STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495156	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Old Southwest Health and Rehabilitation	324 King George Ave SW Roanoke, VA 24016

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)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. 3. For Resident #104 facility staff failed to provide written evidence the resident or resident representative agreed to or declined to develop an advance directive. Resident #104's admission Record listed diagnoses which included but were not limited to vascular dementia, dependence on respirator (ventilator), and persistent vegetative state. The annual minimum data set with an assessment reference date of 06/24/24 read the resident was in a persistent vegetative state/no discernible consciousness in Section B (Hearing, Speech, and Vision). Resident #104's clinical record was reviewed on 07/10/24 with no evidence of a written advanced directive noted. No written evidence of the resident or resident representative declining the opportunity to provide an advanced directive was found. A form titled; Advance Care Planning Tracking Form dated 09/29/23 was noted in the clinical record. The form, referred to as the tracking form, named the resident's spouse as the resident representative (RR) with the facility's director of social services being the only signature on the form. Under the area titled Advance Directive Documents in Place, only the box beside Full Code was checked. The tracking form indicated the document was to Review existing Advance Care Plan and the discussion was held with the RR. The director of social services (DSS) was interviewed on 07/11/24 at 9:05 a.m. The director reported the facility's form titled, Advanced Care Planning Tracking Form was available during the most recent survey and was presented to the federal surveyor. The DSS reported the facility plan was to review advance directives with residents and RRs at their next scheduled care plan meeting. On 07/11/24 at 11:30 a.m., this writer and another surveyor met the administrator per his request for clarification of the regulation expectation. After discussion, the administrator verbalized understanding that written evidence of the resident or RR being provided written information concerning the right to accept or refuse medical or surgical treatment and if desired, formulate an advance directive was required. The administrator reported the tracking form was evidence of a discussion and acknowledged he could not provide evidence the resident and/or RR had been provided written information regarding advance directives. (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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
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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 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The policy titled, Advance Directives with a reviewed/revised date of 10/01/21 read in part, Policy: It is the policy of this facility to support and facilitate a resident's right to request, refuse and/or discontinue medical or surgical treatment and to formulate an advance directive . 1. On admission, the facility will determine if the resident has executed an advance directive, and if not, determine whether the resident would like to formulate an advance directive. 2. The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advance directive . During a summary meeting with the administrator, regional director of clinical services, director of nursing, and assistant director of nursing on 07/11/24, the concern regarding written evidence of advance directive options was discussed. No further information was provided prior to exit conference. Based on staff interviews, clinical record review and facility document review, the facility staff failed to ensure that a resident and/or resident representative had an opportunity to develop an advanced directive for three of three residents sampled, resident #101, resident # 103, and resident # 104. The findings included: 1. For resident # 10 (R103), the facility staff failed to provide the resident representative with written information concerning the right to accept or refuse medical or surgical treatment and the option to formulate an advance directive. R103's diagnoses included but were not limited to anoxic brain damage and chronic respiratory failure due to asphyxiation. R103 was not interviewable, and the electronic record indicated there was a parent acting as their representative with a sibling also listed. A progress note written by the social worker with a date of 6/18/24 read, Tried to reach both RP's (responsible party) for the care plan that was unable to leave a message for contact # 1, and left a voice message for contact # 2, waiting on response. On 7/10/24 at 3:33 PM this surveyor met with the Social Worker. When asked if resident #101 has been given the opportunity to develop an advanced directive they stated, During care plan meetings we are asking and reviewing them. They stated that the family did not respond to phone calls/messages and did not attend the care plan meeting, so the IDT (interdisciplinary team) reviewed code status during the most recent meeting. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/11/24 the Social Worker provided the surveyor with a copy of a form entitled, Advanced Care Planning Tracking Form with R103's name on it. The form was dated 9/21/22. The document read in part, Residents/patients and/or their responsible health care decision makers should be provided the opportunity to discus advance care planning with appropriate staff members and medical providers within the first few days of admission to the facility, at times of change in condition, and periodically for routine updating of care plans. The purpose of this tool is to document these discussions. Under the heading Describe the key aspects of the discussion the only thing written on was DNR, indicating that the discussion was solely about the resident having a do not resuscitate (DNR) order in place. There was no resident or resident representative signature on the form, the RP's name had been written in by the social worker and they had also written, per care plan conference call. 2. For resident # 101 (R101) the facility staff failed to provide the resident with written information concerning the right to accept or refuse medical or surgical treatment and the option to formulate an advance directive. R101's most recent minimum data set (MDS) assessment with an assessment reference date of 5/18/24 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15, indicating intact cognition. R101 was interviewed and stated they did not remember being provided with any specific information about advanced directives when they admitted or since then. On 7/11/24 the Social Worker provided this surveyor with the Advanced Care Plan Tracking Form for resident #101 that was dated 9/29/23. There was no resident signature on the form. The section entitled Describe the key aspects of the discussion was blank. A copy of the policy entitled, Advanced Directives with a revised date of 10/1/21 was provided. The policy read in part, Advanced Directive is a written instruction, such as a living will, durable power of attorney for health care, Do Not Resuscitate (DNR), physician orders for scope of treatment (POST) recognized by state law (whether statutory or as recognized by the courts of the state), relating to the provision of health care when the individual is incapacitated. Under the heading, Policy Explanation and Compliance Guidelines the document read in part, The facility will provide the resident or resident representative information, in a manner that is easy to understand, about the right to refuse medical or surgical treatment and formulate an advanced directive. On 7/11/24 at 11:30 AM surveyors met with the Administrator. They stated that the Advanced Care Planning Tracking Form is evidence of a discussion with the resident and/or the resident's RP about advanced directives. They were not able to provide evidence that written information was provided or that anything was discussed other than the resident's code status. This concern was reviewed with the Administrator, Regional Director of Operations, Regional Director of Clinical Services, Director of Nursing, Assistant Director of Nursing and MDS Coordinator on 7/16/24 at 2:40 PM. No further information was provided to the survey team prior to the exit conference.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. Based on observation, staff interview, and clinical record review, the facility staff failed to maintain a clean, comfortable, homelike environment for 1 of 24 residents, Resident #118. The findings include: Resident #118's tube feeding pole was observed to have a dried brown substance on the bottom of the tube feeding pole. Resident #118's diagnoses included, but were not limited to, persistent vegetative state and cognitive communication deficit. Section B (hearing/speech/vision) of Resident #118's minimum data set (MDS) assessment with an assessment reference date (ARD) of 05/23/24 was coded to indicate Resident #118 was in a persistent vegetative state. Section K (swallowing/nutritional status) was coded to indicate this resident received nutrition via a feeding tube. On 07/10/24 at 11:00 a.m., the surveyor observed a brown dried substance on the bottom of this residents tube feeding pole. A second observation was made on 07/10/24 at approximately 2:35 p.m. the brown dried substance remained on the bottom of the tube feeding pole. On 07/11/24 at 4:30 p.m., during an end of the day meeting with the Administrator, Regional Director of Clinical Services, Director of Nursing, and Assistant Director of Nursing/Staff Development Coordinator the issue with Resident #118's tube feeding pole was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference on 07/16/24.

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NAME OF PROVIDER OR SUPPLIER Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 324 King George Ave SW Roanoke, VA 24016	

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights. Based on staff interviews, facility document review, and clinical record review, the facility staff failed to ensure that written transfer notices included the required information when provided to five (5) of five (5) residents reviewed for transfers (Resident #109, Resident #116, Resident #121, Resident #125, and Resident #126). The findings include: The transfer notice information documented at the time of Resident #109's, Resident #116's, Resident #121's, Resident #125's, and Resident #126's transfers to a local hospital failed to include the required information. This transfer notice information stated the reason for the transfer was that the facility could not manage the residents' care but did not detail the specific care issues the facility was unable to manage. This transfer notice information failed to provide information about the residents' appeal rights. This transfer notice information failed to include the name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman. The following information was found in a facility policy titled Transfer and Discharge (including AMA) (with a reviewed/revised date of 12/1/22): Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident . Provide transfer notice as soon as practicable to resident and representative. Resident #109's clinical documentation included a Discharge/Transfers form which was dated 6/20/24 and indicated the resident was transferred to a local hospital. This form was not signed by the staff member who completed the form. This form indicated the reason for the transfer was CANNOT MANAGE CARE AT THE FACILITY. This form did not detail the resident's condition that could not be managed at the facility. This form did not provide information related to the resident's appeal rights. This form did not provide the ombudsman contact information. Resident #116's clinical documentation included a Discharge/Transfers form which was dated 6/19/24 and indicated the resident was transferred to a local hospital. This form was not signed by the staff member who completed the form. This form indicated the reason for the transfer was CANNOT MANAGE CARE AT THE FACILITY. This form did not detail the resident's condition that could not be managed at the facility. This form did not provide information related to the resident's appeal rights. This form did not provide the ombudsman contact information. Resident #121's clinical documentation included a Discharge/Transfers form which was dated 6/27/24 and indicated the resident was transferred to a local hospital. This form was not signed by the staff member who completed the form. This form indicated the reason for the transfer was CANNOT MANAGE CARE AT THE FACILITY. This form did not detail the resident's condition that could not be managed at the facility. This form did not provide information related to the resident's appeal rights. This form did not provide the ombudsman contact information. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 324 King George Ave SW Roanoke, VA 24016	

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F 0623 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #125's clinical documentation included a Discharge/Transfers form which was dated 6/12/24 and indicated the resident was transferred to a local hospital. This form was not signed by the staff member who completed the form. This form indicated the reason for the transfer was CANNOT MANAGE CARE AT THE FACILITY. This form did not detail the resident's condition that could not be managed at the facility. This form did not provide information related to the resident's appeal rights. This form did not provide the ombudsman contact information. Resident #126's clinical documentation included a Discharge/Transfers form which was dated 6/17/24 and indicated the resident was transferred to a local hospital. This form was not signed by the staff member who completed the form. This form indicated the reason for the transfer was CANNOT MANAGE CARE AT THE FACILITY. This form did not detail the resident's condition that could not be managed at the facility. This form did not provide information related to the resident's appeal rights. This form did not provide the ombudsman contact information. On 7/15/24 at 3:36 p.m., the Administrator provided the surveyor with a blank copy of a form titled Notice of Transfer/Discharge. This form included sections for the aforementioned information not included in the residents' Discharge/Transfers forms. The Administrator reported they felt as if the required transfer notice information was different for emergency transfers and non-emergency transfers. The Administrator reported this form is not provided with every hospitalization or emergency transfer. On 7/16/24 at 2:45 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Operations, MDS Coordinator, Regional MDS Coordinator, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to ensure transfer notice information included the required information was discussed.

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NAME OF PROVIDER OR SUPPLIER: Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 324 King George Ave SW Roanoke, VA 24016	

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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Notify the resident or the resident's representative in writing how long the nursing home will hold the resident's bed in cases of transfer to a hospital or therapeutic leave. Based on staff interviews, facility document review, and clinical record review, the facility staff failed to have written evidence of providing the bed hold policy to the resident and/or the resident representative when the resident was transferred for five (5) of five (5) residents reviewed for transfers (Resident #109, Resident #116, Resident #121, Resident #125, and Resident #126). The findings include: The facility staff was unable to provide written documentation to indicate the facility's bed hold policy was provided to the following residents at the time of their transfers to a local hospital: Resident #109, Resident #116, Resident #121, Resident #125, and Resident #126. The following information was found in a facility policy titled Transfer and Discharge (including AMA) (with a reviewed/revised date of 12/1/22): Emergency Transfers/Discharges - initiated by the facility for medical reasons, or for the immediate safety and welfare of a resident . Provide a notice of the resident's bed hold policy to the resident and representative at the time of transfer, as possible, [sic] but no later than 24 hours of the transfer. Resident #109's clinical documentation included a Discharge/Transfers form which was dated 6/20/24 and indicated the resident was transferred to a local hospital. No written evidence was found by or provided to the surveyor to indicate the resident and/or resident representative had been provided with written notice of the facility's bed hold policy. Resident #116's clinical documentation included a Discharge/Transfers form which was dated 6/19/24 and indicated the resident was transferred to a local hospital. No written evidence was found by or provided to the surveyor to indicate the resident and/or resident representative had been provided with written notice of the facility's bed hold policy. Resident #121's clinical documentation included a Discharge/Transfers form which was dated 6/27/24 and indicated the resident was transferred to a local hospital. No written evidence was found by or provided to the surveyor to indicate the resident and/or resident representative had been provided with written notice of the facility's bed hold policy. Resident #121's clinical record included a note, dated 6/29/24, indicating a voice mail had been left asking the resident's representative to call the facility about the bed hold policy. Resident #125's clinical documentation included a Discharge/Transfers form which was dated 6/12/24 and indicated the resident was transferred to a local hospital. No written evidence was found by or provided to the surveyor to indicate the resident and/or resident representative had been provided with written notice of the facility's bed hold policy. Resident #126's clinical documentation included a Discharge/Transfers form which was dated 6/17/24 and indicated the resident was transferred to a local hospital. No written evidence was found by or provided to the surveyor to indicate the resident and/or resident representative had been provided with written notice of the facility's bed hold policy. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 0625 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/15/24 at 3:55 p.m., the Administrator reported they had no additional evidence of written bed hold information being provided; the Administrator indicated the bed hold information was provided verbally. On 7/16/24 at 2:45 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Operations, MDS Coordinator, Regional MDS Coordinator, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to have evidence of written notice of the facility's bed hold policy being provided, to the resident and/or the resident representative when a resident is transferred, was discussed.

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NAME OF PROVIDER OR SUPPLIER Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 324 King George Ave SW Roanoke, VA 24016	

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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. Based on staff interview and clinical record review, the facility staff failed to review and revise a comprehensive care plan (CCP) for 1 of 24 residents, Resident #115. The findings include: For Resident #115, the facility staff failed to review and revise the residents CCP to include their Do Not Resuscitate (DNR). Resident #115's diagnosis included adult failure to thrive. Section C (cognitive patterns) of Resident #115's significant change minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/30/24 included a brief interview for mental status (BIMS) score of 6 out of a possible 15 points. Section O (special treatments and procedures) was coded to indicate this resident was receiving Hospice services. A review of Resident #115's clinical record revealed that the facility staff had not revised the CCP regarding the residents current code status. Under the focus area of Advance Directive, the facility staff documented this resident was a Full Code. Interventions included follow facility guidelines for full code. Resident #115's clinical record included the provider order for DNR dated 05/28/24. The clinical record also included a DDNR (durable do not resuscitate) order form dated 05/28/24 signed by the provider and authorized representative. On 07/11/24 at 9:30 a.m., during an interview with MDS nurse #1 this staff reviewed Resident #115's CCP and acknowledged their DNR status had not been updated on the CCP. MDS nurse #1 stated they would update the CCP today. On 07/11/24 at 4:30 p.m., during an end of the day meeting with the Administrator, Regional Director of Clinical Services, Director of Nursing, and Assistant Director of Nursing/Staff Development Coordinator the issue with Resident #115's CCP not being revised to include their current DNR status was reviewed. On 07/12/24 at 10:00 a.m., the Administrator provided the surveyor with an updated care plan indicating Resident #115's CCP had been revised to include their current DNR status. No further information regarding this issue was provided to the survey team prior to the exit conference.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on staff interview, clinical record review, facility document review, and a medication pass and pour observation the facility staff failed to follow professional standards of practice for the administration of medications for 2 of 24 residents, Resident #123, and Resident #110. The findings included: For Resident #123 the facility staff signed a medication as being administered when the medication was unavailable for administration. Resident #123's clinical record listed diagnoses which included but not limited to unspecified asthma, uncomplicated. Resident #123's most recent minimum data set with an assessment reference date of 05/28/24 coded the resident as 3 out of 15 in section C, cognitive patterns. This indicates that the resident is severely cognitively impaired. Resident #123's comprehensive care plan was reviewed and contained a care plan for . is at risk for ineffective breathing d/t (due to) dx (diagnosis) of COPD (chronic obstructive pulmonary disease). Interventions for this care plan include give medications as ordered. Surveyor observed registered nurse (RN) #3 on 07/10/24 at 8:35 am during a medication pass and pour. RN #3 prepared Resident #123's medications, then stated to surveyor that resident's inhaler was not on the cart. RN #3 stated, It was ordered on 07/07/24 and she probably hasn't had it for a few days. Resident #123's clinical record was reviewed on 07/10/24 and contained an order which read in part, Symbicort Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate) 1 puff inhale orally two times a day for SOB (shortness of breath). Rinse mouth after use. Resident #123's electronic medication administration (eMAR) record was reviewed and contained an entry as above. This entry had been initialed for all administrations for the month of July, including 8 am on 07/10/24. Surveyor spoke with licensed practical nurse (LPN) #5 on 07/11/24 regarding Resident #123's Symbicort inhaler. LPN #5 looked in the medication cart, then stated the inhaler was not there, unless it came last night. Surveyor reviewed Resident #123's eMAR and observed that the inhaler had been initialed as administered by LPN #5. Surveyor asked LPN #5 if they had signed the inhaler as administered, and LPN #5 stated, Not sure, I can't remember honestly. Surveyor spoke with the assistant director of nursing (ADON) on 07/12/24 at 10:45 am regarding Resident #123's inhaler, and nursing staff initialing it as administered. ADON stated, they should not sign off if they don't have it. That's just common sense. It also goes to compliance and ethics. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested a copy of the facility standards of practice for medication administration and was provided with a copy of a facility policy entitled Medication Administration which read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 17. Sign MAR after administered. The concern of not following professional standards of practice was discussed with the administrator, director of nursing, assistant director of nursing, regional director of operations, minimum data set coordinator, director of clinical reimbursement, and regional director of clinical services on 07/16/24 at 2:45 pm. No further information provided prior to exit. 2. For Resident #110 the facility staff signed a medication as being administered when the medication was unavailable for administration. Resident #110's clinical record listed diagnoses which included but not limited to chronic pain syndrome. Resident #110's most recent minimum data set with an assessment reference date of 06/07/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #110's comprehensive care plan was reviewed and contained a care plan for . at risk for pain d/t dx (diagnosis) of chronic pain and Gout. Interventions for this care plan included Administer medications per MD orders and 'Medicate as ordered. Resident #110's clinical record was reviewed and contained a physician's order summary which read in part, gabapentin 300 mg. Give one capsule by mouth three times daily for neuropathy. Resident #110's electronic medication administration record (eMAR) for the month of June 2023 was reviewed and contained an entry as above. This entry was initialed as being administered on 06/27/24 at 1:00 pm and 9:00 pm. Resident #110's nurse's progress notes were reviewed and contained a noted dated 06/27/24 which read in part, 6/27/2024 16:29 Gabapentin Oral Capsule 300 mg. Give 1 capsule by mouth three times a day for neuropathy. Med not available. Surveyor spoke with the assistant director of nursing (ADON) on 07/12/24 at 10:45 am regarding Resident #110's gabapentin and nursing staff initialing it as administered. ADON stated, they should not sign off if they don't have it. That's just common sense. It also goes to compliance and ethics. Surveyor requested a copy of the facility standards of practice for medication administration and was provided with a copy of a facility policy entitled Medication Administration which read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 17. Sign MAR after administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Old Southwest Health and Rehabilitation	324 King George Ave SW Roanoke, VA 24016

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)
F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern of not following professional standards of practice was discussed with the administrator, director of nursing, assistant director of nursing, regional director of operations, minimum data set coordinator, director of clinical reimbursement, and regional director of clinical services on 07/16/24 at 2:45 pm. No further information provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

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F 0677

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Provide care and assistance to perform activities of daily living for any resident who is unable.

3. For Resident #104 facility staff failed to provide bed baths twice a week.

Resident #104's admission Record listed diagnoses which included but were not limited to vascular dementia, dependence on respirator (ventilator), and persistent vegetative state. The annual minimum data set with an assessment reference date of 06/24/24 read the resident was in a persistent vegetative state/no discernible consciousness in Section B (Hearing, Speech, and Vision).

Resident #104 was observed on 07/09/24 at approximately 8:55 a.m. The resident was clean, lying in bed with clean sheets.

The resident's clinical record and bathing sheets indicated that since his last admission, Resident #104 received bed baths on:

1. 06/21/24,

2. 06/26/24,

3. 07/05/24 - (eight days between baths) and,

4. 07/09/24.

Partial baths were documented on:

5. 07/11/24 and,

6. 07/13/24.

The administrator, regional director of clinical services, assistant director of nursing, and director of nursing (DON) were informed of the bathing frequency concern and request for any bathing documentation during a summary meeting on 07/11/24 at 4:28 p.m.

On 07/15/24 at 1:38 p.m., the DON reported the facility had no specific bed bath policy; the DON's expectation was for bed baths to follow the state standard of care which was twice/week.

No further information was provided prior to exit conference.

Based on observations, resident and staff interview, clinical record review and facility document review, the facility staff failed to provide the necessary activities of daily living (ADL) care to maintain appropriate grooming/bathing for three of 24 residents in the survey sample, resident # 101, resident # 103 and resident # 104.

The findings included:

1. For resident # 101 (R101), the facility staff failed to provide adequate baths and/or showers.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R101's diagnosis list includes but is not limited to the following: respiratory failure with hypoxia, chronic obstructive pulmonary disease, type II diabetes mellitus, morbid, severe obesity, bipolar disorder unspecified, generalized anxiety disorder, essential hypertension. R101's minimum data set with an assessment reference date (ARD) of 5/18/24 assigns the resident a brief interview for mental status score (BIMS) of 15 out of 15 indicating intact cognition. On 7/9/24 at 4:17 PM this surveyor interviewed R101 about bathing and showering. R101 stated, I guess. When asked if they get enough baths. They could not tell me when they got the last bath, I can't remember. When asked if they would like to have more baths they stated, it'd be okay. On 7/15/24 this surveyor was provided with a print off of R101's bathing records for June and July 2024. The document for June 2024 had bed baths documented for 6/8/24, 6/12/24, 6/13/24, 6/20/24, and 6/26/24 and a partial bath documented 6/16/24. The July record had bed baths documented on 7/2/24, 7/3/24, 7/6/24 and a partial bath on 7/13/24. R101's care plan was reviewed. A focus read, (Resident) has an ADL self-care performance deficit r/t Respiratory failure, COPD, Morbid obesity. One of the interventions read BATHING/SHOWERING: totally dependent 1-2 staff for shower 2x wkly (two times weekly) and prn (as needed). A policy entitled, Activities of Daily Living (ADLs) with a revised date of 12/1/22, read in part, 3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. On 7/15/24 at 1:38 PM this surveyor interviewed the Director of Nursing (DON). When asked what the expectation was for number of showers to be given to each resident they stated, There is no policy for that, we follow the standard of care for Virginia which is twice a week. When asked to verify the number of bed baths given in June and July, they agreed that R101 had five bed baths in June and three thus far in July. On 7/16/24 at 2:44 PM the survey team met with the Administrator, DON, Regional Director of Operations, Regional Reimbursement Specialist, MDS Coordinator, Assistant Director of Nursing and Regional Director of Clinical Services. This concern was discussed. No further information was provided prior to the exit conference. 2. For R103 the facility staff failed to maintain nail care. The findings included: On 7/10/24 at 8:30 AM this surveyor observed the resident in their bed. Fingernails and toenails noted to be long and jagged. Resident was not interviewable and is dependent on staff for all care. On 7/11/24 at 9:24 AM observed resident in their bed. Fingernails and toenails long and jagged. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 7/12/24 at 11:11 AM observed resident in their bed, fingernails and toenails long and jagged. This surveyor interviewed Licensed Practical Nurse (LPN) # 2. Surveyor asked when staff provides nail care for dependent residents, they stated, it's done as needed on bath days. They cut them a few weeks ago. They stated the certified nursing assistants provide fingernail care, but only the podiatrist can cut toenails. They stated that resident was seen by the podiatrist a month or so ago and they would find that documentation. LPN # 2 disagreed with surveyor that resident's fingernails were long, No, they're not too long. On 7/12/24 at 12:10 PM LPN # 2 stated to surveyor, I talked to my Regional (Director of Clinical Services) he/she said (name omitted) fingernails are too long, so we're going to cut them after lunch. Surveyor asked LPN #2 if they had located the documentation of the podiatrist visit as it was not in the clinical record. They stated, I'm going to bring you something but then you'll need to talk to the social worker, that's who takes care of all that. On 7/15/24 at 10:15 AM surveyor observed resident in their bed. Fingernails and toenails were still long and jagged. Surveyor spoke with the Director of Nursing (DON) about the concern and asked for documentation that resident had been seen by the podiatrist. The documentation provided indicated that resident had been seen by the podiatrist April 8, 2023. On 7/15/24 at 12:15 PM this surveyor interviewed the Social Worker. They stated, He/she was seen in April I gave that to (DON), did you not get it? This surveyor informed them the visit note provided by the DON was dated April 2023. They stated, That's not right, the podiatrist was here in May. I called them and they said he/she was seen last in April 2023 but that can't be right. When asked if they keep a copy of the podiatry list that gets sent to the provider, they stated they just email it and He sees who he wants to I guess. Social Worker did provide a copy of the list they sent to the podiatrist on April 30, 2024, with resident # 103's name included. The social worker could not explain why resident was not seen. They indicated that the podiatrist will be back July 29, 2024, and resident will be seen then. This surveyor met with the DON and confirmed that there is no evidence resident has been seen by podiatry since April 8, 2023. Asked DON if there is a policy that says nurses cannot trim toenails and they stated there was not. Informed DON that LPN # 2 had told surveyor fingernails would be trimmed after lunch on 7/12/24 but nails were still long. They stated, I'll take care of that right now. 7/16/24 9:00 AM, fingernails and toenails were observed to be trimmed. On 7/16/24 at 2:44 PM the survey team met with the Administrator, Regional Director of Operations, Regional Director of Clinical Services, Director of Nursing, Assistant Director of Nursing, MDS Coordinator and Regional Reimbursement Specialist. These concerns were discussed, and no further information was provided to the survey team prior to the exit conference.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide appropriate treatment and care according to orders, resident's preferences and goals. 4. For Resident #109, facility staff failed to adhere to the provider ordered maximum dose of 200mg in 24 hours for Imitrex (Sumatriptan Succinate), a medication to treat migraines. The resident received 400mg in 24 hours on 07/04/24 into 07/05/24 and 300mg in 24 hours on 07/10/24. Resident #109's minimum data set with an assessment reference date of 06/09/24 coded the brief interview for mental status summary score a 15 out of 15. The resident was coded as not having behaviors to include inattention, disorganized thinking, or altered level of consciousness. On 07/10/24 at 3:00 p.m. Resident #109 was observed and interviewed. The resident was clean, dressed and lying in her bed complaining of a migraine. The resident reported the staff were not giving her Imitrex for migraines as often as needed. Resident #109's clinical record contained a provider order dated 06/21/24 for Imitrex 100mg give one tablet by mouth every 2 hours as needed for migraine max dose 200mg in 24 hours. On 07/10/24 at approximately 6:40 p.m., Resident #109's July 2024 Medication Administration Record (MAR) was reviewed. The MAR revealed Imitrex 100mg was documented as administered four times for a total of 400mg in 24 hours starting on 07/04/24 into 07/05/24: 1. 07/04/24 at 12:49 p.m. 2. 07/04/24 at 15:14 (3:14 p.m.) 3. 07/04/24 at 19:35 (7:35 p.m.) 4. 07/05/24 at 09:51 (9:51 a.m.) The MAR revealed Imitrex 100mg was documented as administered three times for a total of 300mg in 24 hours on 07/10/24: 1. 07/10/24 at 04:43 a.m. 2. 07/10/24 at 08:24 a.m. 3. 07/10/23 at 13:47 (1:47 p.m.) On 07/10/24 at 7:05 p.m., the director of nursing (DON) was informed of the identified Imitrex doses that exceeded 200mg in 24 hours. The DON acknowledged Resident #109 received more than the ordered amount/dose of the as needed Imitrex. The DON notified the nurse practitioner (NP) via phone with new orders received. On 07/11/24 at 4:20 p.m., the facility's pharmacy returned the surveyor's call and acknowledged 200mg in 24 hours is the maximum dose of Imitrex. The pharmacist suggested contacting the resident's provider for further guidance. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	At the summary meeting on 07/11/24, the administrator and DON were informed of the Imitrex administration that exceeded the maximum dose in 24 hours. The administrator reported the concern will be taken to Risk/QA meeting. The DON reported putting in a new order (100mg every 2 hours for a maximum of two doses in 24 hours) and stated this was a unique case; the 100mg being ordered every 2 hours as needed. Attempted to interview Resident #109 on 07/12/24 at approximately 9:30 a.m. The resident was not in her room and staff reported she was out of the facility at an appointment. The NP was interviewed via phone on 7/12/24 at approximately 12:30 p.m. She reported being notified of the extra doses of Imitrex and stated she ordered bloodwork (CMP - comprehensive metabolic panel) and vital signs since the extra doses of Imitrex could cause bradycardia (low heart rate) and there had not been issues with bradycardia. The NP stated she was aware of some literature that said 300mg was the maximum dose in 24 hours. The NP's progress note dated 07/11/24 read the NP met with Resident #109 and discussed limiting the Imitrex to two doses per day and no more than 10 days/month. The resident acknowledged she had not known of that limited dose per day or per month prior to now and she would track the days on her phone. A different NP (NP #2) wrote a progress note dated 07/12/24 which read the NP's reason for visit was Drug GDR (gradual drug reduction) and allergy reconciliation. The note read, in part, the resident's allergy list included Zolmitriptan. She has been taking Imitrax [sic - Imitrex] for migraine headache, which has been tolerated well. The medication is effective and therapeutic, which is verified as not being a true allergy. Therefore, after discussing the issue with the patient, I preferred to keep the medication in her active medication list . After briefly speaking to Resident #109 in the hall in her wheelchair on 07/15/24 at approximately 11:00 a.m., this surveyor attempted to interview Resident #109 regarding her medications and migraines, but the resident was not in the facility. According to a progress note dated 07/15/24 at 1:52 p.m. the resident had been transferred to the hospital for right flank pain with dysuria (painful urination). A progress note dated 07/16/24 read the resident remained at the hospital. Registered Nurse (RN #4) was interviewed in person on 07/16/24 at 11:35 a.m. regarding the 07/05/24 as needed dose of Imitrex she administered to Resident #109 at 9:51 a.m. The nurse explained prior to administering the Imitrex dose, she would check the resident's allergies and make sure it had been two hours since the resident's last dose. After reading the order to include the maximum 200mg in 24 hours limit, RN #4 acknowledged the dose she had administered on 07/05/24 provided more than 200mg in 24 hours. RN #4 stated, I feel real bad about that, I try to pay close attention. The nurse stated she planned to speak with the DON to see what she needed to do now. These concerns were discussed with the administrator, regional director of clinical services (RDCS), assistant director of nursing (ADON) and DON on 07/11/24 at 4:28 p.m. during a summary meeting. The administrator, ADON, DON, regional director of operations, MDS coordinator, regional MDS coordinator, and RDCS #2 were informed of these concerns during a summary meeting on 07/16/24 at 2:46 p.m. No further information was provided prior to the exit conference. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Based on staff interview, clinical record review, and facility document review the facility staff failed to follow physician's orders for 4 of 24 residents, Resident #110, Resident #112, Resident #113, and Resident #104. The findings included: 1. For Resident #110 the facility staff failed to follow physician's order for the administration of the medications Gabapentin, Levothyroxine, Metolazone, and artificial tears. Resident #110's clinical record listed diagnoses which included but not limited to chronic pain syndrome, chronic diastolic (congestive) heart failure, essential hypertension, and dry eye syndrome of bilateral lacrimal glands. Resident #110's most recent minimum data set with an assessment reference date of 06/07/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #110's comprehensive care plan was reviewed and contained care plans for . has chronic pingueculitis (feeling of something in the eye), . has potential fluid deficit/overload r/t (related to) Diuretic use d/t (due to) CHF (congestive heart failure), HTN (hypertension), and . at risk for pain d/t dx (diagnosis) of chronic pain and Gout. Interventions for these care plans include Administer medications per MD orders and Medicate as ordered. Resident #110's clinical record was reviewed and contained a physician's order summary which read in part, Artificial Tears Solution 1.4%. Instill 1 drop in both eyes three times a day for dry eyes, metolazone oral tablet 10 mg. Give 2 tablet (20 mg) by mouth one time a day for edema, Levothyroxine Sodium Oral Tablet 125 mcg. Give 0.5 tablet (62.5 mcg) by mouth one time a day for hypothyroidism, dose is 62.5, and gabapentin 300 mg. Give one capsule by mouth three times daily for neuropathy. Resident #110's electronic medication administration record (eMAR) for the month of May 2023 was reviewed and contained entries as above. These entries were not initialed as being administered on 05/29/24 at 6:00 am. Resident #110's eMAR for the month of June 2024 was reviewed and contained an entry for gabapentin 300 mg. Give one capsule by mouth three times daily for neuropathy. This entry was coded 9 on 06/28/24 at 6:00 am and 1:00 pm and coded 5 on 06/29/24 at 9:00 pm. Chart code 9 is equivalent to other/see nurse's notes. Chart code 5 is equivalent to Hold/See nurse's notes. Resident #110's nursing progress notes were reviewed and contained notes which read in part, 6/28/2024 05:10. Gabapentin Oral Capsule 300 mg. Give 1 capsule by mouth three times a day for Neuropathy. Texted MD, need script to pharmacy, 6/28/2024 13:47. Gabapentin Oral Capsule 300 mg. Give 1 capsule by mouth three times a day for Neuropathy. Waiting for drug from pharmacy, and 6/28/2024 20:47. Gabapentin Oral Capsule 300 mg. Give 1 capsule by mouth three times a day for Neuropathy. On hold, awaiting further instructions per pharmacy and MD. Surveyor spoke with Resident #110 on 07/10/24 at 11:30 am. Surveyor asked Resident #110 if there was ever a time when they did not get their medications, and Resident #110 stated, Sometimes, they tell me they don't have them. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor spoke with the assistant director of nursing (ADON) on 07/11/24 at 10:45 regarding Resident #110's medications. ADON stated, Either the nurse didn't document, or didn't give it. But, if it's not documented, it's not done. Surveyor spoke with the director of nursing (DON) on 07/15/24 at 10:30 am regarding Resident #110's medications. DON stated, It's unknown if he got his meds or not. Surveyor requested and was provided with a facility policy entitled Medication Administration which read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 17. Sign MAR (medication administration record) after administered. Surveyor requested and was provided with a facility policy entitled Medication Reordering which read in part, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse ia administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medicaiton, time permiting. Surveyor requested and was provided with a facility policy entitled Unavailable Medications which read in part, 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn (as needed), and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications. Surveyor requested and was provided with a list of medications available in the STAT supply. This list included gabapentin 300 mg. The concern of not administering Resident #110's medications per the physician's orders was discussed with the administrator, DON, ADON, Regional Director of Operation, MDS coordinator, Director of Clinical Reimbursement, and Regional Director of Clinical Services on 07/16/24 at 2:45 pm. No further information was provided prior to exit. 2. For Resident #112 the facility staff failed to administer the resident's medications donepezil, atorvastatin, Semglee, tizanidine, trazodone, rivastigmine, Xarelto, and Lortab. Resident #112's clinical record listed diagnoses which included but not limited to diabetes mellitus, unspecified dementia, psychotic disturbance, peripheral vascular disease, and other chronic pain. Resident #112's most recent minimum data set assessment with an assessment reference of 06/27/24 assigned the resident a brief interview for mental status score of 12 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. (continued on next page)

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #112's comprehensive care plan was reviewed and contained care plans which read in part, . has impaired cognitive function/dementia or impaired thought processes r/t (related to), . has peripheral vascular disease (PVD) r/t Diabetes, heart disease, HLD (hyperlipidemia), PAD (peripheral artery disease) with recent bypass surgery, 4th-5th toe amputation rt (right) foot, . has diabetes mellitus, .is at risk for pain d/t (due to) PAD/PVD and chronic pain, . is on anticoagulant therapy d/t hx (history) of bypass surgery, and . takes psychotropic medication d/t dx (diagnosis) of MDD (manic depressive disorder) and insomnia. Resident #112's clinical record was reviewed and contained a physician's order summary which read in part, donepezil HCl oral tablet 5 mg. Give 1 tablet by mouth at bedtime related to unspecified dementia, unspecified severity, with agitation, atorvastatin calcium oral tablet 20 mg. Give 1 tablet by mouth at bedtime for cholesterol, Semglee Solution Pen-Injector 100 unit/ml (insulin glargine). Inject 25 unit subcutaneously one time a day related to Type 2 diabetes mellitus with hyperglycemia, tizanidine HCl 4 mg. Give one tablet by mouth at bedtime for muscle spasms, trazodone HCL oral tablet 150 mg. Give 75 mg by mouth at bedtime for depression, rivastigmine tartrate oral tablet 1.5 mg. Give 1 capsule by mouth two time a day for related to unspecified dementia, unspecified severity, with agitation, Xarelto oral tablet 2.5. Give 1 tablet by mouth two time a day related to peripheral vascular disease, and Lortab tablet 5-325 mg. Give 1 tablet by mouth three times a day for chronic pain. Resident #112's electronic medication administration record (eMAR) for the month of May 2024 was reviewed and contained entries as above. These entries were not initialed as being administered on 05/26/24 at 9:00 pm. Resident #112's eMAR for the month of June 2024 was reviewed and contained an entry for donepezil HCl oral tablet 5 mg. Give 1 tablet by mouth at bedtime related to unspecified dementia, unspecified severity, with agitation. This entry was coded as 9 on 06/07/24. Chart code 9 is equivalent to other/see nurses notes. Resident #112's nurse's progress notes were reviewed, and surveyor could not locate a note related the medication. Surveyor spoke with the assistant director of nursing (ADON) on 07/11/24 at 10:45 regarding Resident #112's medications. ADON stated, Either the nurse didn't document, or didn't give it. But, if it's not documented, it's not done and If the medication is in the Cubex (stat supply), they should have pulled it. Surveyor spoke with the director of nursing (DON) on 07/15/24 at 10:30 am regarding Resident #112's medications. DON stated, It's unknown if he got his meds or not. Surveyor requested and was provided with a facility policy entitled Medication Administration which read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 17. Sign MAR (medication administration record) after administered. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Old Southwest Health and Rehabilitation	324 King George Ave SW Roanoke, VA 24016

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)

F 0684

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Some

Surveyor requested and was provided with a facility policy entitled Medication Reordering which read in part, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reoder the medication, time permiting.

Surveyor requested and was provided with a facility policy entitled Unavailable Medications which read in part, 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn (as needed), and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications.

Surveyor requested and was provided with a list of medications available in the STAT supply. This list included the medication donepezil 5 mg.

The concern of not administering Resident #112's medications per the physician's orders was discussed with the administrator, DON, ADON, Regional Director of Operation, MDS coordinator, Director of Clinical Reimbursement, and Regional Director of Clinical Services on 07/16/24 at 2:45 pm.

No further information was provided prior to exit.

3. For Resident #113 the facility staff failed to administer the medications Lyrica, furosemide, and Levothyroxine were administered per the physician's orders.

Resident #113's clinical record listed diagnoses which included but not limited to chronic pain syndrome, edema, and hypertension.

Resident #113 most recent minimum data set with an assessment reference date of 06/27/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #113's comprehensive care plan was reviewed and contained care plans for . is at risk for pain d/t (due to) decreased mobility, Resident has a dx (diagnosis) of chronic pain, and The resident is on diuretic therapy d/t hx (history) of edema.

Resident #113's clinical record was reviewed and contained a physician order summary which read in part, Lyrica Capsule 100 mg (Pregabalin). Give 1 capsule by mouth three times a day for pain, Furosemide Oral Tablet 40 mg (Furosemide). Give 40 mg by mouth two time a day for edema, and Levothyroxine Sodium 300 mcg tablet. Give 300 mcg by mouth in the morning for thyroid dysfunction.

Resident #113's electronic medication administration record (eMAR) for the months of June and July 2024 were reviewed and contained an entry which read in part, Lyrica Capsule 100 mg (Pregabalin). Give 1 capsule by mouth three times a day for pain. This entry was coded 5 on 06/29/24 at 2:00 pm, 07/01/24 and 07/02/24 at 9:00 am, and coded 9 on 07/02/24 at 9:00 pm, and 07/03/24 at 9:00 am, 2:00 pm, and 9:00 pm. Chart code 5 is equal to hold/see nurses notes and chart code 9 is equal to other/see nurses notes.

(continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER: Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 324 King George Ave SW Roanoke, VA 24016	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Resident #113's nurse's progress notes were reviewed and contained notes which read in part, 6/29/2024 15:19. Lyrica capsule 100 mg. Give 1 capsule three times a day for pain. Do not exceed maximum daily dose of 300 mg. patient lethargic, 7/2/2024 20:27. Lyrica capsule 100 mg. Give 1 capsule three times a day for pain. Do not exceed maximum daily dose of 300 mg. not available, and 7/3/2024 20:19 Lyrica capsule 100 mg. Give 1 capsule three times a day for pain. Do not exceed daily dose of 300 mg. not available. Surveyor could not locate notes related to 07/01/24 and 07/02/24 for the 9:00 am doses or the 07/03/24 9:00 am or 2:00 pm doses. Surveyor could not locate an order hold the medication if the resident was lethargic. Resident #113's eMAR for the month of June 2024 contained an entry which read in part, Furosemide oral tablet 40 mg (Furosemide). Give 40 mg by mouth two times a day for edema. This entry was coded 9 on 06/29/24 at 6:00 am and 11 on 06/29/24 at 2:00 pm. Chart code 9 is equal to other/see nurses notes and chart code 11 is equal to Held per parameters. Resident #113's nurses progress notes were reviewed and contained a note which read in part, 6/29/2024 07:50. Furosemide oral tablet 40 mg. Give 40 mg by mouth two times a day for edema. Held for low BP (blood pressure). Surveyor could not locate a nurse's note for 06/29/24 at 2:00 pm. The order for this medication did not contain parameters. Resident #113's eMAR for the month of May 2024 contained an entry which read in part, Levothyroxine Sodium Oral Tablet 300 mcg. Give 1 tablet by mouth one time a day for thyroid management. This entry was blank on 05/30/24 at 6:00 am. Surveyor spoke with the assistant director of nursing (ADON) on 07/11/24 at 10:45 regarding Resident #113's medications. ADON stated, Either the nurse didn't document, or didn't give it. But, if it's not documented, it's not done, Medications shouldn't be held without an order, and If it the medication is in the Cubex (stat supply), they should have pulled it. Surveyor spoke with the director of nursing (DON) on 07/15/24 at 11:45 am regarding Resident #113's medications. DON stated the resident's Lyrica was on hold due to needing a new prescription sent to the pharmacy. Surveyor requested and was provided with a facility policy entitled Medication Administration which read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 17. Sign MAR (medication administration record) after administered. Surveyor requested and was provided with a facility policy entitled Medication Reordering which read in part, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permiting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER: Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 324 King George Ave SW Roanoke, VA 24016	

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested and was provided with a facility policy entitled Unavailable Medications which read in part, 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn (as needed), and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications. Surveyor requested and was provided with a list of medications available in the STAT supply. This list included the medications Lyrica 50 mg capsules, levothyroxine 100 mcg tablets and furosemide 20 mg tablets. The concern of not administering Resident #113's medications per the physician's orders was discussed with the administrator, DON, ADON, Regional Director of Operation, MDS coordinator, Director of Clinical Reimbursement, and Regional Director of Clinical Services on 07/16/24 at 2:45 pm. No further information was provided prior to exit.

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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 0688 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason. Based on observation, staff interview, and clinical record review, the facility staff failed to ensure physician ordered equipment (splint) was in place to ensure the resident maintained and/or improved their highest level of range of motion (ROM) and mobility for 1 of 3 current residents in the survey sample. Resident #118. The findings include: The facility staff failed to apply a provider ordered splint to the residents right hand. Resident #118's diagnoses included, but were not limited to, persistent vegetative state, muscle weakness, and cognitive communication deficit. Section B (hearing/speech/vision) of Resident #118's minimum data set (MDS) assessment with an assessment reference date (ARD) of 05/23/24 was coded to indicate Resident #118 was in a persistent vegetative state. Section GG (functional abilities and goals) was coded to indicate this resident had limitations in ROM in the upper and lower extremities. Resident #118's comprehensive care plan included the focus area has limited physical mobility related to neurological deficits. Interventions included apply splint per MD order. On 06/21/24 the provider transcribed an order to apply right and left hand splints during the day. When reviewing the clinical record, the surveyor was unable to find this order on the medication administration record (MAR) or the treatment administration record (TAR). During observations on 07/10/24 at 11:00 a.m. and again at 2:35 p.m. Resident #118 was not observed with a splint in place to their right hand. The clinical record did not include any documentation to indicate why this splint was not in place. On 07/11/24 at 10:55 a.m., Resident #118 was observed with their right-hand splint in place. During an interview with Licensed Practical Nurse (LPN) #4 this nurse was asked who had placed the right-hand splint on Resident #118. LPN #4 stated therapy had placed the splints on this resident. On 07/11/24 at 11:00 a.m., during an interview with therapy staff #1 and #2. These staff stated Resident #118's hand splints were the nursing staff's responsibility. On 07/11/24 at 4:30 p.m., during an end of the day meeting with the Administrator, Regional Director of Clinical Services, Director of Nursing, and Assistant Director of Nursing/Staff Development Coordinator the issue with Resident #118's splint not being in place was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, resident interviews, staff interviews, and facility document review, the facility staff failed to ensure water temperatures were maintained at a level to decrease the risk for injuries. The findings include: The facility staff failed to ensure water temperatures were maintained at a level that would decrease the risk for injuries. On 7/10/24 at 11:30 a.m., a surveyor checked the water in the sinks of resident room [ROOM NUMBER] and #309; the water in both rooms was hot to the point that the surveyor could not hold their hand under the stream for more that 2-3 seconds. On 7/10/24 at approximately 11:45, this surveyor checked the water temperature in the sink of room [ROOM NUMBER]. This surveyor was unable to hold their hand under the stream without feeling discomfort from the hot water. On 7/10/24 at 12:05 p.m., this surveyor checked facility water temperatures with the facility's Maintenance Director in three (3) resident rooms. Only one (1) of the (3) resident rooms had a water temperature greater than 120 degrees Fahrenheit. At this time, a resident reported the water temperature in their room had been hotter prior to when the water temperature was checked; this resident also reported the water pressure was greater prior to when the water temperature was checked. Water temperatures checked, on 7/10/24 by the facility staff, indicated water temperatures in eight (8) resident rooms ranged between 121 - 125 degrees Fahrenheit. The facility staff provided the survey team with documentation to indicated they had the facility's plumbing checked and adjusted on 7/10/24. On 7/16/24 at 2:45 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Operations, MDS Coordinator, Regional MDS Coordinator, and Regional Director of Clinical Services. During this meeting, elevated water temperatures in residents' rooms were discussed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 324 King George Ave SW Roanoke, VA 24016	

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. Based on observation, staff interview and facility document review the facility staff failed to ensure licensed nursing staff have the competencies and skill sets necessary to provide care for the residents. The findings included: Surveyor observed registered nursing (RN) #3 on 07/10/24 at 11:15 am performing a blood sugar check for a resident via glucometer. RN #3 did not fully remove the glucometer from the plastic storage bag while checking the residents blood sugar, then returned the glucometer to the bag without cleaning or disinfecting the glucometer. Surveyor spoke with the assistant director of nursing (ADON), who is also the facility staff development coordinator, on 07/11/24 at 1:40 pm regarding RN #3. Surveyor asked ADON if RN #3 had received training on infection control and specifically on cleaning/disinfecting glucometer. ADON stated, We don't have nurse competencies. We don't have a program for that but will be starting one soon. I do have education/in-service training on infection control, glucometer cleaning and others. ADON provided surveyor with a copy of RN #3's job description, signed and dated by RN #3 on 05/22/24. This job description read in part, Administer professional services such as: catheterization, tube feedings, suction, applying and changing dressings/bandages, packs, colostomy, and drainage bags, taking blood, giving massages and range of motion exercises, care for the dead/dying, etc., as required. ADON also provided a copy of an Education In-service Attendance Record for infection control dated 05/22/24, which RN #3 had signed. ADON provided surveyor with a New Hire Orientation form, which included a section for skills checklists and core competencies. These competencies included clean glucometer/PT-INR machine. Surveyor asked ADON to provide RN #3's checklist, and ADON stated, They get their competencies on the floor, and we do not have checklists for competencies. Surveyor requested and was provided with a facility policy entitled Competency Evaluation which read in part, It is the policy of this facility to evaluate each employee to assure appropriate competencies and skills for performing his or her job and to meet the needs of facility residents. 'Competency' is a measurable pattern of knowledge, skills abilities, behaviors, and other characteristics that an individual needs to perform work roles or occupational functions successfully. 3. Initial competency is evaluated during the orientation process. 4. Subsequent and/or annual competency is evaluated at a frequency determined by the facility assessment, evaluation of the training program, and/or job performance evaluations. 6. Checklists are used to document training and competency evaluations. 8. Employee competency forms are maintained in the Staff Development Coordinator's office for current training year, then forwarded to the Human Resources Director for placing into the employee's personnel file. The concern of not ensuring licensed nursing staff have the competencies and skill sets necessary to provide care for the residents was discussed with the administrator, director of nursing, ADON, minimum data set coordinator, regional director of operations, director of clinical reimbursement, and regional director of clinical services on 07/16/24 at 2:45 pm. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

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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 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 3. The facility nursing staff failed to accurately complete the shift change controlled substance inventory count sheets on 5 of 5 medication carts. The facility's shift change controlled substance inventory count sheet forms for 5 of 5 medication carts were noted to have incomplete information. These forms are part of the facility process where licensed nurses document the count of the facility's controlled medication at the time when access to the controlled medications is being transferred from one licensed nurse to another licensed nurse. These forms included the statement: Nurse signatures below denote that the control drug inventory was true and correct at the date and time [sic] shift change or key exchange. On 07/10/24 beginning at approximately 4:00 p.m., the surveyor reviewed the shift change controlled substance inventory count sheets on the narcotic books on each unit. Numerous sheets on each medication cart were observed to contain blanks where the oncoming and/or off going nurse had not signed these sheets. Several sheets were also observed to have no information in the areas designated for the facility name, station, and/or medication cart number. On 07/10/24 at 4:10 p.m., during an interview with the Unit Manager this staff stated the nursing staff had been in-serviced and re-educated on completing these forms. On 07/11/24 at 3:30 p.m., the DON provided the surveyor with a copy of their policy titled, Controlled Substance Administration & Accountability. This policy read in part, It is the policy of this facility to promote safe, high quality patient care, compliant with state and federal regulations regarding monitoring the use of controlled substances. The facility will have safeguards in place in order to prevent loss, diversion or accidental exposure . On 07/11/24 at 4:30 p.m., during an end of the day meeting with the Administrator, Regional Director of Clinical Services, Director of Nursing (DON), and Assistant Director of Nursing/Staff Development Coordinator the issue with the shift change controlled substance inventory count sheets being incomplete was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. Based on staff interview, clinical record review, facility document review and during a medication pass and pour observation the facility staff failed to ensure medications were available for administration for 2 of 24 residents, Resident #123, #113 and failed to ensure the nursing staff correctly implemented the facility schedule control medication monitoring system for 5 of 5 medication carts. The findings included: 1. For Resident #123 the facility staff failed to ensure the medication Symbicort aerosol inhaler was available for administration. Resident #123's clinical record listed diagnoses which included but not limited to unspecified asthma, uncomplicated. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
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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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #123's most recent minimum data set with an assessment reference date of 05/28/24 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 is severely cognitively impaired. Resident #123's comprehensive care plan was reviewed and contained a care plan for . is at risk for ineffective breathing d/t (due to) dx (diagnosis) of COPD (chronic obstructive pulmonary disease). Resident has SOB (shortness of breath) when lying flat. Interventions for this care plan include Give medications as ordered. Surveyor observed registered nurse (RN) #3 on 07/10/24 at 8:35 am during a medication pass and pour. While preparing Resident #123's medications, RN #3 informed surveyor that resident's inhaler was not in the medication cart. RN #3 stated that inhaler had been ordered on 07/07/24, and she probably hasn't had it for a few days. Resident #123's clinical record was reviewed and contained a physician's order summary which read in part, Symbicort Aerosol 160-4.5 MCG/ACT (Budesonide-Formoterol Fumarate). 1 puff inhale orally two times a day for SOB. Rinse mouth after use. Resident #123's electronic medication administration (eMAR) record was reviewed and contained an entry as above. This entry had been initialed for all administrations for the month of July, including 8 am on 07/10/24. Surveyor spoke with an order entry staff at the pharmacy regarding Resident #123's Symbicort inhaler on 07/10/24 at 2:00 pm. Order entry staff stated that they had tried to fill it, but insurance denied payment on 07/07/24. Order entry staff stated that a refill request on 06/29/24 had triggered to switch to generic, but medication was switched to generic on 10/16/23. Surveyor asked order entry staff when medication was last sent to facility, and order entry staff stated that a 30-day supply was sent on 06/06/24. Surveyor spoke with licensed practical nurse (LPN) #5 on 07/11/24 regarding Resident #123's Symbicort inhaler. LPN #5 looked in the medication cart, then stated the inhaler was not there, unless it came last night. Surveyor requested and was provided with a facility policy entitled Unavailable Medication which read in part, 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn, and emergency medications. 3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications. 5. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reaction to omission of the medication. Surveyor requested and was provided with a facility policy entitled Medication Reordering which read in part, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permiting. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

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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 0755

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

The concern of not ensuring residents medications were available for administration was discussed with the administrator, director of nursing, assistant director of nursing, regional director of operations, minimum data set coordinator, director of reimbursement, and regional director of clinical services on 07/16/24 at 2:45 pm.

No further information was provided prior to exit.

2. For Resident #113 the facility staff failed to ensure the medications atorvastatin and semaglutide were available for administration.

Resident #113's clinical record listed diagnoses which included but not limited to type 2 diabetes mellitus with hyperglycemia and morbid obesity due to excess calories.

Resident #113 most recent minimum data set with an assessment reference date of 06/27/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact.

Resident #113's comprehensive care plan was reviewed and contained care plans for . has diabetes mellitus and . has nutritional problem d/t (due to) dx (diagnosis) of obesity. Resident has dx of Type 2 diabetes, CHF (congestive heart failure), and anemia. Interventions for these care plans include Diabetes medication as ordered by doctor and Administer medications as ordered.

Resident #113's clinical record was reviewed and contained a physician's order summary which read in part, Atorvastatin calcium oral tablet 10 mg (Atorvastatin calcium). Give 10 mg by mouth one time a day for hypercholesterolemia, and Semaglutide-Weight Management Subcutaneous Solution Auto-injector 0.25mg/0.5 ml (Semaglutide (Weight Management)). Inject 0.25 mg subcutaneously one time a day every 7 day(s) for Supramorbid obesity/DM.

Resident #113's electronic medication administration records (eMAR) for the months of May, June and July 2024 were reviewed and contained entries as above. For the month of June 2024, the entry for atorvastatin was coded 9 on 06/28/24 at 8:00 am. For the month of July 2024, the entry for semaglutide was coded 9 on 07/01/24 and 07/08/24. Chart code 9 is equivalent to other/see nurses notes.

Resident #113's nurses' progress notes were reviewed and contained progress notes which read in part, 6/28/2024 08:24. Atorvastatin Calcium Oral Tablet 10 mg. Give 10 mg by mouth one time a day for hypercholesterolemia. ordered from pharmacy, 7/1/2024 12:43. Semaglutide-Weight Management Subcutaneous Solution Auto-injector 0.25 mg/0.5 ml. Inject 0.25 mg subcutaneously one time a day every 7 day(s) for Supramorbid obesity/DM. Medication not available; MD notified and aware; pharmacy states that the medication delivery is on the way, and 7/8/2024 11:01. Semaglutide-Weight Management Subcutaneous Solution Auto-injector 0.25 mg/0.5 ml. Inject 0.25 mg subcutaneously one time a day every 7 day(s) for Supramorbid obesity/DM. Medication not available; MD notified and aware; Medication delivery on the way per Pharmacy.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495156	A. Building B. Wing	07/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Old Southwest Health and Rehabilitation	324 King George Ave SW Roanoke, VA 24016

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)
F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and was provided with a facility policy entitled Unavailable Medication which read in part, 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn, and emergency medications. 3. The facility shall follow established procedures for ensuring residents have a sufficient supply of medications. 5. If a resident misses a scheduled dose of the medication, staff shall follow procedures for medication errors, including physician/family notification, completion of a medication error report, and monitoring the resident for adverse reaction to omission of the medication. Surveyor requested and was provided with a facility policy entitled Medication Reordering which read in part, It is the policy of this facility to accurately and safely provide or obtain pharmaceutical services including the provision of routine and emergency medications and biologicals in a timely manner to meet the needs of each resident. 2. Acquisition of medications should be completed in a timely manner to ensure medications are administered in a timely manner. 3. Each time a nurse is administering medications and observes (6) or less doses left of one kind, that nurse will reorder the medication, time permiting. The concern of not ensuring residents medications were available for administration was discussed with the administrator, director of nursing, assistant director of nursing, regional director of operations, minimum data set coordinator, director of reimbursement, and regional director of clinical services on 07/16/24 at 2:45 pm. No further information was provided prior to exit.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER: Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 324 King George Ave SW Roanoke, VA 24016	

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. Based on staff interviews, medical record review and facility document review, the facility staff failed to act on pharmacy recommendations for one of three residents in the survey sample, resident # 101. The findings included: For resident # 101 (R101) the facility failed to act upon the pharmacy recommendations from May 27, 2024, and June 26, 2024. Progress notes in the clinical record indicated that medication regimen reviews had been done May 27,2024 and June 26,2024. This surveyor could not locate the Consultant Pharmacist Recommendation to Physician for either month in the record. On 7/11/2024 this surveyor asked the Director of Nursing (DON) for the pharmacy recommendations for May and June. They brought blank copies of each one. The recommendation for May read, Federal guidelines state psychopharmacological drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in two different quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize mood, or treat psych disorder. This resident has been taking Buspirone 20 mg TID since 5/12/23 without a GDR. Could we attempt a dose reduction at this time to perhaps Buspirone 15 mg TID to verify this resident is on the lowest possible dose? If not, please indicate response below. The June recommendation read, Federal guidelines state psychopharmacological drugs should have an attempt at a gradual dose reduction (GDR) twice per year for the first year in two different quarters with 1 month between attempts, then annually thereafter, when used to manage behavior, stabilize mood, or treat psych disorder. This resident has been taking Hydroxizine 50 mg TID since 12/7/2024 without a GDR. Could we attempt a dose reduction at this time to perhaps 25 mg TID to verify this resident is on the lowest possible dose? If not, please indicate response below. This surveyor clarified with the DON that I needed to see the completed recommendations that had been addressed by the physician. They stated they would return with them. On 7/15/24 this surveyor reminded the DON that I was still waiting to see the pharmacy recommendations for May and June. They provided the June 26, 2024, recommendation signed by the physician and dated 7/9/24. Surveyor asked if they had it on 7/9/24 why did they not provide it on 7/11/24. They stated, I just got it. I sent it to him/her the end of June but I had to call this morning, and this is what I got. Several hours later, they were able to produce the May 27 recommendations after asking their Nurse Practitioner (NP) to review it, as the other provider still had not sent it back. It was dated 7/16/24. They stated they were routinely having trouble getting the recommendations back timely from the psych provider. This concern was reviewed with the Administrator, Regional Director of Operations, Regional Director of Clinical Services, Director of Nursing, Assistant Director of Nursing, MDS Coordinator and Regional [NAME] Specialist on 7/16/24 at 2:44 PM. No further information was provided to the survey team prior to the exit conference.

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NAME OF PROVIDER OR SUPPLIER: Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 324 King George Ave SW Roanoke, VA 24016	

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident’s drug regimen must be free from unnecessary drugs. Based on staff interview, clinical record review and facility documentation review the facility staff failed to ensure 1 of 24 residents was free from unnecessary medications, Resident #110. The findings included: For Resident #110 the facility staff administered the medication metoprolol without checking the residents blood pressure or pulse per the physician's order. Resident #110's clinical record listed diagnoses which included but not limited chronic diastolic (congestive) heart failure, and essential hypertension. Resident #110's most recent minimum data set with an assessment reference date of 06/07/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #110's comprehensive care plan was reviewed and contained care plans for . potential for altered cardiovascular status r/t (related to) hyperlipidemia, and CHF (congestive heart failure) with daily wts (weights) and . has potential fluid deficit/overload r/t (related to) diuretic use r/t CHF, HTN (hypertension). Interventions for these care plan included Monitor vital signs. Notify MD of significant abnormalities and administer medications as ordered. Resident #110's clinical record contained a physician's order summary which read in part, Metoprolol Tartrate Oral Tablet 25 mg. Give 0.5 tablet by mouth two times a day for HTN. Hold if systolic BP (blood pressure) 100 and HR (heart rate) under 60. Resident #110's electronic medication administration record (eMAR) for the month of June 2024 was reviewed and contained and entry as above. From 06/17/24 through 06/28/24, there were no blood pressures or heart rates entered on the eMAR. Surveyor spoke with the director of nursing (DON) on 07/15/24 at 10:30 am regarding Resident #110's medications. DON stated that resident had daily vital signs taken, and if it wasn't recorded on the eMAR, it should be on the vital signs sheet. Surveyor reviewed Resident #110's daily vital signs and could not locate a blood pressure recorded for 06/21/24 and 06/27/24. Surveyor requested and was provided with a facility policy entitled Medication Administration which read in part, Medications are administered by licensed nurses, or other staff who are legally authorized to do so in this state, as ordered by the physician and in accordance with professional standards of practice, in a manner to prevent contamination or infection. 8. Obtain and record vital signs, whin applicable or per physician orders. When applicable, hold medication for those vital signs outside the physician's prescribed parameters. 17. Sign MAR after administered. For those medications requiring vital signs, record the vital signs onto the MAR . Medication requiring vital signs prior to administration: Anti-Hypertensives. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 324 King George Ave SW Roanoke, VA 24016	

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern of not ensuring a resident was free from unnecessary medication was discussed with the administrator, DON, assistant director of nursing, regional director of operations, and regional director of clinical services on 07/16/24 at 2:45 pm. No further information was provided prior to exit.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on staff interview, clinical record review and facility document review the facility staff failed to ensure 1 of 24 resident was free of significant medication error, Resident #110. The findings included: For Resident #110 the facility staff failed to administer the medication metoprolol per the physician's order. Resident #110's clinical record listed diagnoses which included but not limited chronic diastolic (congestive) heart failure, and essential hypertension. Resident #110's most recent minimum data set with an assessment reference date of 06/07/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #110's comprehensive care plan was reviewed and contained care plans for . potential for altered cardiovascular status r/t (related to) hyperlipidemia, and CHF (congestive heart failure) with daily wts (weights) and . has potential fluid deficit/overload r/t (related to) diuretic use r/t CHF, HTN (hypertension). Interventions for these care plan included Monitor vital signs. Notify MD of significant abnormalities and administer medications as ordered. Resident #110's clinical record contained a physician's order summary which read in part, Metoprolol Tartrate Oral Tablet 25 mg. Give 0.5 tablet by mouth two times a day for HTN. Hold if systolic BP (blood pressure) is less than 100 and HR (heart rate) under 60. Resident #110's electronic medication record for the month of June 2024 was reviewed and contained an entry as above. This entry was coded 9 on 06/12/24. Chart code 9 is equivalent to other/see nurse's notes. Resident #110's nurse's progress notes were reviewed and contained a note dated 06/12/24 which read in part, 6/12/2024 09:46. Metoprolol Tartrate Oral Tablet 25 mg. Give 0.5 tablet by mouth two times a day for HTN. Hold id systolic BP is less than 100 and HR under 60. Medication reordered through pharmacy. Surveyor spoke with the assistant director of nursing (ADON) on 07/11/24 at 10:45 regarding Resident #110's medications. ADON stated, If the medication is in the Cubex (stat supply), they should have pulled it. Surveyor requested and was provided with a facility policy entitled Unavailable Medications which read in part, 1. The facility maintains a contract with a pharmacy provider to supply the facility with routine, prn (as needed), and emergency medications. 2. A STAT supply of commonly used medications is maintained in-house for timely initiation of medications. Surveyor requested and was provided with a list of medications available in the STAT supply. This list included metoprolol tartrate 25 mg. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 324 King George Ave SW Roanoke, VA 24016	

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The concern of not ensuring Resident #110 was free from significant medication error was discussed with the administrator, DON, ADON, Regional Director of Operation, MDS coordinator, Director of Clinical Reimbursement, and Regional Director of Clinical Services on 07/16/24 at 2:45 pm. No further information was provided prior to exit.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. Based on staff interview and clinical record review, the facility staff failed to provide laboratory services to meet the needs of the resident for 1 of 4 sampled residents (Resident #122). The findings included: For Resident #122, the facility staff failed to obtain a urinalysis as ordered by the medical provider. The urinalysis was ordered to be obtained between 11/11/22 and 11/12/22; however, it was not obtained until 11/14/22. This was a closed record review. Resident #122's diagnosis list indicated diagnoses, which included, but not limited to Acute and Chronic Respiratory Failure, Obstructive and Reflux Uropathy, Acute Congestive Heart Failure, Dementia, and Chronic Cystitis. The minimum data set (MDS) with an assessment reference date (ARD) of 2/03/23 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. A review of Resident #122's clinical record revealed a medical provider order dated 11/10/22 to obtain a urinalysis with culture and sensitivity (UA C&S) from 11/11/22 through 11/12/22. Surveyor was unable to locate the results of the ordered UA C&S in Resident #122's clinical record. Surveyor spoke with the Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services (RDCS) on 7/11/24 at 4:27 PM and requested the results of the UA C&S. On 7/15/24, the DON provided the lab results for a UA C&S collected on 11/14/22 at 5:00 AM. The UA results were positive for 2+ nitrites, 4+ protein, 1+ urobilinogen, 11-26 red blood cells, 51-100 white blood cells, 5-16 squamous epithelial cells, amorphous crystals, mucus, and triple phosphate crystals. The final culture report revealed greater than 100,000 mixed flora with no predominant microorganisms present. On 7/15/24 at approximately 1:25 PM, surveyor spoke with the DON and inquired why the UA C&S ordered for 11/11/22-11/12/22 was not obtained until 11/14/22. The DON stated they were not sure as the timing did not make sense. Surveyor requested to speak with the medical provider who gave the UA C&S order and the nurse who entered the order on 11/10/22, however, neither were still employed by the facility. The facility was unable to provide the facility lab policy effective in November 2022. On 7/16/24 at 2:45 PM, the survey team met with the facility management team including the Administrator and DON and discussed the concern of the delay in obtaining the UA C&S for Resident #122. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/16/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 324 King George Ave SW Roanoke, VA 24016	

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on staff interviews and clinical record review, the facility staff failed to ensure a medical provider was promptly notified of critical lab values for one (1) of four (4) residents sampled for laboratory review (Resident #114). The findings include: The facility staff failed to ensure Resident #114's critical laboratory results were promptly reported to a medical provider. Resident #114's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/2/24, was signed as completed on 5/19/24. Resident #114 was assessed as usually being able to make self understood and as sometimes being able to understand others. Resident #114's Brief Interview for Mental Status (BIMS) summary score was documented as a six (6) out of 15; this indicated severe cognitive impairment. Resident #114's clinical record included the results of a CBC with auto Differential laboratory test dated 6/1/24. (A Complete Blood Count (CBC) is a laboratory test that measures various components of a blood specimen.) These results indicated the Resident's [NAME] Blood Count (WBC) and Hemoglobin (HGB) Level were critically low. This laboratory result included the following statement: After multiple unsuccessful attempts to notify facility of the critical value by phone, the result was released to be viewed in (system name omitted) and a follow up phone call will be placed in the AM. (WBC, HGB). These laboratory results were reported on 6/1/24 at 9:14 p.m.; the medical provider documented reviewing these results on 6/2/24 at 9:28 a. m. According to a nursing note dated 6/2/24 at 1:03 p.m., Resident #114 was transferred to the local emergency room on 6/2/24 for a blood transfusion. On 7/11/24 at 9:00 a.m., the surveyor interviewed, via telephone, a staff member of the laboratory which obtained and processed Resident #114's aforementioned laboratory test. This staff member reported their protocol is to attempt to notify the facility of a critical laboratory result via telephone three (3) times, after the third unsuccessful attempt to notify the facility, the results are released to be viewed by the facility staff. This laboratory staff member reported the laboratory staff would attempt an additional call during the morning of the next business day. On 7/12/24 at 9:29 a.m., the surveyor interviewed the Director of Nursing (DON) about the laboratory staff being unable to contact the facility with the aforementioned critical laboratory results. The DON reported staff members might be providing resident care and unable to hear the telephone; the DON gave the example of staff administering residents their medications. On 7/12/24 at 10:10 a.m., the DON reported the facility staff is starting to document outstanding diagnostic tests in a 'communication binder' which will allow for reporting of outstanding diagnostic tests between oncoming and outgoing nursing staff at shift change. On 7/16/24 at 2:45 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Operations, MDS Coordinator, Regional MDS Coordinator, and Regional Director of Clinical Services. During this meeting, the delay in medical provider notification of Resident #114's aforementioned critical laboratory results was discussed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER: Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 324 King George Ave SW Roanoke, VA 24016	

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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 0775 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep complete, dated laboratory records in the resident's record. Based on staff interview and clinical record review, the facility staff failed to file laboratory results in the clinical record for 1 of 4 sampled residents (Resident #122). The findings included: For Resident #122, the facility staff failed to file the results of a urinalysis and thyroid-stimulating hormone (TSH) blood test in the resident's clinical record. This was a closed record review. Resident #122's diagnosis list indicated diagnoses, which included, but not limited to Acute and Chronic Respiratory Failure, Obstructive and Reflux Uropathy, Hypothyroidism, Acute Congestive Heart Failure, Dementia, and Chronic Cystitis. The minimum data set (MDS) with an assessment reference date (ARD) of 2/03/23 assigned the resident a brief interview for mental status (BIMS) summary score of 3 out of 15 indicating the resident was severely cognitively impaired. A review of Resident #122's clinical record revealed a medical provider order dated 11/10/22 to obtain a urinalysis with culture and sensitivity (UA C&S) and an order dated 1/04/23 to obtain a TSH level. Surveyor was unable to locate the results of the UA C&S or TSH level in Resident #122's clinical record. Surveyor spoke with the Administrator, Director of Nursing (DON), Assistant DON, and Regional Director of Clinical Services (RDCS) on 7/11/24 at 4:27 PM and requested the results of the UA C&S and TSH. On 7/15/24, the DON provided the lab results for a UA C&S collected on 11/14/22 and TSH level obtained on 1/05/23. The DON stated the lab system was not integrated with the clinical record system at that time and they requested and received all of Resident #122's lab results from the lab provider. In addition to the requested UA C&S and TSH results, the DON provided surveyor with eight (8) additional lab test results which were also not included in Resident #122's clinical record. The fax date printed on the top left corner of each lab result was 7/15/24. The facility was unable to provide the facility lab policy effective November 2022 through February 2023. On 7/16/24 at 2:45 PM, the survey team met with the facility management team including the Administrator and DON and discussed the concern of Resident #122's clinical record failing to include all lab results. No further information regarding this concern was presented to the survey team prior to the exit conference on 7/16/24.

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NAME OF PROVIDER OR SUPPLIER: Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE: 324 King George Ave SW Roanoke, VA 24016	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on staff interviews, facility document review, and clinical record reviews, the facility staff failed to maintain a complete and/or accurate clinical record for three (3) of 24 sampled current residents (Resident #114, Resident #110, and Resident #101). The findings include: 1. The facility staff failed to ensure Resident #114's weight was accurately documented in the resident's clinical record. Resident #114's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 5/2/24, was signed as completed on 5/19/24. Resident #114 was assessed as usually being able to make self understood and as sometimes being able to understand others. Resident #114's Brief Interview for Mental Status (BIMS) summary score was documented as a six (6) out of 15; this indicated severe cognitive impairment. The following information was found in a facility policy titled Weight Monitoring (with a reviewed/revised date of 12/1/22): Weight can be a useful indicator of nutritional status. Significant unintended changes in weight (loss or gain) or insidious weight loss (gradual unintended loss over a period of time) may indicate a nutritional problem. Review of Resident #114's clinical documentation indicated the resident had experienced a greater than 30 pound weight gain between 5/27/24 and 6/6/24. Resident #114's weight was documented as the following: - On 5/27/24 - 109.5 pounds, - On 6/6/24 - 140.0 pounds, - On 6/21/24 - 140.0 pounds, and - On 7/2/24 - 141.6 pounds. On 7/11/24, the Director of Nursing (DON) was asked about Resident #114's significate weight gain. On 7/11/24 at 11:18 a.m., the DON reported the weight gain had not occurred. The DON reported Resident #114 had been reweighed and it was determined that the 35 pounds that should have been deducted due to using a wheelchair scale had not been deducted for the following weights: 6/6/24, 6/21/24, and 7/2/24. On 7/16/24 at 2:45 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Operations, MDS Coordinator, Regional MDS Coordinator, and Regional Director of Clinical Services. During this meeting, Resident #114's aforementioned weights that were incorrectly documented was discussed. 2. For Resident #110 the facility staff failed to ensure an accurate clinical record as evidenced by duplicate physician's order on the medication administration record (eMAR). (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #110's clinical record listed diagnoses which included but not limited to dry eye syndrome of bilateral lacrimal glands. Resident #110's most recent minimum data set with an assessment reference date of 06/07/24 assigned the resident a brief interview for mental status score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident is cognitively intact. Resident #110's comprehensive care plan was reviewed and contained a care plan for . has chronic pingueculitis (feeling of something in the eye). Interventions for this care plan include Administer medications per MD orders. Resident #110's clinical record was reviewed and contained a physician's order summary which read in part, Muro 128 Ophthalmic Ointment 5% (Sodium Chloride Hypertonic). Instill 1 drop in both eyes at bedtime for dry eye syndrome. Resident #110's eMAR for the month of June 2024 was reviewed and contained an order as above, with a listed administration time of 2200 (10:00 pm). Resident #110's eMAR also contained and entry which read in part, Muro 128 Ophthalmic Ointment 5% (Sodium Chloride Hypertonic). Instill 1 drop in both eyes at bedtime for severe dry eye syndrome. Apply to inside lower cul de sac of both eyes. This entry had an administration time of 2100 (9:00 pm). Both orders had been initialed as administered from 06/01/24-06/28/24. On 06/29/24, the eMAR was coded 9 for the 10:00 pm entry. Chart code 9 is equivalent to other/see nurses notes. Resident #110's clinical contained a nurse's progress note which read in part, 6/29/2024 21:14 Muro 128 ophthalmic Ointment 5%. Instill 1 drop in both eyes at bedtime for dry eye syndrome. Duplicate order. The concern of not ensuring an accurate clinical record of was discussed with the administrator, DON, ADON, Regional Director of Operation, MDS coordinator, Director of Clinical Reimbursement, and Regional Director of Clinical Services on 07/16/24 at 2:45 pm. No further information was provided prior to exit. 3. For resident # 101 (R101) the facility staff failed to ensure completeness and accuracy of the resident's medication administration record (MAR) for May 2024. R101's May 2024 MAR was noted to have blanks on 5/27/24 for a 9:00 PM dose of Depakote, a 9:00 PM dose of Pepcid, a 9:00 PM dose of Simvastatin and a 9:00 PM dose of Buspirone. On May 28, 2024, there were blanks noted for a 9:00 AM dose of Zyprexa, a 2:00 PM dose of Vistaril, a 12:00 PM dose of Lorazepam, a 2:00 PM dose of Lactulose, and holes for vital signs ordered to be done at 12:00 AM and 8:00 AM. For May 29, 2024, there were holes noted for 6:00 AM dose of Oxycontin, a 2:00 PM dose of Lactulose, 6:00 AM dose of Vistaril, a 6:00 AM dose of Lorazepam and a 6:00 AM dose of Methacarbamol. The policy entitled, Documentation in the Medical Record with a revised date of 12/1/22, was reviewed. It read in part, Each resident's medical record shall contain an accurate representation of the actual experiences of the resident and include enough information to provide a picture of the resident's progress through complete, accurate, and timely documentation. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024
NAME OF PROVIDER OR SUPPLIER Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 324 King George Ave SW Roanoke, VA 24016	

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with R101 on 7/11/24 at 9:23 AM they stated that they were not sure if they always get their medications as ordered, I take it when they bring it, I just have to trust them. On 7/11/24 at 9:40 AM this surveyor interviewed Licensed Practical Nurse (LPN) # 6. When asked what it meant when there are holes noted for medications they stated, Probably that somebody didn't sign off the MAR, but you know, if it wasn't documented, it wasn't done. On 7/11/24 at 9:42 AM this surveyor interviewed LPN # 1. When asked about the blanks on the MAR they stated, It means it wasn't documented or maybe not done. On 7/11/10 at 10:00 AM am this surveyor met with the Director of Nursing (DON) and the Administrator. Surveyor asked the DON about the holes on R101's MAR. They stated, It's most likely a documentation issue. The survey team met with the Administrator, Regional Director of Operations, Regional Director of Clinical Services, DON, Assistant DON, MDS Coordinator and Regional [NAME] Specialist at 2:44 PM on 7/16/24. This concern was reviewed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on staff interviews, clinical record reviews, and facility document reviews, the facility staff failed to ensure the Quality Assurance and Performance Improvement (QAPI) Program met the needs of the facility as evidenced by repeated deficiencies in the areas of: Resident Rights, Resident Transfers, Quality of Life, Quality of Care, Pharmacy Services, Infection Control, and Staff Training Requirements. The findings include: The facility's Quality Assurance and Performance Improvement (QAPI) program failed to implement measures/actions that corrected deficient practices cited in the previous surveys which resulted in deficient practices being cited during this revisit survey in the same areas of care. The facility's QAPI program failed to ensure residents and/or residents' responsible parties had an opportunity to develop advanced directives as evidenced by deficient practice in the area of Resident Rights. The facility's QAPI program failed to ensure that transferred residents were provided the required transfer and/or bed hold information as evidenced by deficient practice in the area of Admission, Transfer, and Discharge. The facility's QAPI program failed to ensure that residents' bathing needs were met as evidenced by deficient practice in the area of Quality of Life. The facility's QAPI program failed to ensure that residents received their medications as prescribed as evidenced by deficient practice in the areas of Quality of Care and Pharmacy Services. The facility's QAPI program failed to ensure (a) appropriate use and cleaning of a resident's glucometer and (b) residents were offered and/or received vaccinations as evidenced by deficient practices in the area of Infection Control. The facility's QAPI program failed to ensure an effective training program for its staff members as evidence by deficient practice in the area of Training Requirements. On 7/16/24 at 2:45 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Operations, MDS Coordinator, Regional MDS Coordinator, and Regional Director of Clinical Services. During this meeting, the failure of the facility's QAPI program to develop and/or implement action plans to prevent the aforementioned repeat deficiencies was discussed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on staff interview, facility document review and during a medication pass and pour observation the facility staff failed to follow established infection control procedures during finger stick blood glucose monitoring for 1 of 4 observations. The findings included: For Resident #124 the facility staff failed to properly clean and disinfect a blood glucometer. Resident #124's face sheet listed diagnoses which included but not limited to type II diabetes mellitus without complications. Resident #124's comprehensive care plan was reviewed and contained a care plan for . has diabetes mellitus. On 07/10/24 at 11:15, surveyor observed registered nurse (RN) #3 during a medication pass and pour. RN #3 removed a plastic zip lock bag containing Resident #124's glucometer and placed it on top of the medication cart, then removed a glucometer test strip, opened the bag, and placed the strip in the glucometer. RN #3 removed a plastic container of Sani-wipes from the medication cart and placed them of top of the cart. RN #3 removed a wipe from the container, entered Resident #124's room, and wiped the overbed table. RN #3 returned to the medication cart, gathered an alcohol pad, cotton ball, lancet and glucometer in one hand and placed the plastic container of wipes under opposite arm. RN #3 returned to resident's room, placed all items on the overbed table, donned gloves, cleaned resident's finger with alcohol pad, wiped finger with cotton ball, pricked resident's finger with lancet, then applied a drop of resident's blood to test strip in glucometer, only removing part of the glucometer from the plastic bag. After checking resident's blood sugar, RN #3 removed test strip from the glucometer and slid glucometer back into the bag and placed it back onto overbed table. RN #3 picked up used lancet and removed gloves with lancet and used test strip inside. RN #3 then placed gloves in trash in resident's room, washed her hands, gathered the glucometer and container of wipes, and returned to the medication cart. RN #3 placed the plastic bag containing the glucometer on top of the medication cart, donned gloves, removed the glucometer, cleaned it with a wipe and placed it on a tissue to dry. RN #3 removed gloves and once glucometer was dry, returned it to the plastic bag, placed the bagged glucometer back into the medication cart, where it came in contact with three other bagged glucometers. Surveyor spoke with RN #3 on 07/10/24 at 4:25 pm regarding checking a resident's blood sugar. RN #3 stated, I clean surface of med cart, take bagged glucometer out of cart and place on top of cart. I then assemble my supplies (lancet, test strip, alcohol pad, cotton ball), knock on resident's door, wash my hands, put on gloves, clean resident's finger with alcohol, dry with cotton, stick with lancet, check blood sugar, take gloves off with strip inside, place lancet in sharps container. I then clean the glucometer and put back in bag. Surveyor asked RN #3 if they take the bagged glucometer into a resident room, and RN #3 stated, I take the whole thing in there, and place the bag on the bedside table. Surveyor asked RN #3 if they removed the glucometer from the bag when they checked Resident #124's blood sugar, and RN #3 stated, I shouldn't have checked his blood sugar with the glucometer in the bag. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor spoke with the assistant director of nursing (ADON), who is also the facility infection preventionist (IP) on 07/10/24 at 6:55 pm regarding the handling of glucometers. ADON/IP stated, They should clean and disinfect it prior to and after using. Surveyor asked ADON/IP if the glucometer should be removed from the plastic bag prior to entering a resident room, and ADON/IP stated, They shouldn't take Ziploc bag into residents' rooms, and the wipes should stay on the cart. Surveyor asked ADON/IP what would happen if a glucometer were used while still partially inside the bag, and ADON/IP stated, They would have to get a new bag, because that one is considered contaminated. If it is returned to the cart, everything in the cart area is considered contaminated. They would have to clean the cart. Surveyor requested and was provided with a facility policy entitled Blood Glucose Monitoring which read in part, 3. The nurse will abide by the infection control practices of cleaning and disinfection of the glucometer as per the manufacturer's instructions and in accordance with the facility's glucometer disinfection policy. 4. Individual glucometers for residents, will be maintained in a separate plastic bag in the medication cart, and must have proper identification to distinguish between residents and these should not be shared between residents . Procedure: 6. Provide a clean surface for the glucometer to sit if needed (i.e. paper towel). 14. Discard the lancet in a puncture resistant sharps container. 15. Remove the strip and dispose of it properly. 18. Clean and disinfect the glucometer as per manufacturer's instructions. Surveyor spoke with ADON/IP on 07/11/24 at 1:23 pm regarding the disposal of glucometer test strips, and ADON/IP stated, Blood glucose strips should be placed in the sharps container. Surveyor requested and was provided with the manufacturer's instructions for cleaning the glucometer, which read in part, Cleaning and disinfecting can be completed by using a commercially available EPA-registered disinfectant detergent or germicide wipe. Many wipes act as both a cleaner and disinfectant, though if blood is visibly present on the meter, two wipes must be used; use one wipe to clean and a second to disinfect. Surveyor requested and was provided with a facility policy entitled Glucometer Disinfection which read in part, 1. The facility will ensure blood glucometers will be cleaned and disinfected after each use and according to manufacturer's instructions for multi-resident use. 3. The glucometers should be disinfected with a wipe pre-saturated with an EPA registered healthcare disinfectant that is effective against HIV, Hepatitis C, and Hepatitis B virus. Surveyor requested information on the disinfectant used to clean the glucometers and was provided with a copy of the label from a container of Super Sani-Cloth gemicidal disposable wipes. This container listed a dwell time of 2 minutes, and indicated the product was bactericidal, tuberculocidal, and virucidal. Surveyor requested and was provided with an Education In-Service Attendance Record dated 05/22/24 with a topic of glucometer use. This in-service covered the areas of glucometer usage/storage and cleaning, dwell time, purple sanitizer wipes, and infection control. RN #3 had signed this in-service form. ADON/IP provided the surveyor with a glucometer cleaning observation form dated 07/02/24 and signed by both ADON and RN #3. This form indicated that RN #3 demonstrated proficiency in glucometer cleaning. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/16/2024

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The concern of the facility staff failing to follow established infection control procedures during finger stick blood glucose monitoring was discussed with the administrator, director of nursing, ADON/IP, regional director of operations and regional director of clinical services on 07/16/24 at 2:45 pm. No further information was provided prior to exit.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. Based on staff interviews, facility document review, and clinical record review, the facility staff failed to ensure one (1) of three (3) residents sampled for pneumococcal vaccination review were provided the pneumococcal vaccine (Resident #119). The findings include: The facility staff failed to provide Resident #119's pneumococcal vaccine. Resident #119's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 4/29/24, was signed as completed on 5/14/24. Resident #119 was assessed as able to make self understood and as able to understand others. Resident #119's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Review of Resident #119's clinical record failed to provide evidence the resident was up to date on their pneumococcal vaccine. On 7/10/24 at 4:08 p.m., the facility's Assistant Director of Nursing (ADON) provided a copy of a nursing note, dated 4/26/24 at 3:16 p.m., which indicated consent had been obtained for the resident to receive the pneumococcal vaccine. The ADON confirmed no evidence was found to indicate Resident #119 had received the pneumococcal vaccine (after the facility obtained consent on 4/26/24). The following information was found in a facility policy titled Pneumococcal Vaccine (Series) (with a reviewed/revised date of 12/1/2022): - It is our policy to offer our residents and staff immunization against pneumococcal disease in accordance with current CDC guidelines and recommendations. - Each resident will be assessed for pneumococcal immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented, including efforts to determine date of immunization or type of vaccine received. - Each resident will be offered a pneumococcal immunization unless it is medically contraindicated or the resident has already been immunized. On 7/16/24 at 2:45 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Operations, MDS Coordinator, Regional MDS Coordinator, and Regional Director of Clinical Services. During this meeting, the failure of the facility staff to administer Resident #119's pneumococcal vaccine was discussed.

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. 2. The facility staff failed to ensure Resident #119 was offered the 2023-2024 COVID-19 Vaccine. Resident #119's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 4/29/24, was signed as completed on 5/14/24. Resident #119 was assessed as able to make self understood and as able to understand others. Resident #119's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #119's clinical documentation failed to provide evidence the resident was offered the 2023-2024 COVID-19 Vaccine. On 7/10/24 at 4:08 p.m., the facility's Assistant Director of Nursing (ADON) provided a copy of a nursing note, dated 4/26/24 at 2:32 p.m., which indicated the resident's Covid vaccine complete (2+ booster). The ADON confirmed no evidence was found to indicate Resident #119 had been offered the 2023-2024 COVID-19 Vaccine. The following information was found in a facility policy titled Coronavirus Prevention and Response (with a reviewed/revised date of 10/30/23): - Residents will be assessed for Covid [sic]19 immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented in the medical record, including efforts to determine date of immunization or type of vaccine received. - Each resident will be offered a Covid [sic] 19 immunization unless it is medically contraindicated, or the resident has already been immunized. Following assessment for any medical contraindications, the immunization may be administered in accordance with physician-approved standing orders. - The type of Covid [sic] 19 vaccine offered will depend upon and, in accordance with current CDC guidelines and recommendations. On 7/16/24 at 2:45 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Assistant DON, Regional Director of Operations, MDS Coordinator, Regional MDS Coordinator, and Regional Director of Clinical Services. During this meeting, the failure of facility staff to offer Resident #119 the 2023-2024 COVID-19 Vaccine was discussed. Based on staff interview, clinical record review and facility document review the facility staff failed to ensure 2 of 3 residents was offered a 2023-2024 Covid-19 vaccine, Resident #109, and Resident #119. The findings included: 1. For Resident #109, the facility staff failed to offer a 2023-2024 Covid-19 vaccine. Resident #109's clinical record was reviewed, and surveyor could not locate any information that the resident has been offered and/or received an updated Covid-19 vaccine. (continued on next page)

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F 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor spoke with the assistant director of nursing/infection preventionist (ADON/IP) on 07/10/24 at 4:25 regarding Resident #109's Covid-19 vaccine status. ADON/IP stated, We are out of compliance with her Covid vaccine. Surveyor requested and was provided with a facility policy entitled Coronavirus Prevention and Response which read in part, 11. Vaccination Planning: a. Residents will be assessed for Covid 19 immunization upon admission. Self-report of immunization shall be accepted. Any additional efforts to obtain information shall be documented in the medical record, including efforts to determine date of immunization or type of vaccine received. b. Each resident will be offered a Covid 19 immunization unless it is medically contraindicated, or the resident has already been immunized . c. Prior to offering the Covid 19 immunization, each resident or the resident's representative will receive education regarding the benefits and potential side effects of the immunization .f. The resident's medical record shall include documentation that indicates at a minimum, the following: a. The resident or resident's representative was provided education regarding the benefits and potential side effects of the Covid 19 immunization. b. The resident received the Covid 19 immunization or did not receive it due to medical contraindication or refusal. The concern of facility staff failing to offer Resident #109 a current Covid 19 vaccine was discussed with the administrator, director of nursing, assistant director of nursing, regional director of operations, minimum data set coordinator, director of clinical reimbursement, and regional director of clinical services during a meeting on 07/16/24 at 2:45 pm. No further information was provided prior to exit.

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	495156	A. Building B. Wing	07/16/2024

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F 0940 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop, implement, and/or maintain an effective training program for all new and existing staff members. Based on staff interview and facility document review, the facility staff failed to maintain an effective training program for existing staff consistent with their expected roles. The findings include: The facility staff failed to provide evidence of staff training for all their existing facility staff. On 07/11/24 at 3:10 p.m., during an interview with the current Staff Development Coordinator (SDC) this staff stated they had not started any competencies for current staff, they were waiting on Health Care Academy, and they did not know when the start date would be. On 07/11/24 at 4:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), SDC, and Regional Director of Clinical Services (RDCS) the issue with the missing education/competencies was reviewed. The SDC stated they did not have any evidence of competencies for existing staff. The Administrator stated a training tool (Health Care Academy) was to be implemented in July 2024, the RDCS stated there was a delay in receiving supplies and they have been ordered. On 07/12/24 at 11:45 a.m., the SDC stated they did not have a policy on training requirements. The SDC provided the survey team with a copy of their policy titled, Competency Evaluation this policy read in part, It is the policy of this facility to evaluate each employee to assure appropriate competencies and skills for performing his or her job and to meet the needs of facility residents . On 07/16/24 at 2:45 p.m., during a meeting that included the survey team, Administrator, Registered Nurse #1, DON, SDC, Regional Director of Operations, RDCS, and Director of Clinical Reimbursement the issue regarding education for staff was reviewed. The DON stated the third week of July 2024 they would be having their first skills fair. The RDCS stated they had started competencies with staff and then stopped. The RDCS stated they had a lot of education to do with staff and they were going to start from scratch as some employees were no longer employed at the facility. When asked if they had a list of staff that had completed competencies the RDCS stated they did not. No further information regarding this issue was provided to the survey team prior to the exit conference.