STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 Standard Survey was conducted 9/19/17 through 9/21/17. Five complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 113 at the time of the survey. The survey sample consisted of 20 current Resident reviews (Resident #1 through Resident #20) and 7 closed record reviews (Residents #21 through 27).	F 000		
F 157 SS=D	NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) CFR(s): 483.10(g)(14) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to	F 157		10/25/17

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

Electronically Signed | 10/14/2017

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	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

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F 157	Continued From page 1 commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility staff failed to inform the physician of a change in condition for 1 of 22 residents (Resident #22). The findings included: The facility staff failed to inform the physician of a change in condition for Resident #22. The physician was not notified when Resident #22	F 157	The statements made in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain in compliance with all state and federal regulations, the center has taken or will take the actions set forth in this Plan of Correction. In addition, the following plan constitutes the center□s allegation of compliance. All alleged deficiencies have been or will be corrected by the dates	

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F 157	Continued From page 2 developed +1 pitting edema to bilateral lower extremities and the right heel assessed to be "reddened." Resident #22 was admitted to the facility 4/15/16 and readmitted 3/16/17 with diagnoses that included but not limited to right femur fracture with repair, diabetes mellitus type 2, light headed, tingling, pre-syncope, coronary artery disease (CAD), hypertension, deep vein thrombosis, pulmonary embolus, compression fracture of L4 lumbar vertebrae, degenerative disc disease (DDD), peripheral edema, atypical chest pain, pneumonia, syncope and collapse, and right leg pain. Resident #22's admission minimum data set (MDS) with an assessment reference date of 3/23/17 assessed the resident with a brief interview for mental status as 15 out of 15 in Section C BIMS Summary Score. There was no evidence of delirium, psychosis, or behaviors assessed on the admission MDS. Section G Functional Status assessed the resident for bed mobility as 7/0 (activity occurred only once or twice) and required no physical assist from staff. Transfers occurred only once or twice (7) and required no physical help from staff. Walk in corridor and walk in room occurred only once or twice and required two + persons physical assist. Resident #22 required extensive assistance of two + persons for locomotion on and off unit. Resident #22 required extensive assistance of two + persons for dressing and personal hygiene and required extensive assistance of one person for bathing. Eating occurred only once or twice and required set up help only. Section M Skin Conditions assessed that Resident #22 had no unhealed pressure ulcers but was at risk for the	F 157	indicated. F157 1. Resident #22 no longer resides in the facility. 2. Current residents will be reviewed to identify signs of lower extremity pitting edema or skin impairment to heels to ensure MD has been notified. Corrections will be made as indicated. 3. Current licensed nursing staff will be educated regarding MD notification for signs of edema and changes in skin condition. Unit managers and/or designees will review the alerts listing report, review the 24 hour report, and will visualize residents daily 5X week during rounds X4 weeks to identify any significant changes in condition to include edema and skin changes. MD will be notified promptly as indicated. Corrections will be made immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 10-25-17	

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F 157	Continued From page 3	F 157		

development of pressure ulcers. Resident #22 was assessed to have a surgical wound.

Resident #22's current comprehensive care plan identified a focus area that read "Potential for skin impairment Revision on 03/16/2017. Interventions: Keep skin clean and dry, lotion to legs, weekly skin assessments, pressure reduction mattress."

The surveyor reviewed the wound records and weekly skin assessments for Resident #22.

The weekly skin assessment dated 3/17/17 identified a surgical incision to the right hip and the notes read "Right hip with Aquacel dressing intact. Unable to observed (sic) wound. An order to remove dressing in 5 days and apply steri-strips in place. No other skin impairments noted." Note written by licensed practical nurse #1.

The wound record dated 3/17/17 documented the physician was last updated on 3/16/17. The note read "Unable to observe, dressing cannot be remove until 5 days." Note written by licensed practical nurse #1.

The weekly skin assessment dated 3/24/17 read under notes "Hip and sacrum large bruise in fading stages, scab to sacrum, pitting edema +1 edema to BLE (bilateral lower extremity) right heel reddened treatment in place." There was a progress note written 3/24/17 at 22:37 (10:37 p.m.). However, there was no documentation that the physician had been informed of the pitting edema or the reddened area to the right heel. Note written by licensed practical nurse #4. L.P.N. #4 was not available for an interview per

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F 157	Continued From page 4	F 157		

nursing staff.

There were three wound records for 3/24/17 (right hip #1, right hip #2, and right hip #3). L.P.N. #4 assessed the peri-wound tissue to be healthy and bruised.

The surveyor reviewed the progress notes from 3/16/17 through 3/29/17. The progress note dated 3/16/17 (admission) 3:11 p.m. read "Right knee and leg swollen, no pitting edema, cap (capillary) refill < 3, resident's leg with PT and DP (pulses), no signs of circulatory impairment. Resident states his Right leg swollen since admission to hospital."

MD note 3/16/17 read "Venous stasis changes to B/L LE (bilateral lower extremities). Trace edema on Lt (left) LE (lower extremity)."

Progress note dated 3/27/17 at 23:28 (11:28 p.m.) read "N/O (new order) per family request for TED (elastic stockings) during the day for edema and lotion to legs daily for dry skin."

Progress note of 3/29/17 at 17:08 (5:08 p.m.) read "Daughter concerned of edema to LE (lower extremity) and informed of new order placed for TED hose on qam (every morning) and off qpm (every evening) res (resident) placed on podiatry list for tomorrow 033017."

The surveyor interviewed the physician on 9/21/17 at 10:00 a.m. The surveyor reviewed one of the allegations of the complaint. The allegation read that the resident had developed swelling, drainage and pain in his lower extremities which was not addressed by staff.

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F 157	Continued From page 5	F 157		

The surveyor reviewed the weekly skin assessment dated 3/24/17 written by L.P.N. #4 with the physician. The physician (other #4) stated she had not been informed of the bilateral lower edema or the reddened heel. The physician stated the clinical record was full of "MD aware."

The surveyor interviewed the director of nursing on 9/21/17 at 11:00 a.m. concerning the weekly skin assessment on 3/24/17. The DON stated the first thing about the skin assessment was don't use the word "reddened." The DON stated that doesn't describe the wound. The DON stated more documentation was needed to describe the area on the heel. The documentation was lacking. The DON stated more information was needed before the area would be determined to be a pressure. The DON stated a progress note should be written and the physician informed. The DON stated "Technically if a treatment is in place, a nurse doesn't order it." The surveyor was unable to locate a treatment for the reddened heel.

On admission on 3/16/17, the nurse assessed the resident with no edema. On 3/24/17, the nurse assessed the resident with +1 pitting edema to both lower extremities. The surveyor was unable to locate physician notification of the change in condition. The surveyor was also unable to locate notification to the physician of the reddened right heel.

The surveyor informed the administrative staff of the above changes in Resident #22's skin condition without physician notification of the changes on 9/21/17 at 11:25 a.m.

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F 157	Continued From page 6 No further information was provided prior to the exit conference on 9/21/17. This is a complaint deficiency.	F 157		
F 280 SS=D	RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP CFR(s): 483.10(c)(2)(i-ii,iv,v)(3),483.21(b)(2) 483.10 (c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. (c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must-- (i) Facilitate the inclusion of the resident and/or	F 280		10/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 7 resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. 483.21 (b) Comprehensive Care Plans (2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 8 disciplines as determined by the resident's needs or as requested by the resident. (iii) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to review and revise the current comprehensive care plan for 1 of 27 residents (Resident #10). The findings included: The facility staff failed to review and revise the current comprehensive care plan for Resident #10 when weekly weighs were no longer done. The surveyor reviewed Resident #10's clinical record on 9/19/17 and 9/20/17. Resident #10 was admitted to the facility 3/18/10 and readmitted 5/12/2016 with diagnoses that included but not limited to obesity, acute on chronic diastolic heart failure, hypertension, diabetes mellitus type 2, psoriasis, hyperlipidemia, chronic ischemic heart disease, anemia, insomnia, and chronic obstructive pulmonary disease. Resident #10's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 5/2/17 assessed the resident with a cognitive summary score of 12 out of 15 in Section C. BIMS Summary Score. Section K. Height and Weight assessed Resident #10 with no weight loss or weight gain concerns in the last 6 months.	F 280	1. Resident #10□s care plan was corrected to remove weekly weights. 2. Nursing leadership will review current residents that receive weekly weights. Care plans will be corrected as indicated. 3. Current licensed nursing staff will be educated regarding revision and updating comprehensive care plans to meet the active care needs of the residents. Licensed nursing staff will make daily updates to care plans as applicable. Care plans will be reviewed by Unit Manager/designee quarterly with care plan schedule. Corrections will be made immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 10-25-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 9	F 280		

The current comprehensive care-plan identified a focus area that read "Potential for weight fluctuations given dx (diagnosis) of CHF (congestive heart failure), obesity Created on: 08/25/2014, Revision on: 11/20/2015. Interventions/Tasks read in part "Monitor Weight Weekly Created on: 08/25/2014 Revision on: 09/02/2015."

The surveyor reviewed the weight and vitals summary sheet from November 2016 through September 2017. The form documented monthly weights-not weekly as instructed on Resident #10's current comprehensive care plan.

The surveyor informed the corporate registered nurse on 9/20/17 at 12:44 p.m. of the care plan concern. The corporate R.N. stated she would review the information provided.

The surveyor informed the administrative staff of the above concern with Resident #10's current comprehensive care plan on 9/20/17 at 3:08 p.m.

On 9/21/17 at 9:41 a.m., the corporate R.N. informed the surveyor that the care plan had not been revised when weekly weights were no longer done for Resident #10. The corporate R.N. stated Resident #10's care plan had been reviewed and revised on 8/17/16, 11/16/16, 2/15/17, 5/10/17, and 8/9/17. The corporate R.N. stated the "library of interventions" was incorrectly reviewed and stated weekly weights had not been done since 2015.

No further information was provided prior to the exit conference on 9/21/17.

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	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

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F 281	Continued From page 10	F 281		
F 281 SS=D	SERVICES PROVIDED MEET PROFESSIONAL STANDARDS CFR(s): 483.21(b)(3)(i) (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to follow standards of professional practice for 1 of 27 residents (Resident #14). The facility staff failed to write the physician orders for a urinalysis and urinalysis with culture and sensitivity for Resident #14. The findings included: The facility staff failed to follow standards of professional practice for writing physician orders for Resident #14. The facility nursing staff failed to write the physician order for a urinalysis (UA) and UA C&S (culture and sensitivity) obtained on 9/5/17. The surveyor reviewed Resident #14's clinical record on 9/19/17 and 9/20/17. Resident #14 was admitted to the facility 1/17/17 with diagnoses that included but not limited to urinary tract infections, acute respiratory failure with hypoxia, anxiety disorder, gastroesophageal reflux disease, depressive disorder, hypercholesterolemia, dementia without behavioral disturbances, anemia, hypertension,	F 281	1. Resident #14□s current plan of care accurately reflects physician order for urinalysis and culture. 2. Current residents with urinalysis and cultures performed in the last 30 days were reviewed to determine documentation of MD order. Corrections were made as indicated. 3. Current licensed nursing staff were educated regarding documenting new orders when received. Nursing leadership will review laboratory tracking logs and order listing reports daily 5X weekly X2 weeks to ensure urinalysis and cultures have MD orders. Corrections will be made immediately at the time of identification 4. Process will be reviewed in QA committee for two quarters. 5. 10-25-17	10/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 281	Continued From page 11	F 281		

hypothyroidism, type 2 diabetes mellitus, and urinary incontinence.

Resident #14's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/24/17 assessed the resident with a BIMS score of 4 out of 15 in Section C BIMS Summary Score. Section H Urinary Continence assessed Resident #14 to be frequently incontinent of urine.

The surveyor reviewed the laboratory section of the electronic clinical record and found the results of a urinalysis completed on 9/5/17. The progress note dated 9/5/2017 at 23:31 (11:31 p.m.) read "Lab results reviewed with ____ (nurse practitioner-other #3). Told to let ____ (medical doctor other #4) look at the labs [CBC (complete blood count), CMP (comprehensive metabolic panel), U/A (urinalysis)] it (sic) tomorrow."

The surveyor reviewed the electronic clinical record for the orders for the UA and the UA C&S obtained on 9/5/17 but was unable to locate the order.

The surveyor informed the assistant director of nursing (ADON) of the concern on 9/19/17 at 4:30 p.m.

The ADON informed the surveyor on 9/19/17 at 5:00 p.m. that a physician order was not found for the 9/5/17 UA.

The surveyor informed the administrative staff of the above concern on 9/20/17 at 3:08 p.m. and requested the facility standard of professional practice for writing physician orders.

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	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

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F 281	Continued From page 12 The surveyor was provided the professional standard of practice for laboratory/diagnostic testing policy on 9/21/17 at 11:05 a.m. by the corporate registered nurse. The corporate RN stated the policy was their standards when writing laboratory orders. The policy read in part "PROCEDURE: 1. A licensed nurse will obtain laboratory, radiology, or other diagnostic services to meet the needs of its patients as ordered by the physician or physician extender. 3. Laboratory, radiology and other diagnostic services will be provided only when ordered by the physician or physician extender." The corporate RN stated a physician order would be expected to be written. No further information was provided prior to the exit conference on 9/21/17.	F 281		
F 309 SS=D	PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING CFR(s): 483.24, 483.25(k)(l) 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 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	F 309		10/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

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F 309	Continued From page 13 accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and in the course of a complaint investigation, the facility failed to implement physician orders for 2 of 27 Residents, Resident #23 and #22. The findings included. 1. For Resident #23, the facility staff failed to implement physician orders after the Resident had a cardiac catheterization. The record review revealed that Resident #23 was admitted to the facility 01/02/15, had been readmitted on 05/07/17 and was readmitted again on 05/26/17 after a cardiac catheterization. Diagnoses included, but were not limited to, hypertension, coronary artery disease, hypothyroidism, gastroesophageal reflux disease, and major depressive disorder. The Resident had	F 309	1. Resident #22 no longer resides in the facility. Resident #23 no longer resides in the facility. 2. Nursing leadership will review current residents with diagnosis of Diabetes and those who have had consultation appointments in the last 30 days to ensure physician orders have been implemented as indicated. Corrections were made as indicated. 3. Current licensed nursing staff will be educated regarding care needs for residents with diagnosis of diabetes at the time of admission and process for review of consultation reports upon receipt. Unit managers or designee will review residents with diabetes at the time of admission to ensure MD orders have been implemented and will review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

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SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

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F 309	Continued From page 14 been discharged from the facility at the time of the survey. Section C (cognitive patterns) of the Residents initial MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/13/17 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. The Residents CCP (comprehensive care plan) included the focus area "The resident has altered cardiac status r/t (related to) HTN (hypertension), HLD, and angina." Interventions included, but were not limited to, Meds as ordered. The clinical record included a discharge summary from _____ clinic cardiology with a d/c date of 05/26/17. Under the heading of discharge medications was a subheading titled "STOP taking these meds" with fenofibrate (tricor) 145 mg tablet being listed. Under the heading of "START taking these meds" atorvastatin (lipitor) 40 mg 1 tab by mouth every night and carvedilol (coreg) 3.125 mg tablet take 1 tab by mouth two times day with meals were listed. Under the heading "CONTINUE taking these meds which have not changed" the medication hydralazine (apresoline) 10 mg 1 tab by mouth every 8 hours was listed. The clinical record included a medical note dated 05/26/17 that had been authored by _____ MD (medical doctor). This medical note included the exact same documentation regarding medications as listed in the above paragraph. This was the Residents attending physician/medical doctor at the facility. A review of the Residents eMAR's (electronic	F 309	consultation reports daily 5X weekly X4 weeks to ensure accurate order implementation. Corrections will be made immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 10-25-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 309	Continued From page 15	F 309		

medication administration records) for May and June 2017 indicated that the facility had not stopped the medication fenofibrate, had not started the medications atorvastatin and carvedilol, and the Resident had not being administered the medication hydralazine since they had been readmitted to the facility on 05/07/17.

When reviewing the clinical record, the surveyor was unable to locate any documentation as to why the cardiologist and MD orders had not been implemented.

On 09/20/17 at approximately 10:00 a.m. the surveyor spoke with the nurse consultant and administrator regarding Resident #23. Both of these staff stated they did not remember the Resident and nothing regarding the Resident and their medications was communicated to them.

On 09/20/17 at approximately 10:40 a.m. the unit manager identified LPN (licensed practical nurse) #1 as the admitting nurse for 05/26/17.

On 09.20/17 at approximately 10:45 a.m. the surveyor interviewed LPN #1. LPN #1 reviewed the electronic clinical record and when asked about the Residents medications that had been omitted LPN #1 stated she very rarely ever put the medications in the computer and stated she did "...not honestly remember putting the medications in..." the Residents electronic record.

On 09/20/17 at approximately 3:05 p.m. an end of the day meeting was held with the administrative staff of the facility. During this meeting the surveyor requested of the facility any further information they could provide regarding why the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

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F 309	Continued From page 16	F 309		

medication orders were not implemented.

On 09/21/17 at approximately 9:30 a.m. the surveyor spoke with the admissions nurse at the facility LPN #3. After checking the computerized record LPN #3 verbalized to the surveyor that she did not remember if she had admitted the Resident to the facility on 05/26/17.

On 09/21/17 at approximately 9:55 a.m. the surveyor interviewed the MD. The MD verbalized to the surveyor that she did not know why the medication orders had not been implemented and that "Maybe we should have followed the recipe..." referring to the medications ordered by the cardiologist. The MD then added in regards to the medication fenofibrate it would not have hurt the Resident to take the medication and that anyone could take it without problems.

Throughout the course of the survey the facility did not provide the surveyor with a reason as to why the medication orders were not implemented.

No further information regarding the medication orders not being implemented was provided to the survey team prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY
2. The facility staff failed to initiate admission orders for sliding scale insulin and accuchecks as ordered by the physician for Resident #22.

The clinical record of Resident #22 was reviewed 9/19/17 through 9/21/17.

Resident #22 was admitted to the facility 4/15/16 and readmitted 3/16/17 with diagnoses that included but not limited to right femur fracture

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

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F 309	Continued From page 17	F 309		

with repair, diabetes mellitus type 2, light headed, tingling, pre-syncope, coronary artery disease (CAD), hypertension, deep vein thrombosis, pulmonary embolus, compression fracture of L4 lumbar vertebrae, degenerative disc disease (DDD), peripheral edema, atypical chest pain, pneumonia, syncope and collapse, and right leg pain.

Resident #22's admission minimum data set (MDS) with an assessment reference date of 3/23/17 assessed the resident with a brief interview for mental status as 15 out of 15 in Section C BIMS Summary Score. There was no evidence of delirium, psychosis, or behaviors assessed on the admission MDS. Section G Functional Status assessed the resident for bed mobility as 7/0 (activity occurred only once or twice) and required no physical assist from staff. Transfers occurred only once or twice (7) and required no physical help from staff. Walk in corridor and walk in room occurred only once or twice and required two + persons physical assist. Resident #22 required extensive assistance of two + persons for locomotion on and off unit. Resident #22 required extensive assistance of two + persons for dressing and personal hygiene and required extensive assistance of one person for bathing. Eating occurred only once or twice and required set up help only. Section M Skin Conditions assessed that Resident #22 had no unhealed pressure ulcers but was at risk for the development of pressure ulcers. Resident #22 was assessed to have a surgical wound.

Resident #22's current comprehensive care plan identified a focus area that read "The resident has Diabetes Mellitus Revision on 3/16/17." Interventions: Educate resident/family/caregivers

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

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F 309	Continued From page 18	F 309		

as to the correct protocol for glucose monitoring and insulin injections and obtain return demonstration. Continue until comfort level with procedures is achieved. Revision on: 03/16/2017."

During the clinical review of Resident #22's electronic clinical record, the medical note dated 3/16/17 at 16:31 (4:31 p.m.) was reviewed. Assessment and Plan read in part "DM (diabetes mellitus)-continue lantus, ssi (sliding scale insulin), accuchecks, monitor for hypoglycemia."

During the clinical record review, the admission orders dated 3/16/17 were reviewed. Handwritten on the printed orders from the hospital were the following orders by other #4 (medical doctor): SSI (sliding scale insulin), accuchecks, CBC (complete blood count), CMP (comprehensive metabolic profile) Wed (Wednesday).

The surveyor reviewed the March 2017 electronic medication administration record (eMAR). There were no entries for the accuchecks or the SSI on the March 2017 eMAR beginning on 3/16/17.

The surveyor interviewed the physician on 9/21/17 at 10:00 a.m. about the hospital discharge/admission orders dated 3/16/17. The physician (other #4) verified that the handwritten orders on the discharge summary dated 3/16/17 were written by her and included SSI and accuchecks. Other #4 stated those were signed orders. Other #4 stated the resident's family wanted to be in control of Resident #22's care. "We had issues with her. She wanted to be in the driver's seat. I wanted to emulate the situation." The surveyor informed other #4 that the admission orders for accuchecks and SSI were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

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F 309	Continued From page 19 not implemented on admission. Other #4 stated her orders from the discharge summary were not implemented. The surveyor interviewed the director of nursing on 9/21/17 at 11:00 a.m. After providing the discharge summary from the hospital with the handwritten physician orders by other #4, the DON stated the orders for the accuchecks and SSI were missed. The DON stated the nurse that put the orders in probably didn't read everything. The surveyor informed the administrative staff of the above issue with the failure of the facility staff to implement the orders from the hospital that were signed by the admitting physician for accuchecks and SSI on 9/21/17 at 11:25 a.m. The facility provided no further information prior to the exit conference on 9/21/17. This is a complaint deficiency.	F 309		
F 329 SS=E	DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS CFR(s): 483.45(d)(e)(1)-(2) 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or	F 329		10/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

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F 329	Continued From page 20 (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 27 residents (Resident #20) was free of an unnecessary medication. The findings included: The facility staff failed to follow the physician ordered parameters for the administration of anti-hypertensive medications for Resident #20. Resident #20 received Lasix 20 milligrams daily and Metoprolol 125 mg twice a day.	F 329	1. Resident #20 is currently receiving Lasix and Metoprolol per parameters as ordered by the physician. 2. Current residents receiving Lasix and Metoprolol will be reviewed to ensure medications are being administered accurately per parameters as ordered. Corrections were made as indicated. 3. Current licensed nursing staff will be educated regarding administering medications per physician ordered parameters. Nursing leadership will review	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

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F 329	Continued From page 21 The clinical record of Resident #20 was reviewed 9/21/17. Resident #20 was admitted to the facility 9/8/17 with diagnoses that included but not limited to hypertension, anxiety disorder, atherosclerotic heart disease of native coronary artery, heart failure, type 2 diabetes mellitus, hyperlipidemia, hypothyroidism, acute pyelonephritis, atrial fibrillation, urinary tract infection, glaucoma, sepsis, and muscle weakness. Resident #20's admission minimum data set had not yet been completed. The surveyor reviewed the September 2017 physician's orders. The orders read "Lasix Tablet 20 mg (milligram) (Furosemide) Give 1 tablet by mouth in the morning for BLE (bilateral lower extremity) edema Hold if systolic blood pressure is < (less than) 120 and Metoprolol Tartrate Tablet 25 mg Give 125 mg by mouth two times a day related to essential hypertension Don't give if SBP (systolic blood pressure) <120 or HR (heart rate) < than 60." The surveyor reviewed the September 2017 electronic medication administration record. The entry for Lasix was reviewed and read as ordered above. The entry for Lasix had the time of administration and the blood pressure results. The surveyor noted all the boxes for Lasix were initialed that the medication had been administered. However, the blood pressure obtained 9/16/16 at 0900 was 116/62. The blood pressure was below the physician ordered parameter. Lasix 20 mg should have been held based on the physician ordered parameters. The surveyor informed the unit manager licensed	F 329	medication administration records weekly X4 weeks to ensure accuracy of administration of Lasix and Metoprolol orders. Corrections will be made immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 10-25-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 329	Continued From page 22	F 329		

practical nurse #3 of the above concern on 9/21/17 at 8:17 a.m. L.P.N. #3 reviewed the eMAR and stated the medication was not held as it should have been. "I see it was given."

The surveyor reviewed the entry for Metoprolol. Times of administration were 8:00 a.m. and 4:00 p.m. The entry for Metoprolol did not have corresponding blood pressure results or heart rate results.

The surveyor informed the unit manager licensed practical nurse #3 that a copy of the September2017 vital signs record (blood pressure and heart rates) and the September 2017 eMAR would need to be printed.

The surveyor reviewed the blood pressure and heart rate summary form for September 2017.

Metoprolol 125 mg was administered twice per day from 9/8/17 through 9/20/17.

There were two blood pressure that were obtained that followed the physician order-9/17/17 at 8:28 a.m. and 9/19/17 at 8:54 a.m. The surveyor was unable to determine if the blood pressure and heart rates were obtained prior to the administration of the medication Metoprolol. The blood pressures and heart rates recorded were not before the medication administration times of 8:00 a.m. and 4:00 p.m.

9/9/17 14:59 (2:59 p.m.) BP=121/79
9/9/17 17:11 (5:11 p.m.) BP= 94/61
9/10/17 14:59 (2:59 p.m.) BP 108/65
9/10/17 22:59 (10:59 p.m.) BP=105/60
9/11/1713:44 (1:44 p.m.) BP=118/75
9/11/17 22:49 (10:49 p.m.) BP=129/65

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 329	Continued From page 23	F 329		

9/12/17 14:31 (2:31 p.m.) BP=110/65
9/12/1718:23 (6:23 p.m.) BP=108/61
9/12/17 22:59 (10:59 p.m.) BP=119/59
9/13/17 01:46 (1:46 a.m.) =146/84
9/13/17 10:00 BP=123/80
9/13/17 11:07 BP=123/80
9/13/17 21:45(9:45 p.m.) BP=113/58
9/14/17 14:59 (2:59 p.m.) BP=111/75
9/15/17 10:13 BP=100/63
9/15/17 18:48 (6:48 p.m.) BP=125/72
9/16/17 14:18 (2:18 p.m.) BP=116/62
9/16/16 22:59 (10:59 p.m.) BP=114/68
9/17/17 8:28 BP=127/67
9/17/17 14:59 (2:59 p.m.) BP=132/73
9/18/17 10:20 BP= 132/74
9/18/17 14:59 (2:59 p.m.) BP=105/70
9/18/17 17:19 (5:19 p.m.) BP=120/77
9/18/17 22:59 (10:59 p.m.) BP=133/82
9/19/17 8:54 BP=137/76
9/19/17 9:55 BP=134/74
9/19/17 14:59 (2:59 p.m.) BP=117/61
9/19/17 17:42 (5:42 p.m.) BP=110/67
9/19/17 17:43 (5:43 p.m.) BP= 110/67
9/20/17 9:31 BP= 144/68
9/20/17 14:59 (2:59 p.m.) BP= 140/70
9/20/17 22:59 (10:59 p.m.) BP=127/62

Pulse:
9/9/17 14:59 (2:59 p.m.) 91 bpm
9/9/17 17:11 (5:11 p.m.) 105 bpm
9/9/17 22:59 (10:59 p.m.) 69 bpm
9/10/17 14:59 (2:59p.m.) 105 bpm
9/10/17 22:59 (10:59 p.m.) 108 bpm
9/11/17 01:16 (1:16 a.m.) 85 bpm
9/11/17 13:44 91:44 p.m.) 103 bpm
9/11/17 22:49 (10:49 p.m.) 99 bpm
9/12/17 14:43 92:43 p.m.) 100 bpm
9/12/17 18:23 (6:23 p.m.) 110 bpm
9/12/17 22:59 (10:29 p.m.) 65 bpm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 329	Continued From page 24 9/13/17 01:46 (1:46 a.m.) 100 bpm 9/13/17 10:00 88 bpm 9/13/17 21:45 (9:45 p.m.) 89 bpm 9/14/17 14:59 (2:59 p.m.) 50 bpm 9/15/17 10:13 113 bpm 9/15/17 18:48 (6:48 p.m.) 100 bpm 9/16/17 22:59 (10:59 p.m.) 77 bpm 9/17/17 14:59 92:59 p.m.) 74 bpm 9/18/17 14:59 (2:59 p.m.) 110 bpm 9/18/17 22:59 (10:59 p.m.) 99 bpm 9/19/17 14:59 92:59 p.m.) 106 bpm 9/19/17 17:42 (5:42 p.m.) 78 bpm 9/19/17 17:43 (5:43 p.m.) 125 bpm 9/20/17 14:59 (2:59 p.m.) 98 bpm 9/20/17 22:59 (10:59 p.m.) 99 bpm The surveyor informed the unit manager licensed practical nurse #3 of the concern with the inability to determine when the blood pressures/pulse rates were obtained prior to the administration of Metoprolol on 9/21/17 at 8:17 a.m. The surveyor informed the administrative staff of the above issue with the administration of Lasix and Metoprolol that had specific parameters for administration in the end of the day meeting on 9/21/17 at 11:25 a.m. No further information was provided prior to the exit conference on 9/21/17.	F 329		
F 371 SS=E	FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY CFR(s): 483.60(i)(1)-(3) (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.	F 371		10/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 371	Continued From page 25 (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy, facility staff failed to store, prepare, distribute and serve food in accordance with professional standards for food service safety. Findings: The facility kitchen was toured on 9/19/17 at 1:30 PM. The DM (dietary manager) accompanied the surveyor on the initial tour through the kitchen. In the facility freezer, the surveyor observed a box of frozen squash and a box of frozen carrots. The vegetables were contained in the original boxes and bags. The bags and boxes had been opened and the product used by staff.	F 371	1. Frozen vegetables that were observed to be open to air in freezer during surveyor observation were covered. Stacked pans that were observed wet during surveyor observation were dried and put away. 2. Current frozen boxed foods were observed to ensure proper coverage for storage. Nesting pans were observed to ensure dry and no water present. Corrections were made as indicated. 3. Dietary personnel were educated regarding policy for frozen food storage and proper storage of nested pans. Dietary manager will observe freezer 3X weekly X4 weeks to ensure frozen food items are covered. Dietary manager will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

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F 371	Continued From page 26 The boxes were left open and the plastic bags inside the boxes were left open to air and were not re-sealed or covered. There was no "OPEN" date or "USE BY" date recorded by staff on the items in question. The surveyor determined the wrappers were not intact to protect the contents. The DM said they should re-cover it--but it's not sealed when it comes in. They should fold the plastic back over it though. The DM explained to the surveyor the frozen food came in enclosed but not sealed in plastic. He said the plastic was covering the food (squash/carrots) but the bag was not actually factory sealed. He did say the dietary staff should cover the food back with the plastic--but not necessarily seal it shut Several stacks of pans were observed to be on a rack. The pans were separated by the surveyor and moisture droplets were observed to be between the pans. The DM said, "That's just a few drops--they were left to air-dry. A few drops, that's all." The facility policy addressing food storage (Refrigerated and Frozen Food) was obtained on 9/20/17. It contained the following: "....Foods stored in the refrigerator of freezer will be stored in a manner which maintains the food so that it is safe to eat, and retains optimal nutrient content and aesthetic quality.....All refrigerated and frozen foods shall be stored in sealed closed/containers no less than six (6) inches off the floor....." These observations were provided to the facility administrator and DON on 9/20/17 at 3:40 PM. No additional info was provided.	F 371	inspect nesting pans 3X weekly X4 weeks to ensure properly stored and dry. Corrections will be made immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters. 5. 10-25-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 425	Continued From page 27	F 425		
F 425 SS=D	PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH CFR(s): 483.45(a)(b)(1) (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (1) Provides consultation on all aspects of the provision of pharmacy services in the facility; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure medication was available for administration for 1of 27 residents (Resident #21). The findings include: The facility staff failed to have the medication fluoxetine 20mg (for depression) available for administration on 2/4/17. Resident #21 was admitted to the facility on 2/4/17, with diagnoses that included but were not limited to: arthritis, depression, left hip degenerative joint disease with joint replacement and muscle weakness. Resident #21's initial minimum data set (MDS) assessment had not been completed. The physician admission order sheet dated	F 425	1. Resident #21 no longer resides in the facility. 2. Current residents admitted to the facility in the last 14 days that receive antidepressant medication will be reviewed to ensure medication was available at the time of admission and that doses are being administered as ordered by MD. Corrections will be made as indicated. 3. Nursing staff will be educated regarding procedures for acquiring medications from the pharmacy and medication administration to include notification of the pharmacy and MD as indicated. Unit Managers and/or designees will review the missing administrations report and clinical dashboard daily 5x weekly X4 weeks to identify any missed administrations. Any issues will be corrected immediately at the	10/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 425	Continued From page 28 2/3/17 contained an order for: "fluoxetine 20mg. one by mouth in the evening" However, the medication was not available at the facility. Resident #17's electronic medication administration record (eMARs) was reviewed. The eMAR also contained the order: "fluoxetine 20mg. one by mouth in the evening" the medication was documented as administered. The medication fluoxetine 20mg. one by mouth in the evening" was not available for administration by the staff on 2/4/17 during the evening. The surveyor also spoke to the nurse who had documented that the fluoxetine had been administered. LPN #1 stated "She was very anxious on admission. I called the pharmacy to check on delivery, and it wasn't in the stat box either. Her husband went home and got her fluoxetime and brought it in the bottle. I checked the medication and administered her medication brought from her home. On 9/21/17 at 11:25 pm the administrative staff were informed of the medication not being available. Prior to exit on 9/21/17, no further information was provided by the facility related to the fluoxetine being unavailable for administration.	F 425	time of identification 4. Process will be reviewed in QA committee for two quarters. 5. 10-25-17	
F 441 SS=D	INFECTION CONTROL, PREVENT SPREAD, LINENS CFR(s): 483.80(a)(1)(2)(4)(e)(f) (a) Infection prevention and control program. The facility must establish an infection prevention	F 441		10/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 441	Continued From page 29	F 441		

and control program (IPCP) that must include, at a minimum, the following elements:

(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2);

(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;

(ii) When and to whom possible incidents of communicable disease or infections should be reported;

(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;

(iv) When and how isolation should be used for a resident; including but not limited to:

(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 441	Continued From page 30 (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview, and clinical record review, the facility staff failed to follow infection control guidelines/practice during a wound care observation for 1 of 27 residents (Resident #3). The findings include: The facility staff failed to follow infection control practices at the end of wound care for Resident #3. Resident #3 was admitted to the facility 3/21/17 with diagnoses that included but not limited to nontraumatic subarachnoid hemorrhage, esophageal reflux disorder, gastrostomy status, pressure ulcer, and adult failure to thrive.	F 441	Resident #3 is currently receiving wound care according to appropriate infection control practices specific to hand washing. 2. Current licensed nurses will be observed by nursing leadership staff during a treatment pass observation to ensure hand washing practices are being followed. Corrections will be made as indicated. 3. Licensed nursing staff will be educated regarding infection control procedures specific to hand washing during wound care. Treatment pass observations will be performed 3X weekly X4 weeks. Corrections will be made immediately at the time of identification.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 441	Continued From page 31 A review of Resident #3's clinical record revealed on the most recent minimum data set (MDS) with an assessment reference date of 6/27/17, the facility staff assessed the resident to be in a comatose state. A wound care observation was conducted on 9/20/15 at approximately 9:05 am, for Resident #3. The nurse performing the wound care (LPN#1) was observed to not follow infection control practices at the end wound care. LPN#1 was observed cleaning the two open stage III wound. The wound care was performed without issue. The nurse finished the wound care and removed her gloves placing them in the trash with the disposed dressing. She then bagged the trash picked it up placed it under one arm and picked up the unused clean dressing and left the room. She put the trash in the dirty utility room trash can and went to the desk. Informed the surveyor she was taking the unused dressing to the cart to place with Residents dressings. After the wound care was complete the nurse was asked why she didn't wash her hand after removing her gloves and why she placed the trash under her arm against her clothing. "She said I did use had gel. I did place the trash under my arm " The administrator, and director of nursing, was informed of the findings during a meeting with the survey team on 9/21/17 at 11:25 a.m. Prior to exit no further information was provided to the surveyor related to the infection control issue.	F 441	4. Process will be reviewed in QA committee for two quarters. 5. 10-25-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 514	Continued From page 32	F 514		
F 514 SS=D	RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE CFR(s): 483.70(i)(1)(5) (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by:	F 514		10/25/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 514	Continued From page 33 Based on staff interview and clinical record review, the facility staff failed to ensure an accurate and complete clinical record for 1 of 27 residents (Resident #22). The findings included: 1. The facility staff failed to document physician notification of Resident #22's emergency room visit recommendations on 3/23/17 and failed to describe a reddened area on the right heel. Resident #22 was admitted to the facility 4/15/16 and readmitted 3/16/17 with diagnoses that included but not limited to right femur fracture with repair, diabetes mellitus type 2, light headed, tingling, pre-syncope, coronary artery disease (CAD), hypertension, deep vein thrombosis, pulmonary embolus, compression fracture of L4 lumbar vertebrae, degenerative disc disease (DDD), peripheral edema, atypical chest pain, pneumonia, syncope and collapse, and right leg pain. Resident #22's admission minimum data set (MDS) with an assessment reference date of 3/23/17 assessed the resident with a brief interview for mental status as 15 out of 15 in Section C BIMS Summary Score. There was no evidence of delirium, psychosis, or behaviors assessed on the admission MDS. Section G Functional Status assessed the resident for bed mobility as 7/0 (activity occurred only once or twice) and required no physical assist from staff. Transfers occurred only once or twice (7) and required no physical help from staff. Walk in corridor and walk in room occurred only once or twice and required two + persons physical assist. Resident #22 required extensive assistance of	F 514	1. Resident #22 no longer resides in the facility. 2. Current residents most recent weekly skin assessments were reviewed to ensure accurate documentation of description of changes in skin status. Residents with ER visits in the last 30 days were reviewed to ensure notification of attending MD with ER visit recommendations. Corrections were made as indicated. 3. Nursing staff will be educated regarding accurate documentation of description of changes in skin status and process for review of consultation reports upon receipt. Unit managers and/or designees will review the alerts listing report, review the 24 hour report, and will visualize residents daily 5X week during rounds X4 weeks to identify any skin changes and ensure accurate documentation. Unit managers/designee will review consultation reports daily 5X weekly X4 weeks to ensure documentation is present for MD notification. Corrections will be made immediately at the time of identification. 4. Process will be reviewed in QA committee for two quarters 5. 10-25-17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 514	Continued From page 34	F 514		

two + persons for locomotion on and off unit. Resident #22 required extensive assistance of two + persons for dressing and personal hygiene and required extensive assistance of one person for bathing. Eating occurred only once or twice and required set up help only. Section M Skin Conditions assessed that Resident #22 had no unhealed pressure ulcers but was at risk for the development of pressure ulcers. Resident #22 was assessed to have a surgical wound.

The progress note dated 3/22/17 at 19:40 (7:40 p.m.) read "Res with VS (vital signs) wnl (within normal limits) except with decreased heart rate of 42 apically. No s/s (signs or symptoms) of distress noted at this time. ____ other #6 called and n/o (new order) received for EKG. Res along with daughter made aware of n/o. Will continue to monitor." Written by L.P.N. #1.

Progress note dated 3/22/17 23:37 (11:37 p.m.) read "EKG results received and called into other #6. N/o received to send to ER (emergency room) for evaluation. Rsd aware and daughter notified."

Progress note dated 3/23/17 at 07:57 read "Res returned to facility from ____ (name of hospital omitted). Only orders received were to cont (continue) to monitor for bradycardia. RP aware. Res currently resting in bed, call light within reach." Progress note written by L.P.N. #5.

The surveyor reviewed the emergency visit note dated 3/23/17. The HPI (history of present illness) read "Resident #22 is a 91 y.o. (year old) male who presents to _____ (name of hospital) ED (emergency department) from Springtree nursing home with bradycardia. Heart rate in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 514	Continued From page 35	F 514		

40's after being awaken at the nursing home. Pt (patient) is without complaint, denies any chest pain, SOB (shortness of breath), nausea, fever, chills, lightheadedness. Denies any recent change in medications. Pt with hx (history) of PE (pulmonary embolus) in 1985, not currently on blood thinners due to frequent falls. Pt placed in nursing home for recovery from recent hip fracture. Additional hx of DDD (degenerative disc disease), diabetes, HTN (hypertension), CAD (coronary artery disease), BPH (benign prostatic hypertrophy). Former smoker. No other medical complaints at this time. Medical Decision Making-- Only logical potential cause is amlodipine. Recommended stopping this medication and rechecking at nursing home. With essential normal EKG, asymptomatic presentation feel no indication for admission at this time. Final Impression: Bradycardia, drug induced. Asymptomatic bradycardia with first degree heart block all electrolytes normal I suspect amlodipine as cause advised to stop and reassess blood pressure and pulse in 48 hours "doctor with scribe." Discharge Instructions: Stop amlodipine reassess pulse in 48 hours return for any symptoms difficulty breathing chest pain lightheadedness. Written by ____ other #7 (medical doctor)."

The clinical record did not reveal evidence the physician was informed of the recommendations from the ER visit on 3/23/17.

The surveyor interviewed licensed practical nurse #5 on 9/21/17 at 9:50 a.m. The surveyor asked if she remembered Resident #22. L.P.N. #5 stated vaguely. The surveyor provided the note written by her on 3/23/17 and the ER visit recommendations. L.P.N. #5 stated "I always

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 514	Continued From page 36	F 514		

report everything to the doctor. Suppose to document. It's a rule. Must have been a mishap. I left it out."

The surveyor interviewed Resident #22's physician (other #4) on 9/21/17 at 10:00 a.m. Other #4 stated she looked at the recommendations but didn't discontinue the Norvasc. Other #4 provided the surveyor with her application on her phone titled "Epocrates" and looked up Norvasc. Bradycardia was not listed as a side effect. Other #4 stated Resident #22's heart rate had been normal up until 3/22/17. Other #4 stated she knew it wasn't the Norvasc. Other #4 stated the low heart rate was caused by something else but didn't know what.

The physician followed up on the emergency room visit and recommendations but declined the recommendation to discontinue the Norvasc. However, L.P.N. #5 failed to document when the physician was notified of the emergency room doctor's recommendations.

(b) The facility staff failed to document accurately a reddened area on the right heel.

The weekly skin assessment dated 3/24/17 read under notes "Hip and sacrum large bruise in fading stages, scab to sacrum, pitting edema +1 edema to BLE (bilateral lower extremity) right heel reddened treatment in place." There was a progress note written 3/24/17 at 22:37 (10:37 p.m.). However, there was no documentation that the physician had been informed of the pitting edema or the reddened area to the right heel. Note written by licensed practical nurse #4. L.P.N. #4 was not available for an interview per nursing staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495378	A. BUILDING _____ B. WING _____	C 09/21/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGTREE HEALTHCARE & REHAB CENTER	3433 SPRINGTREE DRIVE ROANOKE, VA 24012

(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 514	Continued From page 37 The surveyor interviewed the director of nursing on 9/21/17 at 11:00 a.m. concerning the weekly skin assessment on 3/24/17. The DON stated the first thing about the skin assessment was don't use the word "reddened." The DON stated that doesn't describe the wound. The DON stated more documentation was needed to describe the area on the heel. The documentation was lacking. The DON stated more information was needed before the area would be determined to be a pressure. The DON stated a progress note should be written and the physician informed. The DON stated "Technically if a treatment is in place, a nurse doesn't order it." The surveyor was unable to locate a treatment for the reddened heel. The surveyor informed the administrative staff of the incomplete documentation of Resident #22's clinical record in the end of the day meeting on 9/21/17 at 11:25 a.m. No further information was provided prior to the exit conference on 9/21/17.	F 514		