

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445342	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED  03/26/2026
NAME OF PROVIDER OR SUPPLIER  Westmoreland Care & Rehab Ctr		STREET ADDRESS, CITY, STATE, ZIP CODE  1559 New Highway 52 Westmoreland, TN 37186	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0684</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate treatment and care according to orders, resident's preferences and goals.</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff changed the central line dressing as ordered by the physician for 1 (Resident #84) of 5 sampled residents reviewed for medication regime review. Findings included: A facility policy titled, Dressing Change for Vascular Access Devices, dated 08/2021, revealed, Purpose To prevent local and systemic infection related to IV [intravenous] catheter. Policy 1. Short peripheral catheter dressings are changed every 7 days or when the integrity of the dressing is compromised. Change the dressing if moisture, drainage or blood is present or for further assessment if infection is suspected. 2. Central venous access device and midline dressing changes will be done at established intervals and immediately if the integrity of the dressing is compromised, if moisture, drainage or blood is present, or for further assessment if infection is suspected. * Transparent semi-permeable membrane dressings are changed every 7 days and PRN [pro re nata, as needed]. A Resident Face Sheet revealed the facility admitted Resident #84 on 03/10/2026. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of surgical aftercare and need for assistance with personal care. An admission Minimum Data Set (MDS), with an Assessment Reference Date (ARD) of 03/16/2026, revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident received intravenous (IV) medications and had IV access. Resident #84's Care Plan included a problem statement initiated 03/10/2026, that indicated the resident had a peripherally inserted central catheter. Interventions directed the staff to complete dressing changes as ordered. Resident #84's Physician Order Report revealed an order dated 03/10/2026, for central line dressing change every week on Wednesdays until 03/25/2026. Resident #84's Medication Administration Record [MAR] for the timeframe 03/01/2026 - 03/31/2026, revealed the transcription of a physician's order that directed staff to change the resident's central line dressing every week on Wednesdays. Per the MAR, Licensed Practical Nurse (LPN) #8 initialed the resident's MAR to indicate she changed Resident #84's central line dressing on 03/11/2026 and Registered Nurse (RN) #1 initialed the MAR to indicate she changed the resident's central line dressing on 03/18/2026. During an interview on 03/23/2026 at 2:53 PM, Resident #84 stated they received IV antibiotics as ordered but no one had changed their IV dressing since they arrived at the facility on 03/10/2026. Resident #84 showed the surveyor their IV dressing on their right upper chest and the dressing was 03/10/2026. During an interview on 03/23/2026 at 4:09 PM, RN #1 stated she had not completed any IV dressing changes since 03/02/2026. During an interview on 03/25/2026 at 10:38 AM, LPN #8 stated when she administered IV medication to Resident #84 on 03/11/2026, she noticed the date on the resident's central line dressing was more than a week overdue but did not remember letting anyone know the dressing needed to be changed and did not remember that she initialed the resident's MAR to indicate she changed the central line dressing on 03/11/2026. During a follow-up interview on 03/26/2026 at 7:24 AM, RN #1 stated she accidentally marked (initialed) the dressing change completed on 03/18/2026. RN #1 stated she initialed the dressing change in error. During an interview on 03/25/2026 at 10:56 AM, the Unit Manager stated she expected a RN to change a resident's central line dressing according to the physician's order. During an interview on 03/24/2026 at 2:47 PM, the Director of Nursing stated he expected the nurse to follow the physician's orders.</p>		

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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<p>F 0842</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p>Based on interview and record review, the facility failed to ensure staff completed and accurately documented the status of resident care to be provided for 2 (Resident #59 and Resident #84) of 21 sampled residents. The findings included: 1. A Resident Face Sheet revealed the facility admitted Resident #59 on 08/23/2025. According to the Resident Face Sheet, the resident had a medical history that included dysphagia and protein-calorie malnutrition. A quarterly Minimum Data Set (MDS), with Assessment Reference Date (ARD) of 03/18/2026, Resident #59 had a Staff Assessment for Mental Status (SAMS) that indicated the resident had severely impaired cognitive skills for daily decision making. The MDS indicated the resident had a feeding tube. Resident 59's Care Plan included a problem statement initiated 03/10/2026, that indicated the resident was at risk for complications related to a need for enteral feedings. Resident #59's Physician Order Report revealed an order dated 12/22/2025, for enteral feeding of Jevity 1.5 at 50 milliliters per hours every shift. Resident #59's Observation Detail List Report completed by Registered Nurse (RN) #1 and dated 03/19/2026, revealed the Nutritional interventions section was marked N/A and not Enteral Feedings. Resident #59's Observation Detail List Report completed by RN #1 and dated 03/23/2026, revealed the Nutritional interventions section was marked N/A and not Enteral Feedings. During an interview on 03/25/2026 at 10:50 AM, Licensed Practical Nurse #8 stated the Observation Detail List Report was a nurse's note that should accurately reflect Resident #59's plan of care. During an interview on 03/24/2026 at 2:47 PM, the Director of Nursing stated he expected documentation within the resident's medical record to be accurate and represent the status of the resident.</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, interview, record review, and facility policy review, the facility failed to ensure staff wore a gown and gloves when they provided care to residents on enhanced barrier precautions (EBP) for 2 (Resident #23 and Resident #84) of 5 sampled residents reviewed for infection control. The findings included: 1. A facility policy titled, Enhanced Barrier Precautions revised 03/25/2024, revealed This facility's infection control policies and practices are intended to facilitate maintaining a safe, sanitary, and comfortable environment and to help prevent and manage transmission of diseases and infections. The policy specified, 5. EBP are indicated for residents who have chronic wounds and or indwelling devices regardless of MRDO [multidrug-resistant organisms]. 2. A Resident Face Sheet revealed the facility admitted Resident #23 on 10/08/2025. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of end stage renal disease and dependance on renal dialysis. An admission Minimum Data Set (MDS) dated [DATE], revealed Resident #23 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated the resident had intact cognition. The MDS indicated the resident received dialysis. Resident #23's Care Plan included a problem statement initiated 10/08/2025 and edited 02/14/2026, that indicated the resident required enhanced barrier precautions related to a dialysis shunt. Interventions directed staff to use personal protective equipment as indicated (initiated 10/08/2025). Resident #23's Physician Order Report revealed an order dated 02/13/2026, for enhanced barrier precautions every shift due to a dialysis port. During an observation on 03/25/2026 at 10:18 AM, Licensed Practical Nurse (LPN) #4 and Certified Nursing Assistant (CNA) #5 entered Resident #23's room to prepare the resident for a dialysis appointment. CNA #5 pulled back Resident #23's bed linens to allow LPN #4 to perform a full body skin assessment of the resident. LPN #4 put on a pair of gloves and completed an assessment of Resident #23's dialysis port located in the resident's right upper chest. CNA #5 assisted with turning and repositioning the resident. LPN #4 and CNA #5 did not put on a gown when they performed resident care. During an interview on 03/25/2026 at 10:34 AM, LPN #4 stated she had been educated to wear a gown and gloves when caring for residents on enhanced barrier precautions but felt rushed when the paramedics were waiting and forgot to put on a gown. During an interview on 03/25/2026 at 10:38 AM, CNA #5 stated she had been educated to wear a gown and gloves when she provided care to Resident #23 due to the residents' dialysis port. CNA #5 stated she forgot to wear a gown during the provision of care to the resident. During an interview on 03/26/2026 at 9:25 AM, the Staff Development Coordinator (SDC), who also functioned as the Infection Preventionist, stated staff were to wear a gown and gloves when they provided care to residents with internal devices. The SDC stated he expected the staff to put on a gown and gloves when they provided care to Resident #23's dialysis port. During an interview on 03/26/2026 at 10:26 AM, the Director of Nursing stated residents who had a dialysis port should be placed on EBP and staff should wear a gown and gloves when they provided care to the resident's dialysis port or repositioned the resident in bed. During an interview on 03/26/2026 at 10:06 AM, the Administrator stated she expected LPN #4 and CNA #5 to put on a gown and gloves when they provided care to Resident #23's dialysis port. 3. A Resident Face Sheet revealed the facility admitted Resident #84 on 03/10/2026. According to the Resident Face Sheet, the resident had a medical history that included diagnoses of surgical aftercare and need for assistance with personal care. An admission Minimum Data Set (MDS) dated [DATE], revealed Resident #84 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated the resident had intact cognition. The MDS indicated the resident had three venous and arterial ulcers present and a surgical wound. Resident #84's Care Plan included a problem statement initiated 03/23/2026, that indicated the resident required enhanced barrier/contact precautions related to a wound and a peripherally inserted central catheter line. Interventions directed the staff to wear personal protective equipment (PPE) as indicated. Resident #84's Physician Order Report revealed an order dated 03/10/2026 for (continued on next page)</p>		

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>contact precautions for wounds and an order dated 03/13/2026 for enhanced barrier precautions related to a wound. During an observation on 03/23/2026 at 11:53 AM, the Activity Director (AD) and Hospitality Aide (HA) #13 entered Resident #84's room, put on gloves, and together they each repositioned the resident in their bed. The AD and HA #13 did not put on a gown when they repositioned Resident #84 in bed. During an interview on 03/23/2026 at 12:25 PM, HA #13 stated she obtained assistance from the AD to reposition Resident #84 in bed. HA #13 stated she did not need to wear a gown unless she performed care such as changing the resident's incontinence brief. HA #13 stated did not put on a gown when she repositioned Resident #84 in bed. During an interview on 03/25/2026 at 3:16 PM, the AD stated she assisted HA #13 in repositioning Resident #84 in bed. The AD stated she knew she should have worn a gown and gloves but only put on gloves. During an interview on 03/25/26 at 8:20 AM, the Staff Development Coordinator, who also functioned as the Infection Preventionist stated staff were to wear a gown and gloves when they provided care to residents with a wound. During an interview on 03/24/26 at 3:10 PM, the Director of Nursing stated Resident #84 had a wound and staff were expected to wear a gown and gloves when they provided care to the resident. During an interview on 03/26/2026 at 9:29 AM, the Administrator stated she expected staff to wear the PPE when they entered the room of a resident on enhanced barrier and contact precautions.</p>		