STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 ofthe 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 000	The statements made on this Plan of 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 SS=D	483.15(a) DIGNITY AND RESPECT OF 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	F 241		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Richmond	Administrator	10/7/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

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WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 241	Continued From page 1 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. His MDS also coded the resident to need the assistance of one person for activities of daily living (ADL). 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. " Resident #2's care plan indicated he did resist 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. On 9/15/16 the director of nurses brought a nurses note to the surveyor that read as follows: 9/15/16 08:13 after a great deal of encouragement, resident allowed night shift nursing staff (charge nurse) to trim/cut his finger nails. Prior to exit no further discussion related to the resident's finger nails.	F 241	Resident #2's allowed nursing staff to trim/cut his fingernails on 9/15/16. Current residents were checked for nails needing to be clipped and clipped as needed or refusals documented and care planned. Nursing staff will be re-educated on or before 10/15/16 by the Nurse Practice Educator (NPE) and/or designee on trimming fingernails, as needed, documenting and care planning refusals. Unit manager (UM) and/or designee will monitor residents' fingernails to ensure they are trimmed appropriately or refusals are documented or care planned with corrective action upon discovery. Findings will be reported to the Director of Nursing (DON). Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.	10/15/16
F 252 SS=D	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE	F 252		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 252	Continued From page 2 ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to maintain a clean and homelike environment for 1 of 18 residents in the survey sample (Resident #10) and in the hallway outside the resident dining room. 1. For Resident #10, facility staff failed to retrieve garbage and resident care equipment from the floor. 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 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	F 252	1. On the evening of 9/14/16, nurse management removed the calendar, wipes, tissues & foot rest from the floor in Resident #10's room. Resident rooms were checked by department managers to ensure floors were free of trash and equipment with corrections made upon discovery. Environmental Services will be re-educated on or before 10/15/16 by the NPE and/or designee on keeping the floor in the residents' rooms free of trash & equipment. Findings will be reported to the Administrator. Department managers and/or designee will make room rounds to ensure the floors in resident's rooms are free of trash & equipment daily X 2 weeks then conduct random observations with corrective action upon discovery. Findings will be reported to the Administrator. Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 252	Continued From page 3	F 252		

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.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 252	Continued From page 4 She then pointed down the hall toward the north unit and said he is cleaning stains now. A male housekeeper was cleaning the carpet. On 9/14/16 the surveyor noted the same white stains on the carpet in the same place as aforementioned. On 9/15/16 at approximately 4:00 pm, the stains/spots on the carpet were discussed with the administrator and the director of nurses Prior to exit on 9/15/16 no further information was provided to the surveyor related to the carpet stains.	F 252		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to maintain resident care equipment in a clean and sanitary condition in the shower room on 2 units. The findings include: The facility staff failed to maintain resident care equipment in clean and sanitary condition on the north unit. On 9/15/16 on the north unit the surveyor entered the shower room. In one stall there was multiple shower chairs and bed side commodes, one had rusted arm rest and rusted legs. Sitting on top of one of the chairs was a pair of black shoes. In the	F 253	On 9/15/16, the rusted shower chair in North shower room was removed and properly disposed of. The black shoes were returned to the proper resident on 9/15/16. On 9/15/16, the broken tile was repaired in North shower room by the Maintenance Director. The dark stain in the stall in North shower room is a discoloration of the floor and cannot be removed. On 9/15/16, the Unit manager removed all of the items in South shower room and disposed of them appropriately. The cabinet was relocked. The Maintenance Director removed the broken file holder from the South shower room wall on 9/15/16.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

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WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 253	Continued From page 5 shower room were three broken tile lying on the floor and a dark stain around the tile in the stall that was used to give showers. Two surveyors observed the shower room on the south unit on 9/15/16 at 9:15 am. The cabinet in the shower room was found unlocked with the lock present. The cabinet had a stained and dirty towel covering the shelf. On the towel was the following: 10 open cans of shaving cream that were not labeled with a residents name; 5 razors, 2 used tubes of Colgate tooth paste and box of gloves. One used bar of soap in the box and one bottle of no-rinse shampoo, and an empty bottle of Virex 256. On the wall of the shower room was a plastic broken and busted file holder. The unit manager was asked to come into the shower room and he said he would take care of the issues. At 1:30 pm, the surveyor met with the maintenance director. During the walk through of the facility the surveyor showed the maintenance director the above listed concerns. He stated no one had reported it to him. He also said the rusty chair should be removed. The maintenance director also informed the surveyor of the removal of the busted and broken file holder from the wall of the south unit shower room. During a meeting with the administrator and director of nurses on 9/15/16 the above findings were discussed. Prior to exit on 9/15/16 no further information was provided regarding the environment issues.	F 253	Nursing staff will be reeducated by the NPE and/or designee on or before 10/15/16 on keeping the shower room free of resident's personal belongings, 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 and recommendations.	
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the	F 278		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 278	Continued From page 6 resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure a complete and accurate assessment for 5 of 19 residents (Resident #9, 1, 2, 4, and 10). The findings include: 1. The facility staff failed to ensure a complete and accurate Minimum Data Set (MDS) regarding	F 278	Resident #9 no longer resides in the facility. Resident #1 no longer resides at the facility. Resident #2 will be reassessed for pain and a MDS will be 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 conduct an audit of current residents' most recent MDS to verify completion of 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 sources inaccurate MDS's will be corrected with an ARD on or before 10/29/16. The Director of Nursing will conduct an audit of current residents' most recent MDS to verify accurate coding of oxygen by 10/9/16. The CRCs will correct any inaccurate MDS's by 10/15/16.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 7	F 278		

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

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WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 278	Continued From page 8	F 278	This page was intentionally left blank.	

date) of 2/13/16.

Resident #1 was originally admitted to the facility on 1/17/06 and was readmitted on 2/8/15. Her diagnoses included, but were not limited to: high blood pressure, depression, stroke, anemia, osteoporosis, diabetes and dementia.

The current minimum data set assessment (MDS) with an assessment reference date (ARD) completed on 2/13/16 for Resident #1 was a quarterly MDS assessment. Resident #1 in section C, had a cognitive score of 1/1 (long and short time memory problem) and she scored a 3 for decision making indicating she was severely impaired.
The surveyor observed in section J dash (-) 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 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. "

On 9/14/16 at 4:00pm, the administrator, and director of nurses where informed of the inaccurate MDS.

Prior to exit on 9/15/16 no further information related to the inaccurate MDS.
3.For Resident #2, the facility staff failed to code section J (Pain) on the resident's annual MDS assessment with an ARD (assessment reference date) of 8/24/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 9	F 278	This page was intentionally left blank.	

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 (-) 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 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. "

On 9/14/16 the surveyor interviewed Resident #2. Resident #2 answered without difficulty and accurately.

On 9/14/16 at 4:30pm, the administrator, and director of nurses where informed of the inaccurate MDS.

Prior to exit on 9/15/16 no further information related to the inaccurate MDS.
4. For Resident #4, facility staff failed to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 10	F 278	This page was intentionally left blank.	

that the minimum data set assessment reflected oxygen therapy.

Resident #4 was admitted 4/11/14 with diagnoses including coronary artery disease, congestive heart failure, hypertension, and renal 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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 11	F 278	This page was intentionally left blank.	

status.

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 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).

During clinical record review on 9/15/16, the surveyor noted an order initiated 8/4/14 for hemodialysis 3 X week Tuesday, Thursday, Saturday. There was no order for assessment or care of the access site.

The surveyor was unable to locate a care plan addressing hemodialysis in the resident's record. The surveyor requested a copy of the resident's care plan, but did not receive one prior to exiting the facility.

Clinical record review revealed an order dated 6/27/16 for oxycodone 5 mg twice per day and an order dated 6/27/16 for "Pain monitor Are you free of pain or hurting? every night shift". Pain medication administration and the pain monitor question are documented as administered per orders on the medication administration record.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 12 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 surveyor reported the concern to the facility administrator and chief nursing officer during a summary meeting on 9/15/16. The resident's annual minimum data set assessment dated 7/19/16 was not coded for hemodialysis and the pain assessment was not documented.	F 278		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after	F 280	Resident #9 no longer resides in facility. A plan of correction was initiated on 9/13/16 regarding the plan of care for Resident #9 not containing any problems listed for pain. The plan was further discussed, reviewed & approved during an Adhoc meeting on 9/14/16 by Administrator, Director of Nursing, Manager of Clinical Operations and Medical Director. The plan was completed & presented to the surveyors on 9/15/16.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 13	F 280		

each assessment.

This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review, the facility staff failed review and revise the comprehensive care plan for 1 of 19 residents (Resident #9).

The findings include:

The facility staff failed to review and revise the comprehensive care plan (CCP) for Resident #9 in the area for pain.

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 clinical record was reviewed. The record contained a nursing assessmnet for pain completed by one of the nursing staff on 8/24/16.

Pain care plan was initiated for Resident #9 on 9/13/16 by nursing administration. Re-education was completed with the staff responsible for care plans on 9/15/16 by the Director of Nursing. A 100% audit of current resident charts was completed on 9/13/16 to ensure all residents had pain care plans in place. No other residents had pain care plans missing.

The Director of Nursing will complete a monthly audit of admission care plans to ensure a pain care plan is present with corrective actions made, as needed. Findings will be reported to the Administrator.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 14 The assessment noted Resident #9 had frequent pain at a moderate level in the last 5 days. The CCP was reviewed and did not contain any problems listed for pain. 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.	F 280		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to follow professional standards of nursing practice for 1 of 19 residents (Resident #14). The findings include:	F 281	RN #2 was re-educated on 9/14/16 on medication administration policy regarding medications will not be borrowed from another resident. Nursing staff will be re-educated on or before 10/15/16 by the NPE and/or designee on facility policy that medications will not be borrowed from another resident with corrective action upon discovery.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 15	F 281		

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

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 16 policy stated, "Medications will not be borrowed from another resident". The facility offered no further information prior to survey exit.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based upon observation, interview and record review, the facility failed to provide or arrange services to be provided by a qualified person in accordance with a written plan of care for 1 of 19 residents (Resident #10). 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 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	F 282	A late entry note on Resident #10 was completed on 10/6/16 to indicate that a paramedic, not employed by the facility, had been called to start the IV. Nursing staff will be re-educated by the NPE and/or designee on or before 10/15/16 regarding only qualified facility staff to attempt IV access on residents in our care. If unable to obtain IV access with qualified facility staff, nursing will notify physician to request resident be sent to the ER or other appropriate orders.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 282 Continued From page 17

resident and the resident's room mate about their care and the condition of the facility. The surveyor did not observe any indication that the resident had a hemodialysis access that required care during these visits.

On 9/13/16, the surveyor observed a man in the resident's room who stated he was truing to start an intravenous catheter (IV) access. He was not dressed in scrubs as facility employees appeared to be. The surveyor asked the chief nursing officer who the man was. She stated that she thought he was an emergency medical technician with the local rescue squad. The surveyor asked for a policy governing credentialing non-employees who perform procedures in the facility and concerning skills testing for starting IVs. On 9/14, the chief nursing officer reported that the man was a paramedic and offered a copy of the license wallet card. She stated that a unit manager knew the paramedic and had called him to try to save the resident a trip to the emergency department.

During clinical record review on 9/15/16, the surveyor was unable to locate an order or a progress note in the clinical record indicating that a paramedic not employed by the facility had been called to start the IV.

The surveyor reported the concern to the facility administrator and chief nursing officer during a summary meeting on 9/15/16.

F 282

The Unit managers will review documentation for the next 3 residents with orders for IV access to be obtained to ensure qualified facility staff attempted the IV access and if unsuccessful the resident was sent to the ER or other orders obtained 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.

F 309 SS=E 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING

F 309

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 18 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to ensure communication of the resident's condition with the entity providing hemodialysis and to ensure staff were aware of the care of the dialysis shunt for 1 of 18 residents in the survey sample (Resident #10). 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 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. The surveyor did not observe any indication that the resident had a hemodialysis access that required	F 309	Resident #10 is currently out of the facility. The forms for communication with Dialysis were ordered on 9/15/16 and will be initiated on receipt. The hemodialysis site assessment was initiated on 10/3/16. Hemodialysis care plan was initiated on 9/4/14 and last revised on 9/13/16. The annual minimum data set with assessment reference date 7/19/16 did have Hemodialysis Section O-0100 documented. Nursing staff will be re-educated by NPE and/or designee on or before 10/15/16 on the policy regarding communication with Dialysis, Hemodialysis site assessment, and Hemodialysis care plan.	1015/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 19	F 309		

care during these visits.

During clinical record review on 9/15/16, the surveyor noted an order initiated 8/4/14 for hemodialysis 3 X week Tuesday, Thursday, Saturday. There was no order for assessment or care of the access site.

The surveyor was unable to locate a care plan addressing hemodialysis in the resident's record. The surveyor requested a copy of the resident's care plan, but did not receive one prior to exiting the facility.

Review, on 9/15/16, of nursing progress notes for August and September 2016 revealed one note addressing hemodialysis on 9/28/16: Resident OOF to dialysis. There was no documentation of 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

We currently have no residents on dialysis. Monitoring will be initiated after admission of any resident receiving dialysis with corrective action upon discovery. Unit managers will monitor residents receiving dialysis for completion of Hemodialysis site assessments, hemodialysis care plans and Hemodialysis communication forms weekly 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 20 administrator and chief nursing officer during a summary meeting on 9/15/16. The surveyor considered this to be a pattern with multiple failures and multiple occurrences: There was no evidence of a nursing assessment, no care plan to address the resident's end stage renal disease with hemodialysis, no interchange of information with the dialysis center where the resident received treatment 3 times per week, and hemodialysis did not appear on the minimum data set assessment.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and clinical record review, facility staff failed to provide personal hygiene services, to include the required two showers per week, to 4 of 18 residents in the survey sample (Residents # 3, 5, 11, and 13). 1. For Resident #11, facility staff failed to provide 2 showers per week. Resident #11 was re-admitted to the facility on 1/23/16 with diagnoses including coronary artery disease, end stage renal disease, asthma, post traumatic stress disorder, anxiety, depression, and polyneuropathy.	F 312	Resident #3 receives bed baths a minimum of 2 times per week, per her preference due to refusal to get out of bed. Resident #5 has received 2 showers per week since 9/13/16 except 9/27/16 & 9/30/16 when she refused to shower. Resident #11 has been acutely ill since 9/16/16. Resident has been out to the hospital several times and at times too sick to go to the shower room but has received either a bed bath or shower at least 2 days every week. Resident #13 no longer resides in the facility.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 21	F 312		

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,

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 22	F 312	This page was intentionally left blank.	

diabetes, anxiety, depression, and asthma.

On the quarterly minimum data set assessment with assessment reference date 8/30/16, the resident scored 9/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting others. The resident was assessed as totally dependent on staff for bathing (G0120 A=4, B=2).

During a group interview on 9/14/16 at 11 AM with 10 residents capable of answering questions, residents 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 9/14/16, the surveyor noted that no showers were documented for Resident #3 in August or September 2016. Bed baths were not documented for August 10, 11, and 29, or for September 7 and 13.

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

3. For Resident #5, facility staff failed to provide 2 showers per week.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 23 coronary artery disease, atrial fibrillation, renal 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). During a group interview on 9/14/16 at 11 AM with 10 residents capable of answering questions, residents 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 #3 on August 302015 and oneon September 13 2016. Bed baths were not documented for August 2, 15, and 22, or for September 4. The administrator and director of nursing were notified of the concern during a summary interview on 9/14/15. 4. The facility staff failed to ensure Resident #13 received sufficient baths/showers to provide good	F 312	This page was intentionally left blank.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 24 personal hygiene. Resident #13 was admitted to the facility on 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 care needs will be anticipated and met in order to maintain the highest practicable level of functioning and physical well- being thru the next review date. 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 Resident #13 ' s showers. 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 312	This page was intentionally left blank.	
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS	F 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 328	Continued From page 25	F 328		

The facility must ensure that residents receive proper treatment and care for the following special services:
Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, and clinical record review, facility staff failed to provide necessary care of residents receiving oxygen for 4 of 18 residents in the survey sample (Residents #10, 3, 5, and 1).

1. For Resident #10, facility staff failed to follow physician orders for cleaning and sanitizing oxygen administration supplies.

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 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

Resident #10 is currently out of the facility. For Resident #3, the order for "wipe down O2 concentrator with Saniwipe; clean external filter on O2 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, mask, and storage bag every Wednesday night. Label each component with date & initials every night shift" was completed and documented on 9/15/16. For Resident #5, the order for "wipe down O2 concentrator with Saniwipe; clean external filter on O2 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" was completed and documented on 9/15/16. Resident #1 no longer resides in the facility.

10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 27	F 328	This page was intentionally left blank.	

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.

3. For Resident #3, facility staff failed to follow physician orders for cleaning and sanitizing oxygen administration supplies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 28	F 328	This page was intentionally left blank.	

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.

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).

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 was dated 8/11/16.

During clinical record review on 9/15/16, the surveyor noted an order initiated 2/9/2016 "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."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 29	F 328	This page was intentionally left blank.	

The surveyor reported to the administrator and 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.

Resident #1 was originally admitted to the facility on 1/17/06 and was readmitted on 2/8/15. Her diagnoses included, but were not limited to: high blood pressure, depression, stroke, anemia, osteoporosis, diabetes and dementia.

The current minimum data set assessment (MDS) with an assessment reference date (ARD) completed on 2/13/16 for Resident #1 was a quarterly MDS assessment. Resident #1 in section C, had a cognitive score of 1/1 (long and short time memory problem) and she scored a 3 for decision making indicating she was severely impaired.

Multiple observations were made of Resident #1 throughout the survey process. The Resident was observed to have a suction machine on her table beside the bed. The suction machine had a yankauer suction device attached to the tubing. The suction canister tubing and yankauer were observed to be uncovered. The suction canister was almost full of cloudy water and secretions.

The surveyor asked LPN #4 to come into the resident ' s room. She was then asked if the suction machine should be covered. She looked at the machine and said " I ' m not sure, but the canister needs to be emptied. "

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 328	Continued From page 30 director of nurses where informed of the suction equipment. No further information regarding the above issue was provided to the survey team prior to the exit conference.	F 328		
F 353 SS=E	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review, and clinical record review, the facility failed to ensure adequate staffing to meet the residents' needs on 1 of 3 halls in the facility.	F 353	The survey sample list that was given to the Administrator on 9/15/16 during exit did not have a Resident #16. Physician was notified and orders received on 9/14/16 that is was okay to administer medications late to Resident #'s 14 & 15. Nursing staff will be re-educated on or before 10/15/16 by the NPE and/or designee on actions the facility is taking to provide sufficient nursing staff to ensure medications are administered timely.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 31	F 353		

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.

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 353	Continued From page 32 The resident was assessed with a cognitive score of "15" of "15". Resident #16 was admitted to the facility on 8/17/16 with diagnoses of pain, anemia, hypertension, dementia, aphasia, stroke, hip fracture, and gastro-esophageal reflux disease. The resident was assessed on the admission Minimum Data Set (MDS) with a reference date of 8/24/16 with a cognitive score of "9" of "15". The director of nursing (DON) was asked to provide the as-worked schedule for 9/14/16. The schedule revealed only 2 nurses were scheduled to work the night shift ending the morning of 9/14/16. The administrator, DON, and Medical Director were informed during a meeting with the survey team on 9/14/16 at 4:00 p.m. there was not enough staff to meet the residents' needs for administration of medications timely on 9/14/16. The facility offered that physician orders had been obtained at 10:30 a.m. after administration of medications that it was ok to give the medications late.	F 353		
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	The 2 refrigerators were cleaned on 9/15/16. Environmental Services Director will re-educate Housekeeping employees on or before 10/15/16 to ensure refrigerators are maintained in a sanitary condition.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 33 This REQUIREMENT is not met as evidenced by: Based on observation, and staff interview the facility staff failed to ensure "Resident Designated Refrigerators" on 2 of 2 units were clean. The findings include: On 9/15/16 at 9:30 am, two surveyors observed the nutrition room on the south unit. The refrigerator door was opened to reveal sticky residue on the glass shelf above the chiller drawers. It was also noted that the bottom of the refrigerator also had a red colored sticky residue on it. On the door shelf was an area of a yellow dried substance. The unit manager was asked to come into the nutrition room and look at the refrigerator. He said " we will get that cleaned up. " The surveyor proceeded to the north unit nutrition room. Upon opening the refrigerator door a similar observation was made. On the bottom of the refrigerator was a dark sticky substance as if juice had been spilt. RN #4 was asked to look at the refrigerator and she agreed the refrigerator needed to be cleaned. At 9/15/16 at 4:30 pm, during a meeting with the administrator and director of nurses the refrigerators were discussed. Prior to exit no further information was provided to the surveyor related to the refrigerator.	F 371	Environmental Services Director and/or designee will check to ensure the refrigerators are maintained in a sanitary condition 3 times per week with corrective action upon discovery. Findings will be reported to the Administrator. Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 34 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, facility staff failed to ensure medications were not out of date for 1 of 18 residents in the survey sample (Resident #11).	F 431	Residents #11's Refresh expired eye drops were discarded and replaced on 9/14/16. Medical Records checked for expired eye drops on current residents on 9/14/16 with corrective action upon discovery. NPE and/or designee will re-educate nursing staff on or before 10/15/16 to monitor expiration dates on Resident's eye drops. NPE and/or designee will check the medication carts for expired eye drops monthly X 3 months with corrective action upon discovery. Findings will be reported to the Administrator. Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 35	F 431	This page was intentionally left blank.	

Resident #11 was admitted to the facility on 7/29/15 with diagnoses including coronary artery disease, gastroesophageal reflux disease, end stage renal disease with hemodialysis, depression, post traumatic stress disorder, asthma, and polyneuropathy. 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. The resident was assessed without signs of delirium, psychosis, or behavior symptoms.

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.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 36 expired. She answered that they were. The resident's medication administration record indicated that Rephresh Solution 1.4-0.6% (polyvinyl alcohol-providone) one drop to both eyes one time daily had been administered daily every day in September 2016 until the medication pass on 9/14/16. The concern that the resident's medication and the floor stock supply were out of date was communicated to the administrator and chief nursing officer during a summary meeting on 9/14/16.	F 431		
F 464 SS=D	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility staff failed to ensure furnishings in the main dining room were in good repair. The findings include: During the group interview on 9/14/16 at 11:00 am, in the resident dining room with 10 residents capable of answering questions, the surveyor sat in a chair which wobbled and had a loose arm. The surveyor moved to a chair which was more stable. The activity director took the chair to a	F 464	All dining room chairs were checked for stability and need for repair on 9/15/16 by the Maintenance Director with corrective action upon discovery. Administrator and/or designee will educate the staff to notify the maintenance department of dining room chairs that are unstable or in need for repair and remove the chair from service. Maintenance will repair promptly. Maintenance Department will check the dining room chairs for stability or need for repair every month with corrective action upon discovery. Findings will be reported to the Administrator.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 464	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 room. 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 464	Any trends identified will be reported to the Quality Improvement Committee for further evaluation and recommendations.	
F 507 SS=D	483.75(j)(2)(iv) LAB REPORTS IN RECORD - 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.	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. 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.	10/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 38 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). 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 on 9/14/16, the surveyor noted an order dated 8/31/16 for U/A & C&S (urinalysis with culture and sensitivity). There was a second order dated 9/7/16 "call me U/A results for 8/31 order ? (question) if was tx (treated)". The surveyor was unable to locate results for the lab test or nursing progress notes that addressed the lab test, lab results, or notifying the writer of the two orders. The surveyor asked the resident's nurse for assistance locating the lab results. The nurse and the unit manager were unable to locate lab results, and the unit manager called the pharmacy to fax the lab result to the facility. 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 dated 9/15/16: 8:26 "[ ] PA asked about recent UA C&S results and was advised report was received over the weekend and was	F 507	Medical records and/or designee will audit the medical records of Residents' with orders for U/A & C&S during the month of September to ensure results received, signed by physician and placed in the medical record on or before 10/15/16. Medical records and/or designee will audit the medical records of Residents' with orders for U/A & C&S to ensure results received, signed by physician and placed in the medical record monthly. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 507	Continued From page 39 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". 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.	F 507		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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 by: 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 514	Continued From page 40	F 514		

The findings include:

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

F 514

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 41	F 514	This page was intentionally left blank.	

medication was ordered rather than the time administered for any scheduled medication including pain medications.

The director of nursing (DON) was also asked at the same time about how the facility documented medication administration. The DON stated they did not have a policy,but had always signed at the time ordered rather than time given because with the new computer system, the actual time would show on the MAR. The MAR was reviewed with the DON and revealed there was no exact time of administration noted.

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. The facility staff failed to document the accurate time for administration of narcotic pain medicine for Resident #16.

Resident #16 was admitted to the facility on 8/17/16 with diagnoses of pain, anemia, hypertension, dementia, aphasia, stroke, hip fracture, and gastro-esophageal reflux disease.

The resident was assessed on the admission Minimum Data Set (MDS) with a reference date of 8/24/16 with a cognitive score of "9" of "15".

Resident #16 was observed receiving her 6:00 a.m. pain medication, Norco 5/325 mg, at 7:45 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 42	F 514	This page was intentionally left blank.	

The clinical record was reviewed. The physician ordered the Norco 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 medication was ordered rather than the time administered for any scheduled medication including pain medications.

The director of nursing (DON) was also asked at the same time about how the facility documented medication administration. The DON stated they did not have a policy,but had always signed at the time ordered rather than time given because with the new computer system, the actual time would show on the MAR. The MAR was reviewed with the DON and revealed there was no exact time of administration noted.

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.
3.For Resident #4, facility staff failed to document oxygen therapy in the clinical record.

Resident #4 was admitted 4/11/14 with diagnoses including coronary artery disease, congestive heart failure, hypertension, and renal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 43	F 514	This page was intentionally left blank.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 44	F 514	This page was intentionally left blank.	

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 meeting on 9/15/16.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	09/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
F 000	Initial Comments	F 000	This page was intentionally left blank.	

An unannounced biennial State Licensure 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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Susan Richmond	Administrator	10/7/16