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WESTMORELAND REHABILITATION & HEALTHCARE CENTER	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated standard survey was conducted 03/31/2025 through 04/02/2025, 04/07/2025 through 04/08/2025, and 04/22/2025. Significant corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. Two (2) complaints were investigated during the survey: VA00063802, Substantiated with deficiency VA00061421, Substantiated with deficiency The census in this 66 certified bed facility was 63 at the time of the survey. The survey sample consisted of five (5) Resident reviews (Resident #1 through Resident #5).	F 000		
F 687 SS=G	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on clinical record review, staff, and family interviews, the facility failed to provide the necessary foot care and treatment to avoid complications from conditions such as diabetes,	F 687	1. Resident #5 no longer resides at the facility. The facility failed to provide the necessary foot care and treatment to avoid complications from conditions such	6/4/25

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

Electronically Signed | 05/23/2025

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F 687	Continued From page 1 including referral and treatment by a qualified professional, for one (1) (Resident #5) of five (5) residents in the survey sample, which resulted in harm. The findings included: Resident #5 was admitted to the facility on 07/19/2023 with a diagnosis of diabetes, cerebrovascular accident, dysphagia, aphasia, hypertension, cognitive communication deficiency, chronic ischemic heart disease, adult failure to thrive, malnutrition, hepatitis, and difficulty walking. Resident #5's Quarterly Minimum Data Set (MDS), dated 01/24/2024, scored the resident on the Brief Interview for Mental Status (BIMS) as a 4 out of 15, indicating severe cognitive impairment, but able to complete the BIMS assessment. The resident was not assessed to resist care, including ADL assistance, taking medications, and receiving the care necessary to achieve the resident's goals. The resident was not assessed to have behaviors that would deter receiving care and services. Resident #5 had a care plan dated 7/19/2023 for diabetes mellitus that included proper foot care daily. Avoid tight, pinching shoes. Report any redness, blistering, or open areas promptly to the physician or designee. Check nail length and trim and clean on bath day and as necessary. Provide skin inspection daily during care. Observe for redness, open areas, scratches, cuts, bruises, etc., and report changes to the nurse. Report any changes to the nurse. Review of Resident #5's medical records dated	F 687	as diabetes, including referral and treatment by a qualified professional for resident #5. 2. Current residents have the potential to be affected by deficient practice. DON/designee audited all current residents for foot care. Provider notified for a Podiatry consult for residents with Diabetes and/or foot wounds as indicated from audit and Podiatry consults obtained as ordered by the Provider. 3. DON/designee will re-educate all licensed nursing staff on the policy and procedure for foot care to include contacting the provider as indicated for a Podiatry consult for residents with a diagnosis of Diabetes and/or foot wounds. 4. DON/designee will audit new admissions for a diagnosis of Diabetes and/or a foot wound weekly for six weeks to ensure Provider notification and Podiatry referrals as indicated. DON/designee will audit current residents with a new diagnosis of Diabetes for Provider notification and a Podiatry referral as indicated weekly for 6 weeks. DON/designee will audit nursing skin checks for any new foot wounds to ensure Provider notification and referrals as indicated weekly for 6 weeks. Results of the audits will be submitted to QAPI committee monthly for compliance verification and ongoing audit process. 5. DOC-June 4, 2025	

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12/25/2023 at 5:07 PM documented that Resident#5 was transported to the emergency room (ER) by a family member (FM #2) to be assessed for a fall and weight loss. The emergency room physician's assessment documentation indicated, "Left foot noted with bleeding about the big toenail. Generally speaking, bilateral feet, the patient has significantly overgrown toenails, will need podiatry to evaluate further." Resident #5 was treated and released from the emergency department and returned to the facility on 12/25/2023.

Resident #5's medical record, dated 12/29/2023 at 11:32 PM, documented that the facility's staff obtained a culture of the resident's left toe drainage, but the courier was unable to transport the specimen. The residents' medical records did not indicate why the courier was unable to transport specimens at that time.

Resident #5's medical record, dated 12/30/2023 at 11:56 AM, documented that the resident was diagnosed with a cutaneous abscess of the left great toe: "We will attempt a culture of the drainage, and I will place the patient on Keflex 500 mg every 12 hours for 10 days. We will attempt to get him into a podiatrist as soon as possible."

A review of Resident #5's medical records dated 01/03/2024 at 03:03 AM documented that facility staff again obtained a culture of the resident's left toe and sent it to the lab for examination due to inability to be sent out on 12/29/2023..

Resident #5's medical record, dated 01/05/2024 at 8:09 AM, documented that the facility staff received the results from the resident's left toe

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drainage culture, which was *gram positive; "We are trying to get him to see a podiatrist." *Gram-positive is an essential diagnostic tool/staining, helping to identify the type of bacteria causing an infection and guide appropriate antibiotic treatmenthttps://www.merckmanuals.com/home/infections/bacterial-infections-gram-positive-bacteria/overview-of-gram-positive-bacteria.

Resident #5's medical record, dated 01/08/2024 at 12:00 AM, documented the resident on Doxycycline (an antibiotic) and a "Podiatry consult pending."

Resident #5's medical record, dated 01/09/2024, 05:30 AM, documented that the resident remained on antibiotics for the left great toe; "The resident is on contact precautions due to Methicillin-resistant Staphylococcus aureus (MRSA), (a type of staph bacteria that's resistant to many antibiotics used to treat regular staph infections https://www.mayoclinic.org/diseases-conditions/mrsa/symptoms-causes/syc-20375336).

Resident #5's medical records, dated 01/15/2024 at 1:25 PM, documented that the resident's left toenail was falling off; "No drainage was noted at this time."

Resident #5's medical records, dated 01/19/2024 at 03:25 AM, documented that the resident underwent a procedure by the facility's wound nurse to remove the left great toenail. The facility's wound nurse noted that the "Patient nonverbally expressed too much discomfort to debride."

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Resident #5's medical record revealed that on 02/02/2024, at 12:00 AM, the facility's Nurse Practitioner (NP) documented the resident's left toe as healed.

Resident #5's medical record entry revealed that the facility's wound care nurse was still treating the resident for a great left toe infection after 02/02/2024.

Resident #5's medical records entry dated 2/25/2024 at 12:13 PM documented, "Resident c/o (complaining of) pain of left great toe, removed shoe, and resident indicated relief of pain".

Resident #5's medical record entry was dated 02/26/2024 at 12:00 AM. The facility's NP documented the resident's left great toe cutaneous abscess as resolved.

Resident #5's medical record dated 3/02/2024 at 02:54 AM documented that the resident felt warm to the touch, and vital signs were obtained. The residents' temperature was 102.2 Fahrenheit (F) (Normal temperature for adults is in the range of 97 to 99 (https://www.mayoclinic.org/first-aid/first-aid-fever/basics/art-20056685). The resident was administered a standing order for Acetaminophen 650 milligram (mg) orally.

Resident #5's medical record dated 3/02/2024 at 09:01 AM documented the resident's temperature as 102.3 (F).

Resident #5's medical record, dated 03/06/2024 at 12:00 AM, documented that the facility's NP assessed the resident for "spiking low-grade

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fever of 100.2 this morning. Resident # 5 has been complaining of foot pain. Resident #5 was observed with an additional left great toe site where a previous subcutaneous cyst was infected but had been resolved."

The medical record of Resident #5, dated 03/08/2024 at 9:24 PM, documented "Resident noted to have fever during feeding, 102.3, Tylenol given." The facility staff contacted Resident #5's family member regarding the resident's change in condition. FM requested that the resident be transported to the hospital. Emergency medical service (EMS) transported Resident #5 to the hospital on 3/8/24 at 9:45 PM.

Resident #5's emergency room record dated 3/08/2024 documented the "Resident arrived from a nursing facility, transported by EMS with a fever of 102 (F), as per the patient's sister, he was able to ambulate with a walker 3 months ago, but now is bedridden and has lost lots of weight in the last 3 months." Resident #5 was admitted to the hospital intensive care unit with diagnoses of Sepsis, Gangrene, Osteomyelitis of the left great toe, and pressure ulcer of the left great toe. Resident #5 was immediately scheduled for surgery to amputate his left great toe by the hospital.

An interview was conducted on 4/07/25 at 1:15 PM with Resident #5's Family Member (FM #2) regarding the residents' care in the nursing facility. FM#2 stated the resident had a stroke but was making progress after being hospitalized for several months. FM #2 stated she scheduled and attended all the medical appointments of Resident #5 during his admission. She said she would usually pick up the resident from the

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nursing facility and transport him to wherever he needed. FM #5 stated she would often speak with the facility's NP regarding Resident #5's condition, including the resident's toenails, which needed clipping.

During the above interview with FM #2, she stated the NP told her the facility staff would often skip cutting Resident #5 when the Podiatrist arrived. FM #2 said the NP indicated Resident #5 to be rescheduled to be evaluated by the Podiatrist. FM #2 stated that Resident #5 kept having fevers over the course of weeks, and on 12/25/2023, she transported the resident to the emergency department. FM #2 said she observed Resident #5 while waiting to be seen in the emergency department as he continuously shuffled his left foot back and forth. She said the emergency room nurse removed the resident's shoe and observed a bloody sock filled with pus. FM #2 stated Resident #5's left foot big toenail was partially torn off. FM #2 said once the resident returned to the facility, she once again requested to have the resident assessed by a podiatrist. She stated that the facility staff would always say, "(Resident #5's name) would be seen soon by podiatry, which never happened." FM #2 requested that Resident #5 be transported again to the emergency room on 3/8/2024. She said Resident #5 still had high fevers, and his health declined. FM #2 stated, "(Resident's name) was diagnosed with Sepsis and Gangrene of the left big toe. The hospital doctor told (Resident #5's name) and me that, because of complications and infection in his foot, amputation would be the only recourse. The procedure was scheduled, and I made sure he did not return to (Name of nursing facility)." The reviewed hospital medical records supported the information shared during

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the interview by FM#2.

An interview was conducted on 4/22/2024 at 12:00 PM with the facility's Podiatrist (POD #6) regarding Resident #5's treatment provided during his admission. POD#6 stated that the resident was never assessed during his admission. She said Resident #5 was scheduled to be seen on 12/12/2023, but the resident appeared agitated when she approached him. POD#6 said Resident #5's appointment was documented as a refusal. POD#6 stated she was never informed or contacted by the facility later regarding Resident #5's foot condition. POD #6 stated that the facility staff was responsible for creating the list of residents needing to be assessed during their visits. She said Resident #5 could have been scheduled to be seen by a local Podiatrist if needed.

A review of Resident #5's medical records did not indicate the resident refused any podiatry treatments during the admission.

A meeting was conducted on 4/22/2025 at 12:30 PM with the facility Administrator and Director of Nursing (DON). The DON stated that Resident #5 was scheduled to see the Podiatrist on 12/12/2023, and the resident refused treatment. The DON said the facility staff had no control over who the Podiatrist saw during their visits. It was not explained who prepared the list for the podiatrist visit or why the resident was never evaluated by a qualified professional, who would have been the podiatrist.

The facility's administrator stated that the facility did not have podiatry coverage for a while during this timeframe. The facility administrator emailed

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F 687	Continued From page 8 a copy of a memorandum from the facility's Podiatry vendor regarding the facility's lack of coverage for the following months: "July 2023-November 2023, we did not have a provider available for Westmoreland". "The facility's Podiatrist was on maternity leave from 12/23/2024 through 4/19/2024". No additional information was presented regarding this incident.	F 687		
F 689 SS=D	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: F600 AFTER F689 Based on clinical record review, staff, and resident interviews, the facility staff failed to ensure adequate assistance was implemented for bed mobility, which the facility had control over to prevent accidents for one (1) of five (5) residents in the survey sample, Resident #1. The findings included: Resident #1 was admitted to the facility on 6/3/23 with a diagnosis of Multiple Sclerosis, hemiplegia, and hemiparesis following a stroke affecting the right dominant side, muscle wasting and atrophy at multiple sites, lymphedema, spinal stenosis in	F 689	1. Resident #1 continues to reside at the facility. Resident #1's Kardex and Care plan have been reviewed and/or updated to reflect a two-person assist for bed mobility. A HIPPA compliant identifier has been placed on resident #1's bed to indicate two-person assistance required for bed mobility. 2. Current residents have the potential to be affected by this deficient practice. DON/designee audited current residents for required assistance with bed mobility. DON/designee audited current residents Kardex's to ensure they have been updated to reflect if two-person assist with	6/4/25

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F 689	Continued From page 9 the lumbar region without neurogenic claudication, and pulmonary embolism. Resident #1's Other Payment Assessment Minimum Data Set (MDS) with an assessment reference date of 3/25/25 coded for bed mobility (how the resident moves to and from lying position, turns side to side, and positions their body while in bed) as needing extensive assistance and support from 2 or more persons (s), physical assistance. Resident #1 Brief Interview for Mental Status (BIMS) scored 15 out of 15, indicating no cognitive impairment. Resident had a revised care plan dated 3/3/25 as having an ADL (Activity of Daily Living) self-care performance deficit related to weakness, Stroke, deconditioned status post hospitalization, Hemiparesis/Hemiplegia, muscle wasting and atrophy, and sequelae of the stroke. The care plan failed to address bed mobility needs, including two staff members for assistance. Review of Resident #1's progress notes dated 3/26/25 at 2:41 PM indicated that at approximately 10:40 AM, CNA #1 reported that Resident #1 had fallen out of bed and was lying on the floor. Facility staff documented that Resident #1 was immediately assessed and observed positioned on the right side of the bed on the floor. Resident #1 was alert, responded WNL (Within Normal Limits), and had no pain. ROM (Range of Motion) was WNL. Resident #1 was administered PRN (as needed) Tylenol as a pain preventative. The facility's staff immediately installed bed rails to the upper portion of the resident's bed to assist with bed mobility during turning and repositioning.	F 689	bed mobility is indicated and that the care plan has been updated to reflect if a two-person assist for bed mobility in indicated. 3. DON/designee will re-educate all nursing staff on the policy and procedure for bed mobility to include ensuring appropriate assistance provided as per the resident plan of care. The facility has implemented a process for all residents with two-person assist for bed mobility to have a HIPPA compliant identifier placed on their bed for quick identification to staff. 4. DON/designee will complete audits of residents that require a two person assist for bed mobility to ensure the Kardex, care plan, and identifiers are in place 3x/weekly for 2 weeks, 2x/weekly for 2 weeks, and 1x/weekly for 2 weeks. DON/designee will complete an audit of residents that require a two-person assist with bed mobility to ensure two-person assistance is provided 3x/weekly for 2 weeks, 2x weekly for 2 weeks, and 1x/weekly for 2 weeks. Results of the audits will be submitted to QAPI committee monthly for compliance verification and ongoing audit process. 5. DOC June 4, 2025	

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An interview was conducted on 4/1/25 at 12:10 PM with Resident #1 regarding the incident. Resident #1 was just readmitted to the facility after being hospitalized from 3/26/25 to 3/31/25, for a condition determined to be unrelated to the fall. Resident #1 was eating in the facility's TV room. Resident #1 observed CNA #1 walking with the surveyor into the facility's TV room, at which time she stated, "That's the nurse who dropped me!" Resident #1 expressed that CNA #1 was bathing her and attempted to turn her to the right side. The resident said there were usually two or more nurses helping when repositioning her in bed. Resident #1 said she believed the facility is short of staff. Resident #1 stated, "I remember being turned to the right side of the bed and continuously rolling straight towards the floor. I could hear the CNA repeatedly saying I'm Sorry! I'm sorry! She rushed out of the room to get help, leaving me on the floor alone." Resident #1 said the facility Administrator and Director of Nursing entered the room after the fall. Resident #1 stated she experienced pain in her back, and both legs were swollen. The resident remembered being transferred back into bed after the incident. Resident #1 stated she was having difficulty staying awake and told the facility staff, "Just sit me in a chair." Resident #1 said that since the fall, she felt apprehensive about the staff assisting with bathing or showering.

On 4/1/25 at 12:53 PM with CNA #1, an interview was conducted regarding the residents' fall. CNA said, "I normally don't provide care for this resident, but I did it. I was bathing Resident #1, and I turned the resident onto her side using a drawsheet (a flat sheet, often smaller than a regular bed sheet, used in a healthcare setting to assist in repositioning or transferring patients in

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bed). I pulled too hard on the drawsheet, and Resident #1 rolled towards the right side of the bed. I observed the resident attempting to reach outward with her only functional left arm as she fell onto the floor on the opposite side of the bed, away from me. I heard (Resident #1's name) moaning on the floor. I immediately left the resident's room to get assistance." CNA said that LPN #2 entered the room, assessed the resident, and stayed with the resident on the floor. CNA #1 stated that the Director of Nursing (DON) and nurse practitioner (NP) came into Resident #1's room and assisted with getting the resident back into bed by utilizing the full mechanical lift. CNA #1 said she told everyone present how the incident occurred and that she dropped Resident #1 by accident.

A meeting was conducted on 4/1/25 at 2:28 PM with the Facility's Nurse Practitioner (NP #6), who arrived in Resident #1's room after the fall. NP #6 stated he was called to assist with getting the resident back in bed after the fall. NP #6 said the resident was on the floor when he arrived in the room. NP #6 stated Resident #1 had no broken bones, but he was concerned about her legs swelling. He said the resident had no complaints of pain. NP #6 stated the facility usually waits a couple of hours before calling emergency medical services for residents who fall, if there is no obvious evidence of broken bones or immediate neurological changes.

A review of the facility's residents' fall investigations for January 2025 through March 2025. The facility Director of Nursing (DON) presented the fall investigations binder, but the binder did not include information regarding Resident #1's fall investigation. The investigation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495268	A. BUILDING _____ B. WING _____	C 04/22/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMORELAND REHABILITATION & HEALTHCARE CENTER	2400 MCKINNEY BOULEVARD COLONIAL BEACH, VA 22443

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F 689	Continued From page 12	F 689		

binder was returned to the DON, and the fall investigation binder was asked if it was complete. The DON later returned the investigation binder, and Resident #1's information regarding the resident's fall was included. The DON did not explain why Resident #1's fall investigation was not initially included in the binder.

A meeting with the DON was conducted on 4/1/25 at 2:45 PM regarding Resident #1. The DON stated CNA #1 came to her office for help when Resident #1 fell. The DON said NP 6 and the facility Administrator were in the room. Resident #1 was lying on the floor, lying on her back, and said she was not in pain. The DON stated Resident #1 was assessed, and the resident wanted to get up. She said Neuro checks were within normal limits, and Resident #1 denied hitting her head, which was corroborated by the CNA. DON stated CNA #1 provided morning care to Resident #1, while CNA #1 turned the resident on her side, the resident continued to roll off the mattress to the floor.

The final exit meeting was conducted on 4/22/25 at 12:30 PM with the facility Administrator and Director of Nursing. No additional information was presented regarding this incident.