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 _____	03/25/2021

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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
E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 3/23/21 through 3/25/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey, biennial State Licensure Inspection and COVID-19 focused infection control survey was conducted 03/23/21 through 03/23/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow. The census in this 120 certified bed facility was 93 at the time of the survey. The survey sample consisted of 19 current Resident reviews and 3 closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's	F 550		4/23/21

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

Electronically Signed | 04/14/2021

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to maintain dignity for 1 of 19 residents, Resident #48. The findings included: For Resident #48 the facility staff failed to maintain dignity as evidenced by a posting above resident's bed reading "She is a feeder!!"	F 550	The statements made in the following plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies nor the reported conversations and other information cited in support of the alleged deficiencies. The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth	

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F 550	Continued From page 2 Resident #48's face sheet listed diagnoses which included but not limited to dementia, hypertension, atrial fibrillation, depression, and anxiety. The most recent quarterly MDS (minimum data set) with an ARD (assessment reference date) of 02/25/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out 15 in section C, cognitive patterns. Section G, functional status coded the resident as needing extensive assistance of one person in the area of eating. Resident #48's comprehensive care plan was reviewed and contained a care plan for "The resident has an ADL (activities of daily living) self-care performance deficit r/t (related to) deconditioning and gait/balance issues, feeding assistance". The interventions for this care plan included "Eating: The resident is a feeder" Surveyor observed Resident #48 on 03/23/21 at approximately 4:20 pm. Resident was resting in bed. Surveyor observed a printed sign on wall above head of bed with a pink flower and the words "Nectar-thickened liquids". Hand-written on this sign in black marker in large lettering were the words "She is a feeder!!". Surveyor observed this sign again on 03/24/21 at approximately 8:40 am and 11:25 am and on 03/25/21 at approximately 8:55 am Surveyor spoke with the UM (unit manager) on 03/25/21 at approximately 9:55 am regarding the sign above the resident's bed. UM immediately removed the sign and stated that they think the resident's family had placed it there. Surveyor spoke with resident's adult child on 03/24/21 via	F 550	in the plan of correction. The following plan of correction constitutes the facility□s allegation of compliance. All alleged deficiencies cited have been or will be corrected by the date or dates indicated. F550 1. Resident's sign designating eating assistance was removed from #48 at the time of survey. 2. Current residents that need assistance with eating were reviewed to determine the presence of signage in room. Corrections were made as necessary. 3. Current nursing staff were educated regarding dignity to include respectful identification and communication of eating assistance needs. 4. Unit Manager or designee will observe all Resident rooms per unit per week x4 weeks to ensure no signage present in rooms. Any issues will be addressed immediately at the time of observation. Results will be forwarded to quarterly QA committee meeting. 5. 4/23/2021 6. Elizabeth Finney, DON	

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F 550	Continued From page 3 telephone at approximately 1:30 pm and adult child stated that they had only been having window visits with the resident. The concern of the facility staff failing to protect the residents dignity by labeling them as a "feeder" was discussed with the administrative staff during a meeting on 03/25/21 at approximately 12:45 pm No further information was provided prior to exit.	F 550		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to ensure residents with pressure ulcers receive necessary treatment and services to promote healing as evidenced by failure to initiate wound treatment for 1 of 19 residents, Resident #51. The findings included:	F 686	F686 1. Treatment was initiated to Resident #51□s left great toe on 3/24/2021. 2. Residents with current pressure ulcers were reviewed to ensure presence of treatment order. Corrections were made as necessary. 3. Current licensed nursing staff will be	4/23/21

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F 686	Continued From page 4 For Resident #51, the facility staff failed to initiate treatment to a SDTI (suspected deep tissue injury) to the left great toe noted on readmission on 3/18/21. Resident #51's diagnosis list indicated diagnoses, which included, but not limited to COVID-19, Pneumonia Unspecified Organism, Unspecified Diastolic (Congestive) Heart Failure, Permanent Atrial Fibrillation, Acute Respiratory Failure Unspecified Whether with Hypoxia or Hypercapnia, and Toxic Liver Disease with Hepatic Necrosis without Coma. The most recent admission MDS (minimum data set) with an ARD (assessment reference date) of 2/15/21 assigned the resident a BIMS (brief interview for mental status) score of 11 out of 15 in section C, Cognitive Patterns. Resident #51 was coded as requiring extensive assistance with bed mobility, transfers, dressing, toilet use and limited assistance with personal hygiene in section G, Functional Status. A review of Resident #51's clinical record revealed a "Weekly Skin Evaluation" dated 3/18/21 that documented an area to the resident's "left hammer toe" with the described type as "pressure" measuring "0.1" in length and "0.1" in width with the stage documented as "suspected deep tissue injury". A nursing progress note dated 3/18/21 17:55 (5:55 pm) stated in part, "Resident arrived for admission this shift at 1400 (2:00 pm) via ambulance transport from (hospital name omitted)" and "Resident skin is clean dry to touch, bruising BUE (bilateral upper extremities), resident has moon boots on at this time, resident has open DTI (deep tissue injury) to sacrum at	F 686	educated regarding pressure ulcer treatment initiation at the time the ulcer is identified. 4. Unit Manager or Designee will observe Residents with pressure ulcers weekly x4 weeks to ensure treatments have been initiated. Any issues will be addressed immediately at the time of observation. Process will be reviewed in quarterly QA committee meeting. 5. 4/23/2021 6. Elizabeth Finney, DON	

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F 686	Continued From page 5	F 686		

this time".

Surveyor reviewed Resident #51's current physician's orders and March 2021 TAR (treatment administration record) and was unable to locate a treatment order for the area to the resident's left great toe.

On 3/24/21 at 8:45 am, surveyor spoke with the DON (director of nursing) and the regional nurse concerning the documentation of a SDTI to Resident #51's left great toe without an order for treatment. DON stated they did not know about the area but they will go and see. DON returned at 9:40 am and stated they looked at the area and it is "dark purple", DON further stated Resident #51 has "moon boots" in place and the supervisor looked at the area last night and is entering orders.

On 3/24/21, surveyor noted a new order in Resident #51's clinical record dated 3/24/21 stating, "Cleanse left great toe with NS (normal saline) and apply skin prep BID (twice daily) every day and night shift for DTI", according to the March 2021 TAR, the order date was "3/24/21 0905 (9:05 am)".

On 3/24/21 at 2:25 pm, surveyor spoke with Resident #51 and attempted to ask the resident about the area to their left great toe, however, the resident was unable to coherently answer the surveyor's questions.

On 3/24/21 at approximately 4:00 pm, the survey team notified the administrator, DON, and the regional nurse of the concern of the area to Resident #51's left great toe identified on 3/18/21 that did not have an order for treatment.

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F 686	Continued From page 6 No further information regarding this issue was presented to the survey team prior to the exit conference on 3/25/21.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, facility staff failed to ensure the resident environment remains as free of accident hazards as is possible as evidenced by the presence of an unsecured oxygen cylinder located in the hallway on 1 of 2 facility units, Unit 1. The findings included: The facility staff failed to secure a portable oxygen cylinder on Unit 1 that remained one half full of oxygen. On 3/23/21 at 3:57 pm, surveyor #1 observed an unsecured portable oxygen cylinder located in the hallway of the COVID-19 isolation unit placed against the wall and touching a three-drawer plastic caddy containing PPE (personal protective equipment) supplies on one side and the bristles of a broom on the other side. The portable	F 689	F689 1. Portable oxygen cylinders were secured by staff at time of survey. 2. All oxygen tanks in facility were reviewed to ensure oxygen cylinders are stored securely. Corrections were made as necessary. 3. Facility staff will be educated regarding oxygen cylinder storage to include location of holders and secure storage when in use. 4. Unit Manager or Designee will observe common areas and resident rooms daily for one week then weekly x4 weeks to ensure proper storage of tanks. Any issues will be addressed immediately at the time of observation. Process will be reviewed in quarterly QA committee meeting. 5. 4/23/2021 6. Elizabeth Finney, DON	4/23/21

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F 689	Continued From page 7	F 689		

oxygen cylinder included an attached Linde Integrated Valve. No residents were in the hallway at the time of the observation. At 4:05 pm, surveyor spoke with CNA (certified nursing assistant) #1 who stated the oxygen cylinder may have come off the back of a wheelchair, CNA #1 picked up the oxygen cylinder and carried it out of the COVID isolation unit through a plastic zippered wall and placed it in the seat of an empty wheelchair directly outside of the plastic divider wall, the cylinder remained unsecured. At 4:54 pm, surveyor #2 observed the portable oxygen cylinder in the seat of the wheelchair where it was previously placed by CNA #1. Surveyor #2 confirmed the location of the half full oxygen cylinder with LPN (licensed practical nurse) #1. Surveyor #2 observed five empty oxygen holders located in the oxygen storage area. At approximately 5:14 pm, surveyor #2 observed that the unsecured portable oxygen cylinder remained in the same location in the seat of the wheelchair. At approximately 5:30 pm, surveyor #1 observed CNA #1 with the portable oxygen cylinder in their hands walking towards the plastic zippered divider wall exit of the COVID observation area of Unit 1.

On 3/24/21 at approximately 4:00 pm the survey team notified the administrator, DON (director of nursing), and the regional nurse of the concern of the observation of the unsecured portable oxygen cylinder on Unit 1.

Surveyor requested and received the facility policy entitled, "Respiratory/Oxygen Equipment" which states in part:
"Oxygen Cylinder Use
1. Maintain proper storage, internal transportation and use of oxygen cylinders.

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F 689	Continued From page 8 Oxygen cylinders must be kept secure. a. Do not allow oxygen cylinder to be overturned or sustain a blow that may break off the top. b. Tanks must be in a cart or stand made for the type of tank being used or stored in a rack." No further information regarding this issue was presented to the survey team prior to the exit conference on 3/25/21.	F 689		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 693		4/23/21

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F 693	Continued From page 9 by: Based on observation, staff interview, clinical record review, and facility document review, facility staff failed to ensure a resident who is fed by enteral means receives the appropriate treatment to prevent complications as evidenced by failure to label and date tube feeding formula for 1 of 19 residents, Resident #67. The findings included: For Resident #67, facility staff failed to label and date tube feeding formula being administered on 3/23/21. Resident #67's diagnosis list indicated diagnoses, which included, but not limited to Parkinson's Disease, Pneumonitis due to Inhalation of Other Solids and Liquids, Gastrostomy Status, Dysphagia Oropharyngeal Phase, and COVID-19. The most recent 5 day MDS (minimum data set) with an ARD (assessment reference date) of 3/08/21 assigned the resident a BIMS (brief interview for mental status) score of 5 out of 15 in section C, Cognitive Patterns. In section K, Swallowing/Nutritional Status, Resident #67 was coded as receiving 51% or more total calories received through parenteral or tube feeding and 501 cc/day or more of average fluid intake per day by IV or tube feeding while a resident of the facility and within the last 7 days. On 3/23/21 at 3:36 pm, surveyor observed Resident #67 in bed with a Kangaroo refillable tube feeding formula bag hanging and attached to a pump running at 40 ml/hour. The Kangaroo formula bag was not labeled with the name of the formula and did not include a date and time when	F 693	F693 1. Resident #67□s tube feeding formula was labeled and dated at time of survey. 2. Current residents that receive tube feeding were reviewed to determine the presence of date and labeling on the formula bag. Corrections were made as necessary. 3. Current licensed nursing staff will be educated regarding policy for care of a patient with feeding tube to include properly dating and labeling of formula bag. 4. Unit Manager or Designee will observe Residents receiving tube feeding formula weekly x4 weeks to ensure accuracy of labeling of formula bag. Any issues will be addressed immediately at the time of observation. Process will be reviewed in quarterly QA committee meeting. 5. 4/23/2021 6. Elizabeth Finney, DON	

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F 693	Continued From page 10 started. The Kangaroo formula bag contained approximately 700 ml of a light brown liquid. Surveyor notified LPN (licensed practical nurse) #1 who stated they hung the formula "this morning" and will date it. Resident #67 has a current physician's order dated 3/15/21 stating "Enteral Feed Order every day and night shift Osmolite 1.5 40 ml/hr goal is 60 ml/hr". The order was signed off on the March 2021 MAR (medication administration record) as being administered by LPN #1 on 3/23/21 for day shift. Surveyor requested and received the facility policy entitled, "Care of the Patient with a Feeding Tube" which states in part: Procedure: General Principles related to Enteral Feedings 3. Properly label tube feeding equipment/accessories with the individual's name, room number, date, type of feeding, rate and start time as indicated. On 3/24/21 at approximately 4:00 pm, the survey team notified the administrator, director of nursing, and the regional nurse of the concern of Resident #67's tube feeding not being labeled or dated when hung by the nurse. No further information regarding this issue was presented to the survey team prior to the exit conference on 3/25/21.	F 693		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be	F 761		4/23/21

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F 761	Continued From page 11 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff failed to properly store medications in locked compartments on 1 of 2 facility units, Unit 1. The findings included: On 3/24/21 at 2:50 pm, surveyor observed an unattended medication cart in the hallway of Unit 1 located in the plastic zippered area of the COVID-19 observation area between resident rooms (number omitted) and (number omitted). On top of the medication cart were eight (8) blister pack cards of medications. Surveyor	F 761	F761 1. Medication cards were secured by licensed nurse at time of survey. 2. Current medication storage areas were reviewed to ensure medications are securely stored and locked. Corrections were made as necessary. 3. Current licensed nursing staff will be educated regarding policy for securing medications in locked compartments. 4. Unit Manager or Designee will observe medication storage areas 3x weekly x4 weeks to ensure that all medications are secured and locked. Any issues will be	

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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 761	Continued From page 12 remained beside the medication cart until 2:55 pm when LPN (licensed practical nurse) #1 entered through a plastic zippered divider wall from the COVID isolation area. LPN #1 stated "I just came back from break" and someone delivered them. Surveyor asked LPN #1 if the medications were delivered from the pharmacy and LPN #1 stated "yes". In the direct presence of LPN #1, surveyor observed one blister pack card of Metformin HCL 500 mg (an antidiabetic used to treat diabetes) containing 30 tablets and seven (7) blister pack cards of Methocarbamol 500 mg (a skeletal muscle relaxant used to treat muscle spasms) containing 30 tablets each. LPN #1 picked up the medication cards and began placing them in the medication cart. On 3/24/21 at approximately 4:00 pm, the survey team notified the administrator, director of nursing, and the regional nurse of the concern of the unattended medications observed on top of the medication cart on Unit 1. Surveyor requested and received the facility policy entitled, "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" which states in part, "3.3 Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors". No further information regarding this issue was presented to the survey team prior to the exit conference on 3/25/21.	F 761	addressed immediately at the time of observation. Process will be reviewed in quarterly QA committee meeting. 5. 4/23/2021 6. Elizabeth Finney, DON	