PRINTED: 04/03/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED
		495200	B. WING		C 03/20/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	03/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(- in in a printed to the printed to	BE COMPLETION
	survey was conducted. The facility was in sub CFR Part 483.73, Rec Care Facilities. No encomplaints were invest INITIAL COMMENTS An unannounced Mediconducted 3/12/23 throcorrections are required. CFR Part 483 Federal requirements. Based interview, resident interview, resident interview, resident interview, the facility staff management as evide assessments, monitoriout of 33 residents revinfections and/or woun #4, Resident #10, Resident #10, Resident #149). In identified in the area of and Severity level of 4 Administrator and DON notified on 03/15/2023 process had begun at 3 four complaints were insurvey. One complaint regulations. Three compon-compliant with the deficient practice being the Census in this 65 complete the complete t	on observation, staff rview, family interview, and facility document failed to provide wound nced by an absence of ng, and/or treatment for 5 lewed, resulting in wound d deterioration (Resident ident #42, Resident #36, nmediate Jeopardy was f Quality of Care at a Scope , Pattern. The I (director of nursing) were that the extended survey 3:12 PM. Investigated during the was compliant with the plaints were regulations, resulting in	FO	Preparation and execution of this plan of correction does not constitute admission or agreement of the facts alleged or conclusion of set forth in the statement of deficiencies. The plan of correction is prepared and o executed solely because it is required by both Federal and State Laws	r

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495200	B. WING				C
NAME OF PI	ROVIDER OR SUPPLIER		J. W		EET ADDRESS, CITY, STATE, ZIP CODE	0:	3/20/2023
WESTWO	OD CENTER			20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
SS=D	consisted of 27 curren closed record reviews. Rights Exercised by R CFR(s): 483.10(b)(3)-(\$483.10(b)(3) In the canot been adjudged incourt, the resident has representative, in accounty legal surrogate so the resident's rights to state law. The same-semust be afforded treatr to an opposite-sex spovalid in the jurisdiction (i) The resident represe exercise the resident's rights are delegated to (ii) The resident retains rights not delegated to including the right to reexcept as limited by State (\$483.10(b)(4) The facility of a resident to the extended applicable law.	ey. The survey sample to resident reviews and 6 sepresentative (7)(i)-(iii) ase of a resident who has competent by the state of the right to designate a surdance with State law and designated may exercise the extent provided by ex spouse of a resident ment equal to that afforded use if the marriage was in which it was celebrated dentative has the right to rights to the extent those the representative. If the right to exercise those a resident representative, woke a delegation of rights, ate law. If y must treat the decisions arive as the decisions of a trequired by the court or ent, in accordance with the right to make the resident beyond the	F	551	Resident # 199 discharged from the facility on 3/5/202 and did not return to the facility. The facility was unable to correct action. An initial audit was conducted of all short term care residents who have requested to be transferred to another facility. This audit will also identify the status of the transfer request with any corrective action if needed. Completed on or before 4/4/2023. NHA or designee will reeducate the current Admissions Director and the current Social worker on meeting the needs of transfer request on or before 4/26/2023.	f	4/26/2023

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION AND INCOME.		MULTIPLE CONSTRUCTION BUILDING		
		495200	B. WING				C /20/2023
	ROVIDER OR SUPPLIER OD CENTER SUMMARY ST	ATEMENT OF DEFICIENCIES	- 10	STREET ADDRESS, CITY, STATE 20 WESTWOOD MEDICAL PAI BLUEFIELD, VA 24605	RK		20/2023
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION /E ACTION SHOULD BE ED TO THE APPROPRIAT ICIENCY)	E	(X5) COMPLETION DATE
F 551	of a resident, the faci concerns when and in State law. §483.10(b)(7) In the concerns when and in State law. §483.10(b)(7) In the concerns when and in State law. §483.10(b)(7) In the concerns when and in State law. §483.10(b)(7) In the concerns when and in state expresent under the competent jurisdiction and in the competent jurisdiction law. (i) In the case of a resident and in the concerns when and in the concerns when and in the considered in the considered in the considered with opportucare planning process. This REQUIREMENT by: Based on staff intervince in the facility state in the concerns when and in the concerns when and in the concerns when and in the considered with opportugate planning process. This REQUIREMENT by: Based on staff intervince in the facility of their choice survey sample, Resident representative a facility of their choice survey sample, Resident representative and in the facility staff failed.	are not in the best interests lifty shalf report such in the manner required under case of a resident adjudged e laws of a State by a court ion, the rights of the resident tercised by the resident teted under State law to act aff. The court-appointed re exercises the resident's diged necessary by a court of in, in accordance with State sident representative whose ority is limited by State law the resident retains the right ins outside the ority. nes and preferences must exercise of rights by the ticable, the resident must be nities to participate in the is. is not met as evidenced ew and facility document of failed to assist the e to transfer the resident to e for 1 of 33 residents in the ent #199. to assist the resident #199 to	F	Every admission audited for addited for addited for addited for additional facility weekly monthly X 2	missions who d to be another X 4 then onthly until it, with on upon ilts of the resented to	4/:	26/2023

	MENT OF HEALTH AN RS FOR MEDICARE &						ED: 04/03/202 RM APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIP	PLE CONSTRUCTION	OMB N	O. 0938-039
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD				IPLETED
		495200	B. WING			0.5	C
NAME OF P	PROVIDER OR SUPPLIER			Г	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00	3/20/2023
WESTWO	OOD CENTER				20 WESTWOOD MEDICAL PARK		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			BLUEFIELD, VA 24605		
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 551	Continued From page preference.	3	F	551	1		
	spinal cord). The miniman assessment referent the resident's brief inte (BIMS) a 01 out of 15 in patterns). Section G (find needing extensive mobility, eating, and to contained a document. Determination of Capacattending physician signal lacked sufficient mental appreciate the nature a care decisions. The do 01/20/22. A grandchild Contact #1 and POA - r - medical) on the admiss resident's daughter was Under the assessments a document titled "Post Conference - V 3" with a 12/17/21 was reviewed completed by one of the	t were not limited to, etes Mellitus, and tion of the brain) and ammation of the brain and mum data set (MDS) with rice date of 12/16/21 coded rview for mental status in Section C (cognitive functional status) coded assistance with bed assistance of the although the resident as or physical capacity to and implications of health accument was dated was listed as Emergency medical (power of attorney as a listed as Contact #2. The document was a facility's social services are accidity's social services are accident.					
1	representative would lik Veteran's Administration placement would be ava	e to see if a contracted (VA) Long Term Care					

would like placement in a West Virginia skilled nursing home. The next social services assessment and documentation found in the clinical record was dated 01/13/2022 and read

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/03/2023 **CENTERS FOR MEDICARE & MEDICAID SERVICES** FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING_ COMPLETED 495200 B. WING 03/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK **WESTWOOD CENTER BLUEFIELD, VA 24605** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 4 F 551 within the discharge planning/social service plan that social services would assist the family with their preference of transferring the resident to a facility in West Virginia, preferably a VA contract facility. Resident #199 remained in the facility until being transferred to an acute care hospital approximately three (3) months after admission. The administrator was notified of clinical record findings during an in-person interview in her office on 3/14/23 at 1:15 p.m. The surveyor requested to speak with the social services employee involved with Resident #199. The administrator reported that social worker was no longer employed at the facility but would have her call the surveyor if possible. The facility's current social worker was not employed at the facility during Resident #199's stay. On 3/20/23, the administrator provided an email from the facility's social worker to a West Virginia nursing home which read the social worker was following up on a referral request. The email was dated 2/21/22 and indicated the West Virginia nursing home had not received any earlier referral and had been having difficulties with their faxes. The social worker (SW - not a current facility employee) who completed the Post Admission

Patient-Family Conference was interviewed via phone on 3/16/23 at 2:56 p.m. At the time of Resident #199's admission, her sole responsibility was to complete the Post Admission document. She recalled finding out the resident was not service - connected enough to be in a Veteran's Administration facility. She reported that after the

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		1	STREE	T ADDRESS, CITY, STATE, ZIP CODE	0:	3/20/2023	
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F 551	resident became Covi could not be transferred asked why a transfer whis admission and bed 6 weeks), she reported worker had the primarifacility residents' social time. That social work employed at the facility interviewed. These findings were diadministrator in the could administrator in the afternoon.	d positive on 1/25/22, he ed for 20 days. When was not facilitated between coming Covid positive (over d that a different social y responsibility for the all service needs during that her was not currently y and could not be iscussed with the inference/family room on ed.		551				
SS=D	facility and when the re Medicaid of- (A) The items and serv nursing facility services for which the resident r (B) Those other items a facility offers and for which arged, and the amouservices; and (ii) Inform each Medica changes are made to the specified in §483.10(g) section. §483.10(g)(18) The factoresident before, or at the periodically during the resident of the section o	cility must— id-eligible resident, in dmission to the nursing esident becomes eligible for cices that are included in a under the State plan and may not be charged; and services that the nich the resident may be int of charges for those id-eligible resident when the items and services (17)(i)(A) and (B) of this	F 5		Resident #2 was issued an ABN notification on or before 3/20/2023. An initial Medicare audit was completed of all residents to ensure ABN notifications were provided per Medicaid/Medicare coverage/ Liability requirements for the last 30 days. Completed on or before April 5, 2023	4	/26/2023	

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STATEMENT	OF DEFICIENCIES	(24) 550 (555)	T			OMB NO. 0938-039	
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100		E CONSTRUCTION		E SURVEY IPLETED
		495200	B. WING			0.	C
NAME OF F	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1 03	3/20/2023
WESTWO	OD CENTER				20 WESTWOOD MEDICAL PARK		
				8	BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COMPLETION DATE
	covered under Medical facility's per diem rate. (i) Where changes in condition and services covered Medicaid State plan, the notice to residents of the reasonably possible. (ii) Where changes are items and services that facility must inform the 60 days prior to implere (iii) If a resident dies on transferred and does in facility must refund to the representative, or estandeposit or charges alresper diem rate, for the direction of the facility must refund to the resided or reserved or facility, regardless of an individual state of discharge notice require (iv) The facility must reresident representative the resident within 30 condition of the facility must not conflict these regulations. This REQUIREMENT is by: Based on interviews an facility staff failed to profice facility (SNF) Advance Non-coverage (ABN) not resident coverage (ABN) not resident in the service of the profice of the service of the profice of the profic	y charges for services not are/ Medicaid or by the coverage are made to items by Medicare and/or by the ne facility must provide the change as soon as is a made to charges for other at the facility offers, the resident in writing at least mentation of the change. It is hospitalized or is not return to the facility, the he resident, resident actually retained a bed in the my minimum stay or mements. If the facility mentation contract by or on seeking admission to the with the requirements of the solution of the charge of the facility. The seeking admission to the my minimum that the facility of the f	F	582	NHA or designee will reeducate the Clinical Reimbursement Coordinator, Business Office Manager and the Assistant Business Office Manager on the required submission of the Advanced Beneficiary notification to be completed. This education to be completed on or before 4/26/2023. An audit will be completed of all residents who are required to receive an ABN notice to ensure they have received the notice with any corrective action needed. This audit will be completed weekly X 4 then monthly X 2 weeks or until 100% compliance, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.		4/26/2023

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		495200	A. BUILD			С	
	PROVIDER OR SUPPLIER			STRI 20 W	EET ADDRESS, CITY, STATE, ZIP CODE VESTWOOD MEDICAL PARK JEFIELD, VA 24605	03	3/20/2023
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	residents were selected beneficiaries who were Medicare covered Par remaining in the past of survey; this list was provided a SNF ABN of required skilled services. Medicaid services. On 3/13/23 at 1:13 p.m. Office Manager (BOM) discharged from Part Abenefit days remaining #2 stayed in the facility Resident #2 should had On 3/13/13 at 3:35 p.m. email from the facility's Reimbursement which did not have a "formal" of Beneficiary Protection reported the facility foll Medicare & Medicaid Sincluding the Medicare Manual. On 3/13/23 at 3:46 p.m. Reimbursement Coord acknowledged Resider a SNF ABN. The survey team met we Administrator and Direct 3/17/23 at 4:01 p.m. D	ere selected for SNF in Review. These three (3) and from the list of Medicare is discharged from a it A stay with benefit days is months prior to the covided by facility staff 2 was marked as not being due to "resident no longer is (and) switched to in., the facility's Business is stated Resident #2 was is with three (3) skilled it the BOM stayed Resident if The BOM acknowledged ive received a SNF ABN. in., the BOM provided an is Director of Clinical indicated that the facility policy to address issuing in Notification. This email iows CMS (Centers for iservices) guidance, Claims Processing in, the facility's Clinical inator (CRC) in #2 should have received with the facility's ctor of Nursing (DON) on	F	582			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		20/2023	
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F 635 SS=D	to issue Resident #2 a resident was discharg benefit days remaining Admission Physician (CFR(s): 483.20(a)	a SNF ABN when the led from Part A services with g. Orders for Immediate Care	F 5		4	/26/2023	
	must have physician of immediate care. This REQUIREMENT by: Based on interviews a facility staff failed to each	at the time of admission, to		Resident #46 was discharged 2/16/2023 and did not return to the facility. The facility was unable to correct action.			
	Resident #46 was trar local emergency depa a.m. The facility staff wound care and medic #46, at the time of the Resident #46's minimum (MDS), with an assess of 12/15/22, was dated 12/29/22. Resident #4 never or rarely able to never or rarely able to Resident #46 was dock dependent on others for dressing, toilet use, and a.m.	ity on 2/14/23 at 4:35 p.m. Insported via ambulance to a surtment on 2/16/23 at 11:56 failed to promptly obtain cation orders, for Resident readmission. Imm data assessment sment reference date (ARD) das being completed on 46 was documented as understand others and as make self understood. Sumented as being totally for eating, bed mobility, and personal hygiene.		An initial audit was completed by DON/designee on 3/27/2023 of all new admissions from the last 7 days to ensure each admission arrived to the facility with transfer paper work from the admitting hospital and to validate all orders were initiated upon admission. All newly admitted residents have the potential to be affected by the alleged deficient practice.			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495200	B. WING			1	C /20/2023
	ROVIDER OR SUPPLIER OD CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 00	2012020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 635	disorder, irregular hea and dysphagia. On 3/15/23 at 11:07 a Nursing (DON) and th (MCL) confirmed new residents at the time of the confirmed of the confirmed new residents at the time of the confirmed new residents at the time of the confirmed new residents at the time of the confirmed new residents at 11:10 a no paperwork arrived readmission at 2/14/25 facility staff should have discharging hospital to the confirmed new resident the DON of the confirmed new resident the DON of the confirmed new resident the polytopic new resident the polytopic new resident	.m., the facility's Director of e Market Clinical Leader orders were required for of readmission to the facility. .m., the DON reported that with the resident on 3. The DON reported that we contacted the cobtain orders for Resident reported that if facility staff orders from the hospital, or the Assistant DON should call Director via call Director reported that the ve called the sending facility	F	335	NPE/designee will provide re-education to all current licensed nursing staff and additional and newly hired licensed nursing staff prior to the start of their first shift on the process to initiate when admission transfer paper work is not received from the transferring facility upon admission to the Westwood Center. The re-educations will be completed on or before 4/26/2023 or upon hire.		4/26/2023
	hospital was stamped the facility on 2/15/23 stamped). This discharged information: - " pressure ulcers of topographic sites" - New discharged med 200 mg tablet daily by (b) chlorhexidine glucoml mucous membrane - Continued medication ml daily; (b) Eliquis 2.5 ascorbic acid (vitamin	of skin on multiple dications: (a) amiodarone mouth for five (5) days and onate 0.12% mouthwash 10 of twice a day for thirty days. ons: (a) liquid multivitamin 5 ong tablet twice a day; (c)			The Director of Nursing/designee will complete an audit on all newly admitted residents to ensure each admission arrived to the facility with transfer paper work from th admitting hospital and to validate all orders were		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495200	B. WING		C 03/20/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	03/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 635	Continued From page 10 as needed; (e) lorazepam 0.5 mg tablet every eight (8) hours as needed; (f) midodrine 10 mg tablet three time a day; (g) pantoprazole 40 mg daily; (h) oxycodone-acetaminophen 10-325 mg tablet twice a day as needed; and (i) lacosamide 150 mg twice a day. Resident #46 had no medications documented as being administered on 2/15/23. All the medication orders were dated 2/15/23 at 10:05 p.m., with scheduled medications to begin on the moming of 2/16/23. Resident #46's clinical documentation had no orders for wound care for the resident's 2/14/23 - 2/16/23 stay at the facility.		F. 63	initiated upon admission weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI	4/26/2023	
				committee for review.		
	3/17/23 at 4:01 p.m. I surveyor discussed th to obtain readmission The DON confirmed th received not medicatic confirmed that Reside orders for the stay refe Administrator and the readmission orders sh the same day Resider Accuracy of Assessme CFR(s): 483.20(g) §483.20(g) Accuracy of The assessment must resident's status. This REQUIREMENT by:	ector of Nursing (DON) on During this meeting, the e failure of the facility staff orders for Resident #46. nat Resident #46 had ons on 2/15/23. The DON nt #46 had no wound care erenced in this report. The DON reported that rould have been obtained at #46 arrived at the facility.	F 64	Resident #4 Modification of MDS Section M M0100. Determination of Pressure Ulcer/Injury Risk Subsection Z. None of the above was corrected.		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495200	B. WNG			1	С
NAME OF P	ROVIDER OR SUPPLIER			=	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	/20/2023
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WESIWO	OD CENTER				BLUEFIELD, VA 24605		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION		D.F.
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
F 641	Continued From page	: 11	F	641	ho completed Of		126/2023
	review, the facility staff failed to ensure an				An audit will be completed of	4	1/26/2023
	accurate minimum da	ta set (MDS) assessment			all current residents with		
	for 1 of 33 residents, I	Resident #4.			wounds to ensure their		4
	The finalines is study to d				individual MDS ARD		
	The findings included:				Assessments Section M Skin		
	For Resident #4 the fa	acility staff failed to properly			Conditions is correct with		
	code a wound on the				corrective action if needed.		
					(5)		
		eet listed diagnoses which					
	included but not limite				- and the inner will ro		
	depression, anxiety, a	nd contractures of muscles.			DON/ designee will re-		
	The most recent MDS	with an assessment			educate current MDS		
		6/23 assigned the resident			Coordinator on the Section		
	a brief interview for me	ental status score of 14 out			M based on the Centers for		
	of 15 in section C, cog				Medicare & Medicaid		
	indicates that the resid	lent is cognitively intact.				7	
		ions, subsection M1040, and skin problems coded					
	the resident as "none	of the above present". This					
	subsection includes su				Services Long - Term Care		
		•			Facility Resident Assessment		
	Resident #4's comprel	hensive care plan was			Instrument 3.0 User's		
	reviewed and containe	ed care plans for "Resident			Manual Chapter 3, Skin		
	at nutrition risk r/t (rela				Conditions. This education		
	healing"and" is at	nd to R (right) hip skin fold,			will be provided on or before		
		related to diagnosis of MS			will be provided on or be-		
		paired mobility Type:			4/26/2023.		
	Pressure ulcers."	, , , , , , , , , , , , , , , , , , , ,					
		irector of nursing (DON) on					
		egarding Resident #4's					
		at wound to resident's right I versus a pressure ulcer.					
	p io a bargioai frouito	rotodo a pressure dicei.					
	Surveyor spoke with N		6				1
	03/20/23 at 10:55 am regarding Resident #4's						

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (V4) PROVIDENCIES

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495200	B. WNG				С
NAME OF F	PROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	0:	3/20/2023
WESTWO	OOD CENTER			20 WESTWOOD MEDICAL PARK			
	OD CENTER				UEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI; TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E NTE	(X5) COMPLETION DATE
F 641	wound. Surveyor aske "surgical PI" stands fo know what that is". Mi resident "had a hip do Surveyor asked MDS and MDS coordinator some type of surgery Surveyor asked MDS coded on the resident MDS coordinator state. The concern of not corassessment was discuadministrator, DON, at 03/20/23 at 3:00 pm.	ed MDS coordinator what r, and MDS stated "I don't DS coordinator also stated ne some time ago". This to clarify this statement, stated that resident had to hip in the past. This if this should have been s MDS assessment, and do that it should have been. Trectly coding an MDS assed with the and Market Clinical Lead on	Fé	641	All current residents with wounds, MDS ARD Assessments Section M Skin Conditions coding will be audited weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.		4/26/2023
			F6	55	Resident # 149 was discharged from the facility on 1/23/2023 and did not return to the facility. The facility was unable to correct the action. Resident #36 skin integrity plan of care was updated to reflect current skin integrity interventions. An initial audit was completed by DON/designee of all current residents with impaired skin integrity to ensure a baseline		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		495200	B. WING	_		03/	20/2023
NAME OF P	ROVIDER OR SUPPLIER			Π	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTWO	OD CENTER			1	20 WESTWOOD MEDICAL PARK		
					BLUEFIELD, VA 24605		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	_	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	REGULATORY OR L	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI. TAG		(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 655	Continued From page	13	F	655	5	4	/26/2023
,	(E) Social services.					i	, ====
	(F) PASARR recomme	endation, if applicable.			comprehensive skin integrity		
	0.400 0.44) (7) = 1		1		care plans were initiated		
	§483.21(a)(2) The fact	ility may develop a			upon admission and revised		
	care plan if the compre	plan in place of the baseline					
	(i) Is developed within	1 48 hours of the resident's			based on the residents		
	admission.	To read of the foodones			current status.		
	(ii) Meets the requirem	nents set forth in paragraph					
	(b) of this section (exc	epting paragraph (b)(2)(i) of					
	this section).				NPE/designee will provide		
	§483.21(a)(3) The fac	rility must provide the			re- education on the process		
		esentative with a summary					
		an that includes but is not			for developing and updating		
	limited to:				baseline comprehensive skin		
	(i) The initial goals of t				care plans to reflect the		
		resident's medications and			resident's current status on		
	dietary instructions. (iii) Any services and t	trootmonts to be			admission and with any		
	administered by the fac	cility and personnel acting			significant change in		
	on behalf of the facility				condition, to all current		
	(iv) Any updated inform	nation based on the details			licensed nurses and		
	of the comprehensive	care plan, as necessary.			additional and newly hired		
		is not met as evidenced			licensed nursing staff prior to		
	by: Based on staff intervie	w and clinical record	l l		the start of to the start of	1	
		ed to initiate a care plan			the start of to the start of		- 1
	within 48 hours that ad	dressed the resident's					
		33 residents, Resident #36			educations will be completed		- 1
	and #149				on or before 4/26/2023 or		
	1 For Doo!dout#00 (upon hire.		
	1. For Resident #36, fa	acility staff failed to care plan to address the					
	resident's needs as evi	denced by failure to					
	address surgical wound	ds on the care plan within					- 1
	48 hours of admission.						
	Resident #36 was adm	itted to the facility with			e		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	(X3) DATE SURVEY COMPLETED	
		495200	B. WING		*	1	C	
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	20	TREET ADDRESS, CITY, STATE, ZIP CODE 0 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 03	/20/2023	
PRÉFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
	type 2 diabetes mellitu polyneuropathy, peripli morbid obesity, obstru weakness, hypertensit disease with heart failuskin and subcutaneous resistant staphylococcobstructive pulmonary exacerbation, atrial fibescherichia coli, and biminimum data set assereference date 2/1/23, on the brief interview from the brief interview from the brief interview concerning life in the facomplaints. When que (the right lower leg end a sock) the resident sathe dressing on the leg. Clinical record review rhospitalizations with wothough 1/3/23 and 1/1. Prior to the hospitalization record review revealed A physician order dates for Cleanse area to right Apply xeroform, then coevery day shift Tue, The treatment was not docut 12/1, 6, 8, 13, 15, and 22/1, 6, 8, 13	by listed date of diagnosis) as with diabetic heral vascular disease, ctive sleep apnea, muscle we heart and chronic kidney ure, local infection of the stissue, methicillin us aureus infection, chronic disease with acute rillation, sepsis due to acteremia. On the essment with assessment the resident scored 14/15 or mental status, and was nout signs of delirium, s affecting care. The resident on 3/12/23 acility. The resident had no estioned about wound care led in a stump covered with id staff usually changed wound daily. Evealed two recent cound infections: 12/2722 4 through 1/20/23. The resident was and right below the knee in the resident was and right below the knee	F	655	DON/designee will complete audits on all newly admitted residents to ensure baseline comprehensive skin care plans are developed upon admission and revised to reflect current status of the resident weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.		2/26/2023	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495200	B. WING			1	C 8/20/2023
	ROVIDER OR SUPPLIER OD CENTER			20	REET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK UEFIELD, VA 24605	1 00	12012023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	1/3/23. Per the hospit was admitted with sep amputation) infection, surgeon assessed the determined there was intervention. Dressing orders. On 1/3/23, the resident orders for wound care system. Nursing documents assessments from 12/2. The resident was hospithrough 1/20/23. A facility nursing note of the properties or in the properties of the propert	pitalized 12/27/22 through tail discharge, the resident pais, right BKA (below knee fever, and more. The right BKA wound and no need for surgical ps continued per surgeon at returned to the facility. No were entered in the mentation included no skin 28/22 through 1/20/23. Ditalized from 1/14/23 dated 1/20/23 documented ed via non-emergent BLS esident is awake, alert, make his needs known per men PICC line is in place in ent will be receiving IV mouth for VRE and Proteus a buttocks are reddened, essing over RLE/foot. Enhanced barrier se, and staff is aware of the m before providing care, that he needs to sanitize and his room, and notify the ecomes soiled or loose form. No orders for wound were entered in the eturn from the hospital.	F	655			

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION			E SURVEY IPLETED
		495200	B. WING_				0.3	C 8/20/2023
WESTWO	ROVIDER OR SUPPLIER OD CENTER			20 W	ET ADDRESS, CITY, STATE, ZIP CODE ESTWOOD MEDICAL PARK EFIELD, VA 24605		1 00	720/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	C	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE		(X5) COMPLETION DATE
	and wrap with gauze a shift for wound healing documented as compled 29. The resident's compred address not address a intervention to monitor of infection and notify 1/26/23. There was not revision as the resider infections and experied to treat wounds and work the most recent intervention and the most recent intervention and experied to treat wounds and work the most recent intervention and the most recent intervention and the survey assistant director of nuadmission process. Penurse gets the dischard hospital. The admission discharge summary. The entered into the system the resident arrives (the hythe ADON or DON) physician or nurse pracadmission orders. As admission orders to vesummary orders match the electronic record. department asks the fapaperwork. A skin checarrival. Dressings are	oly non-adherent dressing and ACE bandage every day g. Wound care was not leted on 1/25, 26, 28, and shensive care plan did not actual skin integrity wound for worsening signs PCP until a revision on evidence of care plan at was hospitalized with need surgical interventions ound-related infections. Pention revision was ordered dated 7/1/22. For interviewed the arising (ADON) about the er the ADON, the admission ge summary from the on orders are in the The admission orders are in by the floor nurse when its step may be performed. The nurse calls the conditioner to review the econd nurse looks at the erify the discharge in the admission orders in Someone in the nursing amily to sign the admission ck is done within 2 hours of usually noted during the assessments are usually hours. There was no revising the resident's	Fe	555				
	.j							

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495200	B. WING			ı	С
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	03	/20/2023
WESTWO	OD CENTER			:	20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		k
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	3/20/23 that the basel provide enough inform	the administrator and ing a summary meeting on	F	655			
	a baseline care plan to healthcare information resident as evidenced wound treatment on the Resident #149 was adprimary diagnosis encaftercare following sur Secondary diagnoses due to underlying concephropathy, atrial fibridisease with heart failt following a procedure-surgical site-subseque weakness, and difficult admission minimum dawith assessment referencesident scored 13/15 mental status and was of delirium, psychosis, care. The MDS also do had surgery during the surgery requiring SNF surgical wounds, and suffered wounds, a	in necessary to care for a by absence of surgical are baseline care plan. Imitted to the facility with ounter for orthopedic gical amputation. included diabetes mellitus dition with diabetic fillation, hypertensive heart are, asthma, infection superficial incisional ant encounter, muscle ty walking. On the fata set assessment (MDS) ence date 1/19/2023, the fonthe brief interview for assessed as without signs or behaviors affecting for mented the resident prior 100 days, recent care, infection of the foot, surgical wound care.					
	documented under Foo	cus: Actual skin impairment al amputation of toes to					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		E SURVEY PLETED
		495200	B. WING			1	C /20/2023
	ROVIDER OR SUPPLIER OD CENTER			20	TREET ADDRESS, CITY, STATE, ZIP CODE D WESTWOOD MEDICAL PARK SLUEFIELD, VA 24605	03	120/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATÉ
F 655	amputations (revised surveyor requested hi not receive it prior to to Interventions initiated check, Dressing change PCP orders, obtain sk dietician consult as net of the property of the pro	r complications R/T said 1/24/23 by DON the story of changes, but did he end of the survey) 1/14/23: Weekly skin ges will be provided per illed PT/OT evaluation, and reded. re not initiated until oner (FNP) note dated cute visit for follow-up foot of toes on right foot. FNP current pain regimen and for ollow-up with surgeon on note dated 1/18/23 re visit at the request of the address right foot pain and and hallucinations. The calling the surgeon's office orders. New orders written laboratory testing for mbalances, wound dressing cular antibiotic rocephin for ent Administration Record order to Cleanse Right n warm soap & H2O. Pat der dry dressing every day wound care. The treatment dministered 1/19, 1/20, /25. The nurse, LPN #5 erview to determine	F	355			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495200	B. WNG				C
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	03/	/20/2023
WESTWO	OD CENTER				ESTWOOD MEDICAL PARK EFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	;	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 655	the hospital on 1/25/2 complications after an On 3/14/23, the surve assistant director of nu admission process. Pourse gets the discharthospital. The admissi discharge summary entered into the system the resident arrives (the by the ADON or DON) physician or nurse proposition or nurse proposition or ders. As admission orders to vesummary orders matched electronic record. department asks the fipaperwork. A skin chearrival. Dressings are skin check. The other done within the first 48. The surveyor spoke we concerning the resider infection. The FNP strurse was instructed the wound orders on 1/16, surgeon on 1/18/23 be no wound or dressing that failure to perform contribute to infections. The surveyor notified the director of nursing duri 3/14/23 that the baseli	and was admitted for inputation. yor interviewed the cursing (ADON) about the er the ADON, the admission are summary from the on orders are in the The admission orders are in by the floor nurse when his step may be performed in the nurse calls the admission orders in the admission orders in Someone in the nursing amily to sign the admission orders in Someone in the nursing amily to sign the admission orders of usually noted during the assessments are usually the assessments are usually the admission orders. With the FNP on 3/20/23 and the the wound care and attend that the wound care of call the physician for the physician for the admission orders. The FNP stated dressing changes could in the administrator and and a summary meeting on the care plan did not thation for staff to provide	Fe	55			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495200	B. WING _		C 03/20/2023
	ROVIDER OR SUPPLIER OD CENTER SUMMARY STA	STEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	
PREFIX TAG	(EACH DEFICIENC)	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION
F 656 F 656 SS=D	S483.21(b)(1)(\$483.21(b) Comprehe \$483.21(b)(1) The fac implement a compreh care plan for each res	omprehensive Care Plan 3) Insive Care Plans Ility must develop and ensive person-centered ident, consistent with the	F 6:	مدم و در و المساهمة	
	medical, nursing, and needs that are identificassessment. The comb describe the following (i) The services that are or maintain the resider physical, mental, and prequired under §483.2 (ii) Any services that wunder §483.24, §483.2 provided due to the reunder §483.10, including treatment under §483. (iii) Any specialized serehabilitative services provide as a result of frecommendations. If a findings of the PASAR rationale in the resider (iv) In consultation with resident's representatif (A) The resident's goardesired outcomes. (B) The resident's prefitutive discharge. Facili whether the resident's community was assessed.	ludes measurable mes to meet a resident's mental and psychosocial ed in the comprehensive prehensive care plan must re to be furnished to attain nt's highest practicable psychosocial well-being as 4, §483.25 or §483.40; and rould otherwise be required 25 or §483.40 but are not sident's exercise of rights ng the right to refuse 10(c)(6). rvices or specialized the nursing facility will PASARR facility disagrees with the R, it must indicate its tt's medical record. the resident and the ve(s)- s for admission and erence and potential for tities must document		An initial audit was completed by DON/design of all current residents with impaired skin integrity to ensure comprehensive skintegrity care plans are inclusive with wound care interventions to meet the resident's needs. NPE/designee will provid re-education on the proof for initiating and updatin comprehensive skin care plans to reflect the interventions to meet the residents' wound care net to all current licensed nurand additional and newly hired licensed nursing staprior to the start of to the start of their first shift. The re-educations will be completed on or before 4/26/2023 or upon hire.	e e cess g e e e e e e e e e e e e e e e e e

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE COMP	SURVEY
		495200	B. WNG_			ı	C 20/2023
	ROVIDER OR SUPPLIER OD CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE O WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	03/	20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	entities, for this purpo (C) Discharge plans in plan, as appropriate, i requirements set forth section. §483.21(b)(3) The ser by the facility, as outling care plan, musticiii) Be culturally-compathis REQUIREMENT by: Based on staff intervictinical record review, initiate interventions to wound care needs for (Resident #149). Resident #149 was an diagnoses to include aftercare following sur mellitus due to underly nephropathy, atrial fib disease with heart fail following a procedure-surgical site-subseque weakness, and difficult The minimum data set the assessment referreviewed. The resider interview for mental st without signs of delirius affecting care. The Miresident had surgery crecent surgery requirir	the comprehensive care in accordance with the in paragraph (c) of this vices provided or arranged ned by the comprehensive betent and trauma-informed is not met as evidenced ew, family interview and the facility staff failed to address the resident's 1 of 33 residents reviewed dimitted to the facility with encounter for orthopedic in interview in a condition with diabetic rillation, hypertensive heart ure, asthma, infection experficial incisional ent encounter, muscle ity walking. It assessment (MDS) with ence date 1/19/2023 was not scored 13/15 on the brief atus, and was assessed as im, psychosis, or behaviors DS also documented the during the prior 100 days, no SNF care, infection of nods, and surgical wound	F6	356	DON/designee will complete audits on all current residents with wound care needs to ensure comprehensive skin care plans are revised to reflect interventions for wound care needs of the resident weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	4,	/26/2023

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		CONSTRUCTION		SURVEY PLETED
		495200	B. WING_			1	C /20/2023
	ROVIDER OR SUPPLIER OD CENTER	•		20	REET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK LUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 656	R/T (related to) surgior right footis at risk for amputations (revised Interventions initiated check, Dressing chan PCP orders, obtain stidictican consult as not initiated by DON on 1 pain/discomfort and T and Monitor for worse increased redness, drincision site, increase abnormal findings. Act monitoring were not part 11 days after the resident A family nurse practition 1/16/23 indicated an apain after amputation FNP plan was to contrain and for wound or right surgeon on wound or 1/18/23 indicated an arequest of the family a foot pain and reported hallucinations. The Fifthe surgeon's office to New orders written for laboratory testing for imbalances, wound drintramuscular antibiot. The first wound treatment the record on 1/18/20 added to care plan into The surveyor notified.	caus: Actual skin impairment cal amputation of toes to r complications R/T said 1/24/23 by DON) 1/14/23: Weekly skin ges will be provided per cilled PT/OT evaluation, and geded. Interventions /24/23: monitor for a according to PCP orders ening of incision site: rainage, dehiscence of d pain. Notify PCP of any citual wound care orders and placed on the care plan until dent's admission. Oner (FNP) note dated acute visit for follow-up foot of toes on right foot. The inue current pain regiment of foot - Follow-up with ders. A FNP note dated acute care visit at the land nursing to address right divivid dreams and NP noted personally calling to obtain wound care orders. The Neurontin for pain; infection or chemical ressing changes and ic rocephin for 3 days. Interventions on 1/24/23.	F6	556			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE	SURVEY PLETED
		495200	B. WING			1	С
NAME OF P	ROVIDER OR SUPPLIER		1	S	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	/20/2023
WESTWO	OD CENTER		20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		0 WESTWOOD MEDICAL PARK		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
SS=D	Continued From page during a summary me Care Plan Timing and CFR(s): 483.21(b)(2)(c) §483.21(b) Comprehe §483.21(b)(2) A comp be- (i) Developed within 7 the comprehensive as (ii) Prepared by an interinctudes but is not limit (A) The attending physical (B) A registered nurse resident. (C) A nurse aide with resident. (D) A member of food (E) To the extent practite resident and the real explanation must be medical record if the pand their resident representations as the resident of the pand their second in the pand their resident representations as determined as requested by the	eting on 3/20/23. Revision i)-(iii) Insive Care Plans rehensive care plan must days after completion of sessment. erdisciplinary team, that ted to— sician. with responsibility for the responsibility for the and nutrition services staff. icable, the participation of esident's representative(s). e included in a resident's articipation of the resident resentative is determined development of the staff or professionals in need by the resident's needs resident.	F	856			1/26/2023
	team after each assess comprehensive and quassessments. This REQUIREMENT by: Based on staff intervie facility document review review and revise the comprehensive and quassessments.	is not met as evidenced ew, clinical record review, w, the facility staff failed to comprehensive of care for 1 of 33 residents			NPE/designee will provide re- education on the process for initiating and updating comprehensive skin care plans to reflect the current status of the resident's current skin integrity, to all current licensed nurses and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		495200	B. WNG				С
	ROVIDER OR SUPPLIER OD CENTER	,		STR 20 V	REET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK UEFIELD, VA 24605] 03	3/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
	of care following the dinjury. This was a closed reconstruction. Resident #299's diagradiagnoses, which included the manage of the control	e facility staff failed to sive person-centered plan levelopment of a pressure ord review. nosis list indicated uded, but not limited to pathy, Aftercare following largery, Dislocation of sthesis, Chronic Obstructive Unspecified Dementia, and tus. In data set (MDS) with an edate (ARD) of 10/25/22 a brief interview for mental ry score of 9 out of 15 was moderately cognitively the was coded as being at risk to sulcers/injuries with no sure ulcers/injuries. In the presence of a poisture associated skin street associated skin street associated skin at the presence of a poisture associated skin street associated skin at the presence of a pre	F	657	additional and newly hired licensed nursing staff prior to the start of the start of their first shift. The reeducations will be completed on or before 4/26/2023 or upon hire. DON/designee will complete audits on all current residents with wounds to ensure comprehensive skin care plans are revised to reflect the current skin integrity status weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.	d	4/26/2023

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		LE CONSTRUCTION		E SURVEY IPLETED
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	ROVIDER OR SUPPLIER OD CENTER		i i	2	STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	0.3	12012023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	documentation descrii when noted on 10/23/ Resident #299 was se practitioner (FNP) on stated in part " Wou stage 2 protocol. Dr. [i stage 2 wound with skeep to decrease a subsequent document coccyx until 11/01/22 awas photographed, me that time the area was unstageable pressure measuring 9.15 cm in with 100% slough. This Surveyor reviewe comprehensive persor was unable to locate of injury to the resident's area. The plan of care stating "resident has e to decreased activity a incontinence of bowel 10/18/22. According to Resident #299 was ad 10/18/22 and the nursi entitled "Nursing Docu 10/18/22 at 11:07 pm of moisture associated the coccyx.	coing the area to the coccyx 22. Item by the family nurse 10/24/22, the progress note and care to buttocks per name omitted] consult for bugh to buttocks" Item by the family nurse 10/24/22, the progress note and care to buttocks per name omitted] consult for bugh to buttocks" Item by the family nurse 10/24/22, the progress note and outtocks" Item by the family nurse 10/24/22, the progress note and season and the area to the area to the area to the sacrum length and 4.91 cm in width and 4.91 cm in width occurrented plan of care and occurrentation of a pressure coccyx/buttocks/sacral included a focus area accoriation to coccyx related and intermittent and bladder" created on	F	657			
	Clinical Reimbursemer regarding Resident #29 informed the CRC they	nt Coordinator (CRC) 99's plan of care. Surveyor					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER		-		REET ADDRESS, CITY, STATE, ZIP CODE	03	/20/2023
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(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		
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F 657			F6	357	w		4/26/2023
	#299's plan of care. O	CRC reviewed the resident's					
	plan of care and stated, "it's not on here anywhere". This Surveyor asked the CRC if the						
	pressure area should	have been on the plan of					
	care, and they stated i	it probably should have					
	been updated. Survey	yor asked the CRC how					
	they were notified whe	en a plan of care needed to					
	be revised and they st	ated staff talk about ng meetings and care plans					
	are reviewed during th	e MDS review.					
	Surveyor requested ar	nd received the facility					
	policy entitled "Skin In	tegrity and Wound					
	Management" which re	ead in part "The plan of					
	care for the patient will						
		om the comprehensive and wound evaluation. Staff					
		e and monitor patients for					
	changes and implemen	nt revisions to the plan of					
	care as needed11.	Review care plan and					
	revise as indicated"						
	On 3/20/23 at 2:57 pm	, the survey team met with					
	the administrator, direct	ctor of nursing, and the					
	staff failing to revise Re	d discussed the concern of					
	•	-centered plan of care to					
	reflect the developmen	t of an unstageable					
	pressure injury.						
	No further information	regarding this concern was					
	presented to the survey	y team prior to the exit			Resident #10 labs were		
	conference on 3/20/23.				repeated on 2/13/2023 with		
		et Professional Standards	F 6	58	no critical findings. Resident		
SS=D	CFR(s): 483.21(b)(3)(i)						
§483.21(b)(3) Comprehensive Care Plans	nensive Care Plans		#14 labs were repeated on				
	The services provided	or arranged by the facility,			2/23/2023 with no critical		
					findings.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
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	ROVIDER OR SUPPLIER OD CENTER			20	REET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK -UEFIELD, VA 24605] 03	8/20/2023	
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	as outlined by the commust- (i) Meet professional set This REQUIREMENT by: Based on staff interviand facility document failed to follow profess for the notification and laboratory test results Resident #10, and Retent #10, and Retent #10 the findings included: 1. For Resident #10 the the provider, assess a a critical potassium (Kolevel. Resident #10's face shincluded but not limited obstructive pulmonary cell carcinoma of skin, Resident #10's most rewith an assessment recoded the resident as cognitive patterns. This is severely cognitively Resident #10's comprereviewed and contained is at nutrition risk r/t (retexture diet, diuretic, unhyperkalemia" Intervincluded "Labs per ordinal"	standards of quality. Is not met as evidenced ew, clinical record review, review, the facility staff sional standards of practice assessment of critical for 2 of 33 Residents, sident #14 be facility staff failed to notify and/or treat the resident for level and a critical glucose neet listed diagnoses which d to anemia, chronic disease, dementia, basal and hypertension. becent minimum data set ference date of 02/07/23 out of 15 in section C, indicates that the resident impaired. behensive care plan was d a care plan for "Resident elated to) need for altered anderweight, entions for this care plan ers".	F 6	558	An audit was completed on all labs ordered for the previous 30 days to ensure no critical labs were received and not followed up on by the attending physician, with corrective action if needed. This audit to be completed on or before 4/26/2023. NPE or designee will reeducate all current licensed nursing staff on how to obtain and report critical labs. The NPE/designee will also provide the education to all additional and newly hired licensed nursing staff prior to the start of their first shift. This education to be completed on or before 4/26/2023 or upon hire.		4/26/2023	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION		E SURVEY PLETED
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NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	03	/20/2023
WESTWO	OD CENTER			2	20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 658	which read in part, "To Reference: 3.6-5.6 m 1944. Result verified it called to and read back 02/08/2023 19:39:05 is "Test: Glu (glucose), Reference: 70-110, Result verified by repeto and read back by .02/08/2023 19:50:54 is Critical called to and romitted) at 02/08/2023 omitted)". Handwritten report read in part "No don't see Kayexelate? This note did not have #10's clinical record alsame laboratory report the bottom of the report orders given 2/13 for risigned by the facility for (FNP). According to Discovered by the facility for (FNP). According to Discovered by the facility for its Surveyor reviewed progress notes on 03/locate any documenta had been notified or an resident had complete. This Surveyor spoke woursing (ADON) on 03 regarding Resident #1 stated that MD/FNP shand that the facility stated and ADON stated "Not and ADON stated "Not and ADON stated "Not and ADON stated" Not all stated that MD/FNP shand that the facility stated and ADON stated "Not and ADON stated" Not and ADON stated "Not and ADON stated" "Not all stated that MD/FNP shand that the facility stated and ADON stated" "Not and ADON	est: K, Result: 6.6, Flag: *H, Eq/L, Reported: 02/08/23 by repeat analysis. Critical ck by (name omitted) at by (initials omitted)" and Result: 37, Flag: *L, reported: 02/08/23 1957: eat analysis. Critical called (name omitted) at by (initials omitted). ead back by (name 3 19:52:18 by (initials on one on the bottom of this one on the bottom of the one	F	658	An audit for critical labs will be completed daily during the clinical morning meeting with corrective action if necessary. This audit to be completed weekly X 4 then monthly X 2 or until 100% compliant, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.		4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE	03	/20/2023
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should, but they coul assessments. This Surveyor spoke (MD) on 03/15/23 at Surveyor asked MD in Resident #10's critical they did not recall be surveyor that it was provided in the surveyor spoke with 03/15/23 at 5:04 pm. with the FNP and conductive outcome. The waste outcome. The waste outcome was treatment should critical lab values, and providers should have assessed, administer (dextrose [sugar] 5% potassium levels, fing check blood sugar levels blood sugar was extra resident should have hyperkalemia (high potassium surveyor spoke 1:55 pm regarding Resident out the surveyor spoke 1:55	with the facility physician 4:05 pm via telephone. If they had been notified of al lab values, and MD stated ing notified. MD stated to cossible the facility family NP) had been notified stated they would ask FNP. If facility MD again on MD stated they had spoken infirmed that the FNP had not ritical results returned on 23. MD stated that this is d "glad the resident had no it is Surveyor asked MD d have been done related to d MD stated that one of the e been notified immediately, been immediately in water) for the high per stick blood sugar to vels, and given glucose gel if emely low. MD stated that gotten "acute care for	F	658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		IDENTIFICATION AND ADDROG		FIPLE CONSTRUCTION NG	(×	(X3) DATE SURVEY COMPLETED	
		495200	B. WING_			C 03/20/2023	
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		00/20/2020	
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F 658	which read in part "Pi physician/APP (advai diagnostic test results any critical values. 5. physician/APP notific medical record." The concern of the fa MD/FNP, not assessi resident was discusse DON, and Market Clir 3:00 pm.	"NSG 103 Diagnostic Tests" ractice Standards: 4. Notify need practice practitioner) of s. 4.1 Notify immediately for Document date and time of ation and response in the cility staff not notifying the	F6	58			
	after receiving telepholow blood glucose lev "Low blood sugar (als many causes, includir too much insulin, takin medicines, exercising drinking alcohol. Blooconsidered low Low dangerous and should possible. (Downloade https://www.cdc.gov/dblood-sugar.html on 3 Resident #14's minim	more than normal, and d sugar below 70 mg/dL is w blood sugar can be d be treated as soon as d from liabetes/managing/manage- /16/23) um data set (MDS) assessment reference date as dated as being 2. Resident #14 was					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER	-100200	1	- 5	STREET ADDRESS, CITY, STATE, ZIP CODE	03/	/20/2023
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WESTWO	OD CENTER				BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 658	others. Resident #14 problems with short-to Resident #14 was assassistance with bed mand personal hygiene diagnosed with diabet Resident #14's clinical laboratory report indice glucose level was call at 9:03 p.m. Resident was documented as 470 - 110 mg/dL. Resident #14's clinical progress note dated 2 nursing progress note information: "Received initials omitted) Lab were sident of 42 from lab placed in Rounding Boresident assessment as sugar check were conrelated to this low blood earlier nursing progres #14 had laboratory blood 2/21/23 at 5:37 a.m.) glucose/sugar level was at 6:05 a.m.; this resure the Director of Nursing #14's critically low blood DON reported a finger have been immediated and the resident should be a service with the director of solutions and the resident should be a service with the director of sursing #14's critically low blood DON reported a finger have been immediated and the resident should be a service with the director of sursing #14's critically low blood DON reported a finger have been immediated and the resident should be a service with the director of sursing #14's critically low blood DON reported a finger have been immediated and the resident should be a service with the servi	metimes able to understand was assessed as having arm and long-term memory. Sessed as requiring nobility, dressing, toilet use, . Resident #14's was ses. I record included a sating a critical low blood ed to the facility on 2/21/23 at #14's blood glucose level 2 with reference range of	F	658			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495200	B. WING _		C 03/20/2023	
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 00/	20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 658	On 3/16/23 at 12:22 p interviewed the facility telephone. The Medic resident should have	e.m., the surveyor o's Medical Director via cal Director confirmed the been assessed for buld have had a finger stick	F 6	58		
	policy titled "NSG115 Practice Provider (AP revision date of 12/1/2 patient who has a chalaboratory values, or alicensed nurse will observations" The survey team met Administrator and Dire 3/17/23 at 4:01 p.m. I surveyor discussed that o assess Resident #1 aforementioned critical level. Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fur applies to all treatment facility residents. Base assessment of a resident residents receive accordance with profe practice, the compreheare plan, and the residents.	P) Notification" (with a 21): "Upon identification of a ange in condition, abnormal abnormal diagnostics, a Perform appropriate clinical with the facility's ector of Nursing (DON) on During this meeting, the e failure of the facility staff 4 after receiving the ally low blood glucose/sugar remarkal principle that t and care provided to ad on the comprehensive ent, the facility must ensure treatment and care in ssional standards of ensive person-centered	F 68	1. Patient #149 is no longer in the facility. Patients #4, #10, #36 and #42 received a head to toe skin assessment by a licensed nurse to ensure no additional skin breakdown and current	4/	26/2023

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL [*] A. BUILDI		ONSTRUCTION			E SURVEY PLETED
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F 684	Continued From page		Fe	684				
	Based on observation	n, staff interview, resident			wounds had ordered			
	facility document rovice	riew, clinical record review, ew, the facility staff failed to			treatments in place, and	4		
		ement as evidenced by the			dressings changed, date			
	absence of assessme	nts, monitoring, and/or			and times to reflect	u		4/26/2023
		33 residents. This resulted			treatment per physician	¹c	nee.	1,20,2020
		id/or wound deterioration ident #4, Resident #4,			orders. All listed residen			
		sident #149. The facility			risk for skin breakdown			
		nt provider orders at the			plans have been updated			
	time they were ordered	d for 1 of 33 residents			reflect the current status			
	reviewed, Resident #1	99.						
	On 3/15/23 at 3:50 PM	I, the surveyors notified the			each resident's skin integ to include actual skin	grity		
	facility of the Immediat	te Jeopardy determination,						
	Level IV Pattern. The f	facility staff implemented an			breakdown. All current			
		as verified by the survey			residents have the poter			
	and document reviews	al observations, interviews,			to be affected by alleged	1		
	notified that the Immed removed on 3/17/23 at	diate Jeopardy was			deficient practice.			
					2. All current reside			
					with wounds were audite			
	The findings included:					ea		i
	1 For Booldont #10 th	a familia, mante for the dist			by DON/designee on			
	1. For Resident #10 the	e racility starr railed to ement resulting in a wound			3/15/2023 to ensure			
	infection.	one it resulting in a would			physician's order is in pla			
					and treatments complete			
	Resident #10's face sh	eet listed diagnoses which			ordered as evidenced by			
	included but not limited				completion of noted			
	cell carcinoma of skin,	disease, dementia, basal			treatment and			
	and the state of t	and hypottonoion.			documentation thereof.	То		
		ecent minimum data set			be completed on or before	re		
		ference date of 02/07/23			3/16/2023.			
		out of 15 in section C,						
	cognitive patterns. This	indicates that the resident						

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY
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	ROVIDER OR SUPPLIER OD CENTER			20 V	REET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK UEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	conditions, subsection Wounds, and Skin Proas having open lesion rashes, cuts (e.g., car Resident #10's compreviewed and contained at risk for skin breakded decreased mobility, in oxygen use" Interveinclude "Observe skin (activities of daily living provide wound treatmeskin checks by licensed Resident #10's clinical contained a physician' month of March 2023, "Cleanse growth the colution, pat dry, apply dressing to wound bed dressing, change BID needed) every day shi "Cleanse scalp wound and water, cleanse pesolution, pat dry, apply and cover entire scalp BID and PRN every day and cover entire scalp BID and PRN every day and cover entire scalp BID and PRN every day shi "Cleanse growth to ce one section for initials"	impaired. Section M, skin M1040, Other Ulcers, oblems coded the resident (s) other than ulcers, ocer lesion). ehensive care plan was ed a care plan for "Resident own r/t (related to) continence, fragility of skin, intions for this care plan condition daily with ADL's g) and report abnormalities, ent as ordered, and weekly enurse." I record was reviewed and sorder summary for the which read in part enter of back with Dakin's read and secure with dry (twice a day) and PRN (as fit for wound care" and (exposed skull) with soap riwound with Dakin's ratio of the interest	F	584	100% skin sweep was completed on 3/15/2023 to identify any previously unidentified pressure injuries and or wound. Upon identification of possible pressure injuries and or wound physician notification to be completed, new orders obtained and treatments implemented per order as evidenced by completion of noted treatment and documentation thereof. To be completed on or before 3/16/2023. New admission skin assessments to be completed by wound care lead/DON/Designee within 24 hours of admission beginning 3/16/2023. Physicians to be notified of any identified break in skin integrity, obtain physician's order for treatment and treatments implemented per order as evidenced by completion of noted treatment and documentation thereof. To be completed on or before		/26/2023
			_	_	3/16/2023.		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	((X3) DATE S	
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				BLUEFIELD, VA 24605			
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F 684	03/12/23 at 3:30 pm. In orderessing was obsewound. Exposed skull Resident #10's clinica "Physician's Telephon 02/06/23, which read (three times a day)-word 10 days." This Surveyor, along word (LPN) #1 and certified observed Resident #1 Surveyor observed dressed to the control of the contro	Resident was resting in bed; rived in place to scalp was observed by surveyor. I record contained a e Order" form dated in part "Keflex 500 mg TID bund infection top of head x with licensed practical nurse nurse's aide (CNA) #1 0 on 03/13/23 at 1:00 pm. essing in place to resident's A #1 and LPN #1 rolled	Fé	Documentation of wou assessment to be comp by wound care lead/DON/Designee on skin integrity reports the includes measurements descriptions of wound. report is kept in the skin integrity binder located the DON office. When the report is completed and the wound is resolved the skin integrity report will uploaded into the reside	the pat sand This in the formula be ents	: 4,	/26/2023
	asked LPN #1 if dress LPN #1 first stated that yeah, it does". Surveyed date on the dressing will march 9th". Surveyor dressing once it was redate on the dressing to along with initials. Whe dressing from Resident observed moderate and the dressing and wour brown ring, with drainaringed area. Surveyor	emoved and observed the o read "03/09/23 7a-7p" en LPN #1 removed the at #10's wound, surveyor mount of drainage both on ad bed. Dressing had a dark age in the center of the asked LPN #1 to describe 1 stated "greenish-brown, e."LPN #1 stated to the ag to the date on the		electronic medical record be completed on or befor 3/16/2023. 3. All current licer nursing staff on site we immediately educated NPE/designee on Skin Integrity Protocol and Wound Management. A additional current licer nursing staff will be record to have said education to their first scheduled	nsed re by All sed juired prior		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495200	B. WNG			1	C . 8/20/2023
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	LPN #1 if lesion had vobserved it, and LPN more drainage." LPN from resident's scalp a scalp wound was not a dressing. on it. This Surveyor of greenish discharge on later informed surveyor have a dressing on scale wound infection starting. This Surveyor spoke wound infection starting (ADON) on 03 regarding Resident #1 asked ADON what the wound care, and ADO the nurses to follow the each resident regarding. This Surveyor reviewer record and could not leassessments, including the scale of the second and could not leassessments, including the scale of the second and could not leassessments, including the scale of the second and could not leassessments, including the scale of the second and could not lease the second and the s	ack lesion. Surveyor asked vorsened since they last #1 stated, "It definitely has #1 removed the dressing and stated to surveyor that supposed to have a served scant amount of a scalp dressing. LPN #1 or that Resident #10 should alp lesion. 10's clinical record revealed ed on oral antibiotic for ag 03/14/23. with the assistant director of 6/14/23 at 10:50 am 0's wound care. Surveyor in expectations were for N stated they would expect e physician's orders for ag wound care.	F	384	4. All residents with wounds including new admissions will be audited to ensure physician is notified, treatment is obtained, treatment is completed per order as evidenced by date, time, initials on dressings, daily x14 days or until 100% compliance is achieved then 3 times a week until 100% compliance achieved. Then weekly x 3 weeks until 100% compliance achieved, then monthly x 3 months until 100% compliance achieved. To be completed on or before 3/16/2023.with ongoing educations as referenced above to be completed prior to shift start.		4/26/2023
	wound management. I	15/23 at 10:00 am regarding DON stated they measure nat information is located in d that weekly skin be performed on all			5. Plan of correction reviewed in Ad Hoc QAPI meeting on 3/15/2023 with the IDT team. Results of audits will continue to be reviewed in monthly QAPI meetings		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495200	B. WING		1	C //20/2023	
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 00	120/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD I		(X5) COMPLETION DATE	
F 684	This Surveyor reviews record and could not I assessments. This Survey team spo practitioner (FNP) on regarding wound man FNP if missed assess changes not being do contribute to wound in that it could. The concern of not prowas discussed with the Market Clinical Lead of	ed Resident #10's clinical ocate any skin ke with family nurse 03/20/23 at 1:25 pm agement. Surveyor asked ments and dressing	F 68	84			
	Resident #4 was admi and readmitted on 06/sheet listed diagnoses limited to multiple scle and contractures of 14 out patterns. This indicate cognitively intact. Sect coded the resident as	ement which resulted in the for a wound infection. Itted the facility on 02/13/21 08/21. Resident #4's face which included but not rosis, depression, anxiety, uscles. It is a set (MDS) with need the date (ARD) of 02/06/23 a brief interview for mental of 15 in section C, cognitive is that the resident is ion M, skin conditions, having one stage 1 s present upon admission.					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495200	B. WNG			1	C /20/2023
	ROVIDER OR SUPPLIER			20 WE	ET ADDRESS, CITY, STATE, ZIP CODE ESTWOOD MEDICAL PARK EFIELD, VA 24605	1 00/	2012020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	_	(X5) COMPLETION DATE
F 68.4	wounds and skin prol "none of the above princludes surgical wou #4's admission MDS coded the resident as pressure ulcer preser stage IV pressure ulc and one unstageable admission. Resident #4's compre reviewed and contain at nutrition risk r/t (rel Surgical PI Open wor fold, healing. PI Rt. H continuing impaired s diagnosis of MS (mul mobility Type: Pre for both care plans in treatment as ordered' This Surveyor spoke 03/12/23 at 3:10 pm. wounds to right hip ar is supposed to be do some nurses that dor "I'm lucky if they do it was concerned that we done as ordered. Sur #4 on 03/13/23 at 11: their wound care had resident stated, "the of yesterday (03/12/23) hasn't been changed This Surveyor, along (LPN) #1 and certified observed Resident #4	colems coded the resident as resent". This subsection ands. Section M of Resident with an ARD of 02/20/21 shaving one stage III at upon admission, one er present upon admission pressure ulcer present upon pressure ulcer present upon admission pressure ulcer present upon and to Rt. (right) hip skin at the form and " is at risk for kin integrity related to tiple sclerosis), impaired source ulcers." Interventions cluded "Provide wound" and "Labs per orders". With Resident #4 on Resident #4 on Resident stated they have not heel and that wound care net wice a day, but there are not to it. Resident #4 stated, once a day." Resident #4 yound care was not being veyor spoke with Resident if been completed, and dressing was changed around lunch time and	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495200	B. WING			1	C /20/2023
	ROVIDER OR SUPPLIER OD CENTER			20	REET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK .UEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD		_	(X5) COMPLETION DATE
F 684	#1 stated to LPN #1, date on it". Surveyor a should be dated, and be. Surveyor observe dated. LPN #1 remove "well, that tells me it's Surveyor asked LPN a dressing had not beer stated by the color of of drainage on the dressing had not beer stated by the color of of drainage on the dressident #4's clinical contained a physician month of March 2023. "Cleanse post-surgical Dakin's solution, pat of the wound bed, cover we secure with dry dressiday and night shift for Date 02/28/2023 Star "Wound(s): Monitor so surrounding tissue and status of dressing(s), Documentation in NN every day shift. Order Date 03/13/2023." Resident #4's TAR for was reviewed and corpart, "Cleanse post-su with Dakin's solution, powder to wound bed and secure with dry devery day and night solution, let dry and a secure are to right I betadine, let dry and a secure with dry and a secure with dry and a secure with dry devery day and night solution, let dry and a secure with dry devery day and night solution, let dry and a secure with dry devery day and night solution, let dry and a secure with dry devery day and night solution, let dry and a secure with dry devery day and night solution, let dry and a secure with dry devery day and night solution, let dry and a secure with dry devery day and night solution, let dry and a secure with dry devery day and night solution, let dry and a secure with dry devery day and night solution, let dry and a secure with dry dry and night solution, let dry and a secure with dry dry and night solution, let dry and a secure with dry dry and night solution, let dry and a secure with dry dry and night solution.	essing became visible, CNA it (dressing) don't have a asked LPN #1 if dressing LPN #1 stated that it should d that dressing was not ed the dressing, and stated, not been changed." #1 how they could tell in changed, and LPN #1 the gauze and the amount essing. record was reviewed and is order summary for the	F	684			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ONSTRUCTION	(X3) DATE	SURVEY PLETED
		495200	B. WING			1	C /20/2023
	ROVIDER OR SUPPLIER OD CENTER		·	20 V	EET ADDRESS, CITY, STATE, ZIP CODE NESTWOOD MEDICAL PARK JEFIELD, VA 24605	1 00.	2012020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	site(s) daily for status wound pain. Monitor for applicable, Additional (nurse's notes) as need to all ordered times. Date 03/12/2023. Starentries were initialed a for all ordered times. This Surveyor reviewer record from January to of wound treatment properties of wound treatment properties. Resident #4's clinical record "summary form of in part "Chief complaint Problem: Follow-up with fold. Duration: Chronic Culture done and resure the complete of Systems Skinip skin fold. Physical hip skin fold is tender syellow/white drainage noted. Optifoam patch Labs/Radiology/Tests. been collected and resure the collected	of surrounding tissue and for status of dressing(s), If Documentation in NN eded every day shift. Order at Date 03/13/2023." These as having been completed as present for documentation rovided to the right hip, right gress of the wounds. The cord contained an "Acute dated 01/25/23, which read ant/Nature of Presenting rounds. Location: Right hip acute. Its pending. Quality: Stable. Its pending. Quality: Stable. Its pending. Quality: Stable. Its pending wound to right to touch. There is to wound, and a foul odor is a in place. Labs: Wound culture has sults pending per nursing. It wound treatment." This was urse practitioner (FNP).	F	684			
	order was signed by the	ne FNP. Resident #4's ed a laboratory report dated					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			NSTRUCTION	11.1	E SURVEY IPLETED
		495200	B. WING			01	C 3/20/2023
	ROVIDER OR SUPPLIER OD CENTER			20 W	ET ADDRESS, CITY, STATE, ZIP CODE ESTWOOD MEDICAL PARK EFIELD, VA 24605	1 00	012012023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)			(X5) COMPLETION DATE
F 684	presence of Proteus ribacterium. Resident #4's treatmee (TAR) for the month or reviewed and containing part, "Cleanse right hicleanser), pat dry, app. Optifoam on wound ethealing." This entry halisted and was initialed. There were no previous related to right hip not. The TAR for January aread in part "Cleanse IHWC. Apply 4 x 4 booptifoam) gauze or opday shift Mon, Wed, Fdate-01/04/2023, -D/Cdate-02/02/2023", "Cleanse IHWC. Apply 4 x 4 booptifoam for cushion. care-start date-01/30/2date-02/09/2023" and daily for status of surropain. Monitor for statu applicable, every day heel wound was not in 01/02, 01/03, 01/06, 0 Resident #4's TAR for reviewed and contained part, "Cleanse right hip Dakin's solution, pat deperi-wound. Wet-to-drewound bed. Secure with the status of surropain. Wet-to-drewound bed. Secure with the same part wound. Wet-to-drewound bed. Secure with the same part wound bed. Secure with the same part wound. Secure with the same part wound.	alture which indicated the nirabilis, a gram-negative on administration record of January 2023 was ed and entry which read in p with IHWC (wound oly Maxsorb, and place very night shift for wound ad a start date of 01/30/23 d as being completed. Us wound care orders ed on this TAR. Also contained entries which area to right heels with arder (sic) gauze or tifoam for cushion. every ri, Sun for wound care-start is (discontinue) eanse area to right heel with arder (sic) gauze or every night shift for wound 2023, -D/C "Wound(s): Monitor site(s) bunding tissue and wound so of dressing(s), if shift. The treatment to the litialed as completed on 1/15, 01/18, and 01/23. The month of February was ed entries which read in p surgical wound with	F	584			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495200	B. WING			1	C
	ROVIDER OR SUPPLIER OD CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE O WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 03.	/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	completed on 02/18/2 February did not contamonitoring. The TAR for February which read in part, "Cl with IHWC. Apply 4 x optifoam for cushion. care-start date-01/30/3 date-02/09/2023" and with IHWC. Apply beta prep every night shift treatment was not initi 02/18/23. Resident #4's clinical physician's telephone which read in part "(1) (every) day (2) Repea Barker consult wound signed by the physiciar record also contained summary for the mont read in part "Culture wonly for Wound Infectia a start date of 02/25/2 results of this wound of this Surveyor spoke woursing (ADON) on 03 regarding Resident #4 stated the culture order collected 3 times, and contacted for results, tho have a specimen.	also contained entries leanse area to right heel 4 boarder (sic) gauze or every night shift for wound 2023, -D/C "Cleanse area to right heel adine, let dry and apply skin for wound care." This aled as completed on record contained a order form dated 02/16/23, Rocephin 1 gm I.V. q t wound culture x 7 (3) vac R hip." This order was in. Resident #4's clinical a physician's order h of February 2023, which round to Right hip one time on for 1 day" This order had 3. Surveyor could not locate culture.	F	684			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495200	B. WING			1	C /20/2023
	ROVIDER OR SUPPLIER OD CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	at the contracted lab or regarding Resident #4 stated that the only we specimens they had read 02/10/23. MT stated other orders or specim Resident #4. This Surveyor spoke was expected the wound to be done, and FNP stated about the result they had done it and left FNP if they expected thave been done, and Surveyor asked FNP if they expected thave been done, and Surveyor asked FNP if dressing changes not could contribute to we stated that it could. This Surveyor spoke was 10:50 am regarding Surveyor asked ADON were for wound care, would expect the nurs orders for each reside Surveyor asked ADON dated and initialed by wound care. ADON la nursing (DON), facility dressings needed to be This Surveyor requestion.	with medical technician (MT) on 03/20/23 at 10:15 am It's wound cultures. MT ound culture orders and eceived were on 01/17/23 ted they had received nomens for wound cultures for with FNP on 03/20/23 at ked FNP when they culture ordered on 01/30/23 stated they expected it to be e. FNP said when they ts, "couple of nurses stated ab lost it". Surveyor asked the repeat wound culture to FNP stated they did. If missed assessments and being done as ordered and infections and FNP with the ADON on 03/14/23 and Resident #4's wound care. In what their expectations and ADON stated they es to follow the physician's and regarding wound care. If if wound dressings should stated that they should be the nurse completing the ter stated per director of a policy did not state that	F	684			
	which read in part, "2.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY ETED
		495200	B. WNG			C 03/2	0/2023
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		00,12	0/2020
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F 684	and initials. 27. Apply This Survey team sponursing (DON) on 03/wound management. wounds weekly, and to their office. Surveyor should be dated and in DON stated that is no but they were hoping that is the expectation aforementioned policy "apply prepared label" they did not know. Surveyor existed that I was surgical rather the asked DON stated that I was surgical rather the asked DON what type had to the hip and DON he/she has had a hip He/She has about an This Surveyor reviewere record and could not I assessments, including description of wounds This Surveyor request "Skin Integrity Report" contained in a notebooffice. The Skin Integrity Resident #4 indicated both pressure and sur indicate an initial wound measurements beging continuing weekly untwound is decreasing in their surveyor in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound is decreasing in the surveyor request indicate an initial wound in the surveyor request in the	ondary dressing with date prepared label." Oke with the director of 15/23 at 10:00 am regarding DON stated they measure hat information is located in asked DON if dressings nitialed when changed, and it a part of the facility policy, to have that changed, as it. Surveyor referred DON to it, and asked DON what it meant, and DON stated reveyor asked DON if and was pressure related Resident #4's hip wound an pressure. Surveyor is of surgery the resident had in stated, "Looks to me like replacement at some point. 18" scar on that hip." The de Resident #4's clinical ocate any wound any measurements or it. It is dealy would be in the DON's it is report forms for that wound to right hip was rigical. The form did not and date and contained	F 68				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY		
		495200	B. WNG_			1	C 20/2023
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	ODE	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ION SHOULD B		(X5) COMPLETION DATE
F 684	tissue injury. Wound wacquired, with measur 02/09/23 and continui	445 heel, staged as a deep was marked as in-house rements beginning on ng weekly through 03/09/23. indicate no change to	F 6	384			
	#4's hip wound was s and was provided with which read in part "Ap Chief Complaint: Skir present illness): Patie decubitus ulcers that a debridement of both. I to be anemic with hen will admit him/her to o transfer transfusion be Plan transfer back to a Probable wound VAC	are necrotic. He/She needs He/She also has been noted noglobin in the eight. We					
	for Resident #4 was d	oviding wound management iscussed with the nd Market Clinical Lead on					
	No further information	was provided prior to exit.					
	3. For Resident #42 the wound management, infection.	ne facility staff failed provide resulting in a wound	=				
	included but not limite	neet listed diagnoses which d to hypertensive heart chronic kidney disease,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		MULTIPLE CONSTRUCTION ULDING			(X3) DATE SURVEY COMPLETED	
			A. BUILD	NG_				
		495200	B. WING			C 03/20/2023		
NAME OF P	ROVIDER OR SUPPLIER			8	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	LUILULU	
MESTMO	OD CENTER			2	0 WESTWOOD MEDICAL PARK			
WESTWO	OD CENTER .			E	BLUEFIELD, VA 24605			
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION DATE	
					DEFICIENCY)			
F 684	Continued From many	46	_					
F 004	Continued From page		F	384				
	disease, and anxiety.	us, peripheral vascular						
	Resident #42's most r	recent minimum data set						
	with an assessment re	eference date of 02/04/23						
		a brief interview for mental						
		of 15 in section C, cognitive skin conditions coded the						
		e stage II pressure ulcers						
		on admission, and no other						
	skin conditions.							
	Resident #42's compr	rehensive care plan was						
		ed a care plan for "Resident						
		down related to top of right						
		pper buttocks, left lower coccyx, and sacrum related						
		incontinence." Interventions						
		uded "Observe skin for						
		in breakdown, provide						
		ordered, weekly skin checks				,		
	by licensed nurse, an assessment to include	•						
	description of wound.							
		ord was reviewed and						
		's order summary for the						
		, which read in part " ound to R ankle. Needs to						
		ossible", "Cleanse area to						
	top of right foot with D	Dakin's solution, 25%, pat						
		nonstick pad to wound bed.						
		ng daily and prn (as needed)						
		und care", "Cleanse stage 3 b L (left) lower buttock with						
	Dakin's solution, pat of							
		kin's wet to dry to wound bed						
	and secure with dry d	ressing BID (twice a day)						
	and PRN every day a	nd night shift for wound						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495200	B. WING_			1	C 20/2023
	ROVIDER OR SUPPLIER OD CENTER			20	TREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK LUEFIELD, VA 24605	1 03/	20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	with Dakin's solution, periwound, apply Dak and secure with dry d day and night shift for "Cleanse stage 3 PU solution, pat dry, appl apply Dakin's wet to cwith dry dressing BID night shift for wound cunstageable PU on cc pat dry, apply skin pre Dakin's wet to dry to dry dressing BID and shift for wound care for unstageable PU to ce solution, pat dry, appl apply Dakin's wet to day and night shift for "Cleanse unstageable solution, pat dry, appl apply Santyl on nonst dressing BID and PRI for wound care for 14 tablet 800-160 mg (Sulfamethoxazole-Tr	a 3 PU to L upper buttock pat dry, apply skin prep to sin's wet to dry to wound bed ressing BID and PRN every wound care for 2 weeks", to R buttocks with Dakin's y skin prep to periwound, dry to wound bed and secure and PRN every day and care for 2 weeks", "Cleanse occyx with Dakin's solution, ep to periwound, apply wound bed and secure with PRN every day and night	F	584			
	Resident #42's clinica "Physician's Telephon 02/27/23, which read Macrobid. (2) Bactrim BID (twice a day) x 10 ankle, foot." This ordenurse practitioner (FN	ne Orders" form dated in part "(1) DC (discontinue) DS 1 tab PO (by mouth) days-wound infections R er was signed by the family					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495200	B. WING				C /20/2023
	ROVIDER OR SUPPLIER OD CENTER			20	TREET ADDRESS, CITY, STATE, ZIP CODE D WESTWOOD MEDICAL PARK LUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	and contained entries entries had not been it two separate occasion 2023 TAR contained e "Cleanse area to right cleanser), pat dry and dressing every day sharea to right posterior and apply 4 x 4 bordeday shift for open area with IHWC, pat dry, and dressing every day sharea to coccapply bordered foam open area." Each of the initialed as completed occasions. This Surveyor, along to (LPN) #1 observed Resacrum, coccyx, and to pm. Dressing to sacrud Dressings to resident had dates and initials. completed wound carrethe day. Surveyor ask when the dressings to been changed, and LE date, there was no was was last completed. This Surveyor spoke was nown as a completed. This Surveyor spoke was last completed. This Surveyor spoke was last completed. This Surveyor spoke was last completed.	f March 2023 was reviewed as above. Each of these nitialed as completed on as. Resident #42's February entries, which read in part heel with IHWC (wound apply bordered foam ift for open area", "Cleanse thigh with IHWC, pat dry, red foam dressing every a", "Cleanse top of right foot apply bordered foam ift for abrasion", and exx with IHWC, pat dry, and dressing every day shift for abee entries had not been on three separate with licensed practical nurse esident #42's dressings to buttocks on 03/13/23 at 2:30 m did not have a date on it. Is foot, heels, and ankles all LPN #1 stated they had be to these area's earlier in led LPN #1 how they knew of the sacral area had last lend they would care with the assistant director of	F	684			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(XX	(X3) DATE SURVEY COMPLETED		
		495200	B. WNG _			C 03/2	0/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 684	and ADON stated that initialed by the nurse ADON later stated pe state that dressings in This Surveyor request facility policy entitled which read in part, "2. Prepared label or sec and initials. 27. Apply The Survey team sponursing (DON) on 03/wound management. wounds weekly, and to their office. Surveyor should be dated and in DON stated that is no but they were hoping that is the expectation aforementioned policy "prepared label" mean not know. This Surveyor request "Skin Integrity Report contained in a notebol office. This notebook	d dressings should be dated, it they should be dated and completing the wound care. It DON, facility policy did not eeded to be dated. Ited and was provided with a "Wound Dressings: Aseptic". Gather supplies: 2.7 ondary dressing with date prepared label." Ited with the director of 15/23 at 10:00 am regarding DON stated they measure that information is located in asked DON if dressings nitialed when changed, and the apart of the facility policy, to have that changed, as in Surveyor referred DON to you and asked DON what the hand the hand they did the dand was provided with the director of the dand was provided with the dand was provi	F6				
	sacrum/coccyx, right thigh/lower buttock ar to upper left buttock. marked as present up measurements begin continuing through 03	buttock, left outer and a stage II pressure areas Each of these areas were bon admission, with weekly aning on 02/01/23 and 8/14/23. These ted the right heel wound					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG			SURVEY PLETED
		495200	B. WING_			1	C /20/2023
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ON SHOULD BI IE APPROPRIA		(X5) COMPLETION DATE
F 684	decreased from 2.5 ci cm, sacram/coccyx wilength from 2 cm to 1 from 1 cm to 2.6 cm ato .25 cm. Right buttool length from 1 cm to 0. width from 0.5 cm to 0 depth of 0 to 0.25 cm. decreased in length from a depth of 0 wound decreased in leincreased in width from went from a depth of 0 wound decreased in width from went from a depth of 0. Two surveyors, along Resident #42's wound LPN #1 stated that are right foot and right and rather than pressure. It dark brown eschar and was unstageable pressures resident's sacral area were red with slough practitioner (FNP) on 0 regarding wound man FNP if missed assessichanges not being docontribute to wound in that it could. The concern of not prowas discussed with the Market Clinical Lead of	m x 1.7 cm to 2.1 cm x 1.3 ound had decreased in cm, but increased in width and went from a depth of 0 cks wound decreased in 8 cm, and increased in 0.6 cm, and went from a Right outer thigh wound om 2 cm to 1.4 cm, and m 1 cm to 1.5 cm, anad 0 to .25 cm. Left buttock ength from 2 cm to 1.8 cm, m 1.5 cm to 1.7 cm, and 0 to 0.25 cm. with LPN #1 observed ls on 03/14/23 at 4:45 pm. eas to the top of resident's cle/lower leg were arterial Resident's right heel had d LPN #1 stated that area sure ulcer. Areas to (sacrum, coccyx, buttocks) oresent in wound bed. ke with family nurse 03/20/23 at 1:25 pm agement. Surveyor asked ments and dressing	F 6	584			

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				,		(0
		495200	B. WING	_		03/	20/2023
	ROVIDER OR SUPPLIER OD CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	e 51	F	684			
	4. For Resident #36, ordered wound care t	facility staff failed to provide opromote healing.					
	Resident #36 was admitted to the facility with diagnoses including (by listed date of diagnosis) type 2 diabetes mellitus with diabetic						
	polyneuropathy, perip morbid obesity, obstra weakness, hypertens disease with heart fai skin and subcutaneou resistant staphylococ obstructive pulmonar exacerbation, atrial fil escherichia coli, bact data set assessment date 2/1/23, the resid brief interview for mer assessed as without so or behaviors affecting	cheral vascular disease, active sleep apnea, muscle live heart and chronic kidney dure, local infection of the as tissue, methicillin cus aureus infection, chronic y disease with acute orillation, sepsis due to eremia. On the minimum with assessment reference ent scored 14/15 on the intal status and was signs of delirium, psychosis, care.					
	Clinical record review hospitalizations with with through 1/3/23 and 1/	wound infections: 12/27/22					
	record review revealed A physician order data for Cleanse area to ri (wound cleanser). Apwith border foam each wound care. The treat as completed 12/1, 1	ation on 12/27/22, clinical and added and added and added and and all and added	ž				

		(X3) DATE SURVEY COMPLETED					
		495200	B. WING_				C /20/2023
	ROVIDER OR SUPPLIER OD CENTER			20 V	EET ADDRESS, CITY, STATE, ZIP CODE VESTWOOD MEDICAL PARK JEFIELD, VA 24605		ZUIZUZU
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	12/27. A nursing progress no Note: Resident noted lower area. Redness, surrounding scabbing nurse contacted Dr. w wound in AM 2) CBC BMP (basic metabolic 7 days. The most recent prior a nursing progress no following skin injury/w identified and were evoluted and were evoluted and were evoluted and the Entry: Note: An inin-house acquired Locassessed today. Progressed to	the dated 12/26/22 stated to have scab on LLE front swelling and pain with bleeding present. This with new orders: 1) Culture (complete blood count) and panel) 3) Keflex PO BID x mention of the wound was at dated 12/21/22: The round(s) were previously valuated as follows: diabetic ulcer to right rote dated 12/21/22 - mproving diabetic wound cation: Right Calf was nosis: Monitor/Manage: thievable due to untreatable Resident/Responsible Party ioner has been notified: 1. 21/22 Note: A skin check	F6	584	DEFICIENCY)		
	determined there was	right BKA wound and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULT A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		495200	B. WING	-		C	
NAME OF P	ROVIDER OR SUPPLIER	433200	D. W	STREET ADDRESS, CITY, STA	ATE ZIP CODE	03/2	20/2023
				20 WESTWOOD MEDICAL F	•		
WESTWO	OD CENTER			BLUEFIELD, VA 24605			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD B ICED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	Continued From page	± 53	F 6	84			
	orders for wound care system. Nursing docu assessments from 1/3	mentation included no skin					
	documented resident and went to hospital.	flushed, vomiting, low BP					
	through 1/20/23. Per summary, discharge of proteus and Vancomy bacteremia. The sumstaff had been notified	pitalized again from 1/14/23 the hospitalist discharge diagnoses included ESBL roin resistant enterococcus mary indicated the facility If the resident would need s for 13 additional days.	-				
	oriented, and able to a his usual. A double luright upper arm. Resident luright upper arm. Resident but blanchable, and dower extremity)/foot a (clean/dry/intact). Enhare in place, and staff glove and gown befor resident is aware that hands before leaving nurse if his dressing but while he is out of his reare/dressing change system at the time of	non-emergent BLS esident is awake, alert, make his needs known per men PICC line is in place in dent will be receiving IV mouth for VRE and Proteus is buttocks are reddened, ressing over RLE (right amputation site is CDI tanced barrier precautions is aware of the need to the providing care, and the needs to sanitize his his room, and to notify the the provident of the received or loose froom. No orders for wound to swere entered in the treturn from the hospital.					

PRINTED: 04/03/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C 495200 B. WING 03/20/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK WESTWOOD CENTER BLUEFIELD, VA 24605 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLÉTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 684 Continued From page 54 F 684 cleanser), pat dry, apply non-adherent dressing and wrap with gauze and ACE bandage each day shift for wound healing. Wound care was not documented as completed on 1/25/23, 1/26/23, 1/28/23, and 1/29/23. The resident's comprehensive care plan did not address actual skin integrity intervention to monitor wound for worsening signs of infection and notify PCP until a revision on 1/26/23. There was no evidence of care plan revision as the resident was hospitalized with infections and experienced surgical interventions to treat wounds and wound-related infections. On 3/14/23, the surveyor interviewed the assistant director of nursing (ADON) about the admission process. Per the ADON, the admission nurse gets the discharge summary from the hospital. The admission orders are in the discharge summary. The admission orders are entered into the system by the floor nurse when the resident arrives (this step may be performed by the ADON or DON (director of nursing)). The nurse calls the physician or nurse practitioner to review the admission orders. A second nurse looks at the admission orders to verify the discharge summary orders match the admission orders in the electronic record. Someone in the nursing department asks the family to sign the admission paperwork. A skin check is done within 2 hours of arrival. Dressings are usually noted during the skin check. The other assessments are usually done within the first 48 hours. During a meeting on 3/20/23 for the surveyors to discuss wound care issues, the FNP (family nurse practitioner) stated that failure to perform dressing changes could contribute to infections.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION	(X	(3) DATE SURVEY COMPLETED
		495200	B. WING_			C
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CO 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	ODE	03/20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE
F 684	director of nursing du 3/20/23 that the failu consistently in the fa	e 55 d the administrator and uring a summary meeting on re to provide wound care cility resulted in harm to the re-hospitalizations and	F6	84		
	provide post-operative in re-hospitalization at Resident #149 was a primary diagnosis en aftercare following sus secondary diagnosis underlying condition and additional diagnosis underlying asthma, infector procedure-superficial site-subsequent encound difficulty walking assessment (MDS) was date 1/19/2023, the reprior interview for meassessed as without or behaviors affecting documented the resigning 100 days, recent (skilled nursing and for the foot, surgical work care.	diabetes mellitus due to with diabetic nephropathy, bees including atrial ive heart disease with heart tion following a I incision surgical bunter, muscle weakness, . On the minimum data set with assessment reference resident scored 13/15 on the				
	section Patient Disch	y dated 1/13/23 under the earge Instructions/Transfer, ions, Type: Surgical Incision,				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		495200	B. WNG_			C 03/20/2023
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
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F 684	dressing daily. This simmediately followed Continue and Medica sections of the docum Are to Continue list w facility's electronic clinical recorder was not englectronic clinical recorded at 1/13/23 docum post right second toe notes dated 1/13, 1/1 wrap to right foot ampost right foot and revised Interventions initiated check, Dressing chan PCP orders, obtain sloccupational therapy) consult as needed. In DON on 1/24/23: mor TX according to PCP orders and Monitor for increased redness, dincision site, increase abnormal findings. A family nurse practitit 1/16/23 indicated an apain after amputation plan was to continue wound of right foot -F wound orders. A FNI indicated an acute call	with saline and place dry section of the document the Medications You Are to tions to Stop Taking ment. The Medications You as entered as orders in the mical record. The wound matered into the facility's ord. The admission note ented a dressing to right foot amputation. Skilled nursing 4, and 1/15 document the mutation site continues. The admission note ented a dressing to right foot amputation. Skilled nursing 4, and 1/15 document the mutation site continues. The admission note ented a dressing to right foot amputation. Skilled nursing 4, and 1/15 document the mutation site continues. The admission note ented a dressing to right foot amputation, and dietician more swill be provided per cilled PT/OT (physical and more evaluation, and dietician more reventions initiated by more for pain/discomfort and more for pain/discomfort and more spin for pain site: mainage, dehiscence of dipain. Notify PCP of any The admission site: mainage, dehiscence of dipain. Notify PCP of any The admission site: mainage, dehiscence of dipain. Notify PCP of any The admission site: mainage, dehiscence of dipain. Notify PCP of any The admission site: mainage, dehiscence of dipain. Notify PCP of any The admission site: mainage, dehiscence of dipain. Notify PCP of any The admission site: mainage, dehiscence of dipain. Notify PCP of any The admission site: mainage, dehiscence of dipain. Notify PCP of any The admission site: mainage, dehiscence of dipain. Notify PCP of any The admission site: mainage, dehiscence of dipain. Notify PCP of any	F 6	84		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION		SURVEY
		495200	B. WING			1	C /20/2023
	ROVIDER OR SUPPLIER OD CENTER			;	STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 03	2012023
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F 684	FNP noted personally to obtain wound care for Neurontin for pain; infection or chemical i	and hallucinations. The calling the surgeon's office orders. New orders written	F	684			
	(TAR) documented an Foot, surgical site, wit Dry. Cover with "steril shift (12 hour 6 A) for was documented as a 1/21, 1/22, 1/24, and was unavailable for in whether the 1/23 treat	ment was performed.					
		the resident was sent to 3 and was admitted for nputation.					
	admission process. Ponurse gets the dischar hospital. The admissi discharge summary. entered into the system	ursing (ADON) about the er the ADON, the admission rge summary from the on orders are in the The admission orders are m by the floor nurse when his step may be performed					
	physician or nurse pra admission orders. A sadmission orders to versummary orders match the electronic record. department asks the fapaperwork. A skin che	ctitioner to review the second nurse looks at the			,		

		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		F CONSTRUCTION		O. 0938-039	<u> 31</u>
ı	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				2 CONDITION		E SURVEY		
I			495200	B. WNG				С	
ľ	NAME OF F	PROVIDER OR SUPPLIER		D. WING			03	3/20/2023	
					STREET ADDRESS, CITY, STATE, ZIP CODE				
ı	WESTWC	OOD CENTER				20 WESTWOOD MEDICAL PARK			
ŀ	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		<u>_</u>	BLUEFIELD, VA 24605			
	PREFIX TAG	(EACH DEFICIENCY	MEMORY OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPRIOR DEFICIENCY)		E ITE	(X5) COMPLETION DATE	
	F 684	Continued From page	58	E.	684				
			assessments are usually		004				
		done within the first 48	hours.						
		During a discussion or	1 3/15/23 at 10 AM of						
		several residents with	whom surveyors had						
		electronic wound meas	the DON described an						
		facility owns, but which	n no staff member has been						
		trained to use. The DO	ON had 'let the wound						1
		nurse go' after the incident. The DON also stated							1
		the FNP was the one w	who finally looked at the						1
		wound on 1/18/23 and orders.	called the surgeon for						1
		ordorg.							1
		This surveyor spoke wi	th the FNP on 3/20/23						1
		concerning the residen	t's wound care and						ı
		infection. The FNP sta	ted that the wound care						ı
		nurse was instructed to wound orders on 1/16/2	call the physician for						ı
		surgeon on 1/18/23 her	cause the resident still had						ı
		no wound or dressing of	orders. The FNP stated						ı
		that failure to perform d	ressing changes could						ı
		contribute to infections.	-						l
		The resident was admit	And Anna E						
		through 2/14/2023 The	ted to a hospital from 1/25 admission diagnosis was			•			ı
		cellulitis of right foot. D	ischarge diagnoses						l
		included non-healing su	rgical wound to the right						l
		lower extremity, post op	erative amputation wound						
		infection with proteus, w	et gangrene of the post						ı
		operation transmetatars	al amputation; status post		1				
		right foot amputation on	1/31/2023.						
		This surveyor notified th	e administrator and						
	1.	director of nursing durin	g a summary meeting on						
	1	3/14/23 that the failure t	o provide wound care for						
	[1	the first 6 days in the fac	cility resulted in harm to						
	!	the resident resulting in	rehospitalization, wound						
		infection, and amputatio	n of the foot. Further						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY
		495200	B. WING_			1	C 20/2023
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		, 00,	20,2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CORR X (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	_	(X5) COMPLETION DATE
F 684	Continued From page discussions prior to exchange that conclusion	kit on 3/20/23 did not	F	584			
	"1. Patient #149 is no Patients #4, #10, #36 head-to-toe skin asse to ensure no additiona	o longer in the facility. a and #42 received a ssment by a licensed nurse al skin breakdown and					
	and dressings change reflect treatment per p residents at risk for sk have been updated to						
	by DON/designee on physician's order is in completed as ordered completion of noted tr thereof. To be completed 100% skin sweep was identify any previously injuries and or wound possible pressure injunotification to be compand treatments implemented by completed.	place and treatments as evidenced by eatment and documentation eted on or before 3/16/2023. completed on 3/15/2023 to vunidentified pressure Upon identification of ries and or wound physician pleted, new orders obtained, mented per order as tion of noted treatment and of. To be completed on or	02				

AND DIAN OF CORRECTION IDENTIFICATION NUMBER.			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495200	B. WING			1	C /20/2023
	ROVIDER OR SUPPLIER OD CENTER			20	REET ADDRESS, CITY, STATE, ZIP CODE Westwood Medical Park Uefield, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	within 24 hours of adra 3/16/2023. Physician identified break in skir order for treatment and per order as evidence treatment and docume completed on or befor Documentation of wor completed by wound of the skin integrity report measurements and doreport is kept in the skithe DON office. When and or the wound is report will be uploaded electronic medical recipience 3/16/2023. 3. All current licensed immediately educated educator]/designee or Wound Management. licensed nursing staff education prior to their residents with wounds will be audited to ensutreatment is obtained, order as evidenced by dressings, daily x 14 compliance is achieved 100% compliance ach weeks until 100% commonthly x 3 months unachieved. To be completed above to be completed.	care lead/DON/Designee nission beginning s to be notified of any n integrity, obtain physician's d treatments implemented d by completion of noted entation thereof. To be re 3/16/2023 and assessment to be care lead/DON/Designee on rts that includes rescriptions of wound. This rin integrity binder located in n the report is completed resolved this skin integrity d into the resident's rord. To be completed on or I nursing staff on site were by the NPE [nurse practice n Skin Integrity Protocol and All additional current will be required to have said or first scheduled shift. All rincluding new admissions re physician is notified, treatment is completed per odate, time initials on lays or until 100% d then 3 times a week until rieved. Then weekly x 3 repliance achieved, then notil 100% compliance	F	684			

	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		495200	B. WING			1	C /20/2023
	ROVIDER OR SUPPLIER OD CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 03/	2012023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 684	[Interdisciplinary Tean will continue to be rev meetings."		F	684			
	the administrator that was accepted and received evidence for review. credible evidence on a provide evidence thro. The facility presented abatement plan had be evidence of review of previously identified worders and treatments of a full skin assessment provider notification at newly identified wound current wound assess outlined in the abatem residents with wounds.	the facility's abatement plan quested the facility's credible The facility began providing 3/16/23 and continued to ugh 3/17/23 at 4:08 pm. credible evidence that the een implemented, including all current residents with rounds to ensure physician's were in place, completion ents of all current residents, and treatment initiation for ds, documentation of ements, nurse education as ment plan, a daily audit of					×
	reviewed each resider assessment and curre ensure all identified sk order in place and a c description of the wou reviewed the residents provider notification of wounds. The survey training for licensed not the list of active nur signature sheet. The	ent physician's orders to kin wounds had a treatment urrent documented and. The survey team also s' clinical records to verify					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD CENTER			20 V	REET ADDRESS, CITY, STATE, ZIP CODE NESTWOOD MEDICAL PARK UEFIELD, VA 24605	1 03	1/20/2023	
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F 684	was appropriately date physician's order. On 3/17/23 at 4:00 pm the administrator, DOI discussed the facility's DON stated they or the responsible for the impabatement plan and we completed by the floor. On 3/17/23 at 4:09 pm the administrator, DOI Immediate Jeopardy we No further information presented to the surve conference on 3/20/23. 6. The facility staff fail orders for Clindamycin Lasix (diuretic) injectal supplement) were impresedent #199. Resident #199's admis diagnoses included but Covid-19, Type 2 Diab Encephalitis (inflamma Encephalomyelitis finter the resident's brief inter (BIMS) a 01 out of 15 interesting the supplement of the supplement of the minima assessment referent the resident's brief interesting the supplement of the	and according to the survey team met with N, and ADON and abatement plan. The eir designee were plementation of the round treatments would be rourses. In the survey team notified N, and ADON that the was abated. It regarding this issue was be team prior to the exit is. In the survey team notified N, and ADON that the was abated. It is a bated. It is a bated of the exit is to the exit is the exi	F	584				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION NG		(X3) DATE COMF	SURVEY
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	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24805			
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	(NP) Acute Visit Docu on 3/02/22. The diagraportion of the docume which included, but we 1. Lasix 20mg intramu. 2. Clindamycin 150mg days for cellulitis of bil 3. Promod (or other promouth daily. A review of Resident & Medication Administra 1. Lasix 20mg IM inject 3/05/22. 2. Clindamycin 150mg 3/04/22. 3. Promod 30ml by mg 3/05/22. The nurse practitioner on 3/02/22 was interviat 2:20 p.m. The NP s for those orders to be 3/03/22. The administrator was on 3/17/23 (via phone) person. No further infect the exit conference. Treatment/Svcs to Pre CFR(s): 483.25(b)(1)(i) \$483.25(b) Skin Integral \$483.25(b) Skin Integral \$483.25(b) (1) Pressure \$483.25(b) (1) Pressure \$483.25(b) (1) Pressure \$483.25(b) (1) Pressure \$483.25(b) Skin Integral	ntained a nurse practitioner ment with a date of service nosis, assessment and plan nt listed provider orders ere not limited to: ascular injection in AM. If by mouth twice a day for 5 ateral lower extremities. Totein supplement) 30ml by the second (MAR) noted: ation Record (MAR) noted: ation was administered on a portion was administered on the second was administered was administered on the second was administered was administered on the second was administered was administered was administered on the second was administered was administere	F 6				
	resident, the facility me						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY
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TO THE OF THE OTHER PROPERTY.				20 WESTWOOD MEDICAL PARK		
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pressure ulcers and do ulcers unless the indiv demonstrates that they (ii) A resident with pressure a vith professional stand promote healing, prevenew ulcers from develor This REQUIREMENT by: Based on observation interview, clinical record document review, the the necessary treatme wound healing and presidents in the survey 299, 199. The findings include: 1. For resident #37, the treatment as ordered to pressure ulcer leading (inflammation of bone course of treating the ireceived a surgical woof a peripherally insert line) for intravenous (IV wound cultures. Each invasive and placed the discomfort and stress. Resident #37's diagno limited to the following	care, consistent with a of practice, to prevent be not develop pressure idual's clinical condition of were unavoidable; and assure ulcers receives and services, consistent dards of practice, to the infection and prevent oping. Is not met as evidenced and resident interview, staff and review, and facility facility staff failed to provide and services to promote event infection for four of 33 are sample, Resident #37, 42, are facility failed to provide to the resident's left heel to osteomyelitis caused by infection). In the infection, resident #37 and debridement, insertion ed central catheter (PICC ov) antibiotics and two of these procedures were e resident at risk for further	F	686	Resident #37 and Resident #42 physician's orders are in place and treatments are being completed as ordered evidenced by completion of noted treatment and documentation thereof. Resident # 199 discharged from the facility on 3/5/2022 and Resident #299 discharged from the facility. The facility was unable to correct action. 100% skin sweep was completed on 3/15/2023 to identify any previously unidentified pressure injuries and or wound. Upon identification of possible pressure injuries and or wound physician notification to be completed, new orders obtained and treatments implemented per order as evidenced by completion of noted treatment and documentation thereof.		4/26/2023

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION		SURVEY PLETED
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F 686	The most recent quar (MDS) with an assess of 12/6/22 assigned the formental status (BIM out of 15, indicating munder the functional a resident was coded a ambulation, with ambor twice in the lookbar assessment interview resident reported a panumeric scale and rewith sleeping and limit activities. On 3/13/23 at 11:30 a resident #37 lying in the Surveyor noted that must their heel that was op Resident stated that the see about it. Surveyor painful and resident smost of the time". During the clinical receivable that the skin was assess wounds identified. The speaks specifically to marked "no" to the promaceration or breakd mention of the left hee practitioner (NP) on 9 stated resident had a	terly minimum data set sment reference date (ARD) ne resident a brief interview (IS) summary score of 12 ninor cognitive impairment. ability section of the MDS, is being independent with culation only occurring once cick period. Under the pain is section of the MDS, ain level of 7 out of 10 on a corted that pain interfered ted their day-to-day impairment as surveyor observed bed with left foot exposed. The sident had a wound on the en with slight drainage. The wound had been there, at the nurse was coming to a saked if the area was tated, "oh yeah, it hurts the facility on Documentation Assessment wed. The nurse documented tessed and there were no the ere is another section that the feet and the nurse	F	686	NPE or designee will reeducate all current licensed nursing staff and all additional and newly hired prior to the start of their first shift on Skin Integrity Protocol and Wound Management. All additional current licensed nursing staff will be required to have said education prior to their first scheduled shift. Reeducations will be completed on or before 4/26/2023 or upon hire. All residents with wounds including new admissions will be audited to ensure physician is notified, treatment is obtained, treatment is completed per order. The audit will be completed weekly X 4 then monthly X 2 months or until 100% compliant, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.		1/26/2023

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	SURVEY
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F 686	with wound cleanser a dressing daily. Accord treatment administration treatment was not don't there were blanks for. The NP saw resident is progress note docume healed except one are should require minimal order was received or frequency of the treatment was not provided 10/6 and 10/29/22. The Note treatment was also not 11/15/22, 11/17/22, 11 November 11, 2022, tiprogress note that the "draining brown drains the antibiotic Bactrim for ally twice daily for 10/2022 TAR indicated the heel wound were not provided 12/6/22, 12/8/22, 12/1 12/27/22, and 12/29/2	off heel wound by cleansing and applying a wet to dry ling to the September 2022 on record (TAR) this he on 9/3/22 and 9/10/22 as those days. #37 again on 9/13/22, the ented in part, "wound has ea of peeling skin, which had treatment". A provider in 9/13/22 to change the ment to every Tuesday, ay. The October 2022 TAR the to the left heel wound in 1/10/22, in 1/12/22, and 11/29/22. On the NP documented in a left heel wound was age" and gave an order for DS 800-160 mg to be given in 1/10/22, i	F	686	DEFICIENCY)		
	the left foot. The concireport stated, "Subtle	osteolysis/erosive changes r calcaneus concerning for					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONST			SURVEY PLETED
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F 686	infected with methicilli aureus (MRSA). Bact daily for ten days was infection. The wound provider order on 1/23 the presence of infect locate the sensitivity roon 1/30/23 the NP do note, "ulcer has worse black areas on edges 2/1/23 another round was ordered twice dail." The MRI was done 2/3 impression was "large osteomyelitis of the portion of the portion of the wound on #37 had a PICC line provided the wound on the left of 2/13/23 the NP do note "left foot wound	e left heel wound was a revealed the wound was a revealed the wound was a revealed the wound was a resistant staphylococcus with DS 800-160 mg twice again ordered for the culture was repeated per 3/23 which was positive for ion. Surveyor was unable to eport in the clinical record. Cumented in a progress and with foul odor and as well as redness". On of the antibiotic Bactrim DS ly for ten days. 3/23 and the report heel wound with osterior calcaneus". Ent a surgical procedure to 2/6/23. On 2/9/23 resident laced, and a wound vac heel.	F	86			
	in the bed and friction new provider order wa the antibiotic Vancomy solution, 1.5 grams ev for a diagnosis of oste On 3/16/23 at 12:53 P Licensed Practical Nu resident #37 and aske TAR's indicated. The	the patient's habit of laying on the foot". On 2-23-23 a as received to administer					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''		CONSTRUCTION	(X3) DATE COMP	SURVEY
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F 686	Continued From page done". Surveyor revie missing treatments ar wound and asked the opinion was. LPN #3 treatment caused the On 3/16/23 at 2:16 Ph Director of Nursing (Director	wed with LPN #3 the and the progression of the m what their professional stated, "I think the lack of wound to get worse". M, surveyor asked the ON) for any wound sident #37's left heel from 23 to current. Im surveyor interviewed ck of documentation on oot wound. DON stated they the facility at that time. d should have been ssion assessment/nursing blicy, and if it was not there, to why. DON agreed that a ould be considered as diabetic. DON also stated "constantly up walking on it is in the bed and foot board", was removed. Surveyor colicy entitled, "Skin Integrity ment", with a revision date of bart, "A comprehensive initial assessment of intrinsic an fluence skin health,		\$86			
	wound to heal will be provided surveyor wit assessments for resid September 2022 to N were labeled as being not the left. DON reported the wound provided surveyor with the provided su	performed". The DON also h copies of wound dent #37's left heel from lovember of 2022, but these g a wound to the Right heel, bried that they began					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 686	Continued From page documented each we On 3/20/23 at 1:40 Ph NP, other staff membe they were aware of the months leading up to NP stated, "no I was missed treatments mito deteriorate, NP stathave". The above concerns and Administrator, Director of Nursing or again with the Administration of the Administration of the exit of the staff #4 on 3/20/23. No further information team prior to the exit of the exit of the exit of the staff #42's face included but not limited disease, heart failure, type 2 diabetes mellithed disease, and anxiety. Resident #42's most in with an assessment resident r	e 69 ek beginning 1/25/23. If surveyor interviewed the er #11. Surveyor asked if the emissed treatments in the the osteomyelitis diagnosis, not". Surveyor asked if the ght have caused the wound ted, "yes it definitely could were discussed with the er of Nursing and Assistant in 3/17/23 at 4:00 PM and estrator and administrative in was provided to the survey conference. The facility staff failed to promote healing and prevent ulcers. The facility staff failed to promote healing and prevent ulcers. The facility staff failed to promote healing and prevent ulcers.		686	DEFICIENCY)	TE	DATE	
	patterns. Section M, s resident as having five	of 15 in section C, cognitive skin conditions coded the e stage II pressure ulcers on admission, and no other						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		O) DATE SURVEY COMPLETED	
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F 686	reviewed and contains has actual skin breaks foot, right heel, left up buttock, right heel, left up buttock, right heel, left up buttock, right buttock, to decreased activity, for this care plan inclusigns/symptoms of sk wound treatment as oby licensed nurse, and assessment to include description of wound. Resident's clinical recontained a physician month of March 2023 consult for necrotic with done as soon as p top of right foot with D dry. Apply Santyl on recover with dry dressin every day shift for word periwound, apply Dak and secure with dry dand PRN every day a care", "Cleanse stage with Dakin's solution, periwound, apply Dak and secure with dry day and night shift for "Cleanse stage 3 PU solution, pat dry, appl apply Dakin's wet to dwith dry dressing BID night shift for wound of	rehensive care plan was ed a care plan for "Resident down related to top of right per buttocks, left lower coccyx, and sacrum related incontinence." Interventions ided "Observe skin for in breakdown, provide rdered, weekly skin checks d weekly wound e measurements and ord was reviewed and 's order summary for the the which read in part" bund to R ankle. Needs to cossible", "Cleanse area to coakin's solution, 25%, pat constick pad to wound bed. and daily and prn (as needed) und care", "Cleanse stage 3 of L (left) lower buttock with	F	886				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
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F 686	pat dry, apply skin prediction of the pattern of th	ep to periwound, apply vound bed and secure with PRN every day and night or 2 weeks", "Cleanse inter sacrum with Dakin's y skin prep to periwound, iry dressing to wound bed ressing BID and PRN every wound care for 10 days", in PU to R heel with Dakin's y skin prep to periwound, ick pad and secure with dry N every day and night shift days", and "Bactrim DS oral imethoprim). Give 1 tablet day for wound infection for	F	\$86			
	nurse practitioner (FN Resident #42's treatm (TAR) for the month or and contained entries entries had not been it two separate occasion 2023 TAR contained e "Cleanse area to right cleanser), pat dry and dressing every day sharea to right posterior and apply 4 x 4 border	ent administration record f March 2023 was reviewed as above. Each of these nitialed as completed on as. Resident #42's February entries, which read in part heel with IHWC (wound					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495200	B. WING			C 03/20/2023		
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F 686	dressing every day shad "Cleanse area to cocapply bordered foam	nd apply bordered foam nift for abrasion", and cyx with IHWC, pat dry, and dressing every day shift for hese entries had not been	F	586				
	(LPN) #1 observed Resacrum, coccyx, and pm. Dressing to sacru Dressings to resident had dates and initials completed wound car the day. Surveyor ask when the dressings to been changed, and L	icensed practical nurse esident #42's dressings to buttocks on 03/13/23 at 2:30 am did not have a date on it. Is foot, heels, and ankles all and the LPN #1 stated they had be to these area's earlier in sed LPN #1 how they knew to the sacral area had last PN #1 stated that without a bay to know when wound care						
	nursing (ADON) on 00 regarding Resident #- asked ADON what the wound care, and ADO the nurses to follow the each resident regarding asked ADON if wound and ADON stated that initialed by the nurse	42's wound care. Surveyor eir expectations were for DN stated they would expect he physician's orders for ng wound care. Surveyor d dressings should be dated, t they should be dated and completing the wound care. r DON, facility policy did not						
	facility policy entitled which read in part, "2	nd was provided with a "Wound Dressings: Aseptic" . Gather supplies: 2.7 ondary dressing with date prepared label."						

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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	OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE		
F 686	Continued From page Survey team spoke w (DON) on 03/15/23 at management. DON st weekly, and that inform office. Surveyor asked be dated and initialed stated that is not a part they were hoping to he the expectation. Surve aforementioned policy "prepared label" mean not know. Surveyor requested at Integrity Report" forms notebook housed in th notebook contained si which addressed unst right heel, right achille buttock, left outer thigh II pressure areas to up these areas were man admission, with weekly on 02/01/23 and contin Two surveyors, along of Resident #42's wound LPN #1 stated that are right foot and right ank rather than pressure. F dark brown eschar and was unstageable press	ith the director of nursing 10:00 am regarding wound ated they measure wounds mation is located in their d DON if dressings should when changed, and DON it of the facility policy, but ave that changed, as that is eyor referred DON to and asked DON what it, and DON stated they did as the DON's office. This is forms for Resident #42, ageable pressure areas to see the state of the seed of t		686	DEFICIENCY)	AIE	DATE		
		th family nurse practitioner 1:25 pm regarding wound or asked FNP if missed							

I AND PLAN OF CORRECTION I IDENTIFICATION NUMBER I		(X2) MUL A. BUILDI		(X3) DATE SURVEY COMPLETED				
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F 686	done as ordered could infections and FNP state the concern of not proportion of the promote healing and pulcers management wadministrator, DON, at 03/20/23 at 3:00 pm. No further information 3. For Resident #299, provide treatment as dexconation that later dinjury and failed to doo the pressure area at the This was a closed reconcern the property of the pressure area at the This was a closed reconcern the property of the pro	ssing changes not being discontribute to wound ated that it could. Dividing treatment to prevent infection of pressure as discussed with the and Market Clinical Lead on was provided prior to exit. If the facility staff failed to predered to an area of eveloped into a pressure cument an assessment of the time of discovery. Dividing treatment to pressure cument an assessment of the time of discovery. Dividing treatment to pressure cument an assessment of the time of discovery. Dividing treatment to pressure cument an area of eveloped into a pressure cument an assessment of the time of discovery. Dividing treatment to pressure cument an area of eveloped into a pressure cument an assessment of the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument and the time of discovery. Dividing treatment to pressure cument to pressure cument and the time of discovery. Dividing treatment to pressure cument to pre	F	586				

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F 686	being at risk of develor ulcers/injuries with no ulcers/injuries. Residence of a surgical associated skin dama. Resident #299 was according to the properties of the properti	pping pressure current unhealed pressure ent #299 was coded for the I wound and moisture	Fé	586					
	entitled "Nursing Docu 10/18/22 at 11:07 pm of moisture associated the coccyx. A physicia with soap and water, p	umentation - V 11" dated documented the presence d skin damage (MASD) to an's order to wash coccyx pat dry, and apply Calazime light shift for excoriation							
	According to the resid Treatment Administrat treatment to the coccy 10/19/22 nightshift, 10 10/22/22 dayshift.	ion Record (TAR) the x was not administered on							
	am stated in part " S [patient] states 'yeah, i A new physician's orde wound cleanser, pat d non-adhesive optifoam needed. Surveyor was	te dated 10/23/22 at 11:00 Stage 3 noted to coccyx. Pt t's sore'. Orders placed" er to cleanse coccyx with ry, apply zguard, place a on every 3 days or as s unable to locate sing the area to the coccyx.							
	stated in part "Wour stage 2 protocol. Dr. [r stage 2 wound with slo	0/24/22, the progress note nd care to buttocks per name omitted] consult for							
		rea to the coccyx until							

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495200	B. WNG			1	C /20/2023	
	ROVIDER OR SUPPLIER OD CENTER			20	TREET ADDRESS, CITY, STATE, ZIP CODE D WESTWOOD MEDICAL PARK LUEFIELD, VA 24605	00/	2012020	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIATE		
F 686	time the area was docunstageable pressure measuring 9.15 cm in with 100% of the would assessment document as a 6 out of 10 stating pain during dressing classessment also note Dr. [name omitted] impart "Cor [name omitted]. Resid debridement next Tue A nursing progress no am documented in part facility for wound debrious for wound debrided the 11/01 they stated they must that day and does not Resident #299's unstawas again assessed a 11/08/22. The area was 11/08/22.	e the wound was red, and assessed. At that cumented as an area to the sacrum length and 4.91 cm in width and bed with slough. The ted the resident's pain level g the resident complains of change and when wet. The d to schedule a consult with mediately. It dated 11/07/22 at 4:59 insultation complete with Dr. ent is to have wound saday 11/15/22 at 9 am" It dated 11/15/22 at 8:49 in Resident #299 departed idement. Important the interview of the coccyx and photographed on as described as measuring 4 cm in width reflecting a wound bed was described in interview the wound nurse interview the wound nurse interview the wound nurse	F	586				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, Z 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		00/20/2020		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			
F 686	Surveyor requested a policy entitled "Skin In Management" with an and a revision date of 6. The licensed nurse 6.5 Complete wound admission/readmissio	and received the facility integrity and Wound in effective date of 7/01/01 if 2/01/23 which read in part: it e will: it evaluation upon ion, new in-house acquired, it ecline in wounds. In the survey team met with ector of nursing, and ursing and discussed the illing to provide treatment to of excoriation to the coccyx easions prior to area in items area when the ecovered. Iteld to ensure pressure ulcer atments were complete for inside the second in the brain and integration of the brain) and insum data set (MDS) with nice date of 12/16/21 coded in existence with bed billet use.	F6	586				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		495200	B. WING			03	/20/2023
	OD CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 80 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	Summary Sheet from dated 12/01/21 which skin integrity as multip decubitus on his left be nursing documentation the resident's skin injutears to bilateral arms Buttocks. Weekly skin 12/17/21 through 03/0 injury/wound regarding described as moisture until 1/21/22 and 1/28, as a pressure injury were remaining weekly skin described the left butto associated skin damag with one week (2/18/2 wound. There was not on the document or with wound measurements. Provider orders for cletthe left buttock with we apply Optifoam every documented for 12/20. The administrator was on 3/14/23 and again on 3/14/23 and again on 3/14/23 at approximative director of nursing (DC not find any wound measurements).	an acute care hospital described Resident #199's ble skin tears and a stage 2 auttock. An admission in progress note described ary/wounds as multiple skin and pressure: Stage 2 Left in check documents, dated 14/22, were reviewed. The graph that the buttocks was associated skin damage 1/22 when it was described ith treatment in place. The check documents books as moisture ge, and a pressure injury 2) not noting the left buttock of further description noted ithin the progress notes; no were found. The progress notes injury to bound cleanser, pat dry, and day shift was not 1/21, 01/25/22, and 3/02/22. Informed of these findings interview in person on 3/19/23. The progress in the progress in the progress on the stage 2 injury to bound cleanser, pat dry, and day shift was not 1/21, 01/25/22, and 3/02/22. The progress in the progress in the progress of the second in the progress of the second in the progress of the progress of the progress of the second in the progress of the p	F	686			
F 693 SS=D	Tube Feeding Mgmt/R	estore Eating Skills	F6	93			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
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NAME OF B	ROVIDER OR SUPPLIER	430200	D. VIIIO.			03/	/20/2023	
	OD CENTER				TREET ADDRESS, CITY, STATE, ZIP CODE O WESTWOOD MEDICAL PARK			
				В	LUEFIELD, VA 24605			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 693	both percutaneous en percutaneous endosc enteral fluids). Based	eral Nutrition c and gastrostomy tubes, doscopic gastrostomy and opic jejunostomy, and on a resident's	F	693	Resident #46 was discharged 2/16/2023 and did not return to the facility. The facility was unable to correct action.	4	/26/2023	
	ensure that a resident §483.25(g)(4) A reside eat enough alone or wenteral methods unles condition demonstrate clinically indicated and resident; and §483.25(g)(5) A reside means receives the appropriate to prevent complic including but not limite diarrhea, vomiting, del abnormalities, and nas This REQUIREMENT by: Based on interviews a facility staff failed to ex included nutrition and 33 residents, Resident received their nutrition means. Resident #46 nutrition and/or fluids of	ent who has been able to with assistance is not fed by as the resident's clinical as that enteral feeding was a consented to by the sent who is fed by enteral oppopriate treatment and possible, oral eating skills cations of enteral feeding and to aspiration pneumonia, hydration, metabolic sal-pharyngeal ulcers. Is not met as evidenced and document review, the asure that admission orders fluid orders for one (1) of a #46. Resident #46 and fluids via enteral was not able to intake orally. (Enteral nutrition is a fion, via tube, directly to an a small intestine.)			An initial audit was completed by DON/designee on 3/27/2023 of all new admissions from the last 7 days who receive their nutrition and fluids via enteral means to ensure orders were obtained at the time of admission to the facility and initiated prior to the start of the enteral feedings. All newly admitted residents with the need for enteral feedings to provide nutrition and hydration have the potential to be affected by the alleged deficient practice.			

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605			
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	readmission to the factor of t	inity. Im., the DON reported no in the resident on the resident on the resident on the resident on the resident or contacted the obtain orders for Resident reported if facility staff orders from the hospital, in the Assistant DON should the Assistant DON should the the recalled the sending facility and Director reported that he recalled the sending facility arriving at the facility), it of 2/14/23 at 11:02 (this interving interving interving the facility), it of 2/14/23 at 4:38 p.m., it of 2/14/23 at 4:38 p.m., it of 2/14/23 at 4:55 p.m., it of 2/14/23 at	F	693	- A	./26/2023	
	3/17/23 at 4:01 p.m. [Ouring this meeting, the					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF PI	ROVIDER OR SUPPLIER	100200			STREET ADDRESS, CITY, STATE, ZIP CODE	03	/20/2023
MECTAC	OD OFFITED				20 WESTWOOD MEDICAL PARK		
WESTWO	OD CENTER			E	BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATÉMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 693	Resident #46 was trar local emergency depa a.m. The facility staff orders for Resident #4 aforementioned stay a Resident #46's minimum (MDS), with an assess of 12/15/22, was dated 12/29/22. Resident #4 never or rarely able to Resident #46 was dood dependent on others of dressing, toilet use, and Resident #46's diagnoral limited to: hemiplegial disorder, respiratory for (Dysphagia is defined swallowing). Resident documented as having feeding tube. On 3/15/23, during and 10:28 a.m., the facility (MCL) confirmed that feeding orders were for aforementioned readn on 3/15/23 at 10:35 at Manager reported that during their 2/14/23 - 20 (NPO is a medical abbut meaning 'nothing by months of the state o	introported via ambulance to a partment on 2/16/23 at 11:56 failed to obtain tube feeding life during the at the facility. It was documented as a understand others and as make self understood. Sumented as being totally for eating, bed mobility, and personal hygiene. Sees included, but were not life personal hygiene. Sees included as a difficulty in the life personal hygiene. Sees included as a difficulty in life personal hygiene. Sees included as a difficulty in life personal hygiene. Sees included as a difficulty in life personal hygiene. Sees included as a difficulty in life personal hygiene. Sees included as a difficulty in life personal hygiene. Sees included as a difficulty in life personal hygiene. Sees	F	693	NPE/designee will provide education on the process to obtain admission orders prior to initiation of enteral feedings and hydration for those residents who require enteral feedings for nutrition and hydration, to all current licensed nurses and additional and newly hired licensed nursing staff prior to the start of to the start of their first shift. The reeducations will be completed on or before 4/26/2023 or upon hire. The Director of Nursing/designee will complete an audit on all newly admitted residents who require enteral feeding for nutrition and hydration weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI	n 0	4/26/2023
	On 3/15/23 at 11:07 a.m., the facility's Director of Nursing (DON) and the MCL confirmed new orders were required for residents at the time of				committee for review.		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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		495200	B. WNG _		03/20/2023		
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
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				BLUEFIELD, VA 24605			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)			
F 695 SS=D	Continued From page surveyor discussed the to obtain tube feeding. The DON confirmed F tube feeding orders for referenced in this report that they were unable tube feeding, and/or the tube feeding, and/or the via tube during the reareport. Respiratory/Tracheosis CFR(s): 483.25(i) § 483.25(i) Respirator tracheostomy care and tracheostomy care and tracheostomy care and tracheola succeare, consistent with practice, the compreheare plan, the resident and 483.65 of this substitute that the process of the substitute of the tracheola succeare plan, the resident and 483.65 of this substitute of the tracheola succeare plan, the resident and 483.65 of this substitute of the tracheola succeare plan, the resident and 483.65 of this substitute of the tracheola succeared and tracheola succeared the	the failure of the facility staff orders for Resident #46. Resident #46 did not have or the readmission out. The DON confirmed to determine the amount of the amount of fluid provided admission referenced in this atomy Care and Suctioning. The that a resident who be including tracheal suctioning, is provided such professional standards of the ensive person-centered the goals and preferences, appart. The DON confirmed to determine the amount of fluid provided admission referenced to tracheal suctioning. The that a resident who be including tracheostomy the tioning, is provided such professional standards of the ensive person-centered the goals and preferences, appart. The DON confirmed to trache amount of fluid provided in the ensity of the provided states and the provided standards of the provided standards and the entity of the provided standards in the entity of the physician the physician in the physician that a resident with the physician the physician that a resident with the entity of the phys	F 69	Resident #38 O2 setting was corrected upon notification during the survey process per physicians order at 3L/M via nasal cannula continuously. The DON or designee will audit all active orders for oxygen via nasal cannula to ensure the order matches the O2 concentrator setting per physicians order. NPE or designee will reeducate all current licensed nursing staff and all additional and newly hired prior to the start of their first shift that the O2 concentrators are to be set	4/26/2023		
	_	esident's comprehensive		per the physicians orders.			
	person-centered care	plan.		Re-educations will be			
	Resident #38's diagno	osis list indicated diagnoses,		completed on or before 4/26/2023 or upon hire.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495200	B. WING_			l	C 20/2023	
	RÖVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		ULD BE		(X5) COMPLETION DATE	
F 695	Subarachnoid Hemon Mellitus, Asthma, and The most recent quart (MDS) with an assess of 12/24/22 assigned for mental status (BIM of 15 indicating the recognitively impaired. requiring extensive as transfers, dressing, to hygiene. The resident receiving oxygen them resident #38's current person-centered care stating, "Resident exhrespiratory complication [chronic obstructive puintervention stating "Office intervention stating intervention intervention stating intervention stating intervention stating intervention intervention stating intervention intervention stating intervention intervention stating intervention stating intervention intervention stating intervention	ot limited to Chronic y Disease, Nontraumatic rhage, Type 2 Diabetes Bipolar Disorder. terly minimum data set ment reference date (ARD) the resident a brief interview S) summary score of 8 out sident was moderately Resident #38 was coded as sistance with bed mobility, filet use, and personal t was also coded as apy within the last 14 days. t physician's orders er dated 2/21/23 for oxygen nute) via nasal cannula t comprehensive plan included a focus area ibits or is at risk for	F6	An audit will be complete all residents who are orded O2 nasal weekly X 4 then monthly X 2 until 100% compliant, with corrective action upon discovery. Results of the audits will I presented to the QAPI committee for review.	ered		/26/2023	

x			

PRINTED: 04/03/2023 FORM APPROVED

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ECONSTRUCTION	(X3) DAT	(X3) DATE SURVEY COMPLETED	
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		495200	B. WING			03	C /20/2023	
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F 756	§483.45(c) Drug Regii §483.45(c)(1) The dru must be reviewed at le licensed pharmacist.	men Review. g regimen of each resident east once a month by a iew must include a review	F	756	Resident #14, Resident #17 and Resident #26 Drug Regiment Review (DRR/MRR) were obtained and the attending physicians will review.		4/26/2023	
	irregularities to the atteracility's medical direct and these reports mus (i) Irregularities includ drug that meets the crit (d) of this section for a (ii) Any irregularities not during this review mus separate, written report attending physician and director and director of minimum, the resident' and the irregularity the (iii) The attending physician regularity has been reaction has been taken be no change in the metal physician should docur the resident's medical in §483.45(c)(5) The facil maintain policies and process and steps when he or she identifier requires urgent action to	teria set forth in paragraph in unnecessary drug. In unserver de			An audit will be completed for the past 30 days of the DRR/MRRs to ensure they have been reviewed by the attending physician with documentation in the residents' health record of any identified irregularity has been reviewed and what, if any, action has been taken to address it. The DRR/MRRS are to be uploaded in their individual electronic medical records. NPE or designee will reeducate all current licensed nursing staff and all additional and newly hired prior to the start of their first shift that the Drug Regiment Review is to be obtained and the attending physicians is to review with documentation			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		ECONSTRUCTION	(X3) DATE	SURVEY
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	ROVIDER OR SUPPLIER OD CENTER			2	TREET ADDRESS, CITY, STATE, ZIP CODE 0 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 03/	20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 756	facility staff failed to e Reviews (MRRs) were provider for three (3) of for unnecessary media #14, Resident #17, and The findings include: 1. The facility staff fail Resident #14's Medica (MRRs) were docume medical provider. Resident #14's minimal assessment, with an a (ARD) of 12/16/22, was completed on 12/29/2 assessed as sometimal understood and as so others. Resident #14 problems with short-te Resident #14 was ass assistance with bed mand personal hygiene. Resident #14's clinical the same note on the (a) 10/25/22; (b) 11/21 note read as "A medic performed - see report comments/reccoments Resident #14's clinical included details of the	and document review, the insure Medication Regimen addressed by a medical of five (5) residents selected cation review (Resident id Resident #26). Iled to ensure three (3) of ation Regimen Reviews inted and addressed by a sum data set (MDS) issessment reference date is dated as being 2. Resident #14 was ies able to make self imetimes able to understand was assessed as having imm and long-term memory. In its immediately interesting in the immediately interestin	F7	756	in the residents health record of any identified irregularity has been reviewed and what, if any, action has been taken to address it. The MMRs are to be uploaded in their individual electronic medical records Re-educations will be completed on or before 4/26/2023 or upon hire. An audit of the DRR/MRS will be completed to ensure they have been reviewed by the attending physician with documentation in the residents' health record of any identified irregularity has been reviewed and what, if any, action has been taken to address it. The DRR/MRRs are to be uploaded in their individual electronic medical records. The audit will be completed weekly X 4 then monthly X 2 months or until 100% compliant, with corrective action if needed. Results of the audits will be presented to the QAPI committee for review.		4/26/2023

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRUCTION IG		(X3) DATE COMP	SURVEY LETED
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F 756	titled "9.1 Medication revision date of 3/3/20 - "The attending physithe residents' health rirregularity has been raction has been taker - "Facility should main of MRRs on file in the resident's permanent This policy was provid 3/14/23 at 3:05 p.m., I Clinical Leader. The survey team met Administrator and Dire 3/17/23 at 4:01 p.m. I surveyor discussed that to ensure documental Resident #14's MRRs the resident's clinical commedical provider. 2. The facility staff fall Resident #17's Medic (MRRs) were documented as were documented as usual understood and usual others. Resident #17 problems with short-teresident #17 was documented as documented as usual understood and usual others. Resident #17 was documented as documented as with short-teresident #17 was documented #17 was document	tion was found in a policy Regimen Review" (with a b): cian should document in ecord that the identified reviewed and what, if any, a to address it." ctain readily available copies Facility as part of the health record." led to the surveyor, on by the facility's Market with the facility's Market with the facility's meeting, the re failure of the facility staff tion of the details of were maintained as part of documentation. led to ensure three (3) of ation Regimen Reviews ented and addressed by a um data set (MDS) assessment reference date as dated as being 2. Resident #17 was by able to make self ly able to understand was assessed as having erm and long-term memory. cumented as requiring nobility, dressing, toilet use,	F7	56			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG		TE SURVEY MPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 756	the same note on the (a) 10/25/22; (b) 11/2 note read as "A medic performed - see repor comments/reccoment Resident #17's clinical included details of the On 3/14/23 at 1:30 p.I Director of Nursing (A unable to find details aforementioned MRR. The following informatitled "9.1 Medication revision date of 3/3/20 - "The attending physithe residents' health rirregularity has been taker - "Facility should main of MRRs on file in the resident's permanent This policy was provid 3/14/23 at 3:05 p.m., I Clinical Leader. The survey team met Administrator and Dire 3/17/23 at 4:01 p.m. surveyor discussed the censure documental Resident #17's MRRs the resident's clinical details and surveyor discussed the resident's clinical details.	Il documentation included following three (3) dates: 1/22; and (c) 1/26/23. The cation regimen review was t for dation(s) [sic] noted". Il documentation failed to aforementioned MRRs. In., the facility's Assistant DON) reported they were of the three (3) s. Ition was found in a policy Regimen Review" (with a bi): ician should document in ecord that the identified reviewed and what, if any, in to address it." Intain readily available copies Facility as part of the health record." If de to the surveyor, on by the facility's Market with the facility's ector of Nursing (DON) on During this meeting, the re failure of the facility staff the details of were maintained as part of documentation.	F 7:	56			
		iled to ensure five (5) of ation Regimen Reviews					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		SURVEY PLETED	
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
WESTWOOD CENTER			20 WESTWOOD MEDICAL PARK			
			BLUEFIELD, VA 24605		,	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		
medical provider: Resident #26's minim assessment, with an a (ARD) of 2/15/23, was on 3/6/23. Resident # usually able to make able to understand other interview for Mental S score of four (4) out of cognitive impairment. documented as required dressing, toilet use, a sesident #26's clinical the same note on the 9/1/22, (b) 10/25/22; (and (e) 1/26/23. The regimen review was promments/reccomented Resident #26's clinical included details of the company of the company of the company of the following information of the same note on the 9/1/23 at 1:32 p. Director of Nursing (A unable to find details aforementioned MRR of the following information of the company of the residents' health in the residents' health in the residents' health in the residents' health in the same naction has been taken. "Facility should main	um data set (MDS) assessment reference date s dated as being completed #26 was documented as self understood and usually hers. Resident #26's Brief status (BIMS) summary if 15; this indicated severe Resident #26 was ring assistance with bathing, and personal hygiene. al documentation included following five (5) dates: (a) (c) 11/21/22; (D) 12/13/22, note read as "A medication performed - see report for dation(s) [sic] noted". al documentation failed to be aforementioned MRRs. m., the facility's Assistant ADON) reported they were of the five (5) as. ation was found in a policy Regimen Review" (with a 0): sician should document in record that the identified reviewed and what, if any, in to address it." intain readily available copies a Facility as part of the	F 75	56			

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		495200	B. WING _		C 03/20/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	03/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 756	This policy was provid 3/14/23 at 3:05 p.m., Solinical Leader. The survey team met Administrator and Direct 3/17/23 at 4:01 p.m. Surveyor discussed the to ensure documentation of the surveyor discussed the	with the facility's Market with the facility's ector of Nursing (DON) on During this meeting, the e failure of the facility staff ion of the details of were maintained as part of	F 7	70	74
SS=E	laboratory services to residents. The facility and timeliness of the sign of the facility provides services, the services requirements for labor of this chapter. This REQUIREMENT by: Based on staff intervifacility document review obtain physician order residents, Resident ## #11, and Resident #15 The findings included: 1. For Resident #4 the physician ordered work work with the physician ordered work resident #4 the physician ordered work resident #4's face she resident #4's face she residents.	/ Services. illity must provide or obtain meet the needs of its is responsible for the quality services. es its own laboratory must meet the applicable ratories specified in part 493 is not met as evidenced ew, clinical record review, ew, the facility staff failed to red labs for 4 of 33 4, Resident #42, Resident 9.		Labs were completed as ordered for Resident #4 and Resident #11. Resident #42 discharged from the facility on 4/3/23 Resident 199 was discharged on 3/5/22 and did not return to the facility. The facility was unable to correct action. An audit will be completed to ensure all ordered labs are obtained for the last two weeks.	4/26/2023

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	SURVEY	
		405000	1				С
		495200	B. WING			03/	20/2023
	ROVIDER OR SUPPLIER OD CENTER			2	STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 770	depression, anxiety, a The most recent MDS reference date of 02/0 a brief interview for m of 15 in section C, cog indicates that the resis Section M, skin condit having one stage one present upon admissi M1040, other ulcers, v coded the resident as present". This subsect wounds. Resident #4's compre reviewed and containe ""Resident at nutrition Wounds: Surgical PI skin fold, healing" a continuing impaired si diagnosis of MS (mult mobility Type: Pres for these care plans in Resident #4's clinical contained a physician dated 01/30/23, which (right) hip wound-redr After culture, start Bar mouth) BID (twice dai infection." This order of Surveyor could not loo ordered wound culture record until one dated Resident #4's clinical	with an assessment 106/23 assigned the resident ental status score of 14 out gnitive patterns. This dent is cognitively intact. Itions, coded the resident as pressure ulcer that was on. Section M, subsection wounds and skin problems "none of the above Ition includes surgical thensive care plan was ed a care plan for risk r/t (related to) Open wound to R (right) hip and " is at risk for kin integrity related to iple sclerosis), impaired esure ulcers." Interventions included "Labs per orders". Trecord was reviewed and 's telephone order form in read in part "(1) Culture R included "Labs PO (by ly) x 10 days wound was signed by the FNP. Cate a lab report for the erin Resident #4's clinical 102/10/23.	F:	770	Nurse Practice Educator/designee will reeducate of licensed nurses regarding how to properly utilize the new process for ordering labs and obtaining specimens. The reeducations will be completed on or prior to 4/26/2023 or upon hire. An audit for ordered and completed labs will be completed labs will be completed daily during the clinical morning meeting with corrective action if necessary, weekly X 4 then monthly X 2 monthly until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.		4/26/2023
	physician's telephone	record contained a order form dated 02/16/23,) Rocephin 1 gm I.V. q					

PRINTED: 04/03/2023 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDI	RIPLE CONSTRUCTION	ISTRUCTION (X3) DATE SUI COMPLET	
		495200	B. WING			03/20/2023
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, Z 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN X (EACH CORRECTIVE / CROSS-REFERENCED TO DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 770	(every) day (2) Reper Barker consult woun signed by the physic record also containe summary for the more read in part "Culture only for Wound Infect a start date of 02/25/2 results of this wound Surveyor spoke with nursing (ADON) on a stated the culture or collected 3 times, and contacted for results not have a specimer not locate results for on 02/25/23. Surveyor spoke with the contracted lab or regarding Resident stated that the only a specimens they had and 02/10/23. MT stother orders or specimens they had and 02/10/23. MT stother orders or specimens they had and 02/10/23. MT stother orders or specimens they had and 02/10/23. MT stother orders or specimens they had and FNP stated they the order date. FNP the results, "couple done it and lab lost in Surveyor requested facility policy entitled starting the state of they are sufficiently policy entitled facility policy entitled."	at wound culture x 7 (3) d vac R hip." This order was ian. Resident #4's clinical d a physician's order of February 2023, which wound to Right hip one time tion for 1 day" This order had 23. Surveyor could not locate culture. the assistant director of 03/17/23 at 12:50 pm. ADON der on 01/30/23 was d when the lab was , they were told the lab did on ADON stated they could culture ordered to be done medical technician (MT) at on 03/20/23 at 10:15 am they wound cultures. MT wound culture orders and received were on 01/17/23 ated they had received no imens for wound cultures for PNP on 03/20/23 at 1:25 pm. When they expected the ed on 01/30/23 to be done, wexpected it to be done on said when they asked about of nurses stated they had	F	770		

Facility ID: VA0271

	F CORRECTION	IDENTIFICATION NUMBER:	' ' '	BUILDING (X3) DATE SUP	
		495200	B. WING _		C 03/20/2023
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 00/20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 770	laboratory, radiologic testing (e.g., fingersting (e.g., fingersting)-will Laboratory services were days a week, 2 licensed outside diagrapplicable certificationstate regulations." The concern of not of wound cultures was cadministrator, DON, a 03/20/23 at 3:00 pm. No further information 2. For Resident #42 to obtain a physician or count) on two separates included but not limited disease, heart failure type 2 diabetes mellified disease, and anxiety. Resident #42's most with an assessment in assigned the resident status score of 11 our patterns. Resident #42's compreviewed and containexhibits or is at risk for complications relations relations.	pulmonary and waived ck glucose monitoring, ill be performed as ordered. will be available on-site, 24 hours a day with a nostic service that meets all in standards and local or btaining physician ordered discussed with the and Market Clinical Lead on in was provided prior to exit. The facility staff failed to dered CBC (complete blood the occasions. Sheet listed diagnoses which ed to hypertensive heart is, chronic kidney disease, tus, peripheral vascular recent minimum data set reference date of 02/04/23 at a brief interview for mental tof 15 in section C, cognitive or cardiovascular symptoms	F 7	70	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495200	B. WING			I .	C 20/2023
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CIT 20 WESTWOOD MEDIC BLUEFIELD, VA 246	CAL PARK		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH COI	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BI ERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 770	plan included "Monito to physician." Resident #42's clinical contained an "Acute Name of the Which read in part, "Content Problem: Fol Assessment and Plan B12, Folate in AM (02) Resident #42's clinical "Physician's Telephon 02/01/23, which read panel, B12, Folate in Asigned by the family in Resident #42's clinical report dated 02/02/23 and iron panel. The laresults for a CBC. Surveyor spoke with the nursing (ADON) on 03 regarding Resident #44 that lab thought CBC 02/02/23 was a mistal resident had just had stated that FNP order 02/10/23. Surveyor spoke with rechnician (MLT) on 0 regarding Resident #4 MLT stated that the or include a CBC. Surveyor spoke with the oricinal content was stated that the ori	I record was reviewed and visit" form dated 02/01/23 hief Complaint/Nature of low-up anemia. Diagnosis, : Anemia -CBC, Iron Panel, vioz/23)-anemia." I record contained a e Orders" form dated in part "2-1-23 CBC, iron AM-anemia." This form was urse practitioner (FNP). I record contained a lab with results of a folate, B12 b report did not contain the assistant director of 8/17/23 at 12:50 pm (2's lab report. ADON stated ordered to be done on (2e, and didn't do it, because it done on 01/31/23. ADON (2ed the CBC to be done on (2e) at 12:50 pm (F·7	70			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		CONSTRUCTION	(X3) DATE COMF	SURVEY
		495200	B. WING_			1	C
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	03/	20/2023
WESTWO	OD CENTER				WESTWOOD MEDICAL PARK LUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 770	Resident #42's clinica report dated 02/10/23 signed by the FNP, w Repeat CBC in AM-2/ white blood cell count a lab report for 02/16/ Resident #42's clinica progress note dated 0 "Lab CBC-wbc 12.3 H (FNP name omitted) r Resident notified." Surveyor spoke with F Surveyor asked FNP in CBC to be done on 02 they had ordered the done. Surveyor requested a facility policy entitled read in part, "Policy:	l record contained a lab with a handwritten note hich read in part "2/15/23 16 due to leukocytosis (high)." Surveyor could not locate	F 7	770			
	testing (e.g., fingerstic hemoccult testing)-wil Laboratory services w seven days a week, 2 licensed outside diagrapplicable certification state regulations." The concern of not oblabs was discussed w and Market Clinical Legal	k glucose monitoring, I be performed as ordered. ill be available on-site,				#1	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495200	B. WNG_			C 03/20/2023	
	ROVIDER OR SUPPLIER			2	TREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605		20/2020
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION .DATE
F 770	Continued From page	96	F7	770			
	obtain the following or glycated hemoglobin or count (CBC) and a copanel (CMP) as order 1/26/23. Resident #11's diagnor limited to the following dysphasia, morbid obdisorder. The most recent Miniman assessment refere assigned the resident status (BIMS) score or resident is cognitively. During a review of resurveyor saw an orde HgbA1C, CBC, CMP starting on 2/16/23. Slocate the results of the medical record. A progress note dated "Attempted to obtain I without success. Resipass on to oncoming unable to find any meattempting to draw the Resident #11 was integrand and did not recall to draw blood on her on 3/14/23 at 9:47 and Director of Nursing (Director of Nursing (Director) and contains a contained to the success of the contained to draw blood on her on 3/14/23 at 9:47 and Director of Nursing (Director)	mum Data Set (MDS) with since date (ARD) of 2/1/23 a brief interview for mental of 15 out of 15 indicating the intact. Sident #11's record, the reput in on 1/26/23 for a to be done every 6 months surveyor was unable to nese labs in the resident's days at 1 stick to the right AC dent stated, "try later". Will nurse". Surveyor was intion of another nurse e lab tests. Enviewed on 3/14/23 at 9:35 any attempts by facility staff recently. In, surveyor asked the book of the stated of the sta					

AND BLAN OF CORRECTION IN IMPER-		(X2) MULT A. BUILD!	TIPLE CONSTRUCTION	O	(X3) DATE SURVEY COMPLETED	
			= 0=			С
		495200	B. WING			03/20/2023
	ROVIDER OR SUPPLIER		`-	STREET ADDRESS, CITY, STATE, ZIF 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATI	(X5) COMPLETION DATE
F 770	above-mentioned prohandwritten note on the read, "I called the lab asked the DON to clallabs had not been drathe staff was contactified them the labs had not follow any orders give Surveyor requested a entitled, "Diagnostic Infollow any orders give Surveyor requested a entitled, "Diagnostic Infollow any orders give Surveyor requested a entitled, "Diagnostic Infollow any orders give Surveyor requested a entitled, "Diagnostic Infollow any orders give Surveyor Reading (e.g., for monitoring, hemocculas ordered. Laborator on-site, seven days a licensed outside diagrapplicable certification state regulations". Surveyor discussed the administrative staff #copy of resident #11's mentioned care refus was a possibility that the staff draw the lab resident refused was This concern was dis Administrator and add 3/14/23 at 5:25 PM. Notes that the staff of the staf	gress note with a he bottom of the page that they have none". Surveyor rify, and they stated that the awn. DON further stated that high the provider to inform a been drawn and would en. Ind received the policy Tests" with a revision date of art, "Diagnostic tests-radiologic, pulmonary, and ingerstick glucose at testing)- will be performed by services will be available week, 24 hours a day with a mostic service that meets all an standards and local or the above issue with 4 on 3/14/23 who provided a se behavior care plan that als and stated that there the resident refused to let. No evidence to verify the ever produced. Cussed with the ministrative staff #4 on No further information was y team prior to the exit	F	770		
		led to ensure provider studies were implemented				

	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMF	SURVEY
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		495200	B. WING_			03/	20/2023
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK		
WESTWO	OD CENTER			B			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 770	when ordered for Res Resident #199's admidiagnoses included by Covid-19, Type 2 Dial Encephalitis (inflammencephalomyelitis brief interesident's brief interesident's brief interesident's brief interesident's brief interesident's brief interesident inte	ssion record listed his at were not limited to, betes Mellitus, and ation of the brain) and flammation of the brain and imum data set (MDS) with nice date of 12/16/21 coded erview for mental status in Section C (cognitive (functional status) coded erview easistance with bed boilet use. Intained a nurse practitioner ment with a date of service nosis, assessment and plan ent listed provider orders for plete blood count), CMP panel), PROBNP (used to in AM." Resident #199's ereviewed and indicated the	F 7	770	DEFICIENCY)		
	3/03/22. The administrator was on 3/17/23 (via phone person.	s informed of these findings e) and again on 03/19/23 in					
F 773 SS=D	exit conference.	was provided prior to the Order/Notify of Results	F 7	73			

STATEMENT OF DEFICIENCIES (X* AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495200	B. WING		C 03/20/2023	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	03/20/2023	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 773	ordered by a physician practitioner or clinical accordance with State practice laws. (ii) Promptly notify the physician assistant, no nurse specialist of lab outside of clinical refewith facility policies are notification of a practification of	ility must- aboratory services only when n; physician assistant; nurse nurse specialist in e law, including scope of ordering physician, urse practitioner, or clinical oratory results that fall rence ranges in accordance ad procedures for cioner or per the ordering is not met as evidenced illed to promptly notify a esident #14's critically low A blood glucose test is a res the level of sugar o called hypoglycemia) has ng missing a meal, taking ng other diabetes more than normal, and d sugar below 70 mg/dL is w blood sugar can be d be treated as soon as d from liabetes/managing/manage- /16/23) um data set (MDS) assessment reference date as dated as being 2. Resident #14 was	F 77	Resident #10 labs were repeated on Feb 13, 2023 with no critical findings. Resident #14 labs were repeated on February 23, 2023 with no critical findings. An audit was completed on all labs ordered for the previous 30 days to ensure no critical labs were received and not followed up on by the attending physician, with corrective action if needed. This audit to be completed on or before April 5, 2023. NPE or designee will reeducate all current licensed nursing staff and all additional and newly hired prior to the start of their first shift on how to obtain and report critical labs. The reeducations will be completed on or prior to 4/26/2023 or upon hire.	4/26/2023	
	assessed as sometim	es able to make self				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION		E SURVEY PLETED
			A. BOILDI	NG_			c
		495200	B. WNG			1	/20/2023
NAME OF P	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WESTWO	OD CENTER			2	0 WESTWOOD MEDICAL PARK		
WESTWO	OD OLIVIER			B	BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 773	Continued From page	e 100	F	773			
	understood and as so	metimes able to understand					1
		was assessed as having					-
	problems with short-to	erm and long-term memory.			An audit for critical labs will		4/26/2023
	Resident #14 was ass	sessed as requiring			be completed daily during		1, 10, 1023
		nobility, dressing, toilet use,			the clinical morning meeting		
		e. Resident #14's was			with corrective action if		
	diagnosed with diabe	tes.			necessary, weekly X 4 then		
	Donidont #4 4la aliaia	d as a said feel adold a			III		
	Resident #14's clinica				monthly X 2 monthly until		
		cating a critical low blood led to the facility on 2/21/23			100% compliant, with		
		it #14 blood glucose level			corrective action upon		
		42 with a reference range of			discovery. Results of the		
	70 - 110 mg/dL.	72 Willia Poloronoo rango or			audits will be presented to		
	,				the QAPI committee for		
	Resident #14's clinica	al record included a nursing	/				
	progress note dated 2	2/21/23 at 9:00 p.m. This			review		
		e included the following ed call from (local hospital					
		vith critical Glucose level on					
		bs drawn this morning,					
	placed in Rounding B	sook for MD to review." No					
	resident assessment	and no finger stick blood					
		mpleted and/or documented					
		entioned critical low blood					
		earlier documented nursing					
	progress note indicate						
		cimens obtained on 2/21/23					
	at 5:37 a.m.) Reside	nt #14's next blood vas documented on 2/23/23					
	at 6:05 a.m.; this resu						
		gned they reviewed this					
	laboratory result on 2						
		nedical provider gave an					
		at 8:38 p.m. for Resident					
	_	be checked twice a day due					
		mia on lab results"; this was					
	dated to be started or	n 2/23/23 at 6:00 a.m.					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE COMP	SURVEY
		495200	B. WNG_				C 20/2023
	ROVIDER OR SUPPLIER			20	REET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK LUEFIELD, VA 24605	00/	2012020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 773	the Director of Nursing #14's critically low blod DON reported a finge have been immediate and the resident show symptoms of low blood The DON reported a shave been promptly relaboratory results. On 3/16/23 at 12:22 printerviewed the facility telephone. The Medical they nor the facility's relative of Resident # glucose/sugar level. confirmed a medical promptly notified of the The Medical Director should have been assand should have had (FSBS) checked. The following informate policy titled "NSG103 revision date of 6/1/2" - "Diagnostic test - incorperformed as ordered - "All diagnostic result attending physician/ar (APP) promptly." - "Notify immediately The survey team met	a.m., the surveyor mone, the Administrator and g (DON) related to Resident od glucose report. The r stick blood sugar should ly obtained for Resident #14 lld have been assessed for d sugar (hypoglycemia). medical provider should otified of the critical of the critical blood. The Medical Director reported neither nurse practitioner had been e critical laboratory result. confirmed the resident sessed for hypoglycemia a finger stick blood sugar tion was found in a facility Diagnostic Tests" (with a l): cluding laboratory will be serie reported to [sic] dvanced practice provider results for any critical values."	F7	7773			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		495200	B. WING			1	C 20/2023
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 773	surveyor discussed th	During this meeting, the e failure of the facility staff edical provider of Resident	F7	773			
	and facility document failed to notify the phy	ew, clinical record review, review, the facility staff rsician/FNP of critical lab dents, Resident #10 and					
	the provider, assess a	ne facility staff failed to notify and/or treat the resident for () level and a critical glucose					
	included but not limite	disease, dementia, basal					1
	with an assessment recoded the resident as	ecent minimum data set eference date of 02/07/23 6 out of 15 in section C, is indicates that the resident impaired.					
	reviewed and contain is at nutrition risk r/t (r texture diet, diuretic, t	ventions for this care plan					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495200	B. WING			C 03/20/2023	
	ROVIDER OR SUPPLIER OD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605			2012020
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 773	contained a laboratory part, "Test: K, Result: 3.6-5.6 mEq/L, Report verified by repeat ana read back by (nam 19:39:05 by (initials (glucose), Result: 37, 70-110, Reported: 02 by repeat analysis. Cr back by (name om 19:50:54 by (initials and read back by (02/08/2023 19:52:18 ld Handwritten note on the part "No nursing no Kayexelate?? Please not have a signature. record also contained laboratory report with bottom of the report, worders given 2/13 for resigned by the facility for (FNP). According to Discovered to potassium. Surveyor reviewed Reprogress notes on 03/locate any documenta had been notified of the glucose levels. Surveyor spoke with the nursing (ADON) on 03 regarding Resident #1 stated that MD/FNP stand that the facility stand that	I record was reviewed and report dated which read in 6.6, Flag: *H, Reference: ted: 02/08/23 1944. Result lysis. Critical called to and e omitted) at 02/08/2023 somitted)" and "Test: Glu Flag: *L, Reference: /08/23 1957. Result verified itical called to and read itted) at 02/08/2023 somitted). Critical called to name omitted) at oy (initials omitted)". The bottom of this report read tes on this 2/8. I don't see get 2/10 labs" This note did Resident #10's clinical a copy of the same a handwritten note at the which read in part "New repeat labs." This note was amily nurse practitioner avis Drug Guide.com, ation used to treat high resident #10's nursing 14/23. Surveyor could not tion that the physician/FNP he critical potassium or	F	773			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		SURVEY PLETED
		495200	B. WNG			I	C /20/2023
WESTWO	PROVIDER OR SUPPLIER OD CENTER			1	STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	03/	20/2023
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E TE	(X5) COMPLETION DATE
	and ADON stated "No Surveyor spoke with the O3/15/23 at 4:05 pm verifical lab value not recall being notifie that it was possible the practitioner (FNP) had them and stated they with the FNP and confident of the critical state of the critical lab value not recall being notified that it was possible the practitioner (FNP) had them and stated they with the FNP and confident of the critical state of the critical value outcome". Surveyor spoke with the pm regarding Resident not been notified of the found it when I rounde were in the facility on Co2/13/23. Surveyor requested an facility policy entitled "I which read in part "Praphysician/APP (advanced diagnostic test results. any critical values. 5. Ephysician/APP notificat medical record."	that I can find". The facility physician (MD) on ia telephone. Surveyor been notified of Resident s, and MD stated they did d. MD stated to surveyor e facility family nurse been notified instead of would ask FNP. The facility MD again on MD stated they had spoken irred that the FNP had not tical results returned on the FNP on 03/20/23 at 1:55 the facility MD stated that this is glad the resident had no the FNP on 03/20/23 at 1:55 the facility MD stated that this is glad the resident had no the FNP on 03/20/23 at 1:55 the facility MD stated they had be critical lab values until "I do next" FNP stated they had be critical lab values un	F	773			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		495200	B. WING			C 03/20/2023	
	ROVIDER OR SUPPLIER OD CENTER			20	REET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK LUEFIELD, VA 24605	03	12012023
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 773	Continued From page	105	F	773			
F 812 SS=D	Food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procur approved or considered state or local authoritici) This may include for from local producers, and local laws or reguloii) This provision does facilities from using progardens, subject to consafe growing and food (iii) This provision does from consuming foods §483.60(i)(2) - Store, serve food in accordant standards for food ser This REQUIREMENT by: Based on observation document review, the prepare, distribute and with professional standards for food items after the facility standards food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the refrigoration of the standards for food items in the standards for food items in the standards for food items in the standards fo	e food from sources ed satisfactory by federal, es. od items obtained directly subject to applicable State llations. s not prohibit or prevent oduce grown in facility ompliance with applicable l-handling practices. s not preclude residents s not procured by the facility. prepare, distribute and nce with professional vice safety. is not met as evidenced n, staff interview, and facility facility staff failed to store, d serve food in accordance dards for food service ff failed to discard an and failed to label opened perator. to label a bag of shredded	F	812	The unlabeled, open bag of shredded cheese was immediately discarded. The opened, expired bottle of Worcestershire sauce was immediately discarded. An audit was completed to ensure no expired food items and/or open, undated food items in the kitchen with no negative findings. Dietary Manager or Designee will provide re-education to all current dietary staff and any new hired dietary staff prior to the start of their first shift of the open dating food products and First in First out (FIFO) process. Reeducations to be completed on or before 4/26/23		4/26/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		711 0012011		C
	495200	B. WING_		03/20/2023
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
the kitchen, surveyor of bag of shredded cheese it in the walk-in cooler. It in the walk-in cooler. It stated, "they just opene go through cheese fast" bag should have a labe "it should have a date of Surveyor then observed Worcestershire Sauce veryor staff #3 stated was in here, I'll through the was in here, I'll through the above concerns and food storage. C.D.M. con items in question had be surveyor reviewed the pentitled, "Food Storage: had a revised date of 4/1 foods will be stored wrang containers, labeled and manner to prevent cross." Surveyor met with the Aladministrative staff #4 of discussed the above containers of the pentitled with the Aladministrative staff #4 of discussed the above containers of the pentitled with the Aladministrative staff #4 of discussed the above containers of the pentitled with the Aladministrative staff #4 of discussed the above containers.	le of Worcestershire the of 9/13/22. I. during the initial tour of oserved an opened, clear e with no label or date on Other staff member # 3 and that the other day, we ". Surveyor asked if the I on it and they stated that in it when it was opened". If a large, opened bottle of with a use by date of stated, "I didn't even know ow it away". Surveyor met with the er (C.D.M.) and reviewed If requested a policy for onfirmed that the food een discarded. Cold Foods". The policy 2018 and read in part: "All pped or in covered dated, and arranged in a se contamination". dministrator, and in 3/13/23 at 5:25 PM and incerns. egarding this concern was eam prior to the exit sure/Good Faith Attmpt in(b)(1)-(4)(f)(1)-(6)(h)(i)	F 86	Dietary Manager or Designee will audit for FIFO and open dating of food products weekly X 4 then monthly X 2 until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review	4/26/2023

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495200	B. WING_		C 03/20/2023
WESTWO (X4) ID		STEMENT OF DEFICIENCIES	ID.	STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605 PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION
F 865	improvement (QAPI) in Each LTC facility, include a multiunit chain, must maintain an effective, QAPI program that for outcomes of care and must: §483.75(a)(1) Maintain demonstrate evidence program that meets the section. This may inclusivate must and reports of identification, reporting and prevention of advidocumentation demonstration of advidocumentation, and eleactions or performance §483.75(a)(2) Present Survey Agency no late promulgation of this reference §483.75(a)(3) Present Survey Agency or Fed annual recertification is during any other survey request; and §483.75(a)(4) Present evidence of its ongoing implementation and the requirements to a Stat surveyor or CMS upon §483.75(b) Program de A facility must design in	ading a facility that is part of the develop, implement, and comprehensive, data-driven cuses on indicators of the quality of life. The facility in documentation and the of its ongoing QAPI endurements of this tude but is not limited to demonstrating systematic graph in the development, valuation of corrective endurement activities; and its QAPI plan to the State of than 1 year after the gulation; and upon request events and gulation; and to CMS upon documentation and gulation and gulat	F8	IDT team has reviewed and revised the PIP plan for the area of Quality of Care related to wound care with the Abatement Plan focus outlined. QA members will meet monthly to review wi corrective action if needed. An audit was conducted on 04/03/23 by QAPI Committee members to ensure all current, open Performance Improvement Plans are appropriately identified via area of concern, have a measurab goal, interventions are detailed and being monitored for progress per QAPI mandates, with corrective action upon discovery.	4/26/2023 th

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	LIA (X2) MUL R: A. BUILD		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
495200			B. WING		C		
NAME OF F	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE] 0:	3/20/2023
WESTWO	OD CENTER				20 WESTWOOD MEDICAL PARK		
WESTWO	OD CENTER				BLUEFIELD, VA 24605		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			х	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	E ATE	(X5) COMPLETION DATE
F 865	Continued From page 108 range of care and services provided by the facility. It must: §483.75(b)(1) Address all systems of care and management practices; §483.75(b)(2) Include clinical care, quality of life, and resident choice; §483.75(b)(3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of a SNF or NF. §483.75(b) (4) Reflect the complexities, unique care, and services that the facility provides.		F	865			4/26/2023
	§483.75(f) Governance The governing body ar (or organized group or full legal authority and of the facility) is resporensuring that: §483.75(f)(1) An ongoi defined, implemented, addresses identified programmers of the QAP during transitions in leasy 483.75(f)(3) The QAP resourced, including erequipment, and technic §483.75(f)(4) The QAP	e and leadership. Ind/or executive leadership individual who assumes responsibility for operation asible and accountable for and QAPI program is and maintained and iorities. Il program is sustained adership and staffing; Il program is adequately asuring staff time,			Current, open Performance Improvement Plans will be reviewed by QAPI Committee members for appropriate identified area of concern, measurable goals, interventions are detailed and being monitored for progress per QAPI mandates, weekly X 4 then monthly X 2 until 100% compliant, with corrective action upon discovery. Results of the audits will be presented to the QAPI committee for review.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		495200	B. WNG			C 03/20/2023		
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605			03	12012023		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(TION SHOULD BE THE APPROPRIA	E TE	(X5) COMPLETION DATE	
F 865	organizational process provided to residents I indicator data, and resother information. §483.75(f)(5) Corrective systems, and are evaluable systems, and a	s, functions, and services based on performance sident and staff input, and we actions address gaps in uated for effectiveness; and pectations are set around choice, and respect. of information. Ty may not require ds of such committee th disclosure is related to a committee with the ection. If the committee to identify ciencies will not be used as is not met as evidenced we and facility document failed to ensure a Quality mance (QAPI) Program to facility as evidenced by an the area of Quality of management.	F	B65	·Y)			

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	0400 000		OMB NO. 0938-039			
AND PLAN	D PLAN OF CORRECTION IDENTIFICATION NUMBER:			LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED		
	495200					С		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		03/20/2023		
WESTA	OOD CENTER							
MESIN	COD CENTER			20 WESTWOOD MEDICAL PARK		•		
(X4) ID	SLIMMADV CTA	TEMENT OF DEFICIENCIES		BLUEFIELD, VA 24605				
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(HOULD BE	(X5) COMPLETION DATE		
F 865	On 3/20/23 at 12:29 pladministrator and disc Program. The administrator and consideration of nursing, into members, the infection medical director attend often additional staff medical	m, surveyor met with the ussed the facility QAPI strator stated the QAA and Assurance) Committee isted of the administrator, erdisciplinary team a preventionist, and the administrator stated the led at least quarterly and embers attended. The AA Committee information	F 8	865				
	Surveyor requested an policy entitled "Center of Performance Improver in part: 2. The QAA Committee 2.8 Assesses, evaluate improvement opportunit 2.8.2 All current regulate including plans of corresurveys and peer review review of the plan of conference on 3/20/23. Infection Prevention & CFR(s): 483.80(a)(1)(2) §483.80 Infection Control The facility must establisin infection prevention and designed to provide a sacomfortable environment.	d received the facility Quality Assurance nent Process" which read s, and identifies potential ties based on: ory on-site assessments, ction, both state/federal w surveys including a rrection egarding this concern was team prior to the exit control (4)(e)(f) bl sh and maintain an control program	F 88	LPN #2 was re-educated Hand Washing per CDC guidelines and Aseptic Technique Dressing Chan by Nurse Practice Educate (NPE) on 03/27/23. This included return demonstration of both ar by LPN #2.	nges or	1/26/2023		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-03		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
495200			B. WING_		С		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	03/20/2023		
WESTWO	OOD CENTER			20 WESTWOOD MEDICAL PARK			
				BLUEFIELD, VA 24605			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DE (X5) COMPLETION ATE DATE		
F 880	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; §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		F 88	An audit was completed on wound care dressing to ensure the Hand Washing per CDC guidelines and Aseptic Technique Dressing Changes by Nurse Practice	4/26/2023		
				Nurse Practice Educator or designee will provide reeducation to the process Hand Washing per CDC guidelines and Aseptic Technique Dressing Changes with all licensed nurses and additional and newly hired licensed nursing staff prior to the start of to the start of their first shift. The reeducations will be completed on or before 4/26/2023 or upon hire.			

STATEMENT OF DEFICIENCIES		OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	040.000			OIVID NO. 0938-0391				
AND PLAN OF CORRECTION			IDENTIFICATION NUMBER:) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED			
			495200	B. WNG	B. WNG		С				
Γ	NAME OF PROVIDER OR SUPPLIER				0.75		0	3/20/2023			
ı						REET ADDRESS, CITY, STATE, ZIP CODE					
ı	WESTWO	OD CENTER		1		WESTWOOD MEDICAL PARK					
-					BLUEFIELD, VA 24605						
	(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE			
		disease or infected ski contact with residents contact will transmit th (vi)The hand hygiene ply staff involved in dires §483.80(a)(4) A syster identified under the factorrective actions take §483.80(e) Linens. Personnel must handle transport linens so as transport linens so as transport linens so as transport linens and update their This REQUIREMENT by: Based on observation, document review, the fiperform hand hygiene a and placing a clean dream of the survey sample, Resident #36 was admidiagnoses including (by type 2 diabetes mellitus polyneuropathy, periphemorbid obesity, obstructive staff.	res with a communicable in lesions from direct or their food, if direct e disease; and procedures to be followed ect resident contact. In for recording incidents cility's IPCP and the in by the facility. It an annual review of its program, as necessary, is not met as evidenced attention after cleaning the wound essing for 1 of 33 residents resident #36. Interview, and facility with a serior of diagnosis is with diabetic eral vascular disease, tive sleep apnea, muscle the heart and chronic kidney	F	380			4/26/2023			
	1	skin and subcutaneous	tissue, methicillin s aureus infection, chronic lisease with acute llation, sepsis due to								

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		495200	B. WING			С		
	NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER			20	REET ADDRESS, CITY, STATE, ZIP CODE WESTWOOD MEDICAL PARK UEFIELD, VA 24605	03	8/20/2023	
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
	data set assessment with assessment reference date 2/1/23, the resident scored 14/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. The surveyor interviewed the resident on 3/12/23 concerning life in the facility. The resident had no complaints. When questioned about wound care (the right lower leg ended in a stump covered with a sock) the resident said staff usually changed the dressing on the leg wound daily. Clinical record review revealed two recent hospitalizations with wound infections: 12/2722 through 1/3/23 and 1/14 through 1/20/23. An order was entered dated 1/24/23 for Cleanse wound to RLE with IHWC (in house wound cleanser), pat dry, apply non-adherent dressing and wrap with gauze and ACE bandage every day shift for wound healing.		F	380				
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	approximately 2:20 PM was no dressing becau removed it to assess th that the resident's beds sanitized by the nurse a for the table to dry. The \$2 as the nurse donned non-adherent pad, non- and a roll of stretch gau wound wash on non-wo	L LPN #2 stated that there use the physician had been seen the nurse was waiting the surveyor observed LPN digloves, then opened a surveyor gauze sponges, uze. The nurse sprayed oven gauze sponges, then in the wound, caught the conges, and patted the dignated the dignated around the						

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 04/03/2023 CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (APPOLINA FOR CORRECTION MURSER: (APPOLINA FOR CORRECTION AND FOR PROPERCIENCIES: (APPOLINA FOR MURSER) (APPOLI	CENTE	RS FOR MEDICARE &	MEDICAID SERVICES				,		RM APPROVE		
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER STREET ADDRESS, CITY, STATE, 2IP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24695 MUST BE PRECEDED BY PLUE PREPRINT PREPREPRINT PREPRINT PREPRINT	AND THE THE THE TELEVOLIA										
WESTWOOD CENTER (XA) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 880 Continued From page 114 sponges, then placed the non-adherent pad and wrapped with stretch gauze. The nurse taped the stretch gauze in place, then dated and initialed another place of tape and placed it on the dressing. After placing the tape, the nurse pushed up from the floor with gloved hands, then discarded gloves, washed hands for approximately 8 seconds, dried hands with paper towels, and used those paper towels to turn off water. The nurse did not change gloves and perform hand hygiene effer cleaning the wound and prior to placing the new dressing. The nurse did not wash hands for the recommended length of time. Hand washing was not performed for the CDC guidelines (https://www.cdc.gov/handwashing/when-how-handwashing,html). Follow these five steps every time: 1-Wet your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. 3-Scrub your hands well under clean, running water. 5-Dry your hands using a clean towel or an air dyer. The administrator and director of nursing were notified of the concern with hand hygiene during a summary meeting on 3/14/23.				B. WNG					1		
PROPRETEX TAG SUMMARY STATEMENT OF DEPTICENCIES (EACH DEPTICENCY MUST BE PRECEDED BY INLIA (EACH DEPTICENCY) F 880 Continued From page 114 sponges, then placed the non-adherent pad and wrapped with stretch gauze. The nurse taped the stretch gauze in place, then dated and initialed another piece of tape and placed it on the dressing. After placing the tape, the nurse pushed up from the floor with gloved hands, then discarded gloves, washed hands for approximately 8 seconds, dired hands with paper towels, and used those paper towels to turn off water. The nurse did not change gloves and perform hand hyglene after cleaning the wound and prior to placing the new dressing. The nurse did not wash hands for the recommended length of time. Hand washing was not performed for the CDC guidelines (https://www.cdc.gov/handwashing/when-how-ha ndwashing.html). Follow these five steps every time: 1-Vet your hands with clean, running water (warm or cold), turn off the tap, and apply soap. 2-Lather your hands by rubbing them together with the soap. Lather the backs of your hands, between your fingers, and under your nails. 3-Scrub your hands for at least 20 seconds. 4-Rinse your hands well under clean, running water. 5-Dry your hands well under clean, running water. 5-Dry your hands using a clean towel or an air dryer. The administrator and director of nursing were notified of the concern with hand hygiene during a summary meeting on 3/14/23.					2	0 WESTWOOD MEDICAL PARK		03	3/20/2023		
sponges, then placed the non-adherent pad and wrapped with stretch gauze. The nurse taped the stretch gauze in place, then dated and initialed another piece of tape and placed it on the dressing. After placing the tape, the nurse pushed up from the floor with gloved hands, then discarded gloves, washed hands for approximately 8 seconds, dried hands with paper towels, and used those paper towels to turn off water. The nurse donned fresh gloves and placed a sock over the resident's new dressing. During wound care observation, the nurse did not change gloves and perform hand hygiene after cleaning the wound and prior to placing the new dressing. The nurse did not wash hands for the recommended length of time. Hand washing was not performed for the CDC guidelines (https://www.cdc.gov/handwashing/when-how-ha ndwashing.html). Follow these five steps every time: 1-Wet your hands with clean, running water (warm or cold), turn of the tap, and apply soap. 2-Lather your hands between your fingers, and under your hands. Secrub your hands well under clean, running water. 5-Dry your hands well under clean, running water. 5-Dry your hands well under clean, running water. 5-Dry your hands using a clean towel or an air dryer. The administrator and director of nursing were notified of the concern with hand hygiene during a summary meeting on 3/14/23.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREF	ıx	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	D BF		COMPLETION	-	
		sponges, then placed wrapped with stretch gauze in place another piece of tape a dressing. After placing up from the floor with g discarded gloves, was approximately 8 secontowels, and used those water. The nurse donn a sock over the resider wound care observation change gloves and per cleaning the wound andressing. The nurse did recommended length of the commended length of the soap. Lather the between your fingers, a 3-Scrub your hands well water. 5-Dry your hands water dryer. The administrator and denotified of the concern was a constant of the concern water the con	the non-adherent pad and pauze. The nurse taped the then dated and initialed and placed it on the the tape, the nurse pushed gloved hands, then hed hands for the dated and placed to turn officed fresh gloves and placed ont's new dressing. During on, the nurse did not form hand hygiene after did prior to placing the new did not wash hands for the offitime. performed for the CDC andwashing/when-how-haw these five steps every with clean, running water the tap, and apply soap. Tubbing them together the backs of your hands, and under your nails. The prior to form together the tap, and apply soap. Tubbing them together the backs of your hands, and under your nails. The prior together the taps are the taps and apply soap. Tubbing them together the backs of your hands, and under your nails. The prior together the taps are the taps and apply soap. Tubbing them together the backs of your hands, and under your nails. The prior together the taps are the taps and apply soap. The prior together the taps are the taps and apply soap. The prior together the taps are the	F	880	presented to the Quality Assurance Performance Improvement (QAPI) committee monthly. The QAPI committee will direct further analysis and interventions based on			4/26/202	3	