STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495200		C 10/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTWOOD CENTER	20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 10/16/23 through 10/17/23. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. A past non-compliance immediate jeopardy was cited at F678. Two complaints were investigated during the survey: VA00059787-non-compliant VA00058970-compliant with regulations The census in this 65 certified bed facility was 57 at the time of the survey. The survey sample consisted of 4 resident reviews (Residents #1 through #4).	F 000		
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and facility document review the facility staff failed to provide basic life support, including cardiopulmonary resuscitation to one of 57, residents, Resident #2. The findings included: For Resident #2, an agency-contracted staff failed to check code status and failed to initiate	F 678	Past noncompliance: no plan of correction required.	

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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F 678	Continued From page 1 basic life support, including cardiopulmonary resuscitation for Resident #2. Resident #2 expired at the facility. Resident #2's face sheet listed diagnoses which included but not limited to acute respiratory failure, chronic obstructive pulmonary disease, chronic kidney disease with heart failure, and diabetes mellitus-type II. Resident #2's most recent minimum data set with an assessment reference date of 07/26/23 assigned the resident a brief interview for mental status score of 3 out of 15 in section C, cognitive patterns. This indicates that the resident was severely cognitively impaired. Resident #2's clinical record was reviewed and contained a physician's order summary which read in part, "Full code." Resident #2's clinical record contained a "Virginia Physician's Orders for Scope of Treatment" form dated 07/25/23, which read in part "A. Cardiopulmonary Resuscitation (CPR): Person has no pulse and is not breathing. [x] Attempt Resuscitation. [] Do Not Attempt Resuscitation (DDNR/DNR/No CPR)." The box for "attempt resuscitation" was marked on this form. Resident #2's clinical record contained nurse's progress notes dated 09/15/23, which read in part "09/15/2023 06:30 Resident unresponsive, no respirations or lung sounds, ... [name omitted] RN, DON [registered nurse, director of nursing] to be notified for further instructions"-signed by licensed practical nurse (LPN) #3, "09/15/2023 07:02 Notified ... [name omitted] RN, DON to report resident unresponsive, stated 'make a note	F 678		

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F 678	Continued From page 2 of it and an RN will be there shortly to pronounce'"-signed by LPN #3, "09/15/202312:40 Notified at approximately 0830 that resident has passed away. DON advised me that resident was a full code but that the nurse assigned to ... [Resident #2] got confused about the resident's code status, therefore she did not initiate CPR. The resident was listed as a Full Code but there had been discussion earlier of the resident moving to an end of life comfort care status. The nurse was an agency nurse and her contract was terminated by the facility. MD was notified. Resident son was notified by me of the incident. He was understanding and advised that he felt like it would not have helped. OLC [Office of Licensure and Certification], APS [Adult Protective Services], Ombudsman and DHP [Department of Health Professions] have been notified as well"-signed by administrator and "09/15/2023 14:28 Notified by ... [name omitted] Agency nurse at approx. 0702 am via phone that resident had passed away. This nurse advised ... [name omitted] to call on call provider and family. This nurse was advised by ... [name omitted], resident had DNR on her chart. ... [name omitted], FNP [family nurse practitioner] advised this nurse via phone that resident had a full code on her chart but nurse ... [name omitted] was confused about code status. This nurse called administrator to advise her that ... [name omitted] the agency nurse did not start cpr. The resident was listed as a Full Code in pcc [point click care]. Previously, there had been discussion of end of life care. ... [name omitted], FNP was notified. Resident's son was notified by administrator of the incident. He was understanding and advised that he felt like it would not have helped. The agency nurse ... [name omitted] contract terminated by the facility."-signed by DON.	F 678		

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F 678	Continued From page 3 During an interview with the facility administrator on 10/16/23 at 11:40 am, the administrator stated that the resident's family had been to the facility earlier in the week to discuss the possibility of comfort care for Resident #2. Administrator stated, "evidently there was some confusion, and a CNA [certified nurse's aide] told the nurse that the resident was DNR." Administrator stated that the nurse's excuse was that the computers were down, but there is a copy of each resident's code status in their paper chart located at the nurse's station. Administrator stated that nurse was an agency staff, and not a facility staff, and that her contract was terminated. Administrator stated that a 100% audit of code orders was completed, and a full plan of correction done immediately. This was provided to the surveyor for review. Surveyor spoke with the director of nursing (DON) on 10/16/23 at 2:20 pm and asked her to relate the events of 09/15/23. DON stated, "I was called at home around 7 am by ... [LPN #3] and informed that Resident #2 had passed, and she needed someone to pronounce. I told her that an RN was on the way. I called the FNP to let her know that Resident #2 had passed, and she had her computer up, and informed me that Resident #2 was a full code. I then called the administrator. Once I arrived at the facility, I checked Resident #2's chart to confirm code status. She was a full code." Surveyor requested and was provided with a facility policy entitled "Procedure: Cardiac and/or Respiratory Arrest. 1. Upon discovery of a patient in cardiopulmonary arrest (e.g., no apparent pulse, blood pressure or respiration, staff will immediately: 1.1 Call for assistance; 1.2 Alert the	F 678		

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F 678	Continued From page 4 licensed nurse and CPR/automated external defibrillator (AED) certified staff. 1.3 Prepare the patient for CPR/AED while determining the presence of a Do Not Resuscitate order (DNR). 2.1 If there is no visual identification of DNR status or no DNR order on the patient's medical record: 2.1.1 CPR/AED certified staff will initiate CPR/AED application. 2.1.4 Continue CPR until one of the following occurs: 2.1.4.1 It is discovered that the patient had a DNR order; 2.1.4.2 Restoration of effective, spontaneous circulation; 2.1.4.3 Care is transferred to a team providing advanced life support..." Facility administrator provided the surveyor with a copy of the facility's "On-Site Orientation Checklist" for agency nurses. This checklist included location of code status and orders, and center process for codes. The administrator also provided an "LPN/LVN Skills Checklist" for LPN #3 that the nursing agency provided to the facility. This form indicated that LPN #3 was able to perform CPR independently. This surveyor reviewed the plan of correction provided by the facility administrator. Plan of correction reads as follows: Advanced Directives Post Non Compliance Plan of Correction September 15, 2023 Corrective Action: 1. The agency nurse was asked to leave the facility. 2. The MD and RP (responsible party) were notified of the incident. 3. All code status orders will be reviewed and updated to reflect the current wishes.	F 678		

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F 678	Continued From page 5 4. All resident care plans will have their advanced directive care plan updated to reflect the most current status. Completed on 09/15/23. Identification of Deficient Practice: All residents in the facility are at risk. A 100% audit will be completed for all residents to ensure that all residents have been offered the ability to complete an advanced directive. All negative findings will be corrected immediately, and their orders will be updated as well as their care plan. Completed on 09/15/23. Systemic Changes: The facility policy and procedure on Advanced Directives has been updated and no changes are warranted at this time. All licensed staff will be in-serviced on facilities P&P for Advanced Directives, immediately, but no later than prior to the start of their next shift. Completed on 09/15/23. Monitoring: Social Services is responsible for maintaining compliance, all code status orders will be reviewed upon admission and quarterly for updates. Completed on 09/15/23 and on-going. Date of Completion: 09/15/23 In-services will continue until all staff are complete. Completed on 09/15 23. Surveyor reviewed credible evidence and confirmed that each item has been completed and on-going monitoring done. Surveyor visualized each resident's code status in the paper charts located at each nurse's station.	F 678		

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F 678	Continued From page 6 Interviews with nursing staff conducted on 10/15/23 confirmed that staff are knowledgeable on what to do in the event of resident being found unresponsive, and where to locate code status for each resident. The concern of an agency staff not providing basic life support to a resident was discussed with the administrator and DON on 10/17/23 at 10:30 am. No further information was provided prior to exit. This is a past non-compliance deficiency.	F 678		