### PRINTED: 10/25/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495378 B. WING 10/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3433 SPRINGTREE DRIVE **SPRINGTREE HEALTHCARE & REHAB CENTER** ROANOKE, VA 24012 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PREFIX** (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 000 INITIAL COMMENTS RECEIVED F 000 An unannounced Medicare/Medicaid star Gard NOV 0 8 2016 survey was conducted 10/18/16 through 10/20/16. The facility was not in compliance with VDH/OLC the Federal Long-Term Care regulations. One complaint was investigated during the survey. The census in this 120 certified bed facility was F281 104 at the time of the survey. The survey sample Resident #17's consisted of 20 current Resident reviews current medication (Residents #1 through #20) and 3 closed record administration reviews (Residents #21-23). record accurately F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET F: reflects physician SS=D PROFESSIONAL STANDARDS order for insulin and The services provided or arranged by the facility current doses given must meet professional standards of quality. are accurately documented. This REQUIREMENT is not met as evidenced 2. Current residents by: receiving insulin Based on staff interview, facility document injections were review, and clinical record review, the facility staff reviewed to failed to follow professional standards of nursing practice in regards to diabetic management for 1 determine of 23 Residents, Resident #17. documentation of MD notification for The findings included. any recent significant change in condition

L LABOÐATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

diastolic congestive heart failure, history of

The facility nursing staff failed to document they had obtained an order from the physician for 10

units of insulin and failed to document they had

The record review revealed that Resident #17

was admitted to the facility 10/14/16. Diagnoses included, but were not limited to, diabetes,

administered the insulin.

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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Event ID: FTDM11

Facility ID: VA0380

and to ensure

were made

indicated.

TITLE

immediately as

accuracy of insulin

orders. Corrections

		AND JUMAN SERVICES				PRIN	ITED: 10/2 ORM APPI	25/2016
		& MEDICAID SERVICES				ОМВ	NO. 093	8-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	1	DATE SUR	VEY
		495378	B. WING				C	340
NAME OF F	PROVIDER OR SUPPLIER		<u></u>	ST	REET ADDRESS, CITY, STATE, ZIP CODE		10/20/20	716
SPRINGT	REE HEALTHCARE	& REHAB CENTER		343	33 SPRINGTREE DRIVE DANOKE, VA 24012			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORREC	TION		
PRÉFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	HORE	COM	(X5) PLETION DATE
F 281	Continued From pa	age 1		204			***	
		on (heart attack), orthostatic	г,	281				
	hypotension, and m	ni (neart allack), ortnostatic			•			
	nypotention, and m	idacie weakileas.			3. Licensed nursing sta	ff		
	There was no comp	oleted MDS (minimum data			were educated			and the second
	set) assessment on	this Resident. However, the			regarding	-		11.10 mm
	Resident was alert	and orientated and had			documentation of			
	shared with the sur	veyor that she had been a			MD notification and			
	diabetic since she v	vas very young.				1		
	0= 40/40/40 =+ =				documenting new	-		
i	On 10/19/16 at app	roximately 3:55 p.m. the			orders when			
	nurse) #1 regarding	d LPN (licensed practical president #17's insulin and			received. Nursing			
	elevated (RS) blood	sugars. LPN #1 reviewed the			leadership will			
	eMAR (electronic m	redication administration	ľ		review shift reports			
	record) with the sur	veyor and stated that on			and order listing			
	10/17/16 the Reside	ents BS was elevated (413)	1		reports daily 5X			
	and she had spoke	n with the doctor and received	1		weekly X6 weeks to			
		s of insulin. When asked	1		-			
-	about the documen	tation regarding the insulin			ensure significant			
	LPN #1 verbalized t	to the surveyor that she had			changes in condition	1		
		for the insulin and did not			have been reported			
		esidents clinical record insulin. LPN #1 then stated "I			to the physician and	1		
		order in but I didn't."			documented and			
	oriodid ridvo pat dis	order in bat raight.			that insulin orders			
	The administrative :	staff were notified of the			are accurate. Any			
	missing documenta	tion in an end of the day			issues will be			
	meeting with the su	rvey team on 10/19/16 at			addressed			
ı	approximately 4:00	p.m. The surveyor requested			immediately at the			
	a copy of what the f	acility would use as a						
		regarding documentation in	-4		time of identification	n.		]
,	regards to diabetic i	шападетепт.	1		4. Process will be			
	On 10/20/16 the nu	rse consultant provided the			reviewed in QA			
	surveyor with a con-	y of a standard of practice			committee for two			
	from the nursing ref	erence "Textbook of			quarters.			
	Medical-Surgical Nu	ursing" eleventh edition.			5. 11-10-2016	Ī		
	"RECORDING THE	DATAThis record provides			3. 11-10-2016			1
		nication among members of						

Event ID: FTDM11

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CENTER	KS FOR MEDICARE	& MEDICAID SERVICES				O	MB NO	). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		CONSTRUCTION		(X3) DAT	TE SURVEY MPLETED
		495378	B. WING				l	C / <b>20/2016</b>
NAME OF P	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP COD	E.		
SDDINGT	DEE UENITUANE	9 DEUAD CENTED	-	34	33 SPRINGTREE DRIVE			
SPRINGI	REE HEALTHCARE	& REHAB CENTER	1		OANOKE, VA 24012			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD	BE	(X5) COMPLETION DATE
F 281	Continued From pa	ige 2	F 2	281 !				
	the health care tear	m and facilitates coordinated						
		nuity of care. The record fulfills						
	other function as we	ell:						
	It serves as the leg-	al and business record for a						
	health care agency	and for the professional staff						
		responsible for the patients	•					
	t serves as a basis	for avaluation the quality and						
	annionisteness of	for evaluating the quality and care and for reviewing the						
	effective use of nat	ient care services"						
	orrodite due or pat	icit care services						
	The nurse consulta	int also provided the surveyor						
	with a copy of their	policy and procedure titled			-			
	"Nursing Document	tation." "Licensed Nurseswill						
	document all pertin	ent nursing assessments, care						
	interventions, and f	ollow up actions in the medical						
	recordDocument	all of the facts and pertinent			·			
	information rejated	to an event, course of			THE PROPERTY OF THE PROPERTY O			
	and deviations from	condition, response to care, n standard treatment along			*			
	with the reason for	the deviationEvery change						
	in the patient's cond	dition or significant patient care						
	issues will be noted	and charted until the						
		d or stabilized. Documentation						
		nce of follow-through is critical.						
	Use summary state	ements to describe changes of						
	condition stating ob	jective facts."						
	The more assessed to							
	that their policies w	ant verbalized to the surveyor were based on nursing			ĺ			
	standards.	ere based on hursing						
	otandardo.				<b>Water</b>			
	No further informati	ion regarding this issue was						
	provided to the sun	vey team prior to the exit						
	conference.	•						
F 323	483.25(h) FREE Of	F ACCIDENT	F 3	323				
	HAZARDS/SUPER							

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Event ID: FTDM11

Facility ID: VA0380

If continuation sheet Page 3 of 18

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		& MEDICAID SERVICES	· · · · · · · · · · · · · · · · · · ·			<u>O</u>	MB NO. 0938-0391
STATEMENT AND PLAN O	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495378	B. WING	}			C <b>10/20/2016</b>
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP	CODE	10/20/2010
SPRING	TREE HEALTHCARE	9 DEUAD CENTED		1	SPRINGTREE DRIVE		
	TREE TEACHTOARE	& REHAD CENTER		ROA	ANOKE, VA 24012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD HE APPROPR	BE COMPLÉTION
F 323	Continued From pa	age 3	· F:	323			
		nsure that the resident	, ,	JZU			
		ns as free of accident hazards	ſ	F323	1. Resident #14	1'c	<del></del>
	as is possible; and	each resident receives	-	ĺ	seatbelt is cu		
	adequate supervision	ion and assistance devices to	[				
	prevent accidents.		-		fastened acc	ording to	
					physician ord	ler.	
					2. Current resid		
			1		with seatbelt		
	This REQUIREME!	NT is not met as evidenced	1		were reviewe		
	by:	***			ensure in use		
	Based on observat	tion, staff interview, and clinical			physician ord	er.	
	record review, the f	facility staff failed to ensure a			Corrections w	vill be	
	hazard free environ	nment for 1 of 23 residents			made immed		
	(Kesident #14). II	he facility staff failed to ensure atbelt was fastened when the			indicated.		
		itbelt was tastened when the id in the wheelchair.			3. Current facilit	hy ctaff	
	resident was up an	d in the wilectorial.			were educate	.y stan	
	The findings include	ed:			1		
					regarding follo		
	The facility staff fail	led to ensure the physician			physician orde		
	ordered seatbelt for	r Resident #14 was fastened			using seatbelt		
	when the resident v	was up and in the wheelchair.	1		Leadership sta	aff will	
					round daily 5x	<b>(</b>	
	1 he clinical record	of Resident #14 was reviewed			weekly X6 wee		
	facility 7/9/15 and r	at #14 was admitted to the readmitted 3/14/16 with		1	ensure seatbe		
		uded but not limited to			in use per phy		et entrement
		rointestinal hemorrhage,			order. Any issu		
	hypothyroidism, hy	pertension, iron deficiency	.		be addressed	nes will	111 Aug # 8
	anemia, dementia v	with behavioral disturbances,	.				
	depressive disorder	r, atrial fibrillation, and muscle			immediately a		Production 1 - 1
	weakness.				time of identif		S. A. Lancardon
	Danidant 44 Alamina	De la companya de la			<ol><li>4. Process will be</li></ol>		
		nificant change in assessment		1	reviewed in QA	i i	1
	assessment refere	(MDS) assessment with an nce date (ARD) of 9/20/16			committee for	two	
	assessed the resid	ent with a cognitive summary	.		quarters.		
	score of 11 out of 1	5 in Section C Summary	<u> </u>		5. 11-10-2016		house to be

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Event ID: FTDM11

Facility ID: VA0380

If continuation sheet Page 4 of 18

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PRINTED: 10/25/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION    X1) PROVIDER/SUPPLIER/CLIA   1   1   1   1   1   1   1   1   1	CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				OMB NO. 0938	10VED 1-0391
SPRINGTREE HEALTHCARE & REHAB CENTER  SPRINGTREE HEALTHCARE & REHAB CENTER  (A) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 323 Continued From page 4  Score. Section P Restraints assessed Resident with functional impairment of the upper extremity on one side. Section J Health Conditions and J1700 Fall History coded Resident #14 without any falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).  Resident #14's current comprehensive care plan created 12/1/15 and reviewed 9/28/16 identified the use of physical restraints-seatbelt rft (related to) poor safety awareness. Interventions "discuss and record with the residentifyamily/caregivers the risk and benefits of the restraint, when the restraint and any concerns or issues regarding			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I		DINSTRUCTION	(X3) DATE SURY	/EY
SPRINGTREE HEALTHCARE & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 323 Continued From page 4 F 323  Continued From page 4 Score. Section P Restraints assessed Resident #14 with use of a trunk restraint that was used less than daily. Section G assessed the resident with functional impairment of the upper extremity on one side. Section J Health Conditions and J1700 Fall History coded Resident #14 without any falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).  Resident #14's current comprehensive care plan created 12/1/15 and reviewed 9/28/16 identified the use of physical restraints-seatbelt r/t (related to) poor safety awareness. Interventions "discuss and record with the resident/family/caregivers the risk and benefits of the restraint, when the restraint should/will be applied, routines while restrained and any concerns or issues regarding			495378	B. WING	<del></del>		C 10/20/20	116
F 323  Continued From page 4 Score. Section P Restraints assessed Resident with functional impairment of the upper extremity on one side. Section J Health Conditions and J1700 Fall History coded Resident #14 without any falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).  Resident #14's current comprehensive care plan created 12/1/15 and reviewed 9/28/16 identified the use of physical restraintts-seatbelt r/t (related to) poor safety awareness. Interventions "discuss and record with the restraint, when the restraint should/will be applied, routines while restrained and any concerns or issues regarding			& REHAB CENTER		3433	SPRINGTREE DRIVE	, , , , , , , , , , , , , , , , , , , ,	-10
Score. Section P Restraints assessed Resident #14 with use of a trunk restraint that was used less than daily. Section G assessed the resident with functional impairment of the upper extremity on one side. Section J Health Conditions and J1700 Fall History coded Resident #14 without any falls since admission/entry or reentry or prior assessment (OBRA or Scheduled PPS).  Resident #14's current comprehensive care plan created 12/1/15 and reviewed 9/28/16 identified the use of physical restraints-seatbelt r/t (related to) poor safety awareness. Interventions "discuss and record with the resident/family/caregivers the risk and benefits of the restraint, when the restraint should/will be applied, routines while restrained and any concerns or issues regarding	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	:	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI	LD BE COMP	X5) PLETION ATE
restraint use. Apply seatbelt. Seatbelt in place while up in wheelchair. Release and reposition seat belt q (every) 2 hours while in w/c (wheelchair) with seat belt on. Toilet prn (whenever necessary). Resident has poor safety awareness with history of falls. Monitor q 30 mins (minutes) while in chair."  Resident #14's October 2016 physician order sheet had an order that read "Seat belt in place while up in wheelchair. Release and reposition seat belt every 2 hours while in w/c with seat belt prn. Toilet prn. Resident has poor safety	F 323	Score. Section P F #14 with use of a tr less than daily. Set with functional importance on one side. Section J1700 Fall History of any falls since admassessment (OBR/Resident #14's curricreated 12/1/15 and the use of physical to) poor safety away and record with the risk and benefits of restraint should/will restrained and any restraint use. Apply while up in wheelch seat belt q (every) 2 (wheelchair) with set (whenever necessary awareness with his (minutes) while in order while up in wheelch seat belt every 2 house in the seat belt every 2 house in th	Restraints assessed Resident runk restraint that was used ction G assessed the resident airment of the upper extremity on J Health Conditions and coded Resident #14 without ission/entry or reentry or prior A or Scheduled PPS).  Tent comprehensive care plant dreviewed 9/28/16 identified restraints-seatbelt r/t (related reness. Interventions "discuss resident/family/caregivers the the restraint, when the be applied, routines while concerns or issues regarding y seatbelt. Seatbelt in place rair. Release and reposition 2 hours while in w/c restraint."  Tober 2016 physician order that read "Seat belt in place rair. Release and reposition order that read "Seat belt in place rair. Release and reposition order that read "Seat belt in place rair. Release and reposition order that read "Seat belt in place rair. Release and reposition or while in w/c with seat belt or w/c with seat belt	•	23			
awareness with hx (history) of falls. Monitor q 30 mins while in chair every shift."  The most recent physical restraint assessment had been completed 9/14/16. Information on the device assessment for the continued use of the physical restraint read "Resident #14 was		awareness with hx mins while in chair  The most recent ph had been complete device assessment	(history) of falls. Monitor q 30 every shift."  sysical restraint assessment d 9/14/16. Information on the for the continued use of the					

unaware of safety boundaries when in wheelchair, hx (history) of leaning forward.

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		VIAN LIGINIYIA SEKAICES					FORM APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				O۱	/IB NO. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		ONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495378	B. WING	i			C <b>10/20/2016</b>
NAME OF I	PROVIDER OR SUPPLIER		L.,	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		10/20/2016
SPRING	TREE HEALTHCARE	& REHAB CENTER		3433	SPRINGTREE DRIVE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIES OF THE PROPRIES OF THE PROPRIES OF THE PROVIDER OF	ULD	BE COMPLETION
F 323	Continued From pa	ae 5	· E ·	323			
		uction trial, resident attempted	' '	,20			
	to lean forward in the ensure safety and p	ne chair, 1:1 intervention to					
	at 3:00 p.m. Reside in a wheelchair and completion of the greturned to the resident 3:55 p.m. The survithe physician order resident if she had stated yes and show of the unfastened by the left side of the was not fastened. I don't want me to fail #14 was able to show of the seat belt wheel Resident #14 was a two straps. After the unable to fasten the	· · · ·					
	licensed practical n p.m. L.P.N. #1 stat of falls and was una She verified that the and stated the resid fasten the seatbelt The surveyor interv	ested the assistance of urse #1 on 10/19/16 at 4:00 red Resident #14 had a history able to fasten the seat belt. It is seatbelt was not fastened dent was unable to unfasten or herself.					

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p.m.

activity staff unfastened Resident #14's seatbelt prior to bingo at 3:00 p.m. The activity director stated the seat belt was not unfastened by activities prior to the activity that started at 3:00

Event ID: FTDM11

Facility ID: VA0380

If continuation sheet Page 6 of 18

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		AND TUMAN SERVICES  & MEDICAID SERVICES				PRINTED: 10/25/201 FORM APPROVE OMB NO. 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILC		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495378	B. WING	i		C 10/20/2016
NAME OF	PROVIDER OR SUPPLIER		<u> </u>	STREE	T ADDRESS, CITY, STATE, ZIP COD	<u>  10/20/2016</u>
SPRING'	TREE HEALTHCARE	& REHAB CENTER		3433 \$	SPRINGTREE DRIVE NOKE, VA 24012	<b>L</b>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE COMPLÉTIO
F 323	Continued From pa	ge 6	F	323		
	the above concern	ned the administrative staff of on 10/19/16 at 4:00 p.m. on was provided prior to the	Ē			
	Hashing the state of the state	DENTS FREE OF DERRORS sure that residents are free of	F	F333	1. Resident #17 is currently receivir accurate type of insulin at the right dose per physicia order.  2. Current resident receiving insulin injections were reviewed to determine accur of physician order.	nt an s
	order for the wrong the Resident had re (b) failed to transcriinsulin which resulte receiving any sliding.  The record review r was admitted to the included, but were rediastolic congestive.	staff had (a) transcribed an type of sliding scale insulin eceived this insulin once and be an order for sliding scale ed in the Resident not g scale insulin coverage.  The revealed that Resident #17 a facility 10/14/16. Diagnoses not limited to, diabetes, theart failure, history of in (heart attack), orthostatic			made immediate indicated. 3. Licensed nursing were educated regarding order transcription for sliding scale insulating leaders will review order listing reports description for statement of the sliding scale insulating reports description for sliding scale insulating reports description for sliding scale insulating reports description for statement of the slight formula insulating reports description for slight formula insulations with slight formula insulations with slight formula indicated in the slight formula i	ely as g staff rulin. hip er aily eeks

There was no completed MDS (minimum data

Event ID: FTDM11

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orders are accurate.

Any issues will be

immediately at the time of identification.

addressed

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

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CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				(	OMB NO. 0938-039	
STATEMENT	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		(X3) DATE SURVEY COMPLETED	_
		495378	B. WING				C 40/20/2046	
	PROVIDER OR SUPPLIER	& REHAB CENTER		STRE 3433 ROA	ATE, ZIP CODE	10/20/2016		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	ıx	PROVIDER'S PLA (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION OF ACTION SHOUL OF THE APPROPRIED TO THE APPROPRIED CIENCY)	D.R.F. COMPLETION	<u></u>
F 333	On 10/19/16 when is clinical record it was eMAR (electronic morecord) included order as per sliding scale transcribed on 10/1 been discontinued of p.m.). Per the docume eMAR Resident # 1 insulin on 10/14/16 at 2100 (9:00 p.m.) locate an order for the sliding scale insulin paperwork from the end of the surveyor interviewe murse) #2 regarding and sliding scale insuling paperwork from the end order into the compovel into the	athis Resident. However, the and orientated.  reviewing the Residents is noted that the Residents dedication administration iders for novolin N insulin inject. This order had been 4/16 at 1243 (12:43 p.m.) and on 10/14/16 at 2249 (10:49 mentation on the Residents 7 had received 4 units of this for a BS (blood sugar) of 265. The surveyor was unable to the novolin N to be used as on the Residents discharge hospital.  roximately 4:25 p.m. the d LPN (licensed practical the Residents elevated BS's sulin order. After reviewing the aid insulin orders LPN #2 reveyor that he was the staff ced the sliding scale insulinuter. LPN #2 then stated that the used as sliding scale and to had discontinued the order.  of nursing) was made aware incerns regarding the insulinuter approximately 4:40 p.m.	F3	333	<ul> <li>4. Process wi reviewed i committee quarters.</li> <li>5. 11-10-2016</li> </ul>	n QA for two		
	#17 had been admit	rveyor that when Resident Ited to the facility the rk had been completed by						

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LPN #2 and that when LPN #2 had added the

Event ID: FTDM11

Facility ID: VA0380

If continuation sheet Page 8 of 18

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

PRINTED: 10/25/2016 FORM APPROVED OMB NO. 0938-0391

OLIVILI	10 FOR WEDICARE	& MEDICAID SERVICES			ON	<u> MB NO. 0938-0391</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED
		495378	8. WING			C <b>10/20/2016</b>
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
SPRING'	TREE HEALTHCARE (	& REHAB CENTER		3433 SPRINGTREE DRIVE		
				ROANOKE, VA 24012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE A	ACTION SHOULD I TO THE APPROPR	BE COMPLETION
F 333	and put in the income that LPN #3 had no insulin order was incidiscontinued. RN # thought she had adinsulin on Friday (10 weekend. But discowork on Monday (10 transcribe the order insulin order. Indica went the entire wee part of the day on M sliding scale insulin BS's were documer Saturday 10/16/16-18 Monday 10/17/16-19 Monday 10/17/16-19	he may have gotten confused rect insulin. RN #1 then stated bitced that the sliding scale accorrect and had the order of stated that LPN #3 had lided an order for humulin R 0/14/16) prior to leaving for the overed when she returned to 0/17/16) that she had failed to r and she then added the ating that Resident #17 had ekend (10/15-10/16/16) and Monday (10/17/16) without any coverage. The Residents inted as follows.  187, 168, 166, and 276 83, 283, 222, and 321. 91, 413, 498, and 471.  sulin order transcribed by LPN uded the following	And the second s	333		
	Humulin R subcutar bedtime If below 60 call MD 200-250=2 units 251-300=4 units 301-350=6 units 351-400=8 units Above 400 call MD RN #1 verbalized to errors would be commany errors RN #1 On 10/20/16 the sur #17 regarding her e	neously before meals and at of the surveyor that medication mpleted. When asked how	- minute per representation - · · · · · · · · · · · · · · · · · ·			

diabetic since she was a child and was use to the

DEPARTMENT OF HEALTH AND JUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

PRINTED: 10/25/2016 FORM APPROVED OMB NO. 0938-0391

•		& MEDICAID SERVICES	<del></del>	<del></del>	C	MB NO. 0938-039
AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495378	B. WING			C 10/20/2016
	PROVIDER OR SUPPLIER TREE HEALTHCARE	& REHAB CENTER		3433	EET ADDRESS, CITY, STATE, ZIP CODE SPRINGTREE DRIVE ANOKE, VA 24012	10/20/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE COMPLETION
F 371	aware her BS's had she stated yes and bad during this time.  The Resident had I tract infection) from other insulin orders timeframe.  The administrative significant medicatiduring a meeting w 10/20/16 at approximate to the sunconference.  483.35(i) FOOD PFSTORE/PREPARE  The facility must - (1) Procure food froconsidered satisfact authorities; and (2) Store, prepare, under sanitary conditions.  This REQUIREMENT.  This REQUIREMENT.  Based on observatifacility document resident in the state of the sunconference.	BS's. When asked if she was dibeen elevated at the facility when asked if she had felt when asked if she had felt when asked if she had not.  Deen treated for a UTI (urinary 10/14-10/18/16 and did have in place during this  Staff were notified of the on errors involving insulin ith the survey team on imately 9:55 a.m.  Ion regarding this issue was vey team prior to the exit  ROCURE, VSERVE - SANITARY  Orm sources approved or story by Federal, State or local distribute and serve food	F	F371	1. Meal trays are currently being served covered through the use of an enclosed car per policy. The fly is no longer present in room 309.  2. Current residents' meal trays were observed during delivery to ensure all food items in separate bowls were covered in an enclosed cart prior to	
FORM CMS-25	manner. 67(02-99) Previous Versions		1	įO	serving. Occupied resident rooms were inspected for presence of flies.	

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made immediately as

applicable.

### PRINTED: 10/25/2016 DEPARTMENT OF HEALTH AND TUMAN SERVICES **FORM APPROVED** CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495378 B. WING 10/20/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3433 SPRINGTREE DRIVE SPRINGTREE HEALTHCARE & REHAB CENTER ROANOKE, VA 24012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DATE DEFICIENCY) 3. Dietary personnel F 371 | Continued From page 10 F 371 and nursing staff were educated The findings include: regarding policy for food preparation On 10/19/16 at 8:20 am, during breakfast trav delivery the surveyor observed trays served to regarding covering room 605, room 608 and 609 that had bowls of food items prior to strawberries that did not have a lid or plastic wrap serving. Dietary covering. The surveyor also observed a large fly manager will observe in room 309. A second surveyor observed an uncovered bowl of strawberries served to room tray line operation 3X 404 weekly X6 weeks to ensure food items in CNA #1 was asked if the residents were severed separate bowls are food that was not covered. She stated " no it is usually covered. "

At 7:50 am, on 10/20/16 the dietary manager was asked if it was the normal practice for the strawberries or other food to be served to the units without a covering. He said, " Usually we cover it. We have bowls with lids or use plastic wrap. "

On 10/19/16 at 4:00 pm, the administrative staff

was notified of the uncovered strawberries.

Review of the policy and procedure titled Dining Services Policies and Procedures revealed the following: Under procedures 4. All meals will be delivered to the nursing units timely and efficiently. All foods served to patients dining in their rooms will be delivered covered through the use of an enclosed cart or an open cart using lids or plastic wrap.

Prior to exit on 10/20/16 no further information was received from the facility related to food service.

covered per policy prior to serving. Maintenance staff will inspect 10% of resident rooms weekly X6 weeks to ensure free from flies. Any issues will be addressed immediately at the time of identification.

- 4. Process will be reviewed in QA committee for two quarters.
- 5. 11-10-2016

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTDM11

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

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STATEMENT	OF DEFICIENCIES	(X1) BBOVIDED STRICE IN	T 2000 4 11 11		· · · · · · · · · · · · · · · · · · ·		<u>MR NO. 0938-0391</u>
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTIO		(X3) DATE SURVEY COMPLETED
			A, BUILL	JING		<del></del>	1
		495378	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER			STREE	ET ADDRESS	, CITY, STATE, ZIP CODE	10/20/2016
SPRING	REE HEALTHCARE	& REHAR CENTED		3433	SPRINGTRE	E DRIVE	
		a KLIMO CENTER		ROA	NOKE, VA	24012	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL	_ ID			DER'S PLAN OF CORRECTION	N (X5)
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CO CROSS-RE	ORRECTIVE ACTION SHOULD FERENCED TO THE APPROPI	N (X5) DBE COMPLETION RIATE DATE
						DEFICIENCY)	· · · · · · · · · · · · · · · · · · ·
E EOO	0			F502	1.		
	Continued From pa	=	F!			laboratory test has	
SS=D	483.75(j)(1) ADMIN	IISTRATION	F:			been completed as	
33-0		ovide or obtain laboratory				ordered.	
	services to meet the	e needs of its residents. The			2.	Current residents	
	facility is responsible	le for the quality and timeliness				with active	
	of the services.					laboratory test	
						orders were	
	This REQUIREMEN	NT is not met as evidenced				reviewed to ensure	
i	by:			1.		complete per MD	
***************************************	Based on staff inte	rview and clinical record				order. Corrections	
	ordered laboratory	staff failed to obtain a physician test for 1 of 23 residents				were made	
:	(Resident #3).	toot for 1 of 20 residents				immediately as	
	· ·					applicable.	££
	The findings include	ed:			3.	Licensed nursing sta	
1	The facility staff fail	ed to obtain a hemoglobin				were educated	
•	A1C for Resident #	3 on 1/4/16.				regarding laboratory	/
				1		process to include accurate order	
		of Resident #3 was reviewed					
		t#3 was admitted to the facility ted 1/14/16 with diagnoses				transcription and completion of lab	
		ot limited to diabetes mellitus,				requisition form.	
	chronic obstructive	pulmonary disease,				Nursing leadership	
	pneumonia, hypoth	yroidism, hypertension,				will review order	
	gastroesopnageal r	eflux disease, dementia disturbances, hyperlipidemia,				listing report daily 5	v
i	pain, lymphedema.	overactive bladder, and major		1,		weekly X6 weeks to	1 1
	depression.		:			ensure test orders	
	D1-1-1-101					have transcribed	
r	Resident #3's quart	erly minimum data set (MDS)  a assessment reference date		ŧ		accurately for	
	(ARD) of 8/17/16 as	ssessed the resident with a				completion. Any	
	cognitive summary	score of 9 out of 15 in Section				issues will be	
	C Summary Score.					addressed	
	The clinical record :	rovoolod o nhumining			1	immediately at the	
	dated 12/31/15 tha	revealed a physician order tread "A1C on 1/4/16." The				time of identification	1 1
FORM CMS-25	67(02-99) Previous Versions			-	Л	Process will be	
	(>= 00) : 1641003 461310115	Obsolete Event ID: FTDM1	11		<b>—</b>	reviewed in QA	18
						committee for two	The potential of the second
						quarters.	
					5.	. 11-10-2016	
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		AND-JUMAN SERVICES				PRINTED: 10/25/2016 FORM APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	<del></del>	·····		OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		ONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495378	B. WING			C 10/20/2016
NAME OF F	PROVIDER OR SUPPLIER		<b>'</b> Т	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 10/20/2010
SPRING	TREE HEALTHCARE	& REHAB CENTER	***************************************		S SPRINGTREE DRIVE ANOKE, VA 24012	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
F 502	Continued From pa	ge 12	, F 5	02		
	surveyor reviewed the paper and elect	the laboratory section in both ronic clinical records and was results of the A1C ordered to		<b>-</b>		
	assistant director or registered nurse on reviewed the physic section of the clinic would call the contr	-				
	nursing stated the I the laboratory test ( The surveyor inform	5 p.m., the assistant director of aboratory had no record that A1C) was obtained on 1/4/16.  ned the administrative staff of				
F 514		n 10/19/16 at 4:00 p.m. ion was provided prior to the 10/20/16.	<u></u> }-			
	RECORDS-COMPI LE	LETE/ACCURATE/ACCESSIB		F514	Resident #14's     restraint assessment     was corrected to	t
	resident in accorda standards and prac accurately docume systematically orga				reflect accurate date of responsible party notification. Residen #16's current dialysis communication	ıt
	information to ident resident's assessm services provided;	ening conducted by the State;			forms are complete	

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		AND TUMAN SERVICES			Manage of the second		M APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					<u>0. 0938-039</u> 1
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495378	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER		1	STR	REET ADDRESS, CITY, STATE, ZIP CODE	1 1	0/20/2016
SPRING	TREE HEALTHCARE	& REHAB CENTER	# 1-4	343	3 SPRINGTREE DRIVE ANOKE, VA 24012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	Κ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 514	Continued From pa	ge 13	F 5	14:			
	This REQUIREMENT by: Based on staff inter and clinical record of to maintain a complimeter for 2 of 23 referenced for 2 of	rview, facility document review review, the facility staff failed lete and accurate clinical esidents. (Resident #16 and ed:  If failed to maintain a complete al record for dialysis Resident #16.  Idmitted to the facility on owing diagnoses of, but not ligh blood pressure, aphasia, codisorder and end stage renal erly MDS (Minimum Data Set) is sment Reference Date) of esident as having a BIMS Mental Status) score of 0 out of 15. The resident was also extensive assistance of 1 staff g and personal hygiene.  Incted a review of Resident #16 in 10/19/16. It was noted by the following dialysis ets did not contain lither post dialysis vital signs weights for the dates of: 27/16, 9/24/16, 9/20/16,			to include weight vital sign documentation.  2. Current resident with restraints or reviewed to ensure accuracy of assessment documentation date of RP notification. Curesidents received dialysis were reviewed to ensure communication forms are computed include weight vital signs.  Corrections we made immediate applicable.	ts were sure for rrent ring sure blete ht and	

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The corporate nurse was notified of the above documented findings by the surveyor on 10/19/16 at 5 pm. The corporate nurse stated "We

Event ID: FTDM11

Facility ID: VA0380

If continuation sheet Page 14 of 18

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DEPARTMENT OF HEALTH	AND UMAN SERVICES		F	PRINTED: 10/25/2016
CENTERS FOR MEDICARE			_	FORM APPROVED 0MB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	B. WING		C 10/20/2016
NAME OF PROVIDER OR SUPPLIER		<del>'</del>	STREET ADDRESS, CITY, STATE, ZIP CODE	10/20/2016
SPRINGTREE HEALTHCARE			3433 SPRINGTREE DRIVE ROANOKE, VA 24012	
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	3. Licensed nursing st were educated	DBE COMPLETION
these were taken. for us to know." T back to the surveyor called the dialysis or weights to me. I an staff here and talk we them know that this we need. " The consurveyor post dialys dates: 9/1/16, \$/6/1 and 10/6/16. The second here corporate nurse standialysis center 's clinical record here corporate nurse standialysis center 's clinical and they fax we talked. "  On 10/20/16 at approadministrative team documented finding	e dialysis center back to see if This information is important he corporate nurse came r at 5:40 pm and stated, " I enter and they faxed these n going to follow up with our with the dialysis staff to let is important information that reporate nurse gave the is weights for the following 6, 9/24/16, 9/27/16, 9/29/16 urveyor asked the corporate hat were in the resident's at the facility and the ted, " No, these were in the inical record they have there are these weights to me after roximately 9:30 am, the was notified of the above	F &	regarding accurate completion of restraint assessme and dialysis communication forms. Nursing leadership will review restraint assessments for accuracy during scheduled quarter review and will review dialysis communication forms weekly X6 weeks to ensure accuracy of documentation. A issues will be addressed immediately at the	nts

No further information was provided to the surveyor prior to the exit conference on 10/20/16.

2. The facility staff failed to ensure the quarterly physical restraint assessments were accurate for Resident #14.

The clinical record of Resident #14 was reviewed 10/19/16. Resident #14 was admitted to the facility 7/9/15 and readmitted 3/14/16 with diagnoses that included but not limited to osteoarthritis, gastrointestinal hemorrhage, hypothyroidism, hypertension, iron deficiency anemia, dementia with behavioral disturbances, depressive disorder, atrial fibrillation, and muscle weakness.

committee for two quarters.

reviewed in QA

time of identification.

. 11-10-2016

4. Process will be

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTDM11

Facility ID: VA0380

If continuation sheet Page 15 of 18



PRINTED: 10/25/2016

		& MEDICAID SERVICES				OI	FORM APPROVE MB NO. 0938-039	D
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILD		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	1
MARK OF	CONTROL OF CHORUSE	495378	B. WING				C 10/20/2016	
NANE UT I	PROVIDER OR SUPPLIER			1	STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
	TREE HEALTHCARE			1 .	3433 SPRINGTREE DRIVE ROANOKE, VA 24012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD	BE COMPLETION	4
F 514	minimum data set ( assessment referer assessed the reside score of 11 out of 1: Score. Section P R #14 with use of a tru less than daily. Section J1700 Fall History of any falls since admit assessment (OBRA Resident #14's curre created 12/1/15 and the use of physical r to) poor safety awar	inficant change in assessment (MDS) assessment with an ince date (ARD) of 9/20/16 ent with a cognitive summary 5 in Section C Summary Restraints assessed Resident unk restraint that was used ction G assessed the resident airment of the upper extremity on J Health Conditions and coded Resident #14 without ission/entry or reentry or prior A or Scheduled PPS).  Tent comprehensive care plant of reviewed 9/28/16 identified restraints-seatbelt r/t (related reness. Interventions "discuss"		514	1			
	risk and benefits of restraint should/will restrained and any crestraint use. Apply while up in wheelchaseat belt q (every) 2 (wheelchair) with se (whenever necessal awareness with hist (minutes) while in characteristic products and an order while up in wheelchaseat belt every 2 hoppin. Toilet prn. Res	eat belt on. Toilet prn ry). Resident has poor safety tory of falls. Monitor q 30 mins hair."  ober 2016 physician order that read "Seat belt in place air. Release and reposition urs while in w/c with seat belt sident has poor safety (history) of falls. Monitor q 30						

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The most recent physical restraint assessment

Event ID: FTDM11

Facility ID: VA0380

If continuation sheet Page 16 of 18

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# DEPARTMENT OF HEALTH AND JUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/25/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	(S FOR MEDICARE	& MEDICAID SERVICES	<del>,</del>			MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495378	B. WING			C 10/20/2016
NAME OF F	PROVIDER OR SUPPLIER			STRE	EET ADDRESS, CITY, STATE, ZIP CODE	
SPRINGT	TREE HEALTHCARE	& REHAB CENTER		3433	SPRINGTREE DRIVE	
				ROA	ANOKE, VA 24012	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  ( MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG	•	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 514	Continued From pa	ge 16	· F t	514		
		d 9/14/16. Information on the				
	device assessment	for the continued use of the				
		ead "Resident #14 was				
	unaware of safety b					
		ory) of leaning forward.				
	to loop forward in the	uction trial, resident attempted	•			
		ne chair, 1:1 intervention to prevention of falls." Section F	•			
		cumented in 1. that the				
	family/POA (power	of attorney)/Decision Maker				
	Notified of Decision	on the use of a seatbelt on			1	
	12/1/2016 and 4. th	nat an LPN (licensed practical	:			
	nurse) provided tha	t information.				
-	The date that the fa	mily was notified of the				
	facility's decision/as	ssessment to continue to use				
	the seatbelt had not	t yet occurred (12/1/2016) and	:			
	there was no specif	ic L.P.N. documented who			* HOME	
	surveyor reviewed t	mily of that decision. The the quarterly physical restraint			· ·	
	assessments dated	3/17/16 and 6/29/16. The				
		hese assessments was				
		rterly assessment completed				
	9/29/16.	,,				
	The surveyor inform	ned the administrative staff of	:			
		on 10/19/16 at 4:00 p.m.				
	Upon completion of	the meeting, the assistant	:			
	director of nursing s	stated she was responsible for	:		1	
	the inaccuracy of th	e assessments.				
	The surveyor review	ved the facility policy on				
	device assessment	s on 10/20/16. The policy				
		Device Assessment is used				
	to provide documen					
	patient/responsible	party has been informed of				
		ts, and potential complications use of a device(s) 5. A				
	ACCUMULTED WHEN THE	COST OF BEVEREINE SERVE				1

licensed nurse will ensure completion of the

DEPARTMENT OF HEALTH CENTERS FOR MEDICARE			PRINTED: 10/25/2016 FORM APPROVED OMB NO. 0938-0391
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	495378	B. WING	C 40/20/2046

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		495378	B. WING		C 10/20/2016	
SPRING	PROVIDER OR SUPPLIER	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3433 SPRINGTREE DRIVE ROANOKE, VA 24012	1 10/20/2016	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 514	having been asses	of the form for any patient sed as needing a device."  ion was provided prior to the	F 51	4:		
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FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: FTDM11

Facility ID: VA0380

If continuation sheet Page 18 of 18



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495378		B. WING		10/20/2016	
NAME OF F	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	TATE, ZIP CODE		20/2010
SPRINGT	REE HEALTHCARE 8	REHAB CENTER	3433 SPR	INGTREE DR E, VA 24012			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
F 000	Initial Comments			F 000			
	Inspection was con 10/20/16. The facil	iennial State Licensunducted 10/18/16 through Iducted 10/18/16 through Ity was in compliance Regulations for the L s.	ough e with the				
	time of the survey. of 20 current Resid	120 bed facility was The survey sample lent reviews (Resider closed records (Res	consisted nts #1				
F 001	Non Compliance			F 001			
		t of compliance with the sure requirements:	he				ŧ
	The facility was not	met as evidenced by in compliance with t tules and Regulations ng Facilities.	he				ļ
	12 VAC 5-371-370. Housekeeping 12 VAC 5-371-370 Reference to F Tag	(A, D, H, J, M) Cross	3				
	12 VAC 5-371-220.	,	to F- 333.				
	12 VAC 5-371-350 12VAC 5-371- 350-	Dietary Services - (E) Cross reference	to F-371				Albanian.
•	12 VAC 5-371-310. 12 VAC 5-371-310	Administration. (A) Cross reference	to F-502				
	12 VAC 5-371-360. 12 VAC 5-371-360 F-514	Clinical Records (A,E,f,j) Cross Refer	ence to				
LABORATOR	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESEN	ITATIVE'S SIG	NATURE	TITLE		(X6) DATE

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State of Virginia				D: 10/25/2016 M APPROVED				
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495378		B. WING		10/2	10/20/2016	
NAME OF PROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, S				
SPRING	STREE HEALTHCARE 8		ROANOKE	NGTREE DF , VA 24012	RIVE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
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