

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2020
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 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 COVID-19 Focused Survey was conducted onsite on 11/16/2020 and offsite 11/16-11/17/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000			
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Survey was conducted onsite 11/16/2020 and continued with offsite review 11/16-11/17/2020. The facility was not in compliance with 42 CFR Part 483.80 infection control regulations, for the implementation of The Centers for Medicare & Medicaid Services and Centers for Disease Control recommended practices to prepare for COVID-19. The census in this 65 certified bed facility was 53 at the time of the onsite survey. During the onsite portion of the survey no residents and 1 staff were positive for COVID-19. However, prior to the exit conference on 11/17/2020 1 resident tested positive for COVID-19. The survey sample consisted of 4 current residents, Residents #1, #2, #3, and #4.	F 000			
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.	F 880			

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495200		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2020	
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 20 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	<p>Continued From page 1</p> <p>§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:</p> <p>§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;</p> <p>§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:</p> <p>(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;</p> <p>(ii) When and to whom possible incidents of communicable disease or infections should be reported;</p> <p>(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;</p> <p>(iv) When and how isolation should be used for a resident; including but not limited to:</p> <p>(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and</p> <p>(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.</p> <p>(v) The circumstances under which the facility must prohibit employees with a communicable</p>			F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2020
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 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	<p>Continued From page 2</p> <p>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.</p> <p>§483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.</p> <p>§483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>§483.80(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 maintain an infection prevention and control program to help prevent the development and transmission of communicable diseases and infections.</p> <p>The findings included:</p> <p>The facility staff failed to screen EMS (emergency medical services) employees prior to allowing them to enter the observation unit of the facility.</p> <p>During initial tour of the facility on 11/16/2020 at approximately 2:50 p.m., the surveyor observed two EMS employees in a residents room. These two EMS employees were assisting Resident #2 out of their wheelchair. Both of the EMS employees were observed by the surveyor to</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2020
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 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	<p>Continued From page 3</p> <p>have gloves and masks in place. The surveyor observed the doors to the resident rooms on this unit to be shut. There were no COVID-19 positive residents on this unit.</p> <p>On 11/17/2020 at 11:20 a.m., during a phone conference with the administrator, DON (director of nursing) and IP (infection preventionist) #1 these staff were asked if ambulance personnel were screened. The IP verbalized that yes they were screened. The surveyor requested to review the screenings of the EMS personnel.</p> <p>The facility staff provided the surveyor with a copy of their policy titled, "IC405 COVID-19" with a revision date of 11/15/2020. This policy read in part, "Purpose to prevent the development and transmission of COVID-19...Entrance Screening...Active screening of all persons entering the Center (such as employees, visitors, medically necessary personnel, contracted staff/vendors, and volunteers) will be done upon entry into the Center..."</p> <p>On 11/17/2020 at 1:55 p.m., during a phone conference with the administrator and DON, the administrator verbalized to the surveyor that they did not have a screening for the two EMS employees and identified LPN (licensed practical nurse) #1 as the nurse working the observation unit.</p> <p>On 11/17/2020 at 3:15 p.m., during an interview with LPN #1, this nurse verbalized to the surveyor that they had not screened the EMS workers yesterday when they picked up Resident #2 or when they brought Resident #2 back to the facility, that they had not seen them come into the unit, and did not know whom had let them in. The</p>	F 880			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/09/2022
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495200	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/17/2020
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 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 4 EMS staff were bring the resident back from a medical appointment and this was not an emergency event. No further information regarding this issue was provided to the surveyor prior to the exit conference on 11/17/2020.	F 880			