PRINTED: 08/11/2023 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
		495200	B. WING _				0 7/2023
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER					SS, CITY, STATE, ZIP CODE MEDICAL PARK A 24605	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EAC	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD B IS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
E 000	Initial Comments		E	000			
F 000	Survey was conducted 6/7/23. The facility with 42 CFR Part 48 preparedness regular The Centers for Mediand Centers for Disepractices to prepare	5 certified bed facility, was survey.	F	000			
	and COVID-19 Focu was conducted 6/5/2	edicare/Medicaid abbreviated s Infection Control survey 3 - 6/7/23. Corrections are nce with 42 CFR Part 483.80 Care infection control					
	regulations) was inve	5 certified bed facility, was survey. The survey sample					
F 883 SS=D	Influenza and Pneum CFR(s): 483.80(d)(1) §483.80(d) Influenza immunizations §483.80(d)(1) Influer policies and procedu (i) Before offering the each resident or the receives education resident.	nococcal Immunizations (2) and pneumococcal nza. The facility must develop	F	983			
ARODATORY	<u> </u>	VELIDDI IED DEDDESENTATIVE'S SIGNIATUR			TITLE		(Y6) DATE

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

TITLE (X6) DATE

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

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		495200	B. WING		06	C 5/07/2023
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 00	70172020
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 883	immunization October annually, unless the contraindicated or the immunized during the street of the contraindicated or the immunized during the street or has the opportunity (iv) The resident's modocumentation that following: (A) That the resider was provided educated and potential side expression in the street of the str	offered an influenza per 1 through March 31 per immunization is medically the resident has already been this time period; the resident's representative to refuse immunization; and tedical record includes indicates, at a minimum, the to resident's representative to resident's representative to resident's representative to resident's representative to regarding the benefits ffects of influenza the either received the influenza to medical contraindications or the medical contraindications or the pneumococcal tresident or the resident's tives education regarding the tial side effects of the toffered a pneumococcal test the immunization is ticated or the resident has	F 88	33		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495200	B. WING		C 06/07/2023
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	1 00/01/2020
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLÉTION
F 883	immunization; and (B) That the residen pneumococcal immute pneumoc	fects of pneumococcal t either received the unization or did not receive munization due to medical efusal. T is not met as evidenced s, clinical record review, and view, the facility staff failed to munization and unization for one (1) of five (5) or immunization review : ad to administer influenza and unization to Resident #7. um data set (MDS) a assessment reference date s dated as completed on r was assessed as being derstood and as being able s. Resident #7 was assessed a memory problems and roblems. Resident #7 was ng supervision for transfers al record included dephone consent being 2 for both the pneumococcal influenza vaccination. No ity staff attempting to occines was found by or	F 88	3	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495200	B. WING _			C 06/07/2023	
NAME OF PROVIDER OR SUPPLIER WESTWOOD CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605	<u> </u>	06/07/2023	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD PREFIX)		HOULD BE	(X5) COMPLETION DATE	
F 883	On 6/6/23 at 9:29 a.m Preventionist (IP) rep tested positive for CC confirmed the resider aforementioned vacci recovered from COVI was present for this in The following informat document titled "IC60 Program" (with a revision "Centers will provided "IC60 Program")	n., the facility's Infection orted Resident #7 had ovID-19 on 10/26/23. The IP of the could have received the ines after they had D-19. (The Administrator interview.) Ition was found in a facility of Influenza Immunization sed date of 5/1/23): the opportunity to receive	F	383			
	and to employees immunization is medipatient/employee has The following informat document titled "IC60 Vaccination" (with a rule "Centers will provide the appropriate pneupatients/residents'	cally contraindicated or the salready been immunized." Ition was found in a facility of Pneumococcal evised date of 11/15/22): Ithe opportunity to receive mococcal vaccine to all					
F 887 SS=D	the failure of facility's Resident #7's influent pneumococcal immur Administrator. COVID-19 Immunizate CFR(s): 483.80(d)(3) (S) (S) (S) (S) (S) (S) (S) (S) (S) (S	nization with the cion (i)-(vii) 0-19 immunizations. The elop and implement policies sure all the following: accine is available to the	F	387			

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F 887	resident or staff mer immunized; (ii) Before offering C members are provid regarding the benefit effects associated w. (iii) Before offering C resident or the resid receives education risks and potential sthe COVID-19 vacci (iv) In situations wherequires multiple doresident representat provided with current additional doses, included the provided with the requesting consent additional doses; (v) The resident, resmember has the opposition of COVID-19 vaccine, (vi) The resident's modocumentation that the following: (A) That the resident was provided educated benefits and potential COVID-19 vaccine; (B) Each dose of CO to the resident divaccine due to medic contraindications or	dically contraindicated or the inber has already been OVID-19 vaccine, all staff ed with education its and risks and potential side with the vaccine; COVID-19 vaccine, each ent representative egarding the benefits and ide effects associated with ine; ere COVID-19 vaccination ses, the resident, ive, or staff member is it information regarding those studing any changes in the potential side effects COVID-19 vaccine, before for administration of any ident representative, or staff contunity to accept or refuse a land change their decision; redical record includes indicates, at a minimum, it or resident representative tion regarding the lar risks associated with and ovid-19 vaccine administered id not receive the COVID-19 cal refusal; and intains documentation related	F 88	7		

_ ` · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
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F 887	includes at a minim (A) That staff were the benefits and por associated with CO (B) Staff were offere information on obta (C) The COVID-19 related information Disease Control and Healthcare Safety N This REQUIREMEN by: Based on interview facility document re ensure COVID-19 in (5) residents sample (Resident #6) The findings included The facility staff faile COVID-19 vaccine Resident #6's mining assessment, with an (ARD) of 3/1/23, was 3/14/23. Resident and able to make self un to understand other Interview for Mental score was document this indicated mode Resident #6 was as assistance with bed and personal hygien Resident #6's clinic consent dated 1/19	um, the following: provided education regarding tential risks VID-19 vaccine; ed the COVID-19 vaccine; and vaccine status of staff and as indicated by the Centers for d Prevention's National Network (NHSN). NT is not met as evidenced rs, clinical record review, and view, the facility staff failed to munization for one (1) of five ed for immunization review e: ed to administer the to Resident #6. num data set (MDS) n assessment reference date as dated as completed on #6 was assessed as being nderstood and as being able s. Resident #6's Brief I Status (BIMS) summary nted as an eight (8) out of 15; rate cognitive impairment. ssessed as requiring extensive I mobility, dressing, toilet use,	F8	87			

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(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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 887	No evidence of the fa administer this vaccir provided to the surve On 6/6/23 at 10:29 a. Preventionist (IP) rev documentation. The aforementioned COV documented as being The following informadocument titled "IC60 (with a revised date oprovide the opportunivaccinations for all do Disease Control and recommendations On 6/6/23 at 3:15 p.n. the failure of facility s	acility attempting to nation was found by or yor. I.m., the facility's Infection iewed Resident #6's clinical IP reported the ID-19 vaccine was not g given. Attion was found in a facility of 5/1/23: "Centers will ity to receive COVID-19 oses following Centers for Prevention (CDC)	F	387			