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 11/01/2018

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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 10/30/18 through 11/01/18. Three complaints were investigated during the survey. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long Term Care facilities. The census in this 65 certified bed facility was 58 at the time of the survey. The final survey sample consisted of 15 current Resident reviews and 3 closed record reviews.	E 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 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/30/18 through 11/01/18. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 65 certified bed facility was 58 at the time of the survey. The survey sample consisted of 15 current Resident reviews and 3 closed record reviews.	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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that	F 550		

RECEIVED
NOV 26 2018
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Richmond
TITLE: Center Executive Director
(X6) DATE: 11/21/18

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 11/01/2018

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 550	Continued From page 1 promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and Resident interview the facility staff failed to knock on door or otherwise announce their self prior to entering Resident's room for 1 of 18 Residents, Resident #28. The findings included: For Resident #28 the facility staff failed to knock	F 550	This deficiency has the potential to affect all other residents. Nurse Practice Educator (NPE) and /or designee will re-educate staff on policy to knock on door or otherwise announce themselves prior to entering resident rooms by 11/30/18. Department managers and manager on duty to monitor during their daily room rounds to ensure staff knock on door or otherwise announce themselves prior to entering resident rooms with corrective action upon discovery X 4 weeks. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for further evaluation and recommendations.	11/30/18

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 11/01/2018

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 550	Continued From page 2 on door or otherwise announce their self prior to entering Resident's room. Resident #28 was admitted to the facility on 04/01/17 and readmitted on 11/07/17. Diagnoses included but not limited to anemia, hypertension, peripheral vascular disease, hyperlipidemia, anxiety, depression, schizophrenia, post-traumatic stress disorder, and chronic obstructive pulmonary disease. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 09/07/18 coded the Resident as 15 of 15 in section C, cognitive status. This is a quarterly MDS. The surveyor was speaking with Resident in his room on 10/30/18 at approximately 1555. Surveyor asked Resident if staff knocked on door prior to entering room and Resident stated, "Sometimes they do and sometimes they just walk in, even when the door is closed". While surveyor was in the room with Resident #28, CNA (certified nurse's aide), #1 entered the room at approximately 1610 without knocking or announcing herself. CNA went to Resident's roommate and asked if he would like his water pitcher refilled. Surveyor then observed CNA #1 enter room numbers 209 and 220 without knocking or announcing herself. The concern of staff entering Residents rooms without knocking was discussed with the administrative team during a meeting on 10/31/18 at approximately 1720. No further information was provided prior to exit.	F 550	This page was intentionally left blank.	
F 578	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir	F 578		

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 11/01/2018

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 578 SS=E	Continued From page 3 CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information.	F 578	Social Services corrected the clinical record of resident #1 to ensure the physician orders correctly reflected the resident's code status on 11/1/18. Social Services corrected the clinical record of resident #42 to ensure the physician orders correctly reflected the resident's code status on 10/30/18. Social Services corrected the clinical record of resident #32 to ensure Section 1 was completed on 10/31/18. Resident #54 no longer resides in the facility. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for further evaluation and recommendations. On 11/1/18, Center Executive Director (CED) re-educated Social Services to ensure physician orders correctly reflect the resident's code status and Sections 1 & 2 are completed.	11/30/18

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 11/01/2018

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 578	Continued From page 4 Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to accurately determine the DNR (do not resuscitate) status for 4 of 18 Residents Resident #1, #42, #54, and #32. The findings included: 1. For Resident #1, the facility staff failed to accurately determine the Residents DNR status. The clinical record included a physicians order for a full code and paperwork to indicate the Resident was a DNR. The clinical record review revealed that Resident #1 had been admitted to the facility 01/19/18. Diagnoses included, but were not limited to, dementia, diabetes, anxiety disorder, depressive disorder, and hypertension. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/03/18 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points. The clinical record (hard chart) included a do not resuscitate order dated 03/05/18 that had been signed by the authorized representative and the medical doctor. The EHR (electronic health record) included a physicians order dated 03/22/18 that indicated the	F 578	Nurse Practice Educator (NPE) to re-educate nurses to ensure physician orders correctly reflect the resident's code status and Sections 1 & 2 are completed by 11/30/18. Social Services conducted an audit of current residents to ensure physician orders correctly reflect the resident's code status and Sections 1 & 2 were completed on 11/2/18 with corrective action upon discovery. Social Services will monitor current resident records to ensure physician orders correctly reflect the resident's code status and Sections 1 & 2 are complete with corrective action upon discovery weekly X 4, then monthly X 2. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly 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 11/01/2018

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 578	Continued From page 5 Resident was a full code. On 10/30/18 at 3:00 p.m., the unit manager reviewed the clinical record with the surveyor regarding the conflicting information concerning the Residents DNR status. On 10/30/18 at 3:41 p.m., the unit manager verbalized to the surveyor that the Residents code status was a DNR and the order had been updated in the EHR. The administrative staff were notified of the above during an end of the day meeting with the survey team on 10/31/18 at 5:18 p.m. No further information regarding the DNR status was provided to the survey team prior to the exit conference. 2. For Resident #42, the facility staff failed to determine the Residents DNR (do not resuscitate) status. The hard chart included a DDNR (durable do not resuscitate) form from the Virginia Department of Health. The EHR (electronic health record) did not include a physicians order. The clinical record review revealed that Resident #42 had been admitted to the facility 08/01/18. Diagnoses included, but were not limited to, benign prostatic hyperplasia, anemia, asthma, basal cell carcinoma, depression, and acute/chronic respiratory failure. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/01/18 included a BIMS	F 578	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 11/01/2018

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 578	Continued From page 6 (brief interview for mental status) summary score of 15 out of a possible 15 points. The Residents hard chart included a DDNR from the Virginia Department of Health that indicated the Resident was a DNR. The EHR did not include any information to indicate the Residents code status. On 10/31/18 at 12:48 p.m., MRS (medical record staff) #1 entered into the EHR a physician's order that indicated the Resident was a DNR. On 10/31/18 at 1:57 p.m., MRS #1 was interviewed regarding the DNR order. This staff person verbalized to the surveyor that the social services had completed an audit and found two Residents in the facility without DNR orders. MRS #1 then stated she went to the chart and verified the DNR and put the order in the EHR. MRS #1 confirmed that she was not a nurse. The administrative staff were notified of the above during an end of the day meeting with the survey team on 10/31/18 at 5:18 p.m. During this meeting, the DON (director of nursing) verbalized to the surveyor that MRS #1 put the order in the computer and then she confirmed the order. No further information regarding the DNR status was provided to the survey team prior to the exit conference. 3. For Resident #32, the facility staff failed to ensure the Residents DDNR (durable do not resuscitate) was complete. Section 1 was left blank. The clinical record review revealed that Resident	F 578	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 11/01/2018

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 578	Continued From page 7 #32 had been admitted to the facility on 08/21/18 and readmitted on 10/27/18. Diagnoses included, but were not limited to, Alzheimer's disease, Type 2 diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. Section C (cognitive patterns) of the Resident's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/28/18, coded the Resident as 06 of 15 in section C, cognitive patterns. The Resident's clinical record included a DDNR order form from the Virginia Department of Health. This form was dated 10/27/18 and read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an informed decision... 2. The patient is INCAPABLE of making an informed decision..." Neither box had been checked. Section 2 read, "If you checked 2 above, check A, B, or C below..." B. was checked and read in part, "While capable of making an informed decision, the patient has executed a written advance directive which appoints a "Person Authorized to Consent the Patient's Behalf" with authority to direct that life-prolonging procedures be withheld or withdrawn ...." This form had been signed by the Residents authorized representative and physician. On 10/31/18 11:55 am the surveyor informed RN (registered nurse) #1 that the DDNR for Resident	F 578	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 11/01/2018

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 578	Continued From page 8 #32 was incomplete. In the first section neither box was checked. The surveyor observed RN#1 pull the DDNR document out of the chart and check the second box of section 1. RN#1 stated Resident was incapable of making decisions. The administrative team was made aware of the above findings on 10/31/18 at 5:19pm. No further information regarding this issue was provided to the survey team prior to the exit conference. 4. For Resident #54, the facility staff failed to ensure the Residents DDNR was complete. Section's 1 and 2 had been left blank. The clinical record review revealed that Resident #54 had been admitted to the facility on 08/10/18 for comfort care. Diagnoses included, but were not limited to, malignant neoplasm of breast, metabolic encephalopathy, chronic kidney disease, and adult failure to thrive. Section C (cognitive patterns) of the Resident's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/15/18, the resident was coded as having short term and long-term memory problems. The Resident's clinical record included a DDNR order form from the Virginia Department of Health. This form was dated 08/15/18 and read in part. Under section 1 "I further certify [must check 1 or 2]: 1. The patient is CAPABLE of making an	F 578	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 11/01/2018

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 578	Continued From page 9 informed decision... 2. The patient is INCAPABLE of making an informed decision..." Neither box had been checked. Section 2 read, "If you checked 2 above, check A, B, or C below..." All three boxes had been left blank. This form had not been signed by the Residents authorized representative, but was signed by physician. The administrative team was made aware of the above findings on 11/01/18 at 2:29pm. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 578	This page was intentionally left blank.	
F 657 SS=C	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to— (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's	F 657		

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 11/01/2018

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 657	Continued From page 10 medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, Resident family interview, and clinical record review the facility staff failed to ensure that comprehensive care plans were prepared, reviewed and revised by an interdisciplinary team that included the necessary members. The findings included: The facility staff failed to ensure that an interdisciplinary team that included the physician and nursing assistants prepared all facility Residents care plans. On 10/30/18 at approximately 1250, surveyor spoke with Resident #9's daughter. Surveyor asked Resident's daughter if she attended Resident's care plan meetings and she stated that she did, but at the last meeting that was held, there were no nursing staff in attendance, only the social worker and a dietician. Resident #28's clinical record was reviewed on 10/31/18 and contained a nurse's progress note dated 09/26/18 which read in part, "09/26/18 08:34 A quarterly Care Plan Meeting was held on	F 657	This deficiency has the potential to affect all other residents. Center Executive Director (CED) to re-educate interdisciplinary team (IDT) that care plan meetings must include the physician, registered nurse and nursing assistant by 11/30/18. Social Services to monitor to ensure care plan meetings include the physician, registered nurse and nursing assistant on an ongoing basis with immediate corrective action. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for further evaluation and recommendations.	11/30/18

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 11/01/2018

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 657	Continued From page 11 09/25/18. ... (name omitted), SS (social services), ... (name omitted) Dietary, ...(name omitted) daughter and ...(name omitted) son were in attendance. Her dietary needs were discussed in detail with the dietician. The family provides pull-ups and reiterated that these should always be used and not the briefs that ... (facility name omitted) provides. Her Care Plan was reviewed in full and will be revised as needed." Surveyor spoke with MDS staff on 10/31/18 at approximately 1530. MDS staff stated that they did not schedule care plan meetings and referred surveyor to social services. Surveyor spoke with social worker on 10/31/18 at approximately 1545. Surveyor asked social worker what staff generally attended Resident care plan meetings and she stated, "Usually the unit manager, social services, dietary staff, family and activities staff. Surveyor asked social worker if the physician or CNA's attended care plan meetings and she replied, "The doctor will come if requested by Resident or family, CNA's don't usually come. The concern of not having an interdisciplinary team that included the physician and CNA was discussed with the administrative staff during a meeting on 10/31/18 at approximately 1720. No further information was provide prior to exit.	F 657	This page was intentionally left blank.	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality.	F 658		

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 11/01/2018

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 658	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to provide services to meet professional standards of practice in regards to documentation of a Resident's death in the facility for 1 of 18 Residents, Resident #54. The findings included: For Resident #54 the facility staff failed to document that the resident had expired. The clinical record review revealed that Resident #54 had been admitted to the facility on 08/10/18 for comfort care. Diagnoses included, but were not limited to, malignant neoplasm of breast, metabolic encephalopathy, chronic kidney disease, and adult failure to thrive. Section C (cognitive patterns) of the Resident's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/15/18, the resident was coded as having short term and long-term memory problems. Resident #54's clinical record was reviewed on 11/01/18. During clinical record review the surveyor was unable to locate any documentation to indicate that Resident #54 had expired. On 11/01/18 at 12:57pm the surveyor spoke with nurse consultant and she clarified to surveyor that no documentation was completed when Resident #54 expired. Resident #54's clinical record also included a DDNR order form from the Virginia Department of	F 658	On 11/1/18, Center Executive Director (CED) re-educated nurse responsible for failure to document resident #54's death in the facility. The Center Nurse Executive (CNE) will conduct an audit to ensure resident who expired in the facility in the last 30 days had appropriate documentation in place, with corrective action upon discovery by 11/30/18. Nurse Practice Educator (NPE) and/or designee to re-educate nurses to document a resident's death in the facility in the medical record by 11/30/18. Nursing administration to review medical record of any resident expiring in the facility within 72 hours to ensure resident's death is documented in the medical record, with corrective action upon discovery. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for further evaluation and recommendations.	11/30/18

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 11/01/2018

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 658	Continued From page 13 Health. This form was dated 08/15/18 and was incomplete. Neither section 1 or 2 was accurately checked. The form had not been signed by the Residents authorized representative, but was signed by physician. The surveyor spoke with the administrator and nurse consultant on 11/01/18 at 1:30pm and requested the facility standards of practice for documentation. The facility was unable to provide surveyor with this requested documentation. Reference: Potter-Perry Fundamentals of Nursing, 6th Edition, page 477. "Documentation is anything written or printed that is relied on as record or proof for authorized persons. Documentation within a client record is a vital aspect of nursing practice. Nursing documentation must be accurate, comprehensive and flexible enough to retrieve critical data, maintain continuity of care, track client outcomes, and reflect current standards of nursing practice." The concern of the facility failing to follow professional standards of practice was discussed with the administrative team during end of day meeting on 11/01/18 at 2:29 pm. No further information was provided prior to exit.	F 658	This page was intentionally left blank.	
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) 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:	F 677		

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 11/01/2018

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 677	Continued From page 14 Based on observation, resident interview, staff interview and clinical record review the facility staff failed to provide ADL (activities of daily living) care for 1 of 18 Residents, Resident #34. The findings included: The facility failed to provide Resident #34 with nail care. The Residents nails were observed by the surveyor to be long and had a dark debris present underneath. The clinical record review revealed that Resident #34 had been admitted to the facility 03/07/18. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, diabetes, dysphagia, chronic kidney disease, low back pain, hypertension, and depressive disorder. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/14/18 included a BIMS (brief interview for mental status) summary score of 11 out of 15 points. Section G (functional status) was coded (3/2) to indicate the Resident required extensive assistance of one person for personal hygiene and dressing. The Residents comprehensive care plan included the focus area of "...requires assistance/is dependent for ADL care in all ADL's related to limited mobility." On 10/30/18 at 3:16 p.m., the surveyor observed Resident #34 in his room. Resident #34's fingernails were observed to be long with debris present underneath. Resident #34 verbalized to the surveyor that his fingernails were longer than	F 677	Nursing staff cleaned and trimmed Resident #34's fingernails on 10/31/18. An audit was completed by nursing administration of current residents fingernails to ensure they were trimmed and cleaned appropriately, with corrective action upon discovery. Nurse Practice Educator (NPE) and/or designee with re-educate nursing staff to clean and trim resident's fingernails routinely by 11/30/18. Unit Managers will observe current residents to ensure fingernails are clean and trimmed, with corrective action upon discovery weekly X 4 then monthly X 2. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for further evaluation and recommendations.	11/30/18

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 11/01/2018

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 677	Continued From page 15 what he would prefer. During a second observation on 10/31/18 at 1:22 p.m., Resident #34's fingernails remained long in appearance and the surveyor was still able to visualize the debris underneath the nails. On 10/31/18 at 3:26 p.m., the unit manager was made aware of the issues with Resident #34's fingernails. The administrative staff were notified of the issue regarding Resident #34's fingernails on 10/31/18 at 5:18 p.m., during a meeting with the survey team. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to follow physicians orders for 1 of 18 Residents, Resident #40. The findings included:	F 684	On 11/21/18, the Medical Director was notified that resident #40 had not received the antibiotic, Zithromax, as ordered. Resident #40 no longer resides at the facility. Center Nurse Executive (CNE) will complete an audit of current residents who had antibiotic orders in the last 30 days to ensure that orders were followed accordingly, with corrective action upon discovery by 11/30/18.	11/30/18

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 11/01/2018

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 684	Continued From page 16 The facility failed to administer the Residents antibiotic zithromax as ordered. The clinical record review revealed that Resident #40 had been admitted to the facility 09/19/18. Diagnoses included, but were not limited to, chronic kidney disease, gastritis, depressive disorder, anxiety disorder, and hypertension. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 09/26/18 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points. The clinical record included the following orders-Zithromax 250 MG 2 tablets for one day and Zithromax 250 MG 1 tablet for 4 days for sore throat. The start date was documented as 09/26/18. A review of the Residents eMARs (electronic medication administration records) revealed that the nursing staff had documented that the medication was not available on 09/26/18 "...medication not available. awaiting arrival from pharmacy." A review of the stat box list revealed that this medication would have been available in stat box for administration. Further review of the eMARs revealed that the nursing staff had administered 2-250 MG (milligram) tablets of zithromax on 09/27/18 at 5:08 a.m. and 1-250 MG at 9:00 p.m. On 09/28/18 and 09/29/18 the staff had documented	F 684	Nurse Practice Educator (NPE) and/or designee will re-educate nurses to ensure antibiotics are given, as ordered by the physician by 11/30/18. Nurse Practice Educator (NPE) will review the Medication Administration Records (MARs) of residents receiving antibiotics to ensure antibiotics are being administered as ordered weekly X 4 then monthly X 2, with corrective action upon discovery. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly 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 11/01/2018

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 684	Continued From page 17 they had administered 1-250 MG tablet and indicating the Resident had received 750 MG on 09/27/18 and 250 MG on 09/28/18 and 09/29/18. The administrative staff were notified of the issues regarding the Residents zithromax on 10/31/18 at 5:18 p.m. No further information regarding the zithromax was provided to the survey team prior to the exit conference.	F 684		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review the facility staff failed to ensure respiratory services were provided for 5 of 18 Residents, #153, #9, #13, #42, #50. The findings included: 1. For Resident #153 the facility staff failed to ensure oxygen was administered per the physician's orders. Resident #153 was admitted to the facility on 10/26/18. Diagnoses included but not limited to	F 695	On 11/1/18, Medical Director was notified that oxygen was not administered as ordered for Resident #153 on 10/31/18. On 10/31/18, the Unit manager notified the Physician Assistant that nurses failed to initiate Resident #50's breathing treatments. PA gave order to discontinue current order and re-start breathing treatments on 10/31/18. The staff appropriately stored Resident #'s 9, 13 42, and 50's oxygen and nebulizer equipment on 10/31/18. Medical Records correctly dated the O2 tubing on Resident #'s 9 and 13 on 10/31/18.	11/30/18

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 11/01/2018

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 695	Continued From page 18 hypothyroidism, hypertension, hypoxemia, chronic obstructive pulmonary disease, pneumonia, history of pulmonary embolism, anemia, diabetes mellitus, hyperlipidemia, gastroesophageal reflux disease, and constipation. Resident is a new admission and a comprehensive MDS (minimum data set) has not yet been completed, however Resident is alert and confused. Surveyor observed Resident #153 on 10/30/18 at approximately 1230. Resident was resting in bed, 02 (oxygen) was in place via nasal cannula at 2 LPM (liters per minute). Resident #153's clinical record was reviewed on 10/30/18. It contained a physician's order summary that read in part, "Oxygen 2/lm via nasal cannula every day shift for hypoxia" and "Oxygen 2/lm via nasal cannula every night shift for hypoxia". On 10/31/18 at approximately 1030, surveyor observed Resident seated in wheelchair in hallway, holding rolled up 02 tubing in her hand. Tubing was not attached to 02 tank, nor was an 02 tank observed in the area. Surveyor again observed Resident #153 on 10/31/18 at approximately 1115. Resident continued to be seated in wheelchair in hallway, holding 02 tubing in hand. Surveyor again observed Resident on 10/31/18 at approximately 1150 seated in hallway. Surveyor spoke with unit manager at this time. Surveyor asked unit manager to review Resident's physician's order regarding 02. Surveyor asked the unit manager if the Resident was on continuous 02 and unit	F 695	Medical Records conducted an audit on 10/31/18 of residents with current orders for oxygen and breathing treatments to ensure equipment was labeled per policy & procedure, with corrective action upon discovery. Nurse Practice Educator (NPE) and/or designee will re-educate nursing on policy & procedure for storing oxygen and nebulizer equipment when not in use, initiating breathing treatments, as ordered, and ensuring oxygen orders are being followed by 11/30/18. Nurse Practice Educator (NPE) and/or designee will re-educate Medical records on appropriate dating of oxygen tubing by 11/30/18. Unit managers conducted an audit on 10/31/18 of residents with current orders for oxygen and breathing treatments to ensure they were being administered as ordered, with corrective action upon discovery. Department managers to monitor on room rounds to ensure Oxygen tubing is dated per policy 2-3 times per week X 4 weeks then monthly X 2, with corrective action upon discovery.	

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 11/01/2018

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 695	Continued From page 19 manager stated that she was. Surveyor then asked unit manager to accompany her to observe Resident, and unit manager stated, "She don't have her 02 on, does she?" Unit manager then proceeded to return Resident to her room and place her 02 back on her. The concern of Resident's oxygen not being administered as prescribed by the physician was discussed with the administrative team during a meeting on 10/31/18 at approximately 1720. No further information was provided prior to exit. 2. For Resident #9 the facility staff failed to ensure respiratory equipment was covered when not in use. Resident #9 was admitted to the facility on 12/29/14 and readmitted on 05/10/16. Diagnoses included but not limited to hypertension, diabetes mellitus, hyponatremia, hyperkalemia, hyperlipidemia, dementia, seizure disorder, malnutrition, anxiety, depression, and chronic obstructive pulmonary disease, The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/21/18 coded the Resident as 5 of 15 in section C, cognitive patterns. This a quarterly MDS. Surveyor observed Resident #9 on 10/30/18 at approximately 1200. Resident was resting in bed, 02 in place via nasal cannula. Surveyor observed Resident's nebulizer mask resting on nightstand, uncovered. Surveyor could not locate a date on the 02 tubing to indicate when it was last changed.	F 695	Unit managers to monitor Oxygen is administered, as ordered weekly X 4 then monthly X 2, with corrective action upon discovery. Unit managers to monitor that breathing treatments are initiated, as ordered weekly X 4, then monthly X 2, with corrective action upon discovery. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly 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 11/01/2018

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 695	Continued From page 20 Surveyor again observed Resident #9 on 10/31/18 at approximately 1345. Resident's nebulizer mask remained on the nightstand uncovered. The surveyor spoke with the infection control nurse on 10/31/18 at approximately 1025. The infection control nurse stated to the surveyor that all oxygen equipment should be in a bag. On 10/31/18 at 10:46 a.m., the Residents oxygen equipment was observed to be covered in a clear bag. Surveyor observed Resident #9 on 10/31/18 at approximately 0830. Resident's nebulizer mask was observed in a bag and 02 tubing was dated with current date. During a meeting with the administrative team on 10/31/18 at approximately 1720, the DON (director of nursing) stated to the survey team that oxygen supplies should be bagged. DON also stated that 02 tubing was changed weekly and should be dated. No further information was provided prior to exit. 3. For Resident #13 the facility staff failed to ensure respiratory equipment was covered when not in use. Resident #13 was admitted to the facility on 04/11/14 and readmitted on 07/23/18. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, neurogenic bladder, urinary tract infection, diabetes mellitus, anxiety, depression, chronic obstructive pulmonary disease, and respiratory failure..	F 695	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 11/01/2018

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 695	Continued From page 21 The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/25/18 coded the Resident as 13 of 15 in section C, cognitive patterns. This is a MDS. Surveyor observed Resident #13 on 10/30/18 at approximately 1315. Resident was resting in bed, 02 in place via nasal cannula. Surveyor observed Resident's nebulizer and C-PAP (continuous positive airway pressure) masks lying in a wire basket attached to the wall adjacent to the Resident's bed. The masks were not covered. There was no date on the 02 tubing to indicate when it was last changed. The surveyor again observed Resident #13 on 10/30/18 at approximately 1350. Resident's 02 equipment remained uncovered. The surveyor spoke with the infection control nurse on 10/31/18 at approximately 1025. The infection control nurse stated to the surveyor that all oxygen equipment should be in a bag. Infection control nurse then stated they did not know where the wire baskets had come from and that was something they just started using. Surveyor observed Resident #9 on 10/31/18 at approximately 0830. Resident's oxygen equipment was observed in a bag and 02 tubing was dated with current date. During a meeting with the administrative team on 10/31/18 at approximately 1720, the DON (director of nursing) stated to the survey team that oxygen supplies should be bagged. DON also stated that 02 tubing was changed weekly and should be dated.	F 695	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 11/01/2018

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 695	Continued From page 22 No further information was provided prior to exit. 4. For Resident #42, the facility staff failed to store the Residents respiratory equipment in a manner to prevent contamination. The clinical record review revealed that Resident #42 had been admitted to the facility 08/01/18. Diagnoses included, but were not limited to, benign prostatic hyperplasia, anemia, asthma, basal cell carcinoma, depression, and acute/chronic respiratory failure. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/01/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded (2/2) to indicate the Resident required limited assistance of one person for bed mobility and transfers. The Residents comprehensive care plan included the focus area "Resident is at risk for complication of infection related to Chemo therapy and steroid use." On 10/30/18 at 10:00 a.m., the surveyor observed the Residents oxygen equipment on the wall in a wire basket beside of the Residents bed. This equipment was uncovered. On 10/31/18 at 1:30 p.m., the oxygen equipment remained in the wire basket beside of the Residents bed attached to the wall. 10/31/18 at 10:24 a.m., during an interview with the designated infection control nurse. This nurse verbalized to the surveyor that all oxygen	F 695	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 11/01/2018

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 695	Continued From page 23 equipment should be in a bag. This staff then stated they did not know where the wire baskets had come from and that was something they just started using. On 10/31/18 at 10:46 a.m., the Residents oxygen equipment was observed to be covered in a clear bag. During an end of the day meeting with the administrative team on 10/31/18 at 5:18 p.m., the DON (director of nursing) verbalized to the survey team that oxygen supplies should be bagged. No further information regarding this issue was provided to the survey team prior to the exit conference. 5. For Resident #50, the facility staff failed to store the Residents respiratory equipment in a manner to prevent contamination and failed to administer the Residents breathing treatments as ordered. The record review revealed that Resident #50 had been admitted to the facility 02/20/17. Diagnoses included, but were not limited to, atrial fibrillation, chronic obstructive pulmonary disease, anemia, hypertension, gastro-esophageal reflux disease, chronic kidney disease, and schizophrenia. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/01/18 included a BIMS (brief interview for mental status) summary score of 0 out of a possible 15 points.	F 695	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 11/01/2018

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 695	Continued From page 24 During initial tour of the facility on 10/30/18 at 10:00 a.m., the Residents nebulizer machine, tubing, and face mask, were observed to be lying uncovered on a brown chair beside the Residents bed along with a dome lid from a food tray. Due to this concern, the Resident was placed in the initial pool for review. The Residents clinical record included an order transcribed by the PA (physicians assistant) on 10/28/17 for duo neb breathing treatments three times a day with mask for one week. When reviewing the Residents eMARs (electronic medication administration records) the surveyor was unable to locate this order. 10/31/18 08:41 a.m., the surveyor observed that the Residents nebulizer equipment was now covered. On 10/31/18 at 9:28 a.m., the unit manager reviewed the clinical record with the surveyor and verbalized to the surveyor he was unable to locate the order on the eMARs regarding the breathing treatment orders. On 10/31/18 at 9:30 a.m., LPN (licensed practical nurse) #1 and the surveyor checked the medication cart for this medication. LPN #1 verbalized to the surveyor that she had not administered any recent breathing treatments to this Resident and was unable to locate any medication regarding breathing treatments for this Resident on the medication cart. 10/31/18 10:24 a.m., the designated infection control nurse verbalized to the surveyor that the Residents nebulizer should have been on a table	F 695	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 11/01/2018

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 695	Continued From page 25 and the nebulizer equipment should have been in a bag. On 10/31/18 at 10:52 a.m., the unit manager verbalized to the surveyor that the breathing treatments had been missed and the PA had been notified. The unit manager stated the PA had given an order to discontinue the breathing treatment and restart the order as of today. The administrative staff were notified of the issues regarding the Residents breathing treatments during a meeting with the survey team on 10/31/18 at 5:18 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 695		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review the facility staff failed to obtain a physician ordered laboratory test for 1 of 18 Residents, Resident #1. The findings included:	F 770	The Physician Assistant was notified on 10/30/18 that the urinalysis ordered on 9/21/18 for Resident #1 was not obtained. Resident #1 suffered no ill effects. The Unit managers will conduct an audit current residents with lab orders in the last 30 days to ensure that no other labs were missed, with corrective action upon discovery by 11/30/18. The lab log will be reviewed as part of the clinical morning meeting to ensure that labs are obtained per orders.	11/30/18

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 11/01/2018

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 770	Continued From page 26 The facility staff failed to obtain a urinalysis as ordered. The clinical record review revealed that Resident #1 had been admitted to the facility 01/19/18. Diagnoses included, but were not limited to, dementia, diabetes, anxiety disorder, depressive disorder, and hypertension. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/03/18 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points. The Residents clinical record included an order dated 09/21/18 for several lab test that included a urinalysis. The surveyor was able to locate the results to all these labs except the urinalysis. On 10/30/18 at 3:00 p.m., the unit manager was asked about the missing urinalysis results. On 10/30/18 at 3:41 p.m., the unit manager verbalized to the surveyor that the urinalysis ordered 09/21/18 was not obtained and the PA (physicians assistant) was notified. The administrative staff were notified of the missing urinalysis during a meeting with the survey team on 10/31/19 at 5:18 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 770	Nurse Practice Educator (NPE) and/or designee will re-educate nurses on process to ensure all urinalyses are obtained, as ordered by 11/30/18. Unit managers will monitor the lab process to ensure urinalyses are obtained, as ordered weekly X 4 then monthly X 2. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for further evaluation and recommendations.	
F 800	Provided Diet Meets Needs of Each Resident	F 800		

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 11/01/2018

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 800 SS=D	Continued From page 27 CFR(s): 483.60 §483.60 Food and nutrition services. The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and during the course of a complaint investigation, the facility staff failed to provide a meal tray for 1 of 18 Residents, Resident #105. The findings included: The facility staff failed to provide evidence that they had provided Resident #105 with a meal tray. This was a closed record review. The office of licensure and certification received a complaint regarding this Resident on 05/24/18 part of this complaint alleged that Resident #105 had been sent to a local hospital on 03/26/18 they returned later that evening. However, they did not receive a lunch tray for 3 days. The clinical record review revealed that Resident #105 had been admitted to the facility on 03/12/18, had been sent out for an evaluation on 03/26/18 they returned later that evening, and had been discharged to a local hospital on 04/06/18. Diagnoses included, but were not limited to, chronic obstructive pulmonary disease, hypertension, dementia, gastro-esophageal reflux disease, gout, benign prostatic hyperplasia,	F 800	Resident #105 no longer resides in the facility. Dietary manager completed an audit on 11/1/18 to ensure that current residents had a diet ticket and received their meal. Nurse Practice Educator (NPE) and/or designee will re-educate nursing and dietary staff to ensure each resident receives a meal tray by 11/30/18. Dietary manager to monitor a meal to ensure current residents receive a meal tray 2-3 times per week X 4 then monthly X 2, with corrective action upon discovery. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for further evaluation and recommendations.	11/30/18

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 11/01/2018

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 800	Continued From page 28 unsteadiness on feet, and history of falling. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 03/19/18 included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points. Section G (functional status) was coded (3/2) for eating to indicate the Resident required extensive assistance of one person for this task. The Residents comprehensive care plan included the following focus areas-"Resident/Patient is dependent for ADL (activities of daily living) care in...eating...potential nutrition concern r/t (related to) therapeutic and/or mechanically altered diet..." Interventions included, but were not limited to "...Monitor intake at all meals...Provide diet as ordered...Supervision/cue/assist as needed with meals..." A review of the Residents ADL record for March 2018 revealed that the facility staff had not documented the Residents lunch intake on 03/29 and had placed a "X" in the box that would have corresponded to lunch for this day. Further review of this ADL sheet revealed that the facility staff had also placed an "X" in the boxes for dinner on 03/13, 03/17, 03/18, 03/20, 03/30 and 03/31. For breakfast on 03/29, the facility staff had also placed an "X." The dietician/food service director had documented a progress note on 03/29/18 at 2:23 p.m., which read in part, "...Will monitor PO (by mouth) intake and supplement intake..." The surveyor interviewed the current DM (dietary	F 800	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 11/01/2018

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 800	Continued From page 29 manager) on 10/31/18 at 6:03 p.m., during this interview the DM verbalized to the surveyor that they were unable to bring up any information regarding this Residents meal intake. On 11/01/18 at 11:28 a.m., the surveyor interviewed CNA (certified nursing assistant) #1. During this interview, CNA #1 verbalized to the surveyor that the family would bring the Resident food. On 11/01/18 at 11:58 a.m., the surveyor interviewed MDS nurse #1 and #2 regarding the "X's" on the Residents ADL sheets. MDS nurse #1 and #2 verbalized to the surveyor that they had been instructed by corporate to put an "X" in any holes they found when doing reviews for MDS assessments. Prior to the exit conference on 11/01/18 the facility staff failed to provide the survey team with evidence that Resident #105 had received a lunch tray on 03/29/19 or for any dates marked with an "X" on the Residents ADL flow sheet. THIS IS A COMPLAINT DEFICIENCY.	F 800	This page was intentionally left blank.	
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and	F 809		

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 11/01/2018

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 809	Continued From page 30 breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on Resident interview, staff interview and clinical record review the facility staff failed to provide evening snack to residents upon their request for 2 of 18 Residents, #22 and #46 The findings included: 1. For Resident #22, facility staff failed to provide evening snack to Resident upon their request. Resident # 22 is a 61-year-old-male who was originally admitted to the facility on 10/26/2015 with a readmission date of 01/19/16. Diagnoses included but were not limited to muscle weakness, depression, emphysema, chronic obstructive pulmonary disease, and asthma. The clinical record for Resident #22 was reviewed on 10/31/18. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 08/20/18 coded the Resident as 15 of 15 in section C, cognitive patterns. On 10/30/18 at approximately 12:56 pm. Resident #22 reported to surveyor in Resident Council	F 809	This deficiency has the potential to affect all other residents. Nurse Practice Educator (NPE) and/or designee to re-educate nursing staff to offer a bedtime snack to residents unless contraindicated and document on the Activities of Daily Living (ADL) flow record by 11/30/18. Nurse Practice Educator (NPE) and/or designee to re-educate dietary staff to provide sufficient bedtime snacks to offer residents by 11/30/18. Dietary manager will update bedtime snack tracking form to include number of items sent, date, time, dietary signature, and nursing signature by 11/26/18. Dietary manager to bring bedtime snack tracking form to clinical morning meeting 2-3 times per week to review with IDT to ensure snacks are being provided weekly X 4 then monthly X 2.	11/30/18

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 11/01/2018

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 809	Continued From page 31 meeting that there are not enough evening snacks for Residents. When Residents are not offered a snack by facility staff and ask for an evening snack they are told there are no more. Resident #22 reports that facility staff is supposed to sign out evening snacks for the unit. The administrator was made aware of concern on 10/30/18 at 03:04 pm. Administrator clarified that CNA's (certified nurse assistant) sign out evening snacks for Residents. Surveyor requested bedtime snack documentation for Resident #22 at this time. The surveyor spoke with Resident #22 on 10/31/18 at 1:59 pm. Resident #22 reported to surveyor that he was not offered a snack last night. Resident reported he got up to get a snack and the "Snack cart was empty from kitchen." On 11/01/18 09:54 am Resident #22 stated he did not get a snack offered to him again last night, he voiced they were on the cart and staff placed them in the pantry, but Resident clarified he was not offered a snack. The surveyor obtained and reviewed ADL (activities of daily living) record for Resident #22 on 11/01/18. "Bedtime Snack %" section of record was coded with an "A" indicating the Resident accepted and a percentage of snack was eaten on 10/8 and 10/22. 10/11 was coded with an "R" indicating the Resident refused snack. All other dates in the month of October were blank. The administration team was made aware on 11/01/18 at 2:29 pm at end of day meeting that Residents are not offered a snack by facility staff. When Resident #22 asked for an evening snack	F 809	Nursing administration to monitor Activities of Daily Living (ADL) records 2-3 times per week to ensure bedtime snacks are being offered and documented, weekly X 4 then monthly X 2, with corrective action upon discovery. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly 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 11/01/2018

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 809	Continued From page 32 he was told they're no more. No further information was provided prior to exit. 2. For Resident #46, facility staff failed to provide evening snack to Resident upon their request. Resident # 46 is a 62-year-old-male who was originally admitted to the facility on 06/23/2017 with a readmission date of 07/05/18. Diagnoses included but were not limited to hemiplegia, depression, complete traumatic knee amputation, peripheral vascular disease, and depression. The clinical record for Resident #46 was reviewed on 10/30/18. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 09/21/18 coded the Resident as 09 of 15 in section C, cognitive patterns. The surveyor spoke with Resident #46 on 10/31/18 at 2:04 pm. Resident #46 reported to surveyor that he was not offered a snack last night. Resident stated "I am told that there are no snacks sometimes when I ask for a snack in the evening around 8-9 pm." The administrator was made aware of concern on 10/31/18 at 5:19 pm during end of day meeting. Administrator clarified that evening snacks are offered to Residents around 8pm. Surveyor requested bedtime snack documentation for Resident #46 at this time. The surveyor obtained and reviewed ADL (activities of daily living) record for Resident #46 on 11/01/18. "Bedtime Snack %" section of record was coded with an "R" on 10/8, 10/11, and 10/22	F 809	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 11/01/2018

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 809	Continued From page 33 indicating the Resident refused snack. All other dates in the month of October were blank. The administration team was made aware on 11/01/18 at 2:29 pm at end of day meeting that Residents are not offered a snack by facility staff. When Resident #46 asked for an evening snack around 8-9 pm he was told they're no more. No further information was provided prior to exit.	F 809	This page was intentionally left blank.	
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842		

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 11/01/2018

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 842	Continued From page 34 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 842	1.The order to "perform foley catheter care every dayshift" was discontinued on 10/30/18 on Resident #42. Nursing administration conducted an audit of current residents with catheter care ordered to ensure there was a continued order for a foley catheter on 10/30/18. Nurse Practice Educator (NPE) and/or designee to re-educate nurses that when an order is received to discontinue a foley catheter, then all catheter orders should be discontinued at that time by 11/30/18. Unit managers to review foley related orders weekly X 4 then monthly X 2 to ensure that when an order is received to discontinue a foley catheter then all catheter orders should be discontinued, with corrective action upon discovery. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for further evaluation and recommendations.	11/30/18

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 11/01/2018

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 842	Continued From page 35 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 clinical record for 3 of 18 Residents, Residents #42, #21 and #32. The findings included: 1. For Resident #42, the facility staff failed to ensure an accurate clinical record in regards to the Residents discontinued foley catheter. The clinical record review revealed that Resident #42 had been admitted to the facility 08/01/18. Diagnoses included, but were not limited to, benign prostatic hyperplasia, anemia, asthma, basal cell carcinoma, depression, and acute/chronic respiratory failure. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/01/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The Residents clinical record included orders to discontinue the Residents foley catheter on 10/26/18. However, a review of the Residents eTARs (electronic treatment administration records) revealed that the nursing staff had initialed the eTARs on 10/27, 10/28, and 10/29 beside the order that read "Perform Foley Catheter Care every day shift." The administrative staff were notified of the	F 842	2. Medical Director was notified on 11/21/18 of blanks in the MARs for Resident #'s 21 and 32 on 10/25/18 and 10/26/18. Nurse Practice Educator (NPE) and/or designee will re-educate nurses to ensure completion of MAR documentation at the end of each shift by 11/30/18. Unit managers to monitor for blanks in the MARs 5 times per week X 4 weeks, weekly X 4, then monthly X 2, with correction action upon discovery. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly 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 11/01/2018

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 842	Continued From page 36 inaccurate clinical record in regards to the Resident's foley catheter on 10/31/18 at 5:18 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #32, facility staff failed to document administration of medication in the clinical record. The clinical record review revealed that Resident #32 had been admitted to the facility on 08/21/18 and readmitted on 10/27/18. Diagnoses included, but were not limited to, Alzheimer's disease, type 2 diabetes mellitus, hypertension, and chronic obstructive pulmonary disease. Section C (cognitive patterns) of the Resident's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/28/18, coded the Resident as 06 of 15 in section C, cognitive patterns. During clinical record review, the surveyor noted blanks in the medication administration record for the following: 10/25 at 2100 and 10/26/18 at 0630 for accu-checks ...; 10/26 at 0000 and the 0600 Albuterol Sulfate Nebulization Solution...; 10/25 at 2100 Apixaban Tablet 2.5 MG ...; 10/25 at 2100 Ativan Tablet 0.5MG (Lorazepam ...; 10/25 at 2100 Clonidine HCL (hydrochloride) tablet 0.1MG ...; 10/25 at 2100 Famotidine tablet 40 MG ...; 10/25 at 2100 Fenofibrate tablet ...; 10/25 at 2100 Lantus SoloStar solution Pen-injector 100 UNIT/ML ...;	F 842	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 11/01/2018

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 842	Continued From page 37 10/26 at 0600 Lantus solution 100 UNIT/ML ...; 10/25 at 2100 Mirtazapine Tablet 7.5 MG ...; 10/25 at 2100 Potassium Chloride ER (extended release) tablet 20 MEQ (milliequivalents) ...; 10/25 at 2100 Psyllium Packet 58.6%...; 10/25 at 2100 Tylenol Tablet 325 MG (Acetaminophen) .... The surveyor reported the concern to the administrative team during meeting on 10/31/18 at approximately 5:19 pm. No further information was provided prior to exit. 3. For Resident #21, facility staff failed to document administration of medication in the clinical record. The clinical record review revealed that Resident #21 had been admitted to the facility on 03/15/18. Diagnoses included, but were not limited to, chronic respiratory failure with hypoxia, type 2 diabetes mellitus, degenerative disease of nervous system, and heart failure. Section C (cognitive patterns) of the Resident's most recent MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/20/18, coded the Resident as 15 of 15 in section C, cognitive patterns. During clinical record review, the surveyor noted blanks in the medication administration record for the following: 10/30 at 0630 Bacitracin ophthalmic ointment ...; 10/1 at 1800 Fortaz Solution Reconstituted 1GM (gram) (CefTAZidime) ...; 10/30 at 0600 Ipratropium-Albuterol Solution ...; 10/1 at 1800 and 9/10 at 0600 Perforomist	F 842	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 11/01/2018

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 842	Continued From page 38 Nebulization Solution 20 MCG/ 2ML ...; 10/1 at 1800 Voltaren Gel 1%...; 09/12, 9/13, 9/14, 9/15 at 0900 and on 09/11, 09/12, 09/13, 09/14 at 2100 Spironolactone Tablet 50 MG ...; 9/19 at 0600 Cefepime HCL Solution Reconstituted 1 GM .... The surveyor reported the concern to the administrative team during meeting on 10/31/18 at approximately 5:19 pm. No further information was provided prior to exit.	F 842	This page was intentionally left blank.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		

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 11/01/2018

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 880	Continued From page 39 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	1.Resident #153 was moved back into her room by the Unit manager on 10/31/18 and isolation precautions were then maintained. No other residents required precautions on 10/31/18. Nurse Practice Educator (NPE) and/or designee to re-educate nursing staff on procedure for contact isolation precautions by 11/30/18. Nursing Practice Educator (NPE) to ensure compliance with contact isolation precautions on an ongoing basis, with corrective action upon discovery. Unit managers will randomly audit residents on precautions to ensure that precautions are maintained per policy & regulations, with corrective action upon discovery. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for further evaluation and recommendations. 2. On 10/31/18, the CNA was observed by the surveyor removing the linen from Resident #42's floor.	11/30/18

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 11/01/2018

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 880	Continued From page 40 §483.60(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility staff failed to follow an established infection control procedures for 2 of18 Residents #153 and #42. The finding included: 1. For Resident #153 the facility staff failed to follow infection control procedures. Resident #153 was admitted to the facility on 10/26/18. Diagnoses included but not limited to hypothyroidism, hypertension, hypoxemia, chronic obstructive pulmonary disease, pneumonia, history of pulmonary embolism, anemia, diabetes mellitus, hyperlipidemia, gastroesophageal reflux disease, and constipation. Resident is a new admission and a comprehensive MDS (minimum data set) has not yet been completed, however Resident is alert and confused. On 10/31/18 at approximately 1024 the nurse educator informed the survey team that Resident #153 was being placed on contact isolation due to having a confirmed case of head lice. The nurse educator stated that Resident and her room mate would be moved into a different room and contact precautions utilized while their current room was deep cleaned. Nurse educator also stated that both Residents would be treated for head lice.	F 880	An audit was conducted on 10/31/18 by administration staff to ensure no dirty linens were in the resident's floor, with corrective action upon discovery. Nursing Practice Educator, (NPE) and/or designee will re-educate the nursing staff on proper handling of dirty linen. Nursing administration will observe for proper handling of dirty linen in resident rooms, 2-3 times per week X 4 weeks then monthly X 2, with corrective action upon discovery. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly 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 11/01/2018

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 880	Continued From page 41 Surveyor observed Resident #153 and her room mate on 10/3/18 at approximately 1115. Residents were seated in the hallway outside of their bedroom. No contact precaution signage or PPE (personal protective equipment) was observed in the area. Surveyor again observed Resident #153 on 10/3/18 at approximately 1150. Resident was still seated in hallway outside of bedroom and no signage or PPE was observed. Surveyor spoke with unit manager on 10/31/18 at approximately 1155 regarding Resident #153. Surveyor asked unit manager if she knew Resident was on contact precautions and she stated that she did. Surveyor then asked unit manager if Resident should be seated in the hallway and unit manager stated that she should not, and proceeded to move Resident back into her room. Surveyor spoke with nurse educator on 10/31/18 at approximately 1205 regarding Resident #163. Nurse educator stated that Resident should not have been in the hallway, but placed on contact precautions immediately. The concern of the facilty not following infection control procedures was discussed with the administrative team during a meeting on 10/31/18 at approximately No further information provided prior to exit. 2. For Resident #42, the facility staff failed to ensure dirty linen was kept off the floor. The clinical record review revealed that Resident #42 had been admitted to the facility 08/01/18. Diagnoses included, but were not limited to, benign prostatic hyperplasia, anemia, asthma, basal cell carcinoma, depression, and	F 880	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 11/01/2018

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 880	Continued From page 42 acute/chronic respiratory failure. Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/01/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded (2/2) to indicate the Resident required limited assistance of one person for bed mobility and transfers. The Residents comprehensive care plan included the focus area "Resident is at risk for complication of infection related to Chemo therapy and steroid use." On 10/31/18 at 1:01 p.m., the surveyor entered the Residents room and was able to observe dirty linen in a corner in the Residents floor. On 10/31/18 at 1:08 p.m., the surveyor observed a CNA (certified nursing assistant) enter the room. This CNA exited the room without removing the linen. On 10/31/18 at 1:12 p.m., this same CNA reentered the Residents room and was observed by the surveyor exiting the room with the linen in a clear plastic bag. During an end of the day meeting with the administrative staff on 10/31/18 at 5:18 p.m., the DON (director of nursing) verbalized to the survey team that the Residents linen should have been bagged and not left in the Residents floor. No further information regarding the linen was provided to the survey team prior to the exit	F 880	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 11/01/2018

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 880	Continued From page 43 conference.	F 880		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the	F 883	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 11/01/2018

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 883	Continued From page 44 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to document on the Residents informed consent if the authorized representative had consented or declined the influenza immunization for 1 of 18 Residents, Resident #1. The findings included: The facility staff failed to document on the Residents informed consent form if the Residents authorized representative had consented or declined the influenza (flu) immunization. The clinical record review revealed that Resident #1 had been admitted to the facility 01/19/18. Diagnoses included, but were not limited to, dementia, diabetes, anxiety disorder, depressive disorder, and hypertension.	F 883	Nurse Practice Educator (NPE) updated Resident #1's consent form to indicate representative consented to the influenza immunization on 10/31/18. Center Nurse Executive (CNE) to conduct an audit of current residents influenza consent form to ensure consents or declination is indicated on the form by 11/30/18, with corrective action upon discovery. Nurse Practice Educator (NPE) and/or designee will re-educate the nursing staff to mark consent or declination on the influenza consent form by 11/30/18. Nurse Practice Educator (NPE) and/or designee will monitor the influenza consent forms for consent or declination weekly X 4, then monthly X 2. Any trends identified will be reported to the Quality Assurance Performance Improvement (QAPI) Committee monthly for further evaluation and recommendations.	11/30/18

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 11/01/2018

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 883	Continued From page 45 Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 10/03/18 included a BIMS (brief interview for mental status) summary score of 3 out of a possible 15 points. The Residents clinical record included a form titled "INFLUENZA IMMUNIZATION INFORMED CONSENT." The facility had documented on this form that phone consent had been obtained. However, none of the blocks had been checked to indicate their choice regarding the influenza vaccine. This form read in part: "I (name of Health Care Decision maker), the health care decision maker for (Resident #1's name), who is my (relationship) and a patient of this Center: (Center name) [] hereby give the Center permission to administer an appropriate (standard dose, high-dose (age 65 years or older), or egg-free) influenza vaccination annually. [] do not give permission for administration of an appropriate (standard dose, high-dose (age 65 years or older), or egg-free) influenza vaccination this year because patient received it on_____, but I hereby give the Center permission to administer an influenza vaccination annually. [] hereby decline the administration of an appropriate (standard dose, high-dose (age 65 years or older), or egg-free) influenza vaccine annually. Reason for declination: _____	F 883	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 11/01/2018

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 883	Continued From page 46 A staff member has reviewed and/or provided me with the Notice of Non-Discrimination and Language Assistance Services information..." The unit manager was made aware of the above on 10/30/18 at 3:00 p.m. When this form was shown to the designated infection control nurse, they stated "Lord, that's me I can't believe I did that." The facility provided the surveyor with a document titled "Update Immunization" that indicated Resident #1 had received the flu vaccine on 10/11/18 and that consent had been confirmed on 10/10/18. The administrative staff were notified of the above during a meeting with the survey team on 10/31/18 at 5:18 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 883	This page was intentionally left blank.	