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 (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 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 		8483 10(a)(14) Notifi	cation of Changes					
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(ii) When making notification under paragraph (g) (14)(i) of this section, the facility must ensure that			lity as specified in					
(14)(i) of this section, the facility must ensure that								
ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE		(14)(I) of this section,	the facility must ensure that					
		 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	 E		TITLE		(X6) DATE

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

09/15/2019

CENTER	S FOR MEDICARE &	ND HUMAN SERVICES MEDICAID SERVICES					MAPPROVE D. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495378		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495378	B. WING			C / 28/2019	
NAME OF PI	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGTI	REE HEALTHCARE & RI	EHAB CENTER			433 SPRINGTREE DRIVE		
				<u>к</u>	OANOKE, VA 24012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 580	Continued From page	e 1	F	580			
	all pertinent informati	on specified in §483.15(c)(2)					
	physician.	ided upon request to the					
	(iii) The facility must	also promptly notify the					
	resident and the resident when there is-	dent representative, if any,					
		n or roommate assignment					
	as specified in §483.						
		lent rights under Federal or ons as specified in paragraph					
	(e)(10) of this section						
	(iv) The facility must	record and periodically					
		mailing and email) and					
	phone number of the representative(s).	resident					
	representative(s).						
	§483.10(g)(15)						
		osite distinct part. A facility istinct part (as defined in					
		e in its admission agreement					
	- ,	tion, including the various					
	· ·	se the composite distinct					
		y the policies that apply to					
	room changes betwe under §483.15(c)(9).	en its different locations					
		Γ is not met as evidenced					
	-	, review of clinical records,			The statements made in this plan of		
	and review of facility	documents, it was			correction are not an admission and	do	
		y staff failed to timely notify a			not constitute agreement with the all	eged	
		tive and medical provider of dition for one (1) of four (4)			deficiencies herein. To remain in compliance with all state and federal		
	sampled residents (F				regulations, the center has taken or take the actions set forth in this Plan	will	
	The findings included	i:			Correction. In addition, the following	ı plan	
	Facility staff member	s failed to notify Resident			constitutes the center⊡s allegation o compliance. All alleged deficiencies		
	-	er and responsible party of a			been or will be corrected by the date		
	change in the resider	nt's skin assessment. On			indicated.		

Facility ID: VA0380

If continuation sheet Page 2 of 10

	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION		NO. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:	. ,	B	· · · ·	OMPLETED
						С
		495378	B. WING			08/28/2019
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP C	ODE	00/20/2010
_				3433 SPRINGTREE DRIVE		
SPRINGT	REE HEALTHCARE & RE	EHAB CENTER		ROANOKE, VA 24012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 580	Continued From page	- ²	F 58			
1 500			F DC			
	discovered an area o	esident #C1's adult child f skin impairment on		1. Resident # C1⊡s resp	onsible party	
		rm. The facility staff's		and provider notified of skir		
		area of skin impairment		May 25th	rinpaintent	
	identified that facility	•		2. Current residents' wee	kly skin	
	-	es in the resident's skin prior		assessments were reviewe	•	
		by the resident's adult child.		notification of provider and		
	•	and by or provided to the		party (RP) for any new skin		
		e facility staff notified the		Corrections were made as		
		e party or the resident's		3. Current licensed staff v	•	
		r to the skin area being		regarding professional nurs	ing standards	
	found by the resident	's family member.		to notify provider and RP w		
		-		condition to include skin im		
	Resident #C1 was ac	mitted to the facility 5/23/14.		Nurse managers will review		
	Resident #C1's diagr	noses included, but were not		skin assessments and wou	nd sheets to	
	limited to: heart failu	re, high blood pressure,		assure documentation of co	ommunication	
	pneumonia, diabetes	, and dementia. Resident		is included. Nurse administ	ration will	
	#C1's quarterly minin	num data set (MDS)		review a 10% sample of co	mpleted skin	
	assessment, with an	assessment reference date		assessments weekly x 4 we	eeks to ensure	
	(ARD) of 6/18/19, had	d the resident assessed as		identified impairments are o		
	rarely/never understo	ood therefore a BIMS (Brief		to MD and RP. Corrections	will be made if	
	Interview for Mental S	Status) score could not be		necessary.		
		ment also had the resident		4. Process will be reviewed	ed in QA	
		g total dependence on staff		committee for one quarter.		
	for bed mobility, trans	sfers, dressing, eating, and				
	The following informa	ation was found in a facility				
		d "Injuries Unknown Origin"				
		e of 11/4/16): "Injuries of				
		ies not witnessed or patient				
		ppened) will be handled the				
	same as an allegation	n of mistreatment, neglect,				
	or abuse and must be	e reported to the Center				
		all patients involved in the				
		licensed nurse must notify				
	the following: a. Atter					
	Responsible Party	"				

If continuation sheet Page 3 of 10

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE & I				FOR	D: 04/29/2022 MAPPROVED O. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	495378	B. WING		30	C 8/28/2019	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO			
			3433 SPRINGTREE DRIVE			
SPRINGTREE HEALTHCARE & RE	HAB CENTER		ROANOKE, VA 24012			
PREFIX (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
 policy/procedure titled Notification" (with an a "The Unit Manager is that notifications by th physicians and respo- change in the care of occurred The Chan notifying the Physicia Responsible Party (R change related to the Notification will occur in the patient's conditi The following informa as part of a late-entry documented for 5/25/ assessment this a.m. to be dermatitis was r below the ac (antecut infected. There was s filled blisters along wi scabbed over. Area m 10cm x 4.5cm with irr responded to this nur- was in any pain by sh This nurse spoke with resident who reported involved in any type of (his/her) arm. A full he completed and no oth nature noted. (Adult of bedside and aware of name omitted) was up that (his/her parent) h arm. (He/She) voiced 	tion was found in a facility d "Documentation and effective date of 2/1/15): responsible for ensuring he Charge Nurses to nsible parties regarding a the patient have properly rge Nurse is responsible for n (MD) and/or the P) whenever there is a care of the patient. when there is a: change ion" tion was found documented nursing progress note '19 at 10:30 a.m.: "On a [sic] area of what looked noted to left inner forearm bital). Area did not look some scattered small fluid th healing ones that were measured approximately regular edges. Resident se when asked if (he/she) naking (his/her) head no. n staff involved in the care of d that resident had not been	F 58				

Facility ID: VA0380

If continuation sheet Page 4 of 10

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/29/2022 MAPPROVED). 0938-0391	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	-	(X3) DATE SURVEY COMPLETED		
		495378	B. WING				C 28/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S	TATE, ZIP CODE			
SPRINGT	REE HEALTHCARE & RE	HAB CENTER		3433 SPRINGTREE DRIVE ROANOKE, VA 24012	i			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 580	reported to this nurse occurred. (Physician's at this time, awaiting (Will continue to monit On 8/28/19 at approxi facility's Director of Nu Director of Nursing (A about the Resident #0 impairment. It was co family member brough facility staff's attention DON reported that an impairment revealed th had knowledge of the family asking about it. was identified that a li noting "scattered/mult one area in the middle appeared whitish in co the family member fin On 8/28/19 at 9:30 a.) there was no clinical of finding prior to the fam DON also confirmed to members, with knowle have notified the resid the resident's response On 8/28/19 at 9:40 a.1 members to timely no provider and response a survey team meetin	In the provided and the provided and the provided and pro	F 58	0				

Facility ID: VA0380

If continuation sheet Page 5 of 10

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		CONSTRUCTION		O. 0938-039 E SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			• •			COMPLETED	
		B. WING			C 08/28/2019		
NAME OF PI	ROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE		
SPRINGT	REE HEALTHCARE & RE	EHAB CENTER			433 SPRINGTREE DRIVE ROANOKE, VA 24012		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTI	ON	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)		COMPLETION
F 580	Continued From page	e 5	F	580			
	This is a complaint de	eficiency.					
F 842 SS=D		dentifiable Information 483.70(i)(1)-(5)	F	842			10/1/19
		nt-identifiable information. elease information that is					
	resident-identifiable to						
	(ii) The facility may re						
	resident-identifiable to						
		ontract under which the agent disclose the information					
	•	the facility itself is permitted					
	to do so.						
	§483.70(i) Medical re						
		rdance with accepted ds and practices, the facility					
		al records on each resident					
	that are-						
	(i) Complete;						
	(ii) Accurately docum						
	(iii) Readily accessibl(iv) Systematically or						
	§483.70(i)(2) The fac	ility must keep confidential					
	all information contain	ned in the resident's records,					
		n or storage method of the					
	records, except wher (i) To the individual, c						
		permitted by applicable law;					
	(ii) Required by Law;						
		yment, or health care					
		tted by and in compliance					
	with 45 CFR 164.506 (iv) For public health	; activities, reporting of abuse,					
		violence, health oversight					
	activities, judicial and	l administrative proceedings,					
	law enforcement purr	poses, organ donation					

Facility ID: VA0380

If continuation sheet Page 6 of 10

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 04/29/2022 FORM APPROVED OMB NO. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495378	B. WING _		C 08/28/2019
NAME OF PI	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIF	P CODE
SPRINGTI	REE HEALTHCARE & RE	HAB CENTER		3433 SPRINGTREE DRIVE ROANOKE, VA 24012	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION O THE APPROPRIATE DATE
F 842	purposes, research p medical examiners, fr a serious threat to he by and in compliance §483.70(i)(3) The fac record information ag unauthorized use. §483.70(i)(4) Medical for- (i) The period of time (ii) Five years from th there is no requireme (iii) For a minor, 3 yea legal age under State §483.70(i)(5) The me (i) Sufficient informati (ii) A record of the res (iii) The comprehensi provided; (iv) The results of any and resident review e determinations condu (v) Physician's, nurse professional's progree (vi) Laboratory, radiol services reports as re This REQUIREMENT by: Based on interviews, and review of facility determined the facility	urposes, or to coroners, uneral directors, and to avert alth or safety as permitted with 45 CFR 164.512. ility must safeguard medical painst loss, destruction, or required by State law; or e date of discharge when ent in State law; or ars after a resident reaches e law. dical record must contain- on to identify the resident; sident's assessments; ve plan of care and services y preadmission screening evaluations and ucted by the State; e's, and other licensed ss notes; and logy and other diagnostic equired under §483.50. T is not met as evidenced , review of clinical records, documents, it was y staff failed to ensure te clinical records for one (1) esidents (Resident #C1).	F	 Documentation of sk was added to resident C² 25th. Current residents we determine appropriate do skin impairments. Any ur skin impairments were co documented per nursing 	1 chart on May ere assessed to ocumentation of ndocumented prrected and

Event ID: DEF511

Facility ID: VA0380

If continuation sheet Page 7 of 10

				LE CONSTRUCTION		<u>10. 0938-039</u> TE SURVEY
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · · ·	MPLETED
						С
		495378	B. WING		0	8/28/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
SPRINGTREE HEALTHCARE & REHAB CENTER			3433 SPRINGTREE DRIVE ROANOKE, VA 24012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 842	Continued From page	e 7	F 84	.2		
		s failed to timely document a		3. Current licensed staff we	re educated	
		C1's skin assessment.		on documenting and reporting		
				of skin condition per policy.		
		dmitted to the facility 5/23/14. noses included, but were not		nurses will report any new ch condition to nurse administration	•	
	-	re, high blood pressure,		administration will audit 10%		
	pneumonia, diabetes	, and dementia. Resident		skin weekly X 4 weeks to dete	ermine that	
	#C1's quarterly minin	, , , , , , , , , , , , , , , , , , ,		there are no undocumented s		
		assessment reference date d the resident assessed as		impairments. Corrections will necessary.	be made as	
	, ,	ood therefore a BIMS (Brief		4. Process will be reviewed	in QA next	
		Status) score could not be		quarter.		
		ment also had the resident				
	-	g total dependence on staff sfers, dressing, eating, and				
	personal hygiene.	siers, dressing, eating, and				
		ation was found in a facility d "Documentation Summary"				
	(with an effective date					
		nd CNAs will document all				
	pertinent nursing assessments, care					
	interventions, and fol record."	low up actions in the medical				
		le as soon as possible after				
	an event or observati	ion is made." e patient's condition or				
		re issues will be noted and				
	charted until the cond					
		tation that provides evidence				
	of follow-through is c	ritical."				
	The following informa	ation was found documented				
	as part of a late-entry	nursing progress note				
		/19 at 10:30 a.m.: "On				
		. a [sic] area of what looked noted to left inner forearm				
		bital). Area did not look				
		some scattered small fluid				

If continuation sheet Page 8 of 10

		D HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 04/29/2022 RM APPROVED O. 0938-0391
STATEMENT OF AND PLAN OF CO	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE SURV COMPLETED	
		495378	B. WING			08	C 3/28/2019
NAME OF PRO	VIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
				34	33 SPRINGTREE DRIVE		
SPRINGTRE	E HEALTHCARE & RE	HAB CENTER		R	DANOKE, VA 24012		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
fi ss 1 rr w T rr ir (() c n b n t t a () b p p rr o a V C fi E a ir fi fi fi fi s s 1 r w T r r v ir r v v T r r v ir r v v t r r v v t r r v v t r v v t r v v t r v v t r v v t r v v t r v v t r v v t r v v t r v v t r v v t r v v t t t t	cabbed over. Area m Ocm x 4.5cm with irr esponded to this nurs vas in any pain by sh This nurse spoke with esident who reported hvolved in any type of his/her) arm. A full he completed and no oth ature noted. (Adult of edside and aware of name omitted) was up hat (his/her parent) h Irm. (He/She) voiced he/she) felt like a [sid edside care. Again the atient's) bedside car tossible injuries durin eported to this nurse occurred. (Physician's at this time, awaiting (Vill continue to monit Director of Nursing (A bout the Resident #0 mpairment. It was co amily member brough acility's taff's attention DON reported that an inpairment revealed that and knowledge of the amily asking about it. vas identified that a li iooting "scattered/multi-	th healing ones that were heasured approximately egular edges. Resident se when asked if (he/she) aking (his/her) head no. In staff involved in the care of that resident had not been of trauma or injury to be to toe assessment er impairments of this hild - name omitted) at iskin irritation. (Adult child's obset at this time due to fact as this place on (his/her) d (his/her) opinion that e) injury had occurred during he staff involved in (the e was asked about any g patient care and was that no injury or trauma had a name omitted) was notified (the physician's) response. or." imately 8:30 a.m., the ursing (DON) and Assistant DON) were interviewed C1's left arm skin onfirmed that the resident's ht the skin impairment to the n on Saturday, 5/25/19. The investigation into this skin that facility staff members area prior to the resident's in a written statement, it censed nurse reported tiple scabbed areas with	F	842			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 04/29/2022 A APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMF	SURVEY LETED
		495378	B. WING				C 28/2019
NAME OF P	ROVIDER OR SUPPLIER		I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.	
SPRINGT	REE HEALTHCARE & RE	HAB CENTER			433 SPRINGTREE DRIVE OANOKE, VA 24012		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 842	On 8/28/19 at 9:30 a. there was no clinical of finding prior to the far DON also confirmed to knowledge of this are have documented the On 8/28/19 at 9:40 a. members to timely do Resident #C1's skin a	iding the area on Saturday. m., the DON confirmed documentation of this skin nily asking about it. The that the facility staff, with a or skin impairment, should a or skin impairment, should	F	842			

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