	(X5) COMPLETION DATE
F 312	insufficiency, diabed dementia. On the quarterly miwith assessment reresident scored 5/1 mental status and viewel of consciousn and without signs of affecting others. The totally dependent of A=4, B=2). During a group inte 10 residents capaboresidents reported freceive two shower were not enough stores and without signs of affecting others. During a group inte 10 residents reported freceive two shower were not enough stores and staff would try there is not enough either. A resident who does week must receive During clinical reconsurveyor noted that for Resident #3 on September 13 2016 documented for Aug September 4.	ease, atrial fibrillation, renal tes, anxiety, depression, and nimum data set assessment ference date 8/25/16, the 5 on the brief interview for was assessed as with altered tess 4-6 days (sign of delirium), f psychosis, or behaviors he resident was assessed as a staff for bathing (G0120 rview on 9/14/16 at 11 AM with the of answering questions, that they frequently did not is per week because there aff to take residents to the sidents stated they would be to get them in the next day, but staff to do extra showers,	F3	This page was intentionally lef	t blank.	8
	notified of the concinterview on 9/14/1	ern during a summary				n

FORM CMS-2567(02-99) Previous Versions Obsolete

received sufficient baths/showers to provide good

Event ID: I7L211

Facility ID: VA0271

If continuation sheet Page 24 of 45



PRINTED: 09/29/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATÉ SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING _ C 09715/2016 B. WING 495200 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER WESTWOOD MEDICAL PARK WESTWOOD CENTER BLUEFIELD, VA 24605 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES 1D (X4) ID (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 312 F 312 Continued From page 24 personal hygiene. Resident #13 was admitted to the facility on This page was intentionally left blank. 5/23/15 and readmitted on 8/8/16. His diagnoses include but are not limited to high blood pressure, hypothyroidism, cerebral infarction, sleep disorder and depression Resident #13's minimum data set (MDS) assessment, with an assessment reference date (ARD) of 08/22/16 assessed him to understand and could be understood. He was assessed to have as cognitive status of 5 out of 15. His assessment revealed in section G, he needed assistance with daily activities of living. Review of Resident #13's current comprehensive care plan revealed under Focus the following: requires assistance is dependent for ADL care in (bathing, grooming, dressing, eating, bed mobility, transfer, locomotion, and toileting) due to cognitive loss/dementia. . Goals: Residents ADL

F 328

SS=D NEEDS

Resident #13 's showers.

review date.

care needs will be anticipated and met in order to

functioning and physical well-being thru the next

Resident #13 's activity of daily living sheet revealed his bathing record for August, 2016. The record revealed he was not getting his showers but getting a partial bath almost every other day. On 9/15/16 at 4:30 pm, the administrator, director of nurses and director of nurses were informed of

Prior to exit on 9/15/16, the above information was again discussed with the administrator, and director of nurses. No further information related to the showers was provided by the facility staff.

F 328 483.25(k) TREATMENT/CARE FOR SPECIAL

maintain the highest practicable level of

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2016

	INCHES OF THE RETT	THE HOME IT CENTROLO			FURW APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		O	MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495200	B. WING		C 09/15/2016
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP CODE	, 00.10.2010
WESTW	OOD CENTED		j	WESTWOOD MEDICAL PARK	
WESTAN	OOD CENTER			BLUEFIELD, VA 24605	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTIO X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 328	Continued From pa	ge 25	F 3	28	
	proper treatment ar special services: Injections; Parenteral and enter Colostomy, ureteror Tracheostomy care Tracheal suctioning Respiratory care; Foot care; and Prostheses. This REQUIREMENT by: Based on observations	stomy, or ileostomy care; ;		Resident #10 is currently out of the facility. For Resident #3, the order "wipe down O2 concentrator with Saniwipe; clean external filter on C concentrator with soap and water & pat dry, change all O2 tubing, nasal cannula or mask, storage bag and humidifier every Wednesday night. Label each component with date & initials" and "wipe down nebulizer with Saniwipe; change tubing, masand storage bag every Wednesday night. Label each component with date & initials every night shift" was	for 22 22 31 . k,
d	necessary care of r	esidents receiving oxygen for the survey sample (Residents		completed and documented on 9/15/16. For Resident #5, the order for "wipe down O2 concentrator wi	r ith
		0, facility staff failed to follow releaning and sanitizing ion supplies.		Saniwipe; clean external filter on O concentrator with soap and water & pat dry, change all O2 tubing, nasal cannula or mask storage has and	ζ
	3/8/16 with diagnos hypertension, heart reflux disease, end hemodialysis, neuro mellitus, anxiety, as	admitted to the facility on es including atrial fibrillation, failure, gastroesophageal stage renal disease with ogenic bladder, diabetes othma, and respiratory failure. The mum data set assessment		cannula or mask, storage bag and humidifier every Wednesday night. Label each component with date & initials" was completed and documented on 9/15/16. Resident # no longer resides in the facility.	

FORM CMS-2567(02-99) Previous Versions Obsolete

with assessment reference date 7/19/16, the resident was scored 15/15 on the brief interview for mental status, and was assessed as without delirium, psychosis, or behaviors affecting others. The resident was assessed with pain (J0300= 1 Yes), but its characteristics and frequently was

Event ID: I7L211

Facility ID: VA0271

If continuation sheet Page 26 of 45





PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

OLIVILLI	O I OIL WILDIOAILE	L & MILDIONID OLIVIOLO			WID NO. 0930-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		495200	B WING	And a state of the	C 09/15/2016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
MECTIMO	OD CENTED			WESTWOOD MEDICAL PARK	
WESTWO	OD CENTER			BLUEFIELD, VA 24605	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION

F 328 Continued From page 26 not documented. Hemodialysis (SectionO0100) was not documented).

The surveyor was in the resident's room several times from 9/13 to 9/15/15, talking with the resident and the resident's room mate about their care and the condition of the facility. On Thursday 9/15/16, the surveyor observed the resident's oxygen concentrator and nebulizer were dated 9/7/16.

During clinical record review on 9/15/16, the surveyor noted an order initiated 6/5/2016 "Wipe down O2 concentrator with Saniwipe; clean external filter on O2 concentrator with soap and water and pat dry, change all O2 tubing, N/C (nasal cannula) or mask, storage bag and humidifier every Wednesday night. Label each component with date and initials." A second order dated 9/6/16 "Wipe down nebulizer with Santi-wipe; change tubing, mask, and storage bag Q Wednesday night. Label each component with date and initials every night shift every Wednesday night." Neither order was documented as completed Wednesday September 15, 2016.

The concern was reported to the administrator and director of nursing during a summary meeting on 9/15/16.

2. For Resident #5, facility staff failed to follow physician orders for cleaning and sanitizing oxygen administration supplies.

Resident #5 was re-admitted to the facility on 5/23/15 with diagnoses including hypertension, coronary artery disease, atrial fibrillation, renal

F 328

Director of Nursing re-educated staff responsible for cleaning and sanitizing oxygen and nebulizer administration supplies on 9/15/16. Department managers and/or designee will make room rounds to ensure the oxygen. nebulizer and suction equipment is bagged and dated appropriately daily X 2 weeks then conduct random observations with corrective action upon discovery. The NPE and/or designee will monitor the documentation for cleaning and sanitizing oxygen and nebulizer administration supplies and suction equipment every month. Findings will be reported to the Administrator.

Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 17L21

Facility ID: VA0271

If continuation sheet Page 27 of 45



VDH/OLC

PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

S FOR MEDICARE	& MEDICAID SERVICES			(OMB NO. 0938-0391
OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	B. WING			C 09/15/2016
ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE	
OD OFWED			WE	STWOOD MEDICAL PARK	
OD CENTER			BL	UEFIELD, VA 24605	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DBE COMPLETION
Continued From na	ao	= 5	220		
·		F3	528		
· ·	es, anxiety, depression, and				
Jementia.			T	his page was intentionally left h	olank.
with assessment refresident scored 5/15 mental status and walevel of consciousnes and without signs of affecting others. That totally dependent or A=4, B=2). While visiting the resurveyor observed to concentrator and tull surveyor was unable cleaning or tubing cleaning or tubing cleaning 9/15/16, the concentrator of the concentrator and tull surveyor was unable cleaning or tubing cleaning or tubing cleaning of tubing cleaning 9/15/16, the concentrator and tull surveyor was unable cleaning or tubing cleaning or tubing cleaning 9/15/16, the concentrator and tubing cleaning or tubing cleaning of tubing cleaning 9/15/16, the concentrator and tubing cleaning or tubing cleaning 9/15/16, the concentrator and tubing cleaning or tubing cleaning 9/15/16, the concentrator and tubing cleaning or tubing cleaning 9/15/16, the concentrator and tubing 9/15/16, the concentrator and 9/15/16, the c	ference date 8/25/16, the 5 on the brief interview for vas assessed as with altered ess 4-6 days (sign of delirium), f psychosis, or behaviors he resident was assessed as a staff for bathing (G0120 esident in the room, the that the resident's oxygen bing were unlabeled. The let of find a date for the last change. When the surveyor gain around 10 AM on the concentrator and tubing				
During clinical recorsurveyor noted an oconcentrator with Salon O2 concentrator dry, change all O2 to mask, storage bag a Wednesday night. Lidate and initials." The administrator are notified of the concession 9/15/15.	ord review on 9/15/16, the order "Wipe down O2 aniwipe; clean external filter with soap and water and pat ubing, N/C (nasal cannula) or and humidifier every abel each component with and director of nursing were ern during a summary meeting				
TOTAL TOTAL OF THE CONTROL TO THE TOTAL TREE TO THE TOTAL TREE TO THE TOTAL TREE TOTAL T	Continued From paginsufficiency, diabet dementia. On the quarterly minwith assessment refresident scored 5/18 mental status and wilevel of consciousne and without signs of affecting others. That totally dependent or A=4, B=2). While visiting the resurveyor observed to concentrator and tules surveyor was unabled be concentrator and tules of the concentrator and tules of the concentrator and tules of the concentrator with San O2 concentrator with San O2 concentrator dry, change all O2 to concentrator dry, change all O2 to concentrator and tules of the concentrator dry, change all O2 to concentrator dry,	ROVIDER OR SUPPLIER OD CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 insufficiency, diabetes, anxiety, depression, and dementia. On the quarterly minimum data set assessment with assessment reference date 8/25/16, the resident scored 5/15 on the brief interview for mental status and was assessed as with altered level of consciousness 4-6 days (sign of delirium), and without signs of psychosis, or behaviors affecting others. The resident was assessed as totally dependent on staff for bathing (G0120 A=4, B=2). While visiting the resident in the room, the surveyor observed that the resident's oxygen concentrator and tubing were unlabeled. The surveyor was unable to find a date for the last cleaning or tubing change. When the surveyor entered the room again around 10 AM on Thursday 9/15/16, the concentrator and tubing remained unlabeled. During clinical record review on 9/15/16, the surveyor noted an order "Wipe down O2 concentrator with Saniwipe; clean external filter on O4 concentrator with Saniwipe; clean external filter on O5 concentrator with Saniwipe; clean external filter on O6 concentrator with Saniwipe; clean external filter on O7 concentrator with Saniwipe; clean external filter on O8 concentrator with Saniwipe; clean external filter on O8 concentrator with Saniwipe; clean external filter on O9 concentrator with Saniwipe; clean external filter on O9	APPECIATION (X1) PROVIDER/SUPPLIER/CLIA (X2) MUL A BUILD (X1) PROVIDER ON DIMBER: 495200 B WING ROVIDER ON SUPPLIER OD CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 F 3 insufficiency, diabetes, anxiety, depression, and dementia. On the quarterly minimum data set assessment with assessment reference date 8/25/16, the resident scored 5/15 on the brief interview for mental status and was assessed as with altered level of consciousness 4-6 days (sign of delirium), and without signs of psychosis, or behaviors affecting others. The resident was assessed as totally dependent on staff for bathing (G0120 A=4, B=2). While visiting the resident in the room, the surveyor observed that the resident's oxygen concentrator and tubing were unlabeled. The surveyor was unable to find a date for the last cleaning or tubing change. When the surveyor entered the room again around 10 AM on Thursday 9/15/16, the concentrator and tubing remained unlabeled. During clinical record review on 9/15/16, the surveyor noted an order "Wipe down O2 concentrator with Saniwipe; clean external filter on O2 concentrator with soap and water and pat dry, change all O2 tubing, N/C (nasal cannula) or mask, storage bag and humidifier every Wednesday night. Label each component with date and initials." The administrator and director of nursing were notified of the concern during a summary meeting on 9/15/15.	CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495200 B WING ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 Insufficiency, diabetes, anxiety, depression, and dementia. Con the quarterly minimum data set assessment with assessment reference date 8/25/16, the resident scored 5/15 on the brief interview for mental status and was assessed as with altered level of consciousness 4-6 days (sign of delirium), and without signs of psychosis, or behaviors affecting others. The resident was assessed as totally dependent on staff for bathing (G0120 A=4, B=2). While visiting the resident in the room, the surveyor observed that the resident's oxygen concentrator and tubing were unlabeled. The surveyor was unable to find a date for the last cleaning or tubing change. When the surveyor entered the room again around 10 AM on Thursday 9/15/16, the concentrator and tubing remained unlabeled. During clinical record review on 9/15/16, the surveyor noted an order "Wipe down O2 concentrator with Saniwips; clean external filter on O2 concentrator with soap and water and pat dry, change all O2 tubing, N/C (nasal cannula) or mask, storage bag and humidifier every Wednesday night. Label each component with date and initials." The administrator and director of nursing were notified of the concern during a summary meeting on 9/15/15.	DE DEFICIENCIES CORRECTION (X1) PROVIDER SUPPLIER A 195200 ROWIDER OR SUPPLIER ROWIDER OR SUPPLIER ROWIDER OR SUPPLIER OD CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 27 Insufficiency, diabetes, anxiety, depression, and dementia. On the quarterly minimum data set assessment with assessment reference date 8/25/16, the resident scored 5/15 on the brief interview for mental status and was assessed as with altered evel of consciousness 4-6 days (sign of delirium), and without signs of psychosis, or behaviors affecting others. The resident was assessed as totally dependent on staff for bathing (G0120 A=4, B=2). While visiting the resident in the room, the surveyor observed that the resident's oxygen concentrator and tubing were unlabeled. The surveyor onted an order "Wipe down O2 concentrator with Saniwipe; clean external filter on O2 concentrator with date and initials." The administrator and director of nursing were notified of the concern during a summary meeting an 9/15/15.

physician orders for cleaning and sanitizing

oxygen administration supplies.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2016 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO	D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION DING		ATE SURVEY DMPLETED
		495200	B, WING	<u> </u>	0:	C 9 /15/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
WESTWO	DOD CENTER			WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SH O ULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 328	Continued From pa	ge 28	F	328		
	5/23/15 with diagnot coronary artery dise	-admitted to the facility on oses including hypertension, ease, atrial fibrillation, renal tes, anxiety, depression, and		This page was intention	nally left blank.	
The second secon	with assessment re- resident scored 5/1 mental status and v level of consciousn and without signs o affecting others. The	nimum data set assessment ference date 8/25/16, the 5 on the brief interview for was assessed as with altered ess 4-6 days (sign of delirium) f psychosis, or behaviors he resident was assessed as n staff for bathing (G0120	*			
	times from 9/13 to resident and the recare and the condit Thursday 9/15/16, 1	n the resident's room several 9/15/15, talking with the sident's room mate about their ion of the facility. On the surveyor observed the concentrator was dated				*
	surveyor noted and down O2 concentrates external filter on O2 water and pat dry, of (nasal cannula) or thumidifier every Wo component with day order dated 9/6/16 Santi-wipe; change bag Q Wednesday	rd review on 9/15/16, the order initiated 2/9/2016 "Wipe ator with Saniwipe; clean 2 concentrator with soap and change all O2 tubing, N/C mask, storage bag and ednesday night. Label each te and initials." A second "Wipe down nebulizer with tubing, mask, and storage night. Label each component s every night shift every				T. T

Wednesday night."

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2016 FORM APPROVED

DEITH	WIENT OF THE KETT	7 11 10 11 0 11 11 0 E 1 1 1 1 0 E 0				MARKOVED
CENTER	RS FOR MEDICARE	& MEDIÇAID SERVICES	,		OMB NO). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	LE CONSTRUCTION		TE SURVEY MPLETED
		495200	B. WING	- Anna Caranta - Anna - An	05	C /15/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTWO	OOD CENTER			WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 328	Continued From pa	ge 29 ted to the administrator and	F 328			
	chief nursing officer that the concentrator appeared not to have been cleaned since 8/11/16 during a summary meeting on 9/14/16. 4. For Resident #1, the facility staff failed to maintain suction equipment in a clean and sanitary manner when not in use.			This page was intentionally lef	t blank.	
	on 1/17/06 and was diagnoses included	iginally admitted to the facility readmitted on 2/8/15. Her , but were not limited to: high pression, stroke, anemia, tes and dementia.				
	(MDS) with an asse completed on 2/13/ quarterly MDS asse section C, had a co short time memory	m data set assessment assment reference date (ARD) 16 for Resident #1 was a assment. Resident #1 in gnitive score of 1/1 (long and problem) and she scored a 3 indicating she was severely				
Object (in) Section Communication (in)	throughout the surv observed to have a beside the bed. The yankauer suction do The suction caniste observed to be unc	ey process. The Resident #1 ey process. The Resident was suction machine on her table e suction machine had a evice attached to the tubing. In tubing and yankauer were overed. The suction canister oudy water and secretions.				
	resident 's room. S suction machine sh	LPN #4 to come into the he was then asked if the ould be covered. She looked said "I'm not sure, but the e emptied."				

FORM CMS-2567(02-99) Previous Versions Obsolete

On 9/14/16 at 4:30pm, the administrator, and

Event ID: I7L211

Facility ID: VA0271

If continuation sheet Page 30 of 45



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495200	B. WING		C 09/15/2016
	PROVIDER OR SUPPLIER		v	TREET ADDRESS, CITY, STATE, ZIP CODE VESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	03/13/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 353	equipment. No further informativas provided to the conference. 483.30(a) SUFFICIPER CARE PLANS The facility must haprovide nursing and maintain the highest and psychosocial with determined by residindividual plans of conference of each of personnel on a 24-locare to all residents care plans: Except when waive section, licensed nupersonnel. Except when waive section, the facility nurse to serve as a duty.	where informed of the suction ion regarding the above issue e survey team prior to the exit ENT 24-HR NURSING STAFF S ave sufficient nursing staff to d related services to attain or st practicable physical, mental, vell-being of each resident, as dent assessments and	Pl re to Ro N' be de tal	the survey sample list that was given the Administrator on 9/15/16 durkit did not have a Resident #16. Thysician was notified and orders accived on 9/14/16 that is was okay administer medications late to esident #'s 14 & 15. The transfer of the transfer	y
	by: Based on observation document review, a facility failed to ens	tion, staff interview, facility and clinical record review, the ure adequate staffing to meet	τ.		

PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

			······································	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	405000	D. IAMAIC		C
	495200	B. WING		09i15/2016
NAME OF PROVIDER OR SUPPLI	ER .		STREET ADDRESS, CITY, STATE, ZIP CODE	
WESTWOOD CENTER			WESTWOOD MEDICAL PARK	
WESTWOOD SERVER			BLUEFIELD, VA 24605	
PREFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATI O N)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION X (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION

F 353 Continued From page 31

This included medication observation of 3 of 19 residents (Resident #14, #15, and #16).

A medication pass and pour observation was conducted on 9/14/16 beginning at 7:40 a.m. The staff nurse (RN#2) stated she had been called in early to administer the 6:00 a.m. medications because there were only 2 nurses on night shift and they were unable to administer the 6:00 a.m. medications on one hall. RN#2 stated, "I guess they were too busy".

RN# 2 was observed giving the 6:00 a.m. medications to Residents #14, #15, and #16. RN#2 stated she had given medications to residents in rooms 209 through 215. The only private room was 215. All other rooms contained 2 residents. RN#2 completed the 6:00 am. medication pass at 8:10 a.m.

Resident #14 was admitted to the facility on 7/1/16 and re-admitted on 8/16/16 with diagnoses of anxiety, depression, diabetes, hypertension, arthritis, bipolar disease, dementia, peptic ulcer disease, urinary tract infection and a recent cough with shortness of breath.

The admission Minimum Data Set (MDS) with a reference date of 7/1/16 assessed the resident with a cognitive score of "14" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene.

Resident #15 was admitted to the facility on 6/26/16 with diagnoses of anemia, atrial fibrillation, hypertension, neurogenic bladder, diabetes, depression, and necrotizing fascititis with a wound.

F 353

Administrative staff will review staffing on a daily basis to ensure sufficient staffing with the staff required adjusted related to census. Center has been and is continuing to recruit for LPNs and RNs by doing the following: advertising in the local newspaper and advertising on social media, and email blasts. The facility is also completing a Wage Analysis and requesting a shift differential for night shift and weekends.

Nursing staff will be observed administering medications randomly one time per week X 4 weeks by NPE and/or designee on or before 10/15/16 to ensure medications are administered timely. Findings will be reported to the Director of Nursing.

Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.

PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	'	TIPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		495200	B:WING			C Ì15/2016
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT X (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 353		ge 32 ssessed with a cognitive score	F 3	53		
	8/17/16 with diagnor hypertension, demer fracture, and gastro. The resident was a Minimum Data Set of 8/24/16 with a co. The director of nurs provide the as-work schedule revealed of the second se	admitted to the facility on uses of pain, anemia, entia, aphasia, stroke, hip o-esophageal reflux disease. Seessed on the admission (MDS) with a reference date ognitive score of "9" of "15". Sing (DON) was asked to seed schedule for 9/14/16. The poly 2 nurses were scheduled of the adding the marriage of				
	9/14/16. The administrator, I were informed durin team on 9/14/16 at enough staff to mee administration of me The facility offered to obtained at 10:30 a medications that it value. 483.35(i) FOOD PR STORE/PREPARE/ The facility must - (1) Procure food fro considered satisfac authorities; and	SERVE - SANITARY om sources approved or tory by Federal, State or local distribute and serve food	F 3	71 The 2 refrigerators were cleaned 9/15/16. Environmental Services Director re-educate Housekeeping employ on or before 10/15/16 to ensure refrigerators are maintained in a sanitary condition.	will	10/15/16

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: I7L211

Facility ID: VA0271

If continuation sheet Page 33 of 45



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		LTIPLE CONSTRUCTION DING	1''	ATE SURVEY OMPLETED
		495200	B. WING			C 19 ⁷ 15/2016
NAME OF I	PROVIDER OR SUPPLIER	433200		STREET ADDRESS, CITY, STATE, ZIP CODE	1 0	9/15/2016
WESTWO	OOD CENTER			WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		LD BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 33	F:	371		
	by: Based on observat facility staff failed to Refrigerators" on 2 The findings include On 9/15/16 at 9:30 the nutrition room o refrigerator door wa residue on the glass drawers.	am, two surveyors observed n the south unit. The is opened to reveal sticky is shelf above the chiller		Environmental Services Director and/or designee will check to ensure the refrigerators are maintained in sanitary condition 3 times per week with corrective action upon discovering Findings will be reported to the Administrator. Any trends identified will be reported to the Quality Improvement Committee for further evaluation are recommendations.	a k very.	
	refrigerator also had on it. On the door sl dried substance.	at the bottom of the d a red colored sticky residue helf was an area of a yellow				è
	nutrition room and le said " we will get th					
	room. Upon openin similar observation the refrigerator was juice had been spilt the refrigerator and	eded to the north unit nutrition in the refrigerator door a was made. On the bottom of a dark sticky substance as if . RN #4 was asked to look at she agreed the refrigerator				Ŷ
	administrator and di refrigerators were d Prior to exit no furth to the surveyor relat 483.60(b), (d), (e) D	m, during a meeting with the irector of nurses the iscussed. er information was provided ted to the refrigerator.	F	431		5
		UGS & BIOLOGICALS Inploy or obtain the services of				

PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

OLITICI	TO TOTT MEDIOMITE	A MICDIOTALD OLITATOLO			IVID IVC	7. 0330-033 T
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	LTIPLE CONSTRUCTION DING		TE SURVEY MPLETED
		495200	B. WING	3	00	C /15/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	11312010
IVAIVIL OI I	ROVIDER OR SOFFEIER			<u> </u>		
WESTWO	OOD CENTER			WESTWOOD MEDICAL PARK		
				BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG) BE	(X5) COMPLETION DATE
E 424	Oastinus d Farman	24	_	755		
F 431	Continued From pa		F 4	431		
	of records of receip controlled drugs in accurate reconciliat records are in order	cist who establishes a system of and disposition of all sufficient detail to enable an tion; and determines that drug r and that an account of all maintained and periodically		Residents #11's Refresh expired ey drops were discarded and replaced 9/14/16. Medical Records checked expired eye drops on current reside on 9/14/16 with corrective action undiscovery.	on l for ents	10/15/16
	labeled in accordant professional princip appropriate access	als used in the facility must be acce with currently accepted ales, and include the ory and cautionary acceptation date when		NPE and/or designee will re-educate nursing staff on or before 10/15/16 monitor expiration dates on Resider eye drops.	to	
	facility must store a locked compartmen	State and Federal laws, the II drugs and biologicals in its under proper temperature to only authorized personnel to keys.		NPE and/or designee will check the medication carts for expired eye dromonthly X 3 months with corrective action upon discovery. Findings we be reported to the Administrator.	ops e	ø
	permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except wher package drug distril	ovide separately locked, I compartments for storage of sed in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit bution systems in which the sinimal and a missing dose can	:	Any trends identified will be report to the Quality Improvement Committee for further evaluation arrecommendations.		
						39
	This REQUIREMEN	NT is not met as evidenced				
	by:	The former as evidenced				33
	Based on observat record review, facili	ion, staff interview, and clinical ty staff failed to ensure ot out of date for 1 of 18				

residents in the survey sample (Resident #11).

		AND HUMAN SERVICES & MEDICAID SERVICES				RINTED: 09/29/2016 FORM APPROVED VIB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	1	(X3) DATE SURVEY COMPLETED
		495200	B. WING			C 09/15/2016
	PROVIDER OR SUPPLIER DOD CENTER			STREET ADDRESS, CITY, STATE, ZIP O WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD	BE COMPLETION
F 431	Continued From pa	ge 35	F 4	31		
	7/29/15 with diagnodisease, gastroesopstage renal disease depression, post traasthma, and polyneminimum data set a reference date 8/15	admitted to the facility on uses including coronary artery phageal reflux disease, end with hemodialysis, aumatic stress disorder, europathy. On the annual assessment with assessment 16/16, the resident scored 14/15 w for mental status. The		This page was intentionally	left bla	ank.

During medication pass observation on 9/14/16 at approximately 8:30 AM, the surveyor observed the bottle of Rephresh eye drops labeled with the resident's name expired 6/16/16. There was no open date on the bottle. The surveyor asked the medication nurse when the bottle had been delivered. She said she would call the pharmacy for a refill.

resident was assessed without signs of delirium,

psychosis, or behavior symptoms.

The surveyor reported the concern to the chief nursing officer during a summary meeting on 9/14/16 and asked when the bottle of Rephresh had been delivered. The chief nurse reported that Rephresh was a floor stock medication, so there would not have been a pharmacy record. Staff would have pulled new bottles as needed.

The surveyor reviewed the floor stock storage cabinet with the central supply staff member on 9/14/15 at approximately 4 PM. The surveyor asked to see the backup containers of Rephresh drops. The staff member stated that there weren't any. The surveyor asked if there had been a backup supply earlier in the day. She stated that there had been three, but they were no good. The surveyor asked if they were

RECEIVED

OCT 11 2016

VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/29/2016 FORM APPROVED

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495200	B. WING		C 09/15/2016
NAME OF I	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE,	
WESTW	OOD CENTER			WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	¥
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 464	The resident's med indicated that Reph (polyvinyl alcohol-preyes one time daily every day in Septer pass on 9/14/16. The concern that the the floor stock supp communicated to the nursing officer during 9/14/16. 483.70(g) REQUIRINACTIVITY ROOMS The facility must prodesignated for resident productions and the second product of	ered that they were. ication administration record resh Solution 1.4-0.6% rovidone) one drop to both had been administered daily mber 2016 until the medication eresident's medication and lay were out of date was the administrator and chiefing a summary meeting on EMENTS FOR DINING & povide one or more rooms lent dining and activities. be well lighted; be well smoking areas identified; be d; and have sufficient space	F 4	131	vere checked 10/15/16 repair on nce Director on discovery. ignee will very the of dining able or in
n	facility staff failed to main dining room w The findings include During the group int am, in the resident of capable of answering			from service. Maintenant promptly. Maintenance Department the dining room chairs for need for repair every more corrective action upon distance.	ce will repair will check r stability or oth with

The surveyor moved to a chair which was more stable. The activity director took the chair to a

Administrator.

Findings will be reported to the



PRINTED: 09/29/2016 FORM APPROVED MENO 0020 02

CLIVILIN	3 I OK MEDICAKE	A MILDIONID SLIVICES			OIVID	NO. 0930-039 I
STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DATE SURVEY COMPLETED
		495200	B. WING			C 09/15/2016
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIF	CODE	
WESTWOOD CENTER				WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 464 (Continued From na	go 37		164	***************************************	

Continued From page 37

work station at the side of the room, saying she would put a "do not sit" sign on it and put it with the other 3 similar chairs.

On 9/15/16 at 9:20 am, the surveyor entered the main dining room to find 3 slightly wobbly chairs. At 1:30 pm, surveyor met with the maintenance director and informed him of the visit to the dining

He informed the surveyor that he had come in early that morning and repaired the chair that had been reported to him.

During a meeting with the administrator and director of nurses on 9/15/16 at approximately 4:00 pm, the above information was discussed. Prior to exit no further information was provided to the surveyor related to the chairs.

F 507 483.75(j)(2)(iv) LAB REPORTS IN RECORD -SS=D LAB NAME/ADDRESS

> The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, facility staff failed to ensure that test results were accurate and are available for clinical management for 1 of 18 residents in the survey sample (Resident #3)

Resident #3 was re-admitted to the facility on 5/23/15 with diagnoses including hypertension, coronary artery disease, atrial fibrillation, renal insufficiency, diabetes, anxiety, depression, and dementia.

Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.

F 507

The U/A & C&S for Resident #3 was obtained, signed by the physician and placed in the resident's record on 9/15/16.

10/15/16

The NPE and/or designee will educate nursing staff on or before 10/15/16 that prior to placing the lab results in the box for the physician to sign, a copy will be placed in the medical record and the lab log book will be updated.

RECEIVED

OCT 11 2016

VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 09/29/2016

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MAPPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495200	B, WING			C 715/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		710/2010
WESTWO	OOD CENTER		1	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 507	Continued From page	ge 38	F 507			
	with assessment re- resident scored 5/15 mental status and w level of consciousne and without signs of affecting others. The	nimum data set assessment ference date 8/25/16, the 5 on the brief interview for vas assessed as with altered ess 4-6 days (sign of delirium), f psychosis, or behaviors he resident was assessed as a staff for bathing (G0120	a R C to p	Medical records and/or designee udit the medical records of desidents' with orders for U/A & & & during the month of Septento ensure results received, signed thysician and placed in the medical record on or before 10/15/16.	t nber l by cal	
	times from 9/13 to 9 resident and the rescare and the condition During clinical recorsurveyor noted and C&S (urinalysis with	the resident's room several 0/15/15, talking with the sident's room mate about their on of the facility. If review on 9/14/16, the order dated 8/31/16 for U/A & culture and sensitivity). If order dated 9/7/16 "call me	a R C b	Medical records and/or designee adit the medical records of esidents' with orders for U/A & &S to ensure results received, so physician and placed in the mecord monthly. Findings will be exported to the Director of Nursing	igned edical	
	U/A results for 8/31 (treated)". The survesults for the lab te that addressed the lootifying the writer of surveyor asked the assistance locating and the unit manageresults, and the unit pharmacy to fax the	order ? (question) if was tx reyor was unable to locate st or nursing progress notes ab test, lab results, or of the two orders. The resident's nurse for the lab results. The nurse er were unable to locate lab manager called the lab result to the facility.	to C	ny trends identified will be report the Quality Improvement committee for further evaluation ecommendations.		
i	The surveyor reported to the administrator and chief nursing officer that the lab results were not available during a summary meeting on 9/14/16. On 9/15/16, the chief nursing officer offered two					
	progress notes date	d 9/15/16: 8:26 "[] PA asked				

about recent UA C&S results and was advised report was received over the weekend and was

PRINTED: 09/29/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING _ 495200 B: WING 09/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK WESTWOOD CENTER BLUEFIELD, VA 24605 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 507 Continued From page 39 F 507 addressed with the on call physician [] and was currently being treated with Rocephin. No further orders were received." and by the same nurse 8:43" [] PA contacted and did confirm that UA C&S results were discussed verbally with all pertinent information given specifically that the results had been received and were reviewed with treatment initiated if indicated".

F 514 483.75(I)(1) RES

SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIB LE

During a summary meeting on 9/15/16, the surveyor informed the administrator and director of nursing that the absence of lab results in the

clinical record was still an issue.

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced

Based on observation, staff interview, and clinical record review, the facility staff failed to ensure a complete and accurate clinical record for 4 of 19 residents (Residents #14, 4, 10 and 15).

F 514

NPE and/or designee will re-educate nurses on or before 10/15/16 on correct documentation for narcotics that are not administered timely. The nurses are to document a progress note for actual administration time. Nurses will also sign narcotics out of the narcotic box for actual administration time.

10/15/16

RECEIVED

OCT 11 2016

VDH/OLC

PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	KO FOR MEDICARE	& MEDICAID SERVICES			<u> </u>	<u>MR MO.</u>	0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		495200	B. WING	3		097 ⁻	C 15/2016
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	CODE		
WESTW	OOD CENTER			WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 514	Continued From pa	-	F!	514 Nursing staff will be observe	ed		

1. The facility staff failed to document the accurate time for administration of narcotic pain medicine for Resident #15.

Resident #15 was admitted to the facility on 6/26/16 with diagnoses of anemia, atrial fibrillation, hypertension, neurogenic bladder, diabetes, depression, and necrotizing fascititis with a wound.

The resident was assessed with a cognitive score of "15" of "15".

Resident #15 was observed receiving his 6:00 a.m. pain medication, Percoset 10/325 mg, at 8:00 a.m. during the medication pass and pour observation conducted on 9/14/16. The staff nurse (RN#2) administering the medication stated she was called in early to administer the 6:00 a.m. medications because the night nurse was unable due to a staffing shortage.

The clinical record was reviewed. The physician ordered the Percoset to be administered every 6 hours with the times set up at midnight, 6:00 a.m., noon, and 6:00 p.m.

The medication administration record (MAR) for September 2016 was reviewed. The nurse had signed the medication was administered at 6:00 a.m. instead of the observed time of 8:00 a.m. RN#2 also signed the narcotic sign out sheet that the medication was administered at 6:00 a.m.

RN#2 was asked on 9/15/16 at 10:00 a.m. about how the medication was documented. RN#2 stated she always documented the time the

Nursing staff will be observed administering medications randomly one time per week X 4 weeks by NPE and/or designee to ensure narcotics that are not administered timely will have a progress note documented noting actual time narcotic was given and the narcotics are signed out of the narcotic box with actual administration time with corrective action upon discovery. Findings will be reported to the Director of Nursing.

Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.

RECEIVED

OCT 11 2016

VDH/OLC

PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	E & MEDICAID SERVICES			0	MB NC	<u>0. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DA	TE SURVEY
		495200	B. WING	;		06	C 9 /15/2016
NAME OF I	PROVIDER OR SUPPLIER	<u></u>		S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE	1	11012010
				i i	ESTWOOD MEDICAL PARK		
WESTWO	OOD CENTER			ı	LUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPULATION DEFICIENCY)) BE	(X5) COMPLETION DATE
F 514	Continued From pa	age 41	F!	514	, 		
• -	·	dered rather than the time	, ,) 1 "			
		ny scheduled medication		-			
	including pain medi				This page was intentionally left b	lank.	
	The director of nurs	sing (DON) was also asked at					
	the same time about how the facility documented						
	medication adminis	stration. The DON stated they					
		cy, but had always signed at the					
		r than time given because with					
		system, the actual time would The MAR was reviewed with					
		aled there was no exact time of					
	administration noted		ja ja				
	The administrator s	and director of nursing were	<u>4</u>)				
	The administrator and director of nursing were informed of the findings during a meeting with the		1				
	survey team on 9/1						
							ě
		failed to document the					
	medicine for Reside	dministration of narcotic pain					
	Illedicine for Acoust	#10.					
		admitted to the facility on					
		oses of pain, anemia,					
	2) ·	entia, aphasia, stroke, hip					
	fracture, and gastro	o-esophageal reflux disease.					
İ	The resident was a	ssessed on the admission					(4)
		(MDS) with a reference date					
	of 8/24/16 with a co	ognitive score of "9" of "15".			The same that different		
	Resident #16 was c	observed receiving her 6:00			RECEIVE	ED	
		on, Norco 5/325 mg, at 7:45					
	a.m. during the med	dication pass and pour			OCT 11 20	16	
		cted on 9/14/16. The staff			WALLON .	^	
		nistering the medication stated			VDH/OL	ما	
	she was called in ea	arly to administer the 6:00					

a.m. medications because the night nurse was

unable due to a staffing shortage.

PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CENTE	NO FOR MEDICARE	A MICDICAID SERVICES			OIMB IM	<u>0. 0938-03</u> 91
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	i	FIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		495200	B. WING		0	C 9715/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
MESTA	OOD CENTED			WESTWOOD MEDICAL PARK		
WES! VV	OOD CENTER			BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC ((EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ige 42	F 51	14		
1	ordered the Norco t	was reviewed. The physician to be administered every 6 s set up at midnight, 6:00 00 p.m.		This page was intentionally les	ft blank.	
	September 2016 was signed the medication a.m. instead of the RN#2 also signed to	ministration record (MAR) for as reviewed. The nurse had ion was administered at 6:00 observed time of 8:00 a.m. the narcotic sign out sheet that administered at 6:00 a.m.				.c.
	how the medication stated she always of medication was ord	n 9/15/16 at 10:00 a.m. about was documented. RN#2 documented the time the dered rather than the time by scheduled medication docations.				#1 6
	the same time about medication administ did not have a policitime ordered rather the new computer s show on the MAR.	sing (DON) was also asked at at how the facility documented stration. The DON stated they by, but had always signed at the than time given because with system, the actual time would The MAR was reviewed with alled there was no exact time of d.				
	informed of the find survey team on 9/14	facility staff failed to document				
		dmitted 4/11/14 with diagnoses artery disease, congestive				į.

heart failure, hypertension, and renal

PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

CLIVIL	NO FOR WEDICARE	& MEDICAID SERVICES			OMB	NO. 0938-0391
_	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING) DATE SURVEY COMPLETED
		495200	B. WING)		C 09/15/2016
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER				STREET ADDRESS, CITY, STATE, WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION E DATE
F 514	Continued From pa	ge 43	F t	514		

insufficiency. On the quarterly minimum data set assessment 7/20/16, the resident scored 15/15 on the brief interview fro mental status. The resident was assessed without signs of delirium, psychosis, or behavioral symptoms. Section O0100 Respiratory Treatment was not coded for oxygen.

The surveyor spoke with the resident in the room on 9/14/16. The resident was wearing oxygen via nasal cannula at 4 L/minute flow rate. The resident's oxygen concentrator had a piece of tape on it which appeared to have 9/15/16 written over 9/4 written in ink with a finer line than the 9/15/16.

Clinical record review on 9/14/16 revealed an order dated 7/13/16 for O2 4L / NC (oxygen at a rate of 4 liters per minute via a nasal cannula). Oxygen therapy did not appear on the resident's treatment administration record and there was no order to clean the equipment or change the tubing on the resident's clinical record.

The administrator and chief nursing officer were notified of the concern during a summary meeting on 9/15/16. The surveyor was offered a corrected minimum data set assessment which reflected oxygen therapy at Section O0100.

4. For Resident #10, facility staff failed to document the resident's condition related to dialysis therapy and intravenous medication.

Resident #10 was admitted to the facility on 3/8/16 with diagnoses including atrial fibrillation, hypertension, heart failure, gastroesophageal reflux disease, end stage renal disease with hemodialysis, neurogenic bladder, diabetes

This page was intentionally left blank.



PRINTED: 09/29/2016 FORM APPROVED OMB NO. 0938-0391

RS FOR MEDICARE	& MEDICAID SERVICES		O	MB NO. 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		(X3) DATE SURVEY COMPLETED
	495200	B WING		C 09/15/2016
PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
OOD OFWEED			WESTWOOD MEDICAL PARK	
JOD CENTER			BLUEFIELD, VA 24605	
(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DE COMPLETION
mellitus, anxiety, as On the annual minir with assessment re resident was scored for mental status, a delirium, psychosis, The resident was as Yes), but its charact not documented. Howas not documented. The surveyor was in times from 9/13 to 9 resident and the	othma, and respiratory failure. In mum data set assessment ference date 7/19/16, the d 15/15 on the brief interview and was assessed as without or behaviors affecting others. Iteristics and frequently was demodialysis (SectionO0100) d). In the resident's room several d/15/15, talking with the dident's room mate about their on of the facility. In the resident's room several d/15/15, talking with the dident's room mate about their on of the facility. In the resident's room several d/15/15, talking with the dident's room mate about their on of the facility. In the resident's room several d/15/15, talking with the dident's room mate about their on of the facility. In the resident's room several d/15/15, talking with the dident's room several d/15/15, talking with the dident's room several d/15/15, talking with the dident's room several d/15/15, talking with the dreview, the surveyor noted	F 5	This page was intentionally left bl	lank.
leaving and returnin week for dialysis. The concern was re and chief nursing of	g to the facility 3 times per ported to the administrator ficer during a summary		RECEIV OCT 11 20	'ED
	PROVIDER OR SUPPLIER SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From pa mellitus, anxiety, as On the annual minin with assessment re resident was scored for mental status, a delirium, psychosis, The resident was as Yes), but its charact not documented. He was not documented. He was not documented. The surveyor was in times from 9/13 to 9 resident and the resident	COPECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495200 PROVIDER OR SUPPLIER OOD CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 44 mellitus, anxiety, asthma, and respiratory failure. On the annual minimum data set assessment with assessment reference date 7/19/16, the resident was scored 15/15 on the brief interview for mental status, and was assessed as without delirium, psychosis, or behaviors affecting others. The resident was assessed with pain (J0300= 1 Yes), but its characteristics and frequently was not documented. Hemodialysis (SectionO0100) was not documented). The surveyor was in the resident's room several times from 9/13 to 9/15/15, talking with the resident and the resident's room mate about their care and the condition of the facility. During clinical record review, the surveyor noted that there were no progress notes for significant events in the resident's care. Staff did not document an order to start an intravenous medication, or which staff member attempted to start the line, or how many attempts were made before a paramedic from the local rescue squad was called to start an intravenous infusion on 8/13/16. The resident had an order for hemodialysis Tuesday, Thursday, and Saturday. When questioned about hemodialysis, nursing staff reported to the surveyor that there were no assessments or documentation of the resident leaving and returning to the facility 3 times per	TOF DEFICIENCIES DE CORRECTION (X1) PROVIDER/SUPPLIER/DEPLICATION NUMBER: 495200 B WING PROVIDER OR SUPPLIER CODD CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 44 mellitus, anxiety, asthma, and respiratory failure. On the annual minimum data set assessment with assessment reference date 7/19/16, the resident was scored 15/15 on the brief interview for mental status, and was assessed as without delirium, psychosis, or behaviors affecting others. The resident was assessed with pain (J0300= 1 Yes), but its characteristics and frequently was not documented. Hemodialysis (SectionO0100) was not documented). The surveyor was in the resident's room several times from 9/13 to 9/15/15, talking with the resident and the resident's room mate about their care and the condition of the facility. During clinical record review, the surveyor noted that there were no progress notes for significant events in the resident's care. Staff did not document an order to start an intravenous medication, or which staff member attempted to start the line, or how many attempts were made before a paramedic from the local rescue squad was called to start an intravenous infusion on 8/13/16. The resident had an order for hemodialysis Tuesday, Thursday, and Saturday. When questioned about hemodialysis, nursing staff reported to the surveyor that there were no assessments or documentation of the resident leaving and returning to the facility 3 times per week for dialysis. The concern was reported to the administrator and chief nursing officer during a summary	A 95200 PROVIDER OR SUPPLIER COD CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 44 mellitus, anxiety, asthma, and respiratory failure. On the annual minimum data set assessment with assessment rereached at 7/19/16, the resident was assessed as without delirium, psychosis, or behaviors affecting others. The resident was assessed with pain (J0300= 1 Yes), but its characteristics and frequently was not documented). Hemodialysis (SectionO0100) was not documented). Hemodialysis (SectionO0100) was not documented). The surveyor was in the resident's room several times from 9/13 to 9/15/15, talking with the resident care. Staff did not document an order to start an intravenous medication, or which staff member attempted to start the line, or how many attempts were made before a paramedic from the local rescue squad was called to start an intravenous infusion on 8/13/16. The resident had an order for hemodialysis Tuesday, Thursday, and Saturday. When questioned about hemodialysis, nursing staff reported to the surveyor that there were no assessments or documentation of the resident leaving and returning to the facility 3 times per week for dialysis. PROVIDER SUPPLY STATE, ZIP CODE WESTWOOD MEDICAL PARK BULEFIELD, VA 24605 B WING STRECT ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK BULEFIELD, VA 24605 PROVIDERS LAND OF CERCH CORRECTION (EACH CORRECTION SHOULD CERCH CORRECTION SHOULD CERCH CORRECTION SHOULD CERCH CORRECTION SHOULD CERCE TO PREFICE TO THE APPROP DEFICIENCY) This page was intentionally left bit in the prefice of the surveyor noted that there were no progress notes for significant events in the resident save. The

VDH/OLC

PRINTED: 09/29/2016

FORM APPROVED State of Virginia STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING _ 495200 B. WING _ 09/15/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD CENTER WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 000 Initial Comments F 000 An unannounced biennial State Licensure This page was intentionally left blank. Inspection was conducted 9/13/16 through 9/15/16. The facility was in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. The census in this 65 bed facility was 57 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents 1 through 16). F 001 Non Compliance F 001 The facility was out of compliance with the following state licensure requirements: This RULE: is not met as evidenced by: The facility was not in compliance with the

following Virginia Rules and Regulations for the Licensure of Nursing Facilities.

12 VAC 5-371-220 Crosswalk to Federal F 241, F309, F312, F328

12 VAC 5-371-250 Crosswalk to Federal F 278 and F280.

12 VAC 5-371-210 Crosswalk to Federal F353

12 VAC 5-371-300 Crosswalk to Federal F431

12 VAC 5-371-370 Crosswalk to Federal F252.

F253, F371, and F464

12 VAC 5-371-360 Crosswalk to Federal F514

RECEIVED

OCT 11 2016

VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 11san

Sichmond

(X6) DATE

STATE FORM