STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	265193	A. Building B. Wing	12/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Westwood Hills Health & Rehabilitation Center	3100 Warrior Lane Poplar Bluff, MO 63901

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to update and revise care plans with specific interventions tailored to meet individual needs for two residents (Residents #67 and #87) out of 18 sampled residents. The facility census was 74.Review of the facility's policy titled, Care Plan Review, undated, showed:- To ensure each resident will have an updated person-centered comprehensive care plan developed and implemented to meet and address the resident's medical, physical, mental and psychological needs;- Care plans are reviewed quarterly and as resident's condition changes;- Individualized to provide person-centered care;- Areas of review to provide but not limited to: activities of daily living (ADLs), nutrition, skin, behaviors, and individualized preferences. 1. Review of Resident #67's medical record showed:- admitted on [DATE];- Diagnoses of Alzheimer's disease (progressive mental deterioration), dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), chronic obstructive pulmonary disease (COPD - a chronic inflammatory lung disease that causes obstructed airflow from the lungs), and major depressive disorder (a serious medical illness that negatively affects how you feel, the way you think and how you act).Review of the facility's Matrix (a reference guide listing all current resident health conditions, care needs, and special treatments for each person) showed:- Resident with falls.Review of the resident's Progress Notes showed:- On 08/23/25, the resident had an unwitnessed fall with a large skin tear to the right elbow;- On 08/28/25, the resident had an unwitnessed fall with a small skin tear to the right outer eyebrow/temple area;- On 10/19/25, the resident had a witnessed fall with no injury ;- On 11/03/25, the resident had an unwitnessed fall with a large, raised area on the forehead;- On 11/19/25, the resident had a witnessed fall with no injury.Review of the resident's Care Plan, revised 12/04/25, showed:- Falls not addressed;- The facility failed to revise or update the resident's care plan with interventions after multiple reported falls.Observations of the resident's room on 12/03/25 at 11:34 A.M., and 2:10 P.M., and 12/04/25 at 11:10 A.M., showed: - Fall mats on the floor on both sides of the bed;- The bed in the lowest position. 2. Review of Resident #87's medical record showed:- admitted on [DATE];- Diagnoses of type II diabetes mellitus (DM - a condition that affects the way the body processes blood sugar), COPD, and major depressive disorder.Review of the facility's Matrix showed:- Resident with falls.Review of the resident's Progress Notes showed:- On 03/09/25, the resident had an unwitnessed fall with no injury;- On 03/28/25, the resident had an unwitnessed fall with an abrasion from the middle to the upper shoulder;- On 07/19/25, the resident had an unwitnessed fall with a large, raised area to the right forehead above the eye;- On 08/08/25, the resident had an unwitnessed fall with no injury;- On 10/14/25, the resident had an unwitnessed fall with no injury;- On 10/22/25, the resident had an unwitnessed fall with no injury.Review of the resident's Care Plan, revised 10/27/25, showed:- A fall on 03/09/25. The resident slid out of the wheelchair and Dysem (a non-slip material used to provide grip and stability) applied to the wheelchair seat;- The facility failed to revise or update the resident's care plan with interventions after multiple reported falls.Observations on 12/02/25 at 10:38 A.M., and 2:44 P.M., and 12/04/25 at 9:18 A.M., showed:- A fall mat on the right (continued on next page)

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.

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

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	side of the bed on the floor;- The bed not in the lowest position.During an interview on 12/02/25 at 1:54 P.M., Resident #87 said he/she had several falls in the last few months. A fall mat was placed on the side of his/her bed in case he/she fell off the bed. Sometimes staff lowered his/her bed at night. During an interview on 12/05/25 at 9:33 A.M., the Minimum Data Set (MDS - a federally mandated assessment instrument completed by the facility staff) Coordinator said if a resident had a fall, the care plan should be updated and revised with interventions in place. During an interview on 12/05/25 at 11:25 P.M., the Assistant Director of Nursing (ADON) said if a resident had a fall, there should be fall interventions in place and the care plan should be updated to ensure safety measures for the resident. During an interview on 12/05/25 at 11:27 P.M., the Director of Nursing (DON) said if a resident had a fall, there should be fall interventions in place and the care plan should be updated to ensure safety measures for the resident. During an interview on 12/05/25 at 11:37 A.M., the Administrator said there should be a fall event with interventions put in place after a resident fell. The care plan should be updated to ensure safety measures for the resident had been made.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on observation, interview and record review, the facility failed to ensure one resident (Resident #48) out of 18 sampled residents received treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices related to pain management. The facility's census was 74.Review of the facility's policy titled, Pain Prevention and Treatment, dated October 2017, showed:- Every resident will be assessed for pain using the Pain Screen including an appropriate pain rating scale upon admission and at least quarterly;- Residents who are not able to communicate verbally or have cognitive deficit that precludes them from answering yes/no questions will be screened using the pain observation screen;- Interventions for pain consist of pharmacological (related to drugs and how they relate to the body) and non-pharmacological (without drugs or medicine).1. Review of Resident #48's medical record showed:- An admission date of 11/21/25;- Diagnoses of urinary tract infection (UTI - an infection in any part of the urinary system), severe sepsis (a life threatening emergency that happens when the body's response to an infection damages vital organs), chronic pain (persistent pain that lasts longer than three months), hyperkalemia (abnormally high level of potassium in the blood), severe dementia (a disorder marked by memory loss, personality changes, and impaired reasoning that interferes with daily functioning), depression (a mood disorder causing persistent feeling of sadness and loss of interests), diarrhea (passing loose, watery stools frequently), and osteoporosis (a bone disease causing bones to become brittle).Review of the resident's Baseline Care Plan, undated, showed: - Resident nonverbal, unoriented to person, place and time;- Unable to determine pain scale and location of pain;- Resident received acetaminophen (an over-the-counter (OTC) pain medication) for mild and moderate pain;- Non-pharmacological pain management (i.e., repositioning, shifting or turning someone who can't move).Review of the resident's Staff Pain Assessment, dated 11/24/25, showed:- No signs of pain or possible pain in the last five days;- Resident showed one to two days for the frequency of pain or possible pain in the last five days in which the resident showed evidence of pain or possible pain.Review of the resident's Physician's Order Sheet (POS), dated December 2025, showed:- An order for acetaminophen 650 milligram (mg) extended release (ER) twice a day as needed, dated 11/21/25;- An order for Triad (wound treatment) Paste to all areas of the coccyx (tailbone) as needed, dated 11/21/25;- An order to cleanse the sacrum (area above the tailbone) wound and left leg, apply Medihoney (wound treatment), and bordered foam dressing daily and as needed, dated 11/24/25;- An order for hydrocodone/acetaminophen (a prescription-strength pain medication used to treat moderate to severe pain) tablet 5/325 mg every six hours as needed with special instructions to give before treatment/incontinent care, dated 12/03/25. Review of the resident's Medication Administration Records (MARs), dated November and December 2025, showed: - Acetaminophen 625 mg administered on 11/25/25 at 11:03 P.M., 11/26/25 at 6:40 A.M., 11/27/25 at 6:24 A.M., 11/28/25 at 5:31 A.M., 11/29/25 3:19 P.M., 12/01/25 at 6:41 A.M., 12/02/25 at 4:10 A.M., and 12/03/25 at 5:04 A.M. and 2:22 P.M.;- Hydrocodone/acetaminophen 5/325 mg tablet administered on 12/03/25 at 11:50 P.M., 12/04/25 at 9:42 A.M., and 12/05/25 at 6:32 A.M. During an interview on 12/03/25 at 1:27 P.M., the Director of Nursing (DON) said there should be three Certified Nurse Aides (CNAs) in the resident's room to assist with care because the resident was combative at times during care.Observation on 12/03/25 at 1:30 P.M. of the resident's catheter (a tube inserted into the bladder to drain urine) and incontinent care showed: - The resident lay in bed on his/her back with no wedge under him/her and no dressing on his/her coccyx wound;- CNA D, CNA E, and CNA F provided catheter and incontinent care for the resident;- During care, the resident repeatedly moaned out and showed facial grimacing (expression indicating pain, discomfort, or strong negative emotion);- CNA D held the resident's hands during care and assured the resident that it would be okay, and it would be over soon.During an interview on 12/03/25 at 2:20 P.M., the DON said she just contacted the resident's physician regarding his/her pain. The physician gave a new order for hydrocodone 5/325 (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	mg and the prescription was sent to the pharmacy. The physician had also spoken to the family that morning regarding hospice care while making rounds. During an interview on 12/03/25 at 3:43 P.M., the DON said she had not personally assessed the resident's wound, and was not aware the resident was in pain. She would expect the resident to receive appropriate pain management. The physician did not assess the resident's wound this morning during his/her rounds. During an interview on 12/04/25 at 8:42 A.M., CNA D said he/she believed the resident was in pain during his/her catheter and incontinent care on 12/03/25.During an interview on 12/04/25 at 10:39 A.M., CNA F said during catheter care on 12/03/25, he/she believed the resident was in pain.Observation on 12/04/25 at 11:42 P.M. of the resident's wound care showed: - The resident lay in bed on his/her back with no wedge under him/her;- Certified Medical Technician (CMT) I performed wound care while Registered Nurse (RN) G stood at the head of the bed and held the resident's hands;- The resident verbally moaned two times and showed facial grimacing when CMT I rolled the resident on his/her side to start the wound care;- The resident continued to moan and showed facial grimacing during the entire wound care.During an interview on 12/04/25 at 12:04 P.M., CMT I said he/she thought the resident was in pain during the wound care. The resident had received his/her hydrocodone/acetaminophen dose at 9:42 A.M., and he/she waited two hours for the pain medication to work before providing the resident's wound care. He/she would expect the resident to receive appropriate pain management. During an interview on 12/04/25 at 12:06 P.M., RN G said he/she felt like the resident was most likely in pain during the wound care. The resident had received his/her hydrocodone/acetaminophen dose at 9:42 A.M., and he/she waited two hours for the pain medication to work before providing the resident's wound care. In the past, he/she had not known of the resident to be in pain, nor had it been reported to him/her until yesterday. RN G would expect the resident to have proper pain medication, but the resident was non-verbal which made it difficult to know when the resident was in pain. He/she had not noticed any signs of pain, nor had any been reported to him/her. Observation on 12/05/25 at 9:33 A.M. of the resident's incontinent and wound care showed: - CNA J and CNA K provided incontinent care for the resident;- The resident moaned and showed facial grimacing when CNA K rolled the resident to his/her side;- The resident took his/her left hand and tried to push the mattress off of his/her coccyx area;- CNA K apologized to the resident as he/she cleaned the resident;- The resident moaned and tried to grab CNA K's hand;- CNA J held the resident's hands and assured him/her it would be over soon;- CNA E stood inside the door and asked about the resident's call light;- CNA K requested for CNA E to get CMT I to change the resident's soiled wound dressing on his/her coccyx;- The resident lay on his/her side moaning and showed facial grimacing for 12 minutes while waiting for CMT I to come to the room to provide the wound care;- The resident moaned and tried to reach for CMT I's hand while he/she provided the wound care.During an interview on 12/05/25 at 9:57 A.M., CNA K said when the resident was first admitted to the facility, he/she yelled out in pain during incontinent and wound care. CNA K did let the nurses know when the resident yelled out in pain. He/she was not made aware of the new order of hydrocodone/acetaminophen could be administered prior to care. Staff were trained on non-verbal signs of pain and to report things like facial grimacing or grabbing onto staff like the resident was doing. He/she thought the resident was in pain during the incontinent care.During an interview on 12/05/25 at 11:38 A.M., the DON said she would expect staff to report non-verbal pain cues of combativeness, facial grimacing, and pushing staff away during care and/or treatment.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to ensure two residents (Residents #3 and #36) had medications and biologicals labeled in accordance with currently accepted practices for two medication carts out of two sampled medication carts. This had the potential to affect all residents. The facility's census was 74.Review of the facility's policy titled, Medication Storage, dated October 2017, showed:- All medications must be clearly labeled with the resident name, drug name, strength, dosage, directions, and expiration date;- Any multi-dose vials or solutions, once opened, must be dated and initialed and discarded within 28 days unless manufacturer specifies otherwise.1.Observation of the A Hall medication cart on 12/05/25 at 7:40 A.M., for Resident #3 showed: - One opened bottle of Rybelus (diabetes medication) not labeled; - One opened bottle of prednisolone (eye drops-to treat inflammation of the eye) not labeled;- One opened bottle of fluticasone propionate (a nasal spray-to treat inflammation) not labeled;- One card with five tablets of Bactrim (an antibiotic) Double Strength (DS) tablets with an expiration date of 11/09/25.2. Observation of the B Hall medication cart on 12/05/25 at 7:57 A.M., for Resident #36 showed: - One card of hydroxyzine (an antihistamine medication) 25 milligram (mg) with an expiration date of 05/25/25;- One card of hydroxyzine 25 mg with an expiration date of 07/25/25; - One card of dicyclomine (irritable bowel syndrome medication) 10 mg with an expiration date of 08/25/25;- One card of dicyclomine 10 mg with an expiration date of 11/24/25;- One opened bottle of ciclopriox (fungal and yeast infection medication) solution 8 percent (%) with an expiration date of 5/25/25;- One opened bottle of Active liquid protein not dated.During an interview on 12/05/25 at 8:26 A.M., Certified Medication Technician (CMT) B said expired medications should be removed from the cart and disposed of. Sometimes staff labeled a box and not the actual medication, so when the medication wasn't in the box, the expired date couldn't be seen. During an interview on 12/05/2025 at 8:08 A.M., Licensed Practical Nurse (LPN) C said expired medications should be properly disposed of. Opened bottles should have the opened date written visibly.During an interview on 12/05/2025 at 11:33 A.M., the Director of Nursing (DON) said she would expect expired medications to be disposed of and for a resident not to receive an expired medication.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, interview and record review, the facility failed to follow infection control protocols during wound care for one resident (Resident #81) out of five sampled residents. The facility census was 74.Review of the facility's policy titled, Dressings, Dry/Clean, dated January 2018, showed:- Put on clean gloves;- Assess the wound and surrounding skin for edema, redness, drainage, tissue healing progress and wound stage;- Cleanse the wound. If using gauze, use a clean gauze for each cleansing stroke. Clean from the least contaminated area to the most contaminated area (usually from the center outward);- Use dry gauze to pat the wound dry;- Apply the ordered dressing and secure with tape;- Discard disposable items into the designated container;- Remove disposable gloves and discard into designated container. Wash and dry your hands thoroughly.1. Review of Resident #81's medical record showed: - Diagnoses of cerebral infarction (stroke), vascular dementia (cognitive decline caused by reduced blood flow to the brain), dysphagia (difficulty swallowing), and anxiety (persistent worry and fear about everyday situations).Review of the resident's Physician Order Sheet (POS), dated December 2025, showed:- An order to cleanse and apply Medi-honey (wound treatment that helps clean the wound) to the wound on the left upper thigh, cover with bordered foam daily and as needed (PRN), dated 11/17/25.Observation of the resident's wound care on 12/04/25 at 11:15 A.M., showed: - Enhanced Barrier Precautions (EBP) signage and supplies attached to the outside of the resident's door;- Registered Nurse (RN) A performed hand hygiene, put on a gown and gloves;- RN A placed a barrier on the bedside table and placed the wound care supplies on top of the barrier;- RN A prepared gauze soaked with normal saline to clean the wound;- RN A wiped the wound three times with the same area of the gauze soaked in normal saline and disposed of the dirty gauze;- RN A picked up a clean gauze soaked in normal saline, wiped the wound three times with the same area of the gauze, and disposed of the gauze;- RN A removed gloves, performed hand hygiene, put on clean gloves, performed the wound care as ordered.During an interview on 12/05/25 at 12:28 P.M., the Director of Nursing (DON) said she would expect staff to use a clean gauze with each cleansing stroke of the wound. During a phone interview on 12/09/25 at 8:29 A.M., RN A said he/she used multiple gauze to cleanse the wound and disposed of the gauze after each cleansing stroke.