STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted 02/25/25 through 02/26/25. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. One Complaint was investigation during the survey: VA00063292 - Non-compliant with regulations, past non-compliance. Substantiated. The census in this 65 certified bed facility was 50 at the time of the survey. The survey sample consisted of 2 resident reviews.	F 000		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interviews, clinical record review and facility document review, the facility staff failed to provide supervision to prevent an accident for 1 of 2 resident records reviewed. (Resident #1) The findings were: For Resident #1, facility staff failed to provide supervision to prevent a tissue injury to the	F 689	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/21/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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F 689	Continued From page 1	F 689		

bottom of the resident's feet resulting in admission to an acute care hospital and eventually admission to a burn center.

Resident #1's medical diagnoses included but were not limited to, dementia, Alzheimer's disease with late onset, second degree burn left foot, second degree burn of right foot, local infections of the skin and subcutaneous tissue, difficulty walking, and diabetes mellitus.

Resident #1's minimum data set with an assessment reference date of 01/30/25 was signed as completed on 02/01/25. Within Section C (cognitive patterns) Resident #1 was assigned a brief interview for mental status summary score of 15 out of 15 which indicated the resident's cognition was intact. Section M (skin conditions) indicated Resident #1 had a second or third degree burn.

Resident #1's care plan focus areas included but were not limited to the following:
A. Created upon admission and initiated on 02/13/25: Resident at risk for skin breakdown related to advanced age (greater than 75 years) and intermittent incontinence, redness of groin, diabetic ulcers to 2nd and 4th toes of left foot, burns to bottoms of feet with wound vac in place. Observe skin for signs/symptoms of skin breakdown i.e. redness, cracking, blistering, decrease sensation, and skin that does not blanche easily. Evaluate for any localized skin problems, i.e. dryness, redness, pustules, inflammation. Observe skin condition daily with activities of daily living care and report abnormalities. Weekly skin check by license nurse. Weekly wound assessment to include measurements and description of wound status

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	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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 689	Continued From page 2	F 689		

(created on 10/17/24 and initiated on 02/13/25). Wound VAC to left foot change every Monday, Wednesday, and Friday (created and initiated on 2/18/25).
B. Created on 01/29/25 and initiated on 02/13/25: Resident is resistive to care related to: Resident is continually refusing to allow staff to give him showers as scheduled. Educate resident on importance of leaving dressings intact to aid in the healing process and to refrain from picking at his feet to prevent infection and to enhance healing of the skin. Observe for non-verbal signs of resistance: e.g., rigid body position, clenched fists, etc (created and initiated on 01/29/25).

A provider order dated 02/01/25 read, "Wander Guard Placement due to Poor Safety Awareness, Left Wrist, EXP 5/2027 every day and night shift Check Placement of the Device and in supplemental Documentation - document the location." The care plan included a focus area, "Resident is at risk for elopement related to: Cognitive Loss/Dementia Elopement risk Score= 3 which was created on 02/01/25 and initiated on 02/13/2025. Bracelet Placement to Left wrist, EXP Date 5/20/27.

Resident #1's clinical record was reviewed. A licensed nurse progress note dated 01/22/25 at 4:30 a.m. read, "This nurse called to room by cna (certified nursing assistant) and stated that resident stated he needed nurse to bandage right foot related to it leaking and causing bed linen to be soiled. This nurse then walked back to room to observe residents [sic} foot. Resident in chair oriented x 3. When this nurse walked in room resident was asked to remove his right shoe. when [sic] this nurse took off sock this nurse observed five blistered red and white toes in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 3	F 689		

appearance with fifth toe missing skin and big toe with bubble filled appearance covering approximately 80% of toe. the [sic] bottom half of distal portion of foot red and missing approximately 1/3 of upper layer of skin. Area wet with beefy red appearance. Bloody drainage observed to site. This nurse then proceeded to obtain vitals and then call on call lumina (telehealth service). Resident stated he did not feel any pain and no symptoms of pain or distress was observed. This nurse received order to send out resident for evaluation related to skin presentation on right foot. This nurse propped foot up off of ground and encouraged resident to elevate until EMS (emergency medical services) arrived for ED (emergency department) visit. When this nurse asked resident what happened to foot, resident stated that his foot was like that because of treatment he was receiving and the medication being put on foot. This nurse then proceeded to interview staff to see if they had observed foot prior to this nurse finding place on right foot. Staff stated that this was the first time that they have observed area. When this nurse asked staff members if they could think of any reason why this area could be on foot staff stated that resident has been observed propping feet up on heaters in day room with shoes both on and off for the last couple of days to stay warm. This nurse then called report to (local acute care hospital initials omitted) and stated that this nurse found area on right foot and described details of residents [sic] condition and condition of foot. This nurse was asked about residents [sic] past medical history and if I knew what could have possibly happened to the residents[sic] foot. This nurse then stated that this was the first time I had observed the area but I was informed by cnas that he has recently been propping feet on

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	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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 689	Continued From page 4	F 689		

heaters with shoes both on and off to stay warm. Paperwork was then faxed over to hospital before EMS left." The author of this progress note no longer worked at the facility therefore was not interviewed.

An "AFTER HOURS TELEHEALTH CONSULT" nurse practitioner (NP) note dated 01/22/25 with an electronic signature on 01/23/25 at 3:35 a.m. read in part, "Nursing reports patient presentwith [sic] a left foot injury. A large blister on the bottom of the left foot has popped, resulting in complete loss of skin on the top half of the plantar surface. The patient reports a dull pain in the affected area. The toes are noted to be swollen, and theexposed [sic] area is bright red and bleeding. There is concern for potential infection. The patient is observed to be shaking and trembling. The cause of the injury is unclear, but it is suspected to be due to a burn or a blister from a burn that has completely sheared away.....Plan: Send patient to ER (emergency room) for urgent evaluation and treatment."

On 02/25/25 at 9:25 a.m., the surveyor made observations of resident rooms, therapy room, day rooms, and activity/dining room. No space heaters noted.

The surveyor interviewed Resident #1 in person on 02/25/25 at approximately 11:00 a.m. The resident was lying in bed with his legs and feet completely wrapped up with bed covers. The resident's feet were not visible but there was a wound vac present with tubing seen from the wound vac to the bottom of the bed, under the covers where his feet/legs were wrapped. When asked how he sustained the wounds on his feet, had he been resting his feet on a heat source the

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	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 5	F 689		

resident said, "I never put my feet on any heater. I pulled my chair close to the wall heater in the day room. My shoes were on." The resident described having watery leakage in the floor when he was sitting in his wheelchair and notice the same leakage in the bed. The resident then reported a doctor "down there" said the problem with his feet came from "frostbite" which is how it "dug down to the meat."

The medical director's "Info Note" dated 01/22/25 read in part, "Chief Complaint/Reason for this Visit. The patient is an 80-year-old male with cognitive impairment, seen today for evaluation of a left foot wound. HPI (history of present illness) Relating to this Visit. The patient reportedly sustained a partial-thickness burn to the distal plantar aspect of the left foot while sleeping with his foot on a radiator in the activities room. However, the patient has been wearing socks and shoes for the past 3 days, and the wound appears more consistent with sloughing of the epidermis versus desiccation of the epidermis via burn. The patient's shoe was intact without any evidence of disruption via heat, making it unlikely that the wound is consistent with a burn. The patient is unable to provide an accurate history due to his cognitive status, and reports of the patient sleeping with his foot on the radiator are hearsay, as it was not witnessed that the patient was actually placing his foot on the radiator.... Assessment and Plan 1. I96 Skin sloughing: An 80-year-old male presented with a wound on the plantar aspect of the left foot, initially suspected to be a burn. However, upon examination, the wound was more consistent with sloughing of the epidermis rather than a burn. The macerated appearance of the bilateral foot and the intact nature of the peri wound area are inconsistent

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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 689	Continued From page 6	F 689		

with a thermal injury. The patient's shoe showed no evidence of heat disruption, further supporting this assessment. Plan: Recommended the continued application of Xeroform to the wound. The wound will be monitored for signs of infection or worsening condition. If necessary, a wound care specialist may be consulted for further management. 2. R41.89 Cognitive deficits: The patient's cognitive status was noted during the visit, as he was unable to provide an accurate history. This cognitive impairment may have contributed to the misunderstanding of the wound's etiology. Plan: A cognitive assessment will be scheduled to evaluate the extent of the patient's cognitive deficits. Depending on the results, a referral to a neurologist or geriatrician may be necessary for further evaluation and management. The patient's family will be educated about the importance of monitoring the patient's cognitive status and ensuring his safety. 3. F42.4 Skin-picking disorder: Nursing staff was able to find pieces of the epidermis that had been removed by the patient. It appears that the patient was picking at macerated epidermis and due to his peripheral neuropathy was unable to feel any pain related to the self-inflicted wound. Once again, wound is inconsistent with a burn."

The medical director was interviewed on 02/26/25 at 10:40 a.m. The director reported having spent five (5) years as a wound care professional and a surgeon prior to those five years. The physician reported feeling strongly that Resident #1's wound was macerated tissue but stated he realized the tissue/area could also look like a burn, "easily, close call." The medical director stated, "We have never had any space heaters, tremendous liability." He reported Resident #1 sleeps with shoes and socks on for days at a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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 689	Continued From page 7	F 689		

time, had severe neuropathy so could not feel pain as the resident picked deeply at his skin. Staff found tissue in Resident #1's bed and shoes and socks were not damaged. He stated a severe burn would not have macerated tissue found. In relation to Resident #1's cognition, the physician stated the resident's cognition was relatively intact, he was "tangential (erratic) but redirectable" and able to answer questions appropriately initially but eventually goes on a tangent.

Resident #1 returned to the nursing home facility on 01/24/25, two days after being transfered to the hospital. The hospital discharge summary read in part, "Skin: Left foot: 8x9cm second degree burn with blistering and ulceration on the ball of the left foot, extends 5 cm down the medial aspect of the foot and 2 cm down the lateral aspect, across the entire plantar aspect of the foot, plantar aspect of toes 1-4 with blisters, toes 1 + 4 blisters intact. Right foot: single open 1x2cm blister at the base of the 4th toe." The resident had a follow up appointment with a burn center in an adjacent state on 02/03/25.

The DON reported that Resident #1 was transported to the follow up appointment on 02/03/25 and did not return that evening. Facility staff called the burn center and found out they had admitted Resident #1. The resident returned to the nursing home on 02/13/25 with a wound vac to his left foot. The burn center's "Surgery Discharge Summary" dated 02/13/25 at 6:05 a.m. read in part, "Admission Diagnoses: Burn (any degree) involving less than 10% of body surface. Discharge Diagnoses: Principal Problem: Burn (any degree) involving less than 10% of body surface. Hospital Course: Patient was burned on

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	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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WESTWOOD CENTER	20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 689	Continued From page 8	F 689		

bilateral soles of feet when he had his feet up next to a heater. Initially evaluated by and admitted to OSH (outside hospital) on 1/22/25 where he received IV (intravenous) antibiotics and local wound care for his burns. He was then seen in the (initials omitted) burn clinic on 2/3/2025 where he was evaluated and determined to have full thickness burns requiring operative debridement. Tangential excision of his left foot was done on 2/5/25 and the patient was plast [sic] in a wound vac. When post surgical dressings were removed, the left foot was found to have begun forming granulation tissue. Some areas of the left foot found to have nonviable tissue which was debrided bedside on 2/12/25. Burn team elected to not operate on his right foot but to continue local wound care and allow the burns to heal secondarily.... Thus, the patient is stable and suitable for discharge to the skilled nursing facility where he was a resident prior to admission. All burn wounds open at time of discharge (burn and grafts): TBSA (total body surface area <2% (less than 2%)...."

The administration interviewed everyone employed when Resident #1's foot wounds were identified. Those written interviews were reviewed. One CNA working the night Resident #1's foot wound was identified reported in an interview with administration that Resident #1 wore shoes all the time and will not let staff take them off. The CNA's interview read that night, he saw the resident picking feet in bed and he "consistently (surveyor unable to read the next word) scab and skin." The CNA's interview read "saw feet propped up on heater, space between two Geri chairs. Advised resident to put down. Socks on both feet on heater." The resident had not complained of any pain in his feet "until that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

morning. Stated feet was hurt while picking skin off. Less then an hour feet on heater." On 02/25/25 at approximately 11:40 p.m., the surveyor attempted to call and speak with this CNA, but he did not come to work that night. The CNA who encountered Resident #1 when he called for help with his foot bandage reported in the written interview the resident wore shoes "all the time" and the resident removed his shoes himself at the end of the day. She had never seen him picking at his skin or propping his feet on a heater.

In a meeting with the administrator and DON on 02/26/25 at 4:00 p.m., the concern with Resident #1's tissue injury on both feet was discussed. Whether the origin of the injury was a heater versus macerated tissue was unclear, but both the administrator and DON acknowledged Resident #1 was treated at a burn center for second degree burns. No further information was provided prior to the exit conference.

On 02/25/25 at 1:33 p.m., the administrator discussed the facility reported incident (FRI) and five-day investigation that followed. The administrator presented documentation of the facility's plan of correction which stemmed from Resident #1's injury. The information was reviewed to determine the allegation of compliance date which was documented as 01/24/25 with ongoing monitoring.

On 02/26/25 at 1:07 p.m., the administrator presented the facility's plan of correction (POC) which had a completion date of 01/24/25 and read as follows:

Plan of Correction:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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 689	Continued From page 10	F 689		

How will corrective action be accomplished for those residents found to have been affected by the deficient practice?

On 01/22/25, a Licensed Nurse entered Resident #1 room to check on him due to the resident stating he needed the nurse to bandage right foot related to it leaking.

On 01/22/25, the Licensed Nurse completed an assessment of his feet where it was identified that the resident has multiple blisters and open areas on the right foot. The Licensed Nurse contacted the on-call provider and received orders to send the resident out to the hospital for evaluation. The resident denied pain or discomfort at the time of assessment. Hospital records dated 01/22/25 indicated possible burn to the bottom of each foot.

The baseboard supplemental heating unit located in the day room was turned off at the breaker to ensure the unit is not used for safety concerns on 01/22/25 by the Maintenance Director.

How will the facility identify other residents having the potential to be affected by the same deficient practice?

On 01/23/25, Nurse Managers and/or designee conducted an audit of residents identified with a high risk of foot complications/foot injuries to include a diagnosis of Diabetes Mellitus, diabetic Neuropathy, Peripheral Vascular Disease, Peripheral Arterial Disease, Paralysis, and Loss of Sensation and to validate the implementation of a person centered plan of care to maintain foot health and care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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WESTWOOD CENTER	20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 689	Continued From page 11 On 01/23/25, Nurse Managers and/or designee reviewed Nursing progress notes in the last 90 days to identify any resident with changes in skin condition to include blisters, abrasions, or new skin impairments to verify a treatment plan was implemented to heal and prevent any further skin impairments. Skin assessments on all residents were completed by Licensed Nurses on 01/23/25 to identify any skin impairments. No new skin impairments were identified. On 01/23/25, the Maintenance Director conducted an inspection of all baseboard supplemental heating units an PTACS (heating units in resident rooms) in the facility and recorded the temperature to validate the units were operating below the maximum surface temperature allowed by the Underwriters Laboratory Requirements. All units were operating below the maximum surface temperature. Additionally, the Maintenance Director conducted rounds to verify no unauthorized heating units were identified in resident rooms and common areas. No concerns were identified. Social Service Director and/or designee interviewed alert and oriented residents with a BIMS score of 13 to 15 to identify any concerns related to care and services. Any concerns were addressed through the grievance process. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur:	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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 689	Continued From page 12	F 689		

The Nurse Practice Educator and/or designee re-educated Licensed Nurses and Certified Nursing Assistants on Foot Health and Care with emphasis on diabetic foot care. Education was completed by 01/24/25. Nurse Practice Educator and/or designee will track and verify no Licensed Nurse(s) or Certified Nursing Assistant will be allowed to return to work with scheduled time off, on leave of absence (FMLA), vacation, or PRN until they have successfully completed the education/training. New hires will be educated by the Nurse Practice Educator during the orientation process.

The Administrator re-educated the Maintenance Director on preventative maintenance tasks to ensure heating units are operating below the maximum surface temperature allowed by the Underwriters Laboratory Requirements by 01/23/25.

The baseboard supplemental heating units located in the day rooms will remain disengaged and if supplemental heating is warranted, the Maintenance Director will install an infrared heating panel or install safety guards to eliminate potential risk to residents. A preventative maintenance task will be added to the TELS monitoring system.

How will the facility monitor it's corrective actions to ensure the deficient practice will not recur?

On 01/22/25, the center Administrator conducted an ADHOC Quality Assurance Improvement meeting to review and approve a plan of correction to include education, policies, and procedures and quality improvement monitoring beginning on 01/23/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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WESTWOOD CENTER	20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

The Maintenance Director and or designee to conduct quality improvement monitoring through observation to ensure there are no supplemental heating units in use 5x per week for 4 weeks, 1x weekly for 4 weeks starting on 01/22/25. The Nursing Home Administrator and/or designee will review the results in the monthly QAPI meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of correction will be implemented as necessary.

Beginning 01/23/25, the Director of Nursing, Unit Manager or Designee will assess the feet of 5 residents twice weekly for eight weeks, and then 5 residents weekly for four weeks to ensure proper foot care/health and that appropriate interventions are in place. The Director of Nursing Services and/or designee will review the results of the audits in the monthly Quality Assurance Performance Improvement Committee meeting for one quarter to ensure compliance is achieved and sustained. Subsequent plans of corrections will be implemented as necessary.

The Administrator will report the results of the monitoring to the QAPI committee for review and recommendations for the time frame of the monitoring period or as it is amended by the committee.

Date of compliance: 1/24/25

On 02/26/25, the surveyor reviewed the credible evidence of the plan of correction's implementation. All staff had been educated if not in person, via phone calls by the DON. Those educated via phone calls signed the in-service sheet when they returned to the facility. Staff who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495200	A. BUILDING _____ B. WING _____	C 02/27/2025

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WESTWOOD CENTER	20 WESTWOOD MEDICAL PARK BLUEFIELD, VA 24605

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F 689	Continued From page 14 had been educated via phone but had not yet returned to work were the only ones without signatures. On 02/26/25 at 12:40p.m., the surveyor interviewed in person all patient-care staff working. All interviewees voiced they received education on foot health and care by facility staff in January with one employee stating the education was provided upon being hired recently. This is a past non-compliance deficiency.	F 689		