

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/01/2024  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>495156</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>R</b> <b>07/01/2024</b>
NAME OF PROVIDER OR SUPPLIER  <b>OLD SOUTHWEST HEALTH AND REHABILITATION</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>324 KING GEORGE AVE SW</b> <b>ROANOKE, VA 24016</b>		
(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	
{K 000}	<p>INITIAL COMMENTS</p> <p>Construction Type: III (200)</p> <p>Description of structure: The facility is a single story building with a partial basement. Brick exterior walls and unprotected non- combustible construction. The dining area has wood trusses and sheathing which classifies the building as type III (200) construction. A partial basement contains support services, laundry, mechanical equipment and storage rooms.</p> <p>Sprinkler status: The facility is fully sprinklered with an NFPA #13 system. The system is supplied by city water and the pressure is supplemented by an electric fire pump.</p> <p>An unannounced standard recertification Life Safety Code survey was conducted 03/29/24 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility is not in compliance with the Requirements for Participation Medicare and Medicaid.</p> <p>The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)</p> <p>On 07/01/24 a paper revisit was conducted, and the Facility was found to be in compliance with the Requirements for Participation for Medicare and Medicaid, demonstrate compliance with title. 42 Code of Regulations, Part 483.90 (a) et.seq(Life Safety from Fire)</p>	{K 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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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