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 _____	C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD SOUTHWEST HEALTH AND REHABILITATION	324 KING GEORGE AVE SW ROANOKE, VA 24016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid abbreviated survey was conducted at the facility 08/14/23 through 08/16/23. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. Two complaints were investigated during the survey: VA00059473-non-compliant, deficient practice cited. VA00059143-compliant with regulations. The census in this 109 certified bed facility was 67 at the time of the survey. The survey sample consisted of 2 current resident reviews (Residents #3 and Resident #6) and 4 closed record reviews (Resident #1, Resident #2, Resident #4, and Resident #5).	F 000		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and	F 609	1. The facility recognizes there were no Facility Reported Incidents made regarding residents #1 and #4. 2. All residents have the potential to be impacted by the alleged deficient practice. 3. The Regional Director of Clinical Services will complete education with the Administrator and Director of Nursing regarding FRIs and events requiring reporting to the state. The Administrator and Director of Nursing will educate the IDT regarding FRIs and events requiring reporting. The IDT will review grievances and clinical events and any unusual events in the am clinical meeting to determine if the meet the requirements for a Facility Reported Incident as will follow up as indicated.	9/21/23

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

[signature] NHA for Maina Stephenson NHA | RDO | 9.11.2023

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.

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F 609	Continued From page 1 adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on former resident interview, staff interview, clinical record review and facility document review the facility failed to report incidents for 2 of 6 residents, Resident #1 and Resident #4. The findings included: 1. For Resident #1 the facility staff failed to report an incident of neglect. Resident #1's face sheet listed diagnoses which included but not limited to hemiplegia, chronic obstructive pulmonary disease, hypertension and cognitive communication deficit. Resident #1's most recent minimum data set with an assessment reference date of 07/15/23 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. Section G, functional status, coded the resident as independent in locomotion on and off the unit.	F 609	4. Administrator/designee will complete a quality monitoring audit of significant or unusual events weekly for 6 weeks to ensure proper reporting has been completed. The findings of the quality monitoring will be reported to the Quality Assurance/Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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F 609	Continued From page 2 Resident #1's comprehensive care plan was reviewed and contained care plans for "...enjoys and prefers independent leisure in room such as computer, phone, and TV. He/She wheels around hallways and talks to staff. He/She enjoys going outside to garden", "...has potential to be physically/verbally aggressive r/t (related to) institutional incarceration. He/She was observed cutting prior roommates radio cord and is very argumentative with staff", "...is extremely resistant to any and all medical and clinical recommendations..." Resident #1's clinical record was reviewed and contained a nurse's progress note dated 07/29/23, which read in part "7/29/2023 17:44:00 spoke with ... (name omitted) at ... (name omitted), he/she stated resident had heat stroke and would be admitted to hospital." Resident #1's clinical record contained an "SBAR Communication Form" dated 07/29/23 which read in part "Situation: unresponsiveness. Background: Vital signs: BP: 95/55 Temp: 109. Appearance: resident was observed unresponsive sitting outside in the sun in courtyard upright in his/her wheelchair with head laid back, eyes fixed, rattle noted to breath sounds, shortness of breath/labored breathing noted, no sweating noted, multiple nurses assisted resident inside the building to an empty cool room and applied cool washcloth to forehead, 911 notified, resident left facility via ambulance staff x 5 at 1525. NP (nurse practitioner) ... (name omitted) notified." This surveyor spoke with the administrator, director of nursing (DON), and regional director of clinical services on 08/16/23 at 10:00 am.	F 609		

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F 609	Continued From page 3 Surveyor asked if a facility reported incident had been completed and sent to the Office of Licensure and Certification, and DON stated it had not. Surveyor asked why this had not been done, and DON stated, "He/she does what he/she wants to, when he/she wants to. He/She liked to spend time outside after being incarcerated. We can't force him/her to stay inside." This surveyor requested and was provided with a facility policy entitled "Abuse, Neglect, and Exploitation" which read in part, "VII. Reporting/Response A. The facility with have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is, if the events that cause the allegation involve abuse or result in serious bodily injury, or B. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result is serious bodily injury." The concern on not reporting an incident of neglect was discussed with the administrator, DON, and regional director of clinical services on 08/16/23 at 3:00 pm. No further information was provided prior to exit. 2. For Resident #4 the facility staff failed to report an injury of unknown origin. Resident #4's face sheet listed diagnoses which included but not limited to acute and chronic respiratory failure, chronic obstructive pulmonary disease, end stage renal disease, heart failure,	F 609		

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F 609	Continued From page 4 hypertensive emergency and paroxysmal atrial fibrillation. Resident #4's most recent minimum data set with an assessment reference date of 04/25/23 assigned the resident a brief interview for mental status (BINS) score of 15 out of 15 in section C, cognitive patterns. This indicates that the resident was cognitively intact. Resident #4's comprehensive care plan was reviewed and contain a care plan for "...has altered cardiovascular status r/t (related to) TN (hypertension), HELD (hypertrophied), CAD (coronary artery disease (sent x 2), MI (myocardial infarction (x 4), chronic systolic heart failure EOF (ejection fraction) 30-35%" This surveyor spoke with Resident #2 (BINS=15) on 08/14/23 at 3:35 pm via telephone. Resident #2 stated to surveyor, "While I was there, there was a resident named ... also there. He/She went outside to smoke one evening in the rain, and took a chill. Later on that night, they took him/her out, and I never saw him/her again. This happened on June 9th and I never saw him/her again." Resident #4's clinical record was reviewed and contained a nurse's progress notes, which read in part "6/19/2023 21:01 Note Text: This nurse went into rd (resident) room to give night time meds. Found rsd unresponsive with vomit coming out of his/her mouth lying next to his/her w/c (wheelchair).Yelled out for help. 4 nurses 2 aid and respiratory came to assisted. Called 911, got crash cart, rolled rsd over on his/her side, suctioned rsd mouth. VS (vital signs) taken. 234/156, 12, 98, 75%, 97.4, BS (blood sugar)	F 609		

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F 609	Continued From page 5 187..." and "6/20/2023 6:03 Note Text: Spoke with ... (name omitted) several times this shift. Resident has been admitted to ICU (intensive care unit) with intracranial hemorrhage with midline shift. Nurse stated that resident's parent was was with resident and had made the decision to discontinue life saving measures. Received call that resident had expired at 0345..." This surveyor spoke with the administrator, director of nursing (DON), and regional director of clinical services on 08/16/23/ at 10:00. Surveyor asked if a facility reported incident had been completed regarding this incident, and DON stated that it had not. DON stated that resident had "lots of hospitalizations for multiple issues" and was declining in health. DON stated that they felt it was not an unusual event given resident's declining health status. DON stated "He/She died from a heart problem." This surveyor requested and was provided with a facility policy entitled "Abuse, Neglect, and Exploitation" which read in part, "VII. Reporting/Response A. The facility with have written procedures that include: 1. Reporting of all alleged violations to the Administrator, state agency, adult protective services and to all other required agencies (e.g. law enforcement when applicable) within specified timeframes: a. Immediately, but not later than 2 hours after the allegation is, if the events that cause the allegation involve abuse or result in serious bodily injury, or b. Not later than 24 hours if the events that cause the allegation do not involve abuse and do not result is serious bodily injury." The concern on not reporting an injury of unknown origin was discussed with the	F 609		

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F 609	Continued From page 6 administrator, DON, and regional director of clinical services on 08/16/23 at 3:00 pm. No further information was provided prior to exit.	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview and clinical record review the facility staff failed to follow physician's orders for 1 of 6 residents, Resident #3. The findings included: For Resident #3 the facility staff failed to follow physician's orders for the monitoring of vital signs, specifically blood pressure. Resident #3's face sheet listed diagnoses which included but not limited to syncope and collapse, chronic obstructive pulmonary disease, orthostatic hypotension, and essential hypertension. Resident #3's most recent minimum data set with an assessment reference date of 07/19/23 assigned the resident a brief interview for mental status score of 14 out of 15 in section C, cognitive	F 684	1. The facility recognizes that there was not a blood pressure reading for Resident #3 as ordered. Resident #3 no longer resides at the facility. 2. All residents have the potential to be impacted by the alleged deficient practice. A baseline quality audit will be completed for residents with orders to obtain vital signs. 3. The Director of Nursing/designee will educate CNAs and nurses on proper vital sign documentation and following physician orders. The Unit Managers will review vital sign documentation in the am clinical meeting to verify obtainment as ordered. Follow up with nurses will be completed as indicated. 4. Director of Nursing/designee will conduct a quality monitoring audit of 5 charts per week for 6 weeks to ensure compliance with vital sign documentation. The findings of the quality monitoring will be reported to the Quality Assurance/ Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	9/21/23

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F 684	Continued From page 7	F 684		

patterns. This indicates that the resident is cognitively intact.

Resident #3's comprehensive care plan was reviewed and contained a care plan for "...has significant orthostatic hypotension r/t (related to) autonomic dysfunction, bilateral ICA (internal carotid artery) stenosis >75%." Interventions for this care plan include "Monitor vital signs."

Resident #3's clinical record was reviewed and contained a physician's order summary, which read in part "Vital signs (P [pulse], R [respirations], BP [blood pressure], T [temperature], O2) every shift for monitoring" and "Hydralazine HCL Oral Tablet 25 mg. Give 1 tablet by mouth every 8 hours as needed for htn (hypertension) give for SBP (systolic blood pressure) greater than 180."

Resident #3's electronic medication administration record for the month of August 2023 was reviewed and contained an entry which read in part, "Hydralazine HCL Oral Tablet 25 mg. Give 1 tablet by mouth every 8 hours as needed for htn (hypertension) give for SBP (systolic blood pressure) greater than 180." This entry had not been initialed as having been administered at any time in August.

Resident #3's clinical record contained a vital signs summary, which includes blood pressures. This summary contained daily recorded blood pressures.

This surveyor spoke with the administrator, director of nursing (DON) and regional director of clinical services on 08/16/23 at 10:00 am regarding resident's blood pressure monitoring.

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F 684	Continued From page 8 DON stated that resident is long term care and has blood pressures checked weekly and as needed. This surveyor spoke with DON on 08/16/23 1:00 pm regarding Resident #3. Surveyor advised DON that resident has a physician's order for monitoring of vital signs every shift and has an as needed hypertensive medication. Surveyor asked DON how the nurses know if the resident needs the as needed medication if they are not monitoring blood pressures, and DON stated that the CNA's (certified nurse's aides) check vitals and report to the nurses. DON stated they would check the CNA daily sheets for Resident #3. DON later stated that the daily CNA sheets had been discarded. The concern of not monitoring Resident #3's vital signs per the physician's order was discussed with the administrator, DON, and regional director of clinical services on 08/16/23 at 3:00 pm. No further information was provided prior to exit.	F 684		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, resident interview, and	F 689	1. The facility recognizes that Resident #1 experienced a medical event that resulted in a transfer to the hospital. 2. All residents have the potential to be impacted by the alleged deficient practice. 3. The Administrator and Director of Nursing will educate staff on monitoring residents in extreme weather conditions to ensure appropriate interventions are in place, i.e. proper clothing, hydration, shade, etc. Administrator and Director of Nursing will immediately be notified if a resident refuses to utilize interventions related to the extreme weather conditions and/or return inside the facility as deemed necessary.	9/21/23

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F 689	Continued From page 9 clinical record review, the facility staff failed to provide supervision to ensure resident safety for 1 of 6 residents, Resident #1. The findings included: For Resident #1 the facility staff failed to provide supervision which resulted in the resident being admitted to the hospital for treatment of heat stroke. On the date of this incident (07/29/23), the National Weather Service for the area reported a high temperature of 97 degrees, with a heat advisory in effect. Resident #1's face sheet listed diagnoses which included but not limited to hemiplegia, chronic obstructive pulmonary disease, hypertension, and cognitive communication deficit. Resident #1's most recent minimum data set with an assessment reference date of 07/15/23 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. Section G, functional status, coded the resident as independent in locomotion on and off the unit. Resident #1's comprehensive care plan was reviewed and contained care plans for "...enjoys and prefers independent leisure in room such as computer, phone, and TV. they wheels around hallways and talks to staff. They enjoy going outside to garden", "...has potential to be physically/verbally aggressive r/t (related to) institutional incarceration. They were observed cutting prior roommates radio cord and is very argumentative with staff", and "...is extremely resistant to any and all medical and clinical	F 689	Weekly weather forecasts will be posted at a central location for residents, employees and visitors to notify of potential needed interventions. 4. The Administrator/designee will complete a quality monitoring audit of outside activity to ensure appropriate interventions are provided for residents while outside, i,e, shade, hydration, clothing, etc. The findings of the quality monitoring audit will be reported to the Quality Assurance/ Performance Improvement Committee monthly. The quality monitoring schedule may be modified based on findings with quarterly monitoring by the RDCS/designee.	

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F 689	Continued From page 10 recommendations..." Resident #1's clinical record was reviewed and contained a nurse's progress note dated 07/29/23, which read in part "7/29/2023 17:44:00 spoke with ... (name omitted) at ... (name omitted), they stated the the resident had heat stroke and would be admitted to hospital." Resident #1's clinical record contained an "SBAR Communication Form" dated 07/29/23 which read in part "Situation: unresponsiveness. Background: Vital signs: BP: 95/55 Temp: 109. Appearance: resident was observed unresponsive sitting outside in the sun in courtyard upright in his/her wheelchair with head laid back, eyes fixed, rattle noted to breath sounds, shortness of breath/labored breathing noted, no sweating noted, multiple nurses assisted resident inside the building to an empty cool room and applied cool washcloth to forehead, 911 notified, resident left facility via ambulance staff x 5 at 1525. NP (nurse practitioner) ... (name omitted) notified." Resident #1's clinical record contained a hospital ED (emergency department) provider note which read in part, "Date of Service: 7/29/2023 3:59 PM Profound hyperthermia with 3+ hours of sun exposure in WC (wheelchair) and had previously just eaten lunch and at baseline with Left CVA (cerebrovascular accident) driving the SNF (skilled nursing facility) living. EMS (emergency medical services) enroute noticed a pretty abrupt change and suspect they had seized/aspirated. On arrival had a good respiratory drive and would moan, so elected to cool and bipap. Once down to 104, patient was more purposeful so attempted to engage him/her and they suddenly postured	F 689		

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F 689	Continued From page 11	F 689		

and went rigid with arm swinging and rigidity and appeared to have seized again, then had small amount of vomit that was cleared with suction. Elected to intubate. Previous stroke could make him/her high risk for PSE (portosystemic encephalopathy) though think exposure was cause given his/her +107 temp. There are no other decision makers. Prognosis is grim."

This surveyor spoke with certified nurse's aide (CNA) #1 on 08/14/23 at 1:40 pm. Surveyor asked CNA #1 if they recalled Resident #1, and CNA stated they did. Surveyor asked CNA #1 if they recalled the incident with Resident #1, and CNA #1 stated they did, and that it happened after lunch. CNA #1 stated resident enjoyed being outside and came in and out on their own. CNA stated that Resident #1 "is gonna do what they want to do, and they would tell you that."

This surveyor spoke with CNA #2 on 08/14/23 at 3:10 pm. CNA #2 stated that resident loved to go outside to feed the squirrels. Surveyor asked CNA #2 if they recalled the incident with Resident #1 and CNA #2 stated they did, and that it happened prior to the start of their shift.

This surveyor spoke with Resident #1 via telephone on 08/16/23 at 1:50 pm. Surveyor asked Resident #1 what they recalled about the incident, and Resident #1 stated that they usually go outside early to feed the birds and squirrels, but do not specifically remember anything about the day of the incident.

This surveyor spoke with Resident #7 on 08/16/23 at 2:00 pm. Surveyor asked Resident #7 if they recalled the incident with Resident #1, and Resident #7 stated that they did. Resident #7

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	495156	A. BUILDING _____ B. WING _____	C 08/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OLD SOUTHWEST HEALTH AND REHABILITATION	324 KING GEORGE AVE SW ROANOKE, VA 24016

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

stated that Resident #1 was outside, washing the sidewalk with water hose, and that Resident #1 was already outside when they went out. Surveyor asked Resident #7 how long they were outside, and Resident #7 stated, "around 45 min or an hour." Surveyor asked Resident #7 if any staff came out to check on them or offer fluids while they were outside, and Resident #7 stated no.

The Director of Nursing (DON) provided this surveyor with a signed statement from LPN #1. An excerpt read: "07/29/2023 Rsd (resident) came to nurses station Saturday morning to say hello and then did a morning exercise where they would hold on to the bar and stand up then sit back own several times. Rsd then said that they were going outside, and I told (Resident 1) it was already hot outside, and they don't need to be out there. Rsd looked at this nurse and told me 'ma'am you ever been in prison before, I said nope, you know better that that. (Resident #1) said 'ma'am, I'd rather be dead than not be able to go outside every day.' I said don't stay out there long ..., it's hot. The next time I saw (Resident #1), it was exactly 11:10 am, and I was checking rsd blood sugar and I told ... (names omitted) to come inside. ... (name omitted) came in with me, ... (Resident #1) said they were going to come inside and eat lunch. Several other rsds came in the building when we did, but ... (Resident #1) did not. When lunch trays were passed, ... (Resident #1) came in the building at around 1:15 pm. they ate lunch and sat his/her tray on his/her lap and brought the tray to the tray cart to be put on the cart. Later after second shift arrived, I was getting ready to start my 3:30 pm med pass and ... (Resident #7) rolled into the hallway from outside and said hey help ...

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(Resident #1) is unresponsive. This nurse ran outside, I instructed the resident to go the other nurses station and get that nurse and tell them that I needed help. I ran to rsds calling their name, the were sitting in wheel chair with head back, both arms laid to side and one foot on the pedal, the other on the ground kinda beside the wheel. I attempted to get rsd out of sun. This nurse ran to nurse station 4 the get the two nurses to come assist me with getting rsd in the building. Myself, Nurse 3 and Nurse 4 picked rsd up and carried them out of the sun. Rsd was hot to the touch, they were sweating, their face was slightly swollen by the cheeks, wrist and arm. I instructed nurse 3 to go call 911. Nurse 4 went with nurse 3. I called for CNA 1 to go get me some cold wash clothes and towel, and I placed those on his/her head, waiting for the other nurses to come back. Nurse 3 and Nurse 4 came back and stated rsd was a full code, which CPR was NOT an option because rsd was breathing independently respirations were 24 per min. (Resident #1's) blood pressure was 95/55 and their eyes were fixed with pupils dilated. Ambulance crew came and said it looks like rsd had had heat stroke and began to work on rsd give EKG (electrocardiogram), IV (intravenous) fluids, etc and took rsd. Nurse 3 and Nurse 4 contacted MD. This nurse notified DON..."

The DON provided this surveyor with a typed interview from Resident #7, which read in part "Interview with ... (Resident #7) 7/31/23... who is a resident of our facility... has a BIMS (brief interview for mental status) of 14. Inquired as to what happed on 7/29/23 with resident ... (Resident #1). ... (Resident #7) stated that they were in the courtyard. ... (Resident #7 and Resident #1) had come back from eating lunch

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F 689	Continued From page 14 and returned to the courtyard. ... (Resident #7) stated they encouraged ... (Resident #1) to come out of the sun. ... (Resident #1) stated they would in a bit. ... (Resident #7) stated they think they were probably in the courtyard for maybe an hour or so. ... (Resident #7) stated they saw ... (Resident #1) put their head down and thought they had gone to sleep. A few minutes later they saw (Resident #1) lean their head back. At that point, ... (Resident #7) went over to (Resident #1) and touched them, and called his/her name and when (Resident #1) did not respond, (Resident #7) came inside and went to the nurse and told them that ... (Resident #1) was unresponsive. They stated the nurse went immediately out to check on ... (Resident #1). They stated the nurses then took ... (Resident #1) inside to his/her room." The concern of not providing supervision or extra fluids during an official Heat Advisory from the National Weather Service, resulting in Resident #1 having a heat stroke, was discussed with the Administrator, DON, and Regional Director of Clinical Services on 08/16/23 at 3:00 pm. No further information was provided prior to exit.	F 689		