STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E131	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SW VA M H Inst Geri Trt Ctr	340 Bagley Circle Marion, VA 24354

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 - Many	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. Based on staff interview, clinical record review and facility document review the facility staff failed to periodically review with the resident/resident representative advance directives for all residents of the facility. The findings included:The facility staff failed to ensure that advance directives were periodically reviewed with the resident and/or the resident representative.During clinical record review, surveyors could not locate evidence that each residents advance directive had been reviewed with either the resident or the resident's representative. During an end of day meeting on 12/29/25 at 4:15 pm, the issue of advance directives was discussed with the administrator, registered nurse (RN) #1, and social worker/administrator-in-training (SW/AIT). SW/AIT stated that advance directive information was discussed with the resident/resident representative on admission, a change in the resident's status, and upon resident or family request. Surveyor requested and was provided with a facility policy entitled Advance Directives with an effective date of 09/01/24, which read in part, It is the policy of . (facility name omitted) to comply with applicable statutes and regulations relative to advance directives. Individuals will be informed of their rights regarding health-care decisions, including the right to execute an advance medical directive .1. The patient registrar will inquire whether the individual has an advance directive and will document the response on the face sheet .c. If the individual is unable to produce the advance directive, he/she should be referred to the Programs Director for Extended Rehab Service (ERS) to complete a new form . B. Responsibilities of Treatment Team Members 1. The individual will be informed of the right regarding advance directive through the Patient Rights Program during a meeting with the team social worker. 2. DNR (do not resuscitate) status will be discussed with the individual and or surrogate decision maker upon every admission to . (facility) . 4. If an advance directive has not been completed, or if the individual is unfamiliar with advance directives, the social worker will ask the individual if they would like to receive further information. This policy does not indicate that a periodic review of residents advance directives should be completed. During a meeting with the administrator, RN #1, SW/AIT, and unit nurse coordinator on 12/30/25 at 8:20 am, SW/AIT stated that no resident currently has an advance directive. The administrator stated, We have had them in the past, but not currently. SW/AIT stated that residents are educated on advance directives upon admission and discharge, and that DNR status is reviewed upon a change in condition. The concern of not periodically reviewing advance directives with residents/resident representatives was discussed with the administrator, SW/AIT, RN #1 and unit nurse coordinator on 12/30/25 at 1:20 pm.No further information was provided prior to exit.

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	49E131	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SW VA M H Inst Geri Trt Ctr	340 Bagley Circle Marion, VA 24354

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interviews, clinical record review, and facility document review, the facility staff failed to develop comprehensive care plans (CCPs) that included the residents current code status for all residents in the survey sample. The findings included:The facility staff failed to develop CCPs that included the residents current code status. During the clinical record review, the surveyors were unable to locate information on the resident's CCPs that referenced their current code status. On 12/29/2025 at 4:15 p.m., during an end of the day meeting with the Administrator, Registered Nurse (RN) #1, and Social Worker/Administrator in Training the issue with the code status not being on the resident's current CCP's was reviewed. RN #1 stated they did not think they included the code status on the CCPs. On 12/30/25 RN #1 provided the survey team with a copy of their policy titled, Treatment Planning with an effective date of 08/01/24. This policy read in part, .The purpose of the Comprehensive Treatment Plan (CTP) is to involve the individual in developing an interdisciplinary services plan document and process that is person centered.On 12/30/25 at 8:20 a.m., during a meeting with the Administrator, RN #1, Social Worker/Administrator in Training, and the Unit Nurse Coordinator the issue regarding the resident's current code status not being included on the CCPs was reviewed. The Unit Nurse Coordinator stated they had not been care planning the individuals code status but as of now they were care planned. No further information regarding this issue was provided to the survey team prior to the exit conference.