

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  03/29/2024
NAME OF PROVIDER OR SUPPLIER  Old Southwest Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE  324 King George Ave SW Roanoke, VA 24016	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>47299</p> <p>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.</p> <p>The findings included:</p> <p>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.</p> <p>R103's diagnoses included but were not limited to anoxic brain damage and chronic respiratory failure due to asphyxiation.</p> <p>R103 was not interviewable, and the electronic record indicated there was a parent acting as their representative with a sibling also listed.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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 discuss 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.</p> <p>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.</p> <p>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.</p> <p>R101 was interviewed and stated they did not remember being provided with any specific information about advanced directives when they admitted or since then.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>No further information was provided to the survey team prior to the exit conference.</p> <p>28169</p> <p>(continued on next page)</p>		

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<p>F 0578</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 .</p> <p>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.</p> <p>No further information was provided prior to exit conference.</p>

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>21227</p> <p>Based on staff interviews, clinical record review, and facility document review, the facility staff failed to accurately complete Minimum Data Set (MDS) assessments for one (1) of 21 sampled residents (Resident #62).</p> <p>The findings include:</p> <p>The facility staff failed to correctly assess Resident #62's extremities for functional limitation in range of motion for two (2) MDS assessments.</p> <p>Resident #62's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/2/24, was signed as completed on 3/18/24. Resident #62 was assessed as being in a persistent vegetative state and/or having no discernible consciousness. Resident #62 was assessed as being dependent on others for oral hygiene, toileting hygiene, dressing, personal hygiene, and bathing.</p> <p>Resident #62's MDS assessment with an ARD of 12/3/23 had the resident assessed as no impairment with upper extremity and lower extremity functional range of motion. Resident #62's MDS assessment with an ARD of 3/2/24 had the resident assessed as no impairment with upper extremity functional range of motion. The accuracy of these MDS assessment components was discussed with the facility's Regional Director of Clinical Services (RDofCS) on 3/28/24 at 11:40 a.m.</p> <p>On 3/28/24 at 12:50 p.m., the RDofCS reported the two (2) aforementioned MDS assessment will need to be modified to show functional range of motion limitations in both the upper and lower extremities.</p> <p>The following information was found in a facility policy titled MDS 3.0 Completion (with a reviewed/revised date of 12/1/22): Residents are assessed, using a comprehensive assessment process, in order to identify care needs, strengths and preference to develop an interdisciplinary care plan, and ensure appropriate reimbursement.</p> <p>On 3/28/24 at 3:30 p.m., the survey team met with the facility's Administrator, Director of Nursing, RDofCS, and Regional Director of Operations. During the meeting, Resident #62's aforementioned incorrect MDS assessment items were discussed.</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>21227</p> <p>Based on observations, staff interviews, clinical record review, and facility document review, the facility staff failed to revise resident care plans and/or failed to include the resident in the care plan process for two (2) of 21 sampled residents (Resident #15 and Resident #62).</p> <p>The findings include:</p> <p>1. The facility staff failed to review and revised Resident #62's comprehensive care plan to address a fall and to address the implementation of hand-splints.</p> <p>Resident #62's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/2/24, was signed as completed on 3/18/24. Resident #62 was assessed as being in a persistent vegetative state and/or having no discernible consciousness. Resident #62 was assessed as being dependent on others for oral hygiene, toileting hygiene, dressing, personal hygiene, and bathing.</p> <p>The following information was found in a facility policy titled Care Plan Revisions Upon Status Change (with a reviewed/revised date of 12/1/22): The comprehensive care plan will be reviewed, and revised as necessary, when a resident experiences a status change.</p> <p>On 3/27/24 at 11:53 a.m., the Director of Rehab provided a Functional Maintenance Program (FMP) document dated 2/27/24 by therapy staff and dated 2/28/24 by nursing staff. This document indicated Resident #62 was to receive passive range of motion to their upper extremities and was to receive bilateral hand splints and a left elbow pillow daily.</p> <p>On 3/28/24 at 8:55 a.m., the Director of Rehab provided an FMP document dated 8/18/23 by therapy staff and dated 8/21/23 by nursing staff. This document indicated Resident #62 was to receive passive range of motion and was to receive bilateral hand splints applied daily.</p> <p>On 3/27/24 at 3:11 p.m., the Director of Nursing (DON) reported Resident #62's splints were updated on the care plan on 3/19/24.</p> <p>Resident #62 was care planned for being (a)t risk for falls (related to) impaired mobility, anoxic brain injury. The interventions associated with this section of the care plan were all dated as being initiated on 2/28/23. None of the fall interventions specifically addressed the positioning of Resident #62 in bed.</p> <p>Resident #62 had an unwitnessed fall documented on 10/11/23 at 10:45 a.m. This documentation included the following statement: (Resident) observed face down on belly on floor next to bed in resident room. Multiple staff in to assess. (Respiratory Therapist) placed back onto (ventilator) and (resident) log rolled onto back and blood suctioned from mouth.</p> <p>On 3/26/24 at 9:25 a.m., the Director of Respiratory reported Resident #62 had no purposeful movement. The Director of Respiratory reported Resident #62 was known to move themself with coughing.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/26/24 at 9:40 a.m., Licensed Practical Nurse (LPN) #2 reported Resident #62 had been noted to move themselves with coughing or vomiting. LPN #2 reported that resident positioning with a wedge device could have resulted in the resident falling from the bed when coughing.</p> <p>The following statement was found on a form titled QRM (dated as completed on 10/13/23): Patient in PVS (persistent vegetative state) - Staff (educated) (not) to place (resident) too close to edge of bed .</p> <p>No evidence was found to indicate Resident #62's fall risk care plan was reviewed and revised after the resident experienced a fall on 10/11/23.</p> <p>On 3/27/24 at 4:30 p.m., the survey team met with the facility's Director of Nursing, Regional Director of Clinical Services, and Regional Director of Operations. During this meeting, the failure to review and revise Resident #62's care plan after the resident experienced a fall was discussed.</p> <p>49622</p> <p>2. The facility staff failed to include Resident #15 (R15) as part of the interdisciplinary team for the development of the resident's care plan.</p> <p>R15's diagnoses included but were not limited to, multiple sclerosis, history of falling, major depressive disorder, anxiety disorder and lymphedema.</p> <p>On the most recent Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 1/17/24, R15 was assessed as able to make self understood and able to understand others. R15's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated she was cognitively intact to make decisions.</p> <p>On 03/25/24 at 5:36 PM, surveyor interviewed R15, and she stated she has never attended a care plan meeting and does not know if they (facility) have them.</p> <p>Surveyor requested care plan meeting invitations/notifications and/or care plan meeting attendance sheets for R15. On 03/28/24 at approximately 8:20 AM, the director of nursing (DON) informed surveyor there was no documentation that R15 was ever invited to or attended any care plan meetings since being admitted to the facility. DON stated R15's next care plan review is not due until April, but they (facility) will have a meeting with her today.</p> <p>A facility policy titled Care Planning-Resident and/or Resident Representative participation revealed .7. The facility will honor the resident's choice in individuals to be included in the care planning process .9. The facility will discuss the plan of care with the resident .at regularly scheduled care plan conferences .</p> <p>This concern was discussed during an end of day meeting on 03/28/24 at 3:22 PM with the DON, Administrator, Regional Director of Clinical Services, and Regional Director of Operations. During this meeting, the absence of documentation to show Resident #15's involvement or choice to not be involved in the IDT (interdisciplinary team) care plan development and participation was discussed.</p> <p>No further information was provided to the survey team prior to exit.</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.</p> <p>21227</p> <p>Based on interviews, facility document review, and clinical record review, the facility staff failed to provide splints for one (1) of 21 sampled residents (Resident #62).</p> <p>The findings include:</p> <p>The facility staff failed to implement Resident #62's upper extremity splints as directed by the facility's therapy department.</p> <p>Resident #62's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/2/24, was signed as completed on 3/18/24. Resident #62 was assessed as being in a persistent vegetative state and/or having no discernible consciousness. Resident #62 was assessed as being dependent on others for oral hygiene, toileting hygiene, dressing, personal hygiene, and bathing.</p> <p>The following information was found in a facility policy titled Activities of Daily Living (ADLs) (with a reviewed/revised date of 12/1/22): The facility will provide a maintenance and restorative program to assist the resident in achieving and maintaining the highest practicable outcome based on the comprehensive assessment.</p> <p>The following information was found in an Occupation Therapy Discharge Summary document dated 8/30/23:</p> <ul style="list-style-type: none"> <li>- FMP (Functional Maintenance Program) will be established and executed on ROM (Range of Motion) ex's [sic], proper splint application, wearing time, and proper skin checks .</li> <li>- Splint / Orthotic Recommendations: It is recommended the patient wear a resting hand splint on right hand and on left hand up to 8 hours daily to maintain joint mobility and manage edema.</li> </ul> <p>On 3/27/24 at 11:53 a.m., the Director of Rehab provided a Functional Maintenance Program (FMP) document dated 2/27/24 dated by therapy staff and dated 2/28/24 by nursing staff. This document indicated Resident #62 was to receive passive range of motion to their upper extremities and was to receive bilateral hand splints and a left elbow pillow daily.</p> <p>On 3/27/24 at 3:11 p.m., the Director of Nursing (DON) provided a copy of an order for right- and left-hand splints dated 3/27/24 at 2:59 p.m.</p> <p>On 3/27/24 at 4:30 p.m., the survey team met with the facility's Director of Nursing, Regional Director of Clinical Services, and Regional Director of Operations. During this meeting, the failure to implement Resident #62's upper extremity splints was discussed.</p> <p>On 3/28/24 at 8:55 a.m., the Director of Rehab provided an FMP document dated 8/18/23 by therapy staff and dated 8/21/23 by nursing staff. This document indicated Resident #62 was to receive passive range of motion and was to receive bilateral hand splints applied daily.</p> <p>(continued on next page)</p>		

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<p>F 0676</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>On 3/28/24 at 9:42 a.m., the DON reported they could find no evidence that the aforementioned hand splints, detailed in the FMP documents, had been implemented.</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21227</b></p> <p>Based on observations, interviews, 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 five (5) of 21 sampled residents (Resident #1, Resident #52, Resident #59, Resident #62, and Resident #66).</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>The facility staff failed to provide appropriate bathing and/or showers for Resident #66.</li> </ol> <p>Resident #66's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 2/29/24, was signed as completed on 3/5/24. Resident #66 was assessed as being able to make self understood and as able to understand others. Resident #66'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 #66 was assessed as being depended on others for bathing and personal hygiene. Resident #66 was assessed as requiring assistance with toileting hygiene and dressing.</p> <p>The following information was found in a facility policy titled Activities of Daily Living (ADLs) (with a reviewed/revised date of 12/1/22): 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.</p> <p>The following intervention (initiated on 5/31/23) was found as part of Resident #66's ADL (activities of daily living) self-care performance deficit care plan: BATHING/SHOWERING: totally dependent (on) 1-2 staff for showers 2x wkly (two times weekly) and PRN (as needed).</p> <p>Resident #66's bathing documentation included the following information:</p> <ul style="list-style-type: none"> <li>- For the week of 2/4/24 - 2/10/24, Resident #66 was documented as having received (a) two (2) partial baths (2/9 and 2/10) and (b) one (1) shower (2/8).</li> <li>- For the week of 2/11/24 - 2/17/24, Resident #66 was documented as having received (a) one (1) partial bath (2/11) and (b) two (2) bed-baths (2/12 and 2/15).</li> <li>- For the week of 2/18/24 - 2/24/24, Resident #66 was documented as having received (a) one (1) partial bath (2/24) and (b) two (2) bed-baths (2/20 and 2/22).</li> <li>- For the week of 2/25/24 - 3/2/24, Resident #66 was documented as having received (a) two (2) partial baths (2/28 and 2/29) and (b) one (1) bed-bath (2/26).</li> <li>- For the week of 3/10/24 - 3/16/24, Resident #66 was documented as having received (a) three (3) partial baths (3/10, 3/14, and 3/15) and (b) one (1) bed-bath (3/12).</li> </ul> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>On 3/28/24 at 3:30 p.m., the survey team met with the facility's Director of Nursing, Regional Director of Clinical Services (RDofCS), and Regional Director of Operations. During this meeting, the surveyor discussed Resident #66 bathing documentation. The absence of a written facility policy to detail the frequency of resident baths and/or showers was also discussed. The facility's RDofCS stated a resident should have a full shower/bath at least twice a week but also at the frequency of the resident's preference.</p> <p>2. The facility staff failed to provide appropriate bathing and/or showers for Resident #62. The review of Resident #62's bathing documentation failed to provide evidence of the resident being provided a shower between 2/4/24 through 3/23/24.</p> <p>Resident #62's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/2/24, was signed as completed on 3/18/24. Resident #62 was assessed as being in a persistent vegetative state and/or having no discernible consciousness. Resident #62 was assessed as being dependent on others for oral hygiene, toileting hygiene, dressing, personal hygiene, and bathing.</p> <p>The following information was found in a facility policy titled Activities of Daily Living (ADLs) (with a reviewed/revised date of 12/1/22): 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.</p> <p>The following interventions (initiated on 2/28/23) were found as part of Resident #62's ADL (activities of daily living) self-care performance deficit care plan:</p> <ul style="list-style-type: none"> <li>- BATHING/SHOWERING: is totally dependent on 1-2 staff to provide shower 2xwkly (two times weekly) and as necessary.</li> <li>- BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated.</li> </ul> <p>Resident #62's bathing documentation included the following information:</p> <ul style="list-style-type: none"> <li>- For the week of 2/4/24 - 2/10/24, Resident #62 was documented as having received (a) four (4) partial baths (2/6, 2/8, 2/9, and 2/10) and (b) one (1) bed-bath (2/7).</li> <li>- For the week of 2/11/24 - 2/17/24, Resident #62 was documented as having received (a) two (2) partial baths (2/11 and 2/15) and (b) one (1) bed-bath (2/15). (One of the partial baths and the bed-bath both occurred on 2/15.)</li> <li>- For the week of 2/18/24 - 2/24/24, Resident #62 was documented as having received (a) two (2) partial baths (2/21 and 2/24) and (b) two (2) bed-baths (2/20 and 2/22).</li> <li>- For the week of 2/25/24 - 3/2/24, Resident #62 was documented as having received (a) two (2) partial baths (2/28 and 2/29) and (b) one (1) bed-bath (2/29). (One of the partial baths and the bed-bath both occurred on 2/29.)</li> <li>- For the week of 3/3/24 - 3/9/24, Resident #62 was documented as having received (a) three (3) partial baths (3/4, 3/8, and 3/9) and (b) two (2) bed-baths (3/7 and 3/9). (One of the partial baths and one of the bed-baths both occurred on 3/9.)</li> </ul> <p>(continued on next page)</p>		

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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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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>- For the week of 3/10/24 - 3/16/24, Resident #62 was documented as having received (a) three (3) partial baths (3/10, 3/12, and 3/15) and (b) two (2) bed-baths (3/12 and 3/16). (One of the partial baths and one of the bed-baths both occurred on 3/12.)</p> <p>- For the week of 3/17/24 - 3/23/24, Resident #62 was documented as having received (a) three (3) partial baths (3/18, 3/19, and 3/23) and (b) two (2) bed-baths (3/20 and 3/22).</p> <p>On 3/28/24 at 3:30 p.m., the survey team met with the facility's Director of Nursing, Regional Director of Clinical Services (RDofCS), and Regional Director of Operations. During this meeting, the surveyor discussed the absences of documented evidence to indicate Resident #62 was provided with full baths and/or showers every week. The absence of a written facility policy to detail the frequency of resident baths and/or showers was also discussed. The facility's RDofCS stated a resident should have a full shower/bath at least twice a week but also at the frequency of the resident's preference.</p> <p>3. The facility staff failed to provide appropriate bathing and/or showers for Resident #59.</p> <p>Resident #59's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/7/24, was signed as completed on 3/21/24. Resident #59 was assessed as being in a persistent vegetative state and/or having no discernible consciousness.</p> <p>The following information was found in a facility policy titled Activities of Daily Living (ADLs) (with a reviewed/revised date of 12/1/22): 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.</p> <p>The following interventions (initiated on 1/13/23) were found as part of Resident #59's Functional/ADL (activities of daily living) self-care performance deficit care plan:</p> <p>- BATHING/SHOWERING: [sic] totally dependent on 1-2 staff to provide shower 2xwklly (two times weekly) and as necessary.</p> <p>- BATHING/SHOWERING: Provide sponge bath when a full bath or shower cannot be tolerated.</p> <p>Resident #59's bathing documentation included the following information:</p> <p>- For the week of 3/3/24 - 3/9/24, Resident #59 was documented as having received (a) two (2) partial baths (both documented on 3/7) and (b) one (1) tub-bath (3/5).</p> <p>- For the week of 3/10/24 - 3/16/24, Resident #59 was documented as having received (a) three (3) partial baths (3/10, 3/14, and 3/15) and (b) one (1) bed-bath (3/12).</p> <p>On 3/28/24 at 3:30 p.m., the survey team met with the facility's Director of Nursing, Regional Director of Clinical Services (RDofCS), and Regional Director of Operations. During this meeting, the surveyor discussed Resident #59's ADL care (bathing). The absence of a written facility policy to detail the frequency of resident baths and/or showers was also discussed. The facility's RDofCS stated a resident should have a full shower/bath at least twice a week but also at the frequency of the resident's preference.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>22218</p> <p>4. For Resident #1, facility staff failed to provide daily bed baths.</p> <p>Resident #1 was admitted to the facility with diagnoses which include, but are not limited to, acute and chronic respiratory failure, dysphagia, quadriplegia, chronic decubitus ulcer, and more. The resident utilizes a mechanical chair to ambulate. On the most recent Minimum Data Set assessment, the resident scored 15/15 on the Brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care.</p> <p>During an interview, the resident reported requiring daily bed baths, which were often not done.</p> <p>The surveyor obtained bathing records covering January-March 2024. Staff had charted daily. Per the bathing records, the resident received bed baths on January 1, 18, 20, 26, and 29, leaving a 16 day gap between bed baths. In February, the resident received bed baths on [DATE], 17, 20, and 23, leaving an 8 day gap between baths. In March, the resident received bed baths on [DATE], 15, and 16, 18, 19, and 26 leaving a 10 day gap between baths. There was 1 refusal on 3/5.</p> <p>The administrator, director of nursing, assistant director of nursing, and regional director of clinical services were notified of the concern during a summary meeting on 3/27/2024. The surveyor asked for the bathing policy. The regional director for clinical services reported that the bathing policy addressed the steps staff take to bathe a resident, but did not address frequency of baths.</p> <p>49622</p> <p>5. For Resident #52 (R52) the facility staff failed to maintain toenail care.</p> <p>The findings included:</p> <p>R52's diagnosis list indicated diagnoses that included, but were not limited to, asphyxiation, chronic respiratory failure with hypoxia or hypercapnia, anoxic brain damage, functional quadriplegia, persistent vegetative state, contracture of muscle-multiple sites and cognitive communication deficit. The most recent minimum data set (MDS) dated [DATE], coded the resident as being in a persistent vegetative state.</p> <p>On 03/26/24 at 9:15 AM, surveyor and certified nursing assistant #5 (CNA#5) observed R52's feet. R52's toenails were observed to be very long on both feet and CNA#5 agreed the toenails were too long.</p> <p>On 03/27/24 at 9:39 AM, surveyor observed R52's feet with the director of nursing (DON) and licensed practical nurse # 8 and DON agreed toenails were long and needed cut. DON stated podiatry would do toenails.</p> <p>On 03/28/24 at 8:47 AM, DON informed surveyor R52 had not seen podiatrist since 04/2023 because he owed a balance of \$125. DON stated R52 is not diabetic, and nursing can trim his toenails. At 9:07 AM, DON presented surveyor with a progress note from the social worker dated 3/28/24, that revealed, .talked to the billing department .left an outstanding balance .This has been corrected .going forward the resident will be seen by the podiatrist . DON stated R52 was placed on podiatry list for May 2024, but she would go ahead and do his toenails.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A review of the clinical record revealed the following:</p> <p>A review of R52's care plan included the focus area of, .ADL self-care performance deficit r/t ABI (anoxic brain injury) Persistent vegetative state .BATHING/SHOWERING: Check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse .</p> <p>Surveyor requested and received a facility policy titled, Activities of Daily Living (ADLs) and the document revealed, .2. The facility will provide a maintenance and restorative program to assist the resident .3. A resident who is unable to carry out activities of daily living will receive the necessary services to maintain . grooming .6. Nursing staff will record care as it is provided .and advise the charge nurse of any issues or concerns .</p> <p>This concern was discussed with the Regional Director of Operations, Regional Director Clinical Services, DON, and Administrator and the end of day meeting on 03/27/24 at 4:30 PM.</p> <p>No further information regarding this issue was provided to the survey team prior to exit.</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate pressure ulcer care and prevent new ulcers from developing.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 21227</b></p> <p>Based on interviews, facility document review, and clinical record review, the facility staff failed to provide care and/or treatment to address and/or prevent pressure wounds/area for one (1) of 21 sampled residents (Resident #62).</p> <p>The findings include:</p> <p>The facility staff failed to provide Resident #62's medical provider ordered wound treatments. The facility staff failed to consistently complete skin assessments related to Resident #62's wounds.</p> <p>Resident #62's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 3/2/24, was signed as completed on 3/18/24. Resident #62 was assessed as being in a persistent vegetative state and/or having no discernible consciousness. Resident #62 was assessed as being dependent on others for oral hygiene, toileting hygiene, dressing, personal hygiene, and bathing.</p> <p>The following information was found in a facility policy titled Skin Assessment (with a revised date of 12/1/22):</p> <ul style="list-style-type: none"> <li>- It is our policy to perform a full body skin assessment as part of our systematic approach to pressure injury prevention and management.</li> <li>- A full body, or head to toe, skin assessment will be conducted by a licensed or registered nurse upon admission/re-admission, daily for three days, and weekly thereafter. The assessment may also be performed after a change of condition or after any newly identified pressure injury.</li> <li>- Documentation of skin assessment: Weekly Skin Review in (the facility's electronic clinical record name omitted) a. Include date and time of the assessment, your name, and position title. b. Document observations (e.g. skin conditions, how the resident tolerated the procedure, etc.). c. Document type of wound. d. Describe wound (measurements, color, type of tissue in wound bed, drainage, odor, pain) (Pressure and Non-pressure Wound Log). e. Document if resident refused assessment and why. f. Document other information as indicated or appropriate.</li> </ul> <p>Resident #62 had the following skin orders documented in their clinical record at the facility:</p> <ul style="list-style-type: none"> <li>- On 3/6/23 - (right) buttock: (wound cleaner) spray, pat dry, apply xeroform and cover (with) silicone bordered foam dressing.</li> <li>- On 3/9/23 - Mid-back: (wound cleaner) spray, pat dry, apply xeroform then cover (with) silicone bordered foam dressing as needed for wound healing.</li> </ul> <p>(continued on next page)</p>		

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<p>F 0686</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #62 was transferred to a local hospital on 3/8/24. Review of Resident #62's clinical documentation failed to include evidence of a skin assessment related to skin care orders obtained for skin issues identified prior to the transfer and failed to include evidence of a weekly skin assessment for four (4) weeks after the resident returned to the facility on [DATE]. Resident #62's admission history and physical at the local hospital documented the resident's skin as No rash or scars. No abnormal or suspicious lesions. When Resident #62 was readmitted to the facility on [DATE], they were documented as having four (4) wounds (one (1) on the sacrum, one (1) on the right buttocks, one (1) on the left buttock, and one (1) on the back).</p> <p>The facility staff failed to consistently provide daily wound care as ordered by Resident #62's medical provider after readmission to the facility.</p> <p>- The facility staff failed to provide wound care to the resident's left buttocks on the following dates: 4/4/23; 4/5/23; 4/7/23; 4/10/23; 4/12/23; 4/13/23; 4/14/23; 4/19/23; 4/22/23; 4/25/23; and 4/28/23. - The facility staff failed to provide wound care to the resident's mid-back on the following dates: 4/4/23; 4/5/23; 4/7/23; 4/10/23; 4/12/23; 4/13/23; 4/14/23; 4/19/23; 4/22/23; 4/25/23; and 4/28/23. - The facility staff failed to provide wound care to the resident's right buttocks on the following dates: 4/4/23; 4/5/23; 4/7/23; 4/10/23; 4/12/23; 4/13/23; 4/14/23; and 4/19/23.</p> <p>On 3/28/24 at 3:30 p.m., the survey team met with the facility's Director of Nursing (DON), Regional Director of Clinical Services (RDofSC), and Regional Director of Operations. During this meeting, the failure of the facility staff to provide wound care as ordered after Resident #62 returned from the hospital admission was discussed.</p> <p>On 3/29/24 at 2:48 p.m., the survey team met with the facility's Administrator, DON, and RDofCS. During this meeting, the absence of skin assessments related to the need for the aforementioned 3/6/23 and 3/9/23 wound care orders was discussed.</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>42353</p> <p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>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).</p> <p>The findings included:</p> <p>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.</p> <p>This was a closed record review.</p> <p>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.</p> <p>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.</p> <p>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&amp;S) from 11/11/22 through 11/12/22. Surveyor was unable to locate the results of the ordered UA C&amp;S in Resident #122's clinical record.</p> <p>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&amp;S. On 7/15/24, the DON provided the lab results for a UA C&amp;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.</p> <p>On 7/15/24 at approximately 1:25 PM, surveyor spoke with the DON and inquired why the UA C&amp;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.</p> <p>Surveyor requested to speak with the medical provider who gave the UA C&amp;S order and the nurse who entered the order on 11/10/22, however, neither were still employed by the facility.</p> <p>The facility was unable to provide the facility lab policy effective in November 2022.</p> <p>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&amp;S for Resident #122.</p> <p>(continued on next page)</p>		

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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No further information regarding this concern was presented to the survey team prior to the exit conference on 7/16/24.</p>

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<p>F 0775</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Keep complete, dated laboratory records in the resident's record.</p> <p>42353</p> <p>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).</p> <p>The findings included:</p> <p>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.</p> <p>This was a closed record review.</p> <p>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.</p> <p>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.</p> <p>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&amp;S) and an order dated 1/04/23 to obtain a TSH level.</p> <p>Surveyor was unable to locate the results of the UA C&amp;S or TSH level in Resident #122's clinical record.</p> <p>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&amp;S and TSH.</p> <p>On 7/15/24, the DON provided the lab results for a UA C&amp;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.</p> <p>In addition to the requested UA C&amp;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.</p> <p>The facility was unable to provide the facility lab policy effective November 2022 through February 2023.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0775</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>No further information regarding this concern was presented to the survey team prior to the exit conference on 7/16/24.</p>