

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495378	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 08/20/2025
NAME OF PROVIDER OR SUPPLIER Springtree Healthcare & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 3433 Springtree Drive Roanoke, VA 24012	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. (continued on next page)

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0711</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to review the resident's total program of care from a hospital discharge to include blood glucose checks for 1 of 7 residents, Resident #4. The findings include: The facility staff failed to ensure the attending physician and/or provider reviewed the hospital discharge summary for a hospital stay ending on 08/14/25. Resulting in Resident #4 not receiving blood glucose/blood sugar checks. Resident #4's diagnoses included diabetes. There was no completed minimum data set assessment for this resident. Resident #4 was alert and orientated. Resident #4's clinical record included a discharge summary with a date of service of 08/14/25. Under the heading of CONTINUE taking these medications this paperwork included the following information insulin pen needle 1 each every day, blood glucose meter 1 each every day, glucometer 1 each as directed (diabetes) and glucometer test strips. It also included a dexcom receiver and sensor. Resident #4's clinical record did not include any provider orders for blood glucose/blood sugars to be monitored. On 08/19/25 at 5:10 p.m., during an interview with Physician Assistant (PA) #1 this staff was asked if Resident #4 should have been receiving blood glucose/blood sugar checks. The PA stated yes before meals and at bedtime. The PA stated they had been off, just met the resident today and had received their discharge summary. Further review of the clinical record revealed that an order for accuchecks (blood sugars) before meals and at bedtime had been transcribed into the clinical record on 08/19/25 at 5:16 p.m. On 08/19/25 at 5:25 p.m., during an interview with Licensed Practical Nurse (LPN) #1 this staff acknowledged they had been the admitting nurse for Resident #4 and stated they remembered seeing something about a dexcom, but the resident did not have one. LPN #1 stated they remembered speaking with the Unit Manager but did not remember anything more. The facility nursing staff had documented in a progress note on 08/19/25 at 5:55 p. m. that Resident #4's blood glucose was checked. The blood sugar was documented as 148. On 08/19/25 at 5:30 p.m., during a meeting with the Administrator, Director of Nursing (DON), Regional Nurses #1 and #2, and the Administrator in Training the issue with Resident #4's blood glucose/blood sugars not being ordered upon admit was reviewed. On 08/20/25 at 8:50 a.m., during an interview with Resident #4 this Resident stated the facility staff had not been checking their blood sugars they were checking them now and they were running about what they were prior to being admitted to this facility. On 08/20/25 at 8:55 a.m., during an interview with the Unit Manager, this staff was asked the procedure for approval of orders. The Unit Manager stated if the provider was on site they would have them review the discharge summary. When Resident #4 was admitted there was no provider on site, and they could not recall if anyone had reviewed their orders. When asked what the procedure was if a provider was not in the building the Unit Manager stated they would call the provider to check the orders especially if there was anything that needed to be clarified. On 08/20/25 at 10:35 a.m., during an interview with PA #2, this staff stated when Resident #4 had been admitted they were filling in for another provider. PA #2 stated Resident #4 did not have an actual discharge summary from the hospital in the computer, and they had to utilize what they had. PA #2 stated they did not know if they had a full medication list and they were not at the facility when the Resident was admitted and did not know who approved their orders. On 08/20/25 at 11:30 a.m., the DON provided the survey team with a copy of an in-service/education record dated 08/19/25. The subject of this in-service was admissions/new. The facility staff also provide the survey team with a copy of their policy titled, Admitting a Patient with an effective date of 01/29/24. This policy read in part, PROCEDURE. Obtain provider's orders or verify transfer orders with attending physician for the patient's immediate care. No further information regarding this issue was provided to the survey team prior to the exit conference.</p>		

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist.</p> <p>(continued on next page)</p>

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<p>F 0755</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure medications were available for administration for 2 of 7 residents, Residents #3 and #4. The findings included: 1. The facility staff failed to ensure Resident #3's provider ordered medication Heparin was available for administration. Resident #3's diagnoses included non-traumatic subdural hemorrhage. Resident #3's comprehensive care plan included the focus area anticoagulant, the resident is at risk for bleeding, hemorrhage, excessive bruising and complications related to anticoagulant use secondary to subdural hemorrhage. Interventions included administer medications as ordered. Date created 06/11/24. Resident #3's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/14/24 included a brief interview for mental status (BIMS) score of 15. Indicating Resident #3 was cognitively intact. Resident #3's clinical record included a provider order for Heparin sodium injection solution 5000 UNIT/ML (milliliter) inject 1 ml subcutaneously every 8 hours for anticoagulation. Date of order 06/10/24 start date 06/11/24. A review of Resident #3's medication administration records (MARs) for 07/2024 revealed that for 07/03/24 the facility nursing staff documented a 9 for this medication at 8:00 a.m. and 4:00 p.m. and again on 07/04/24 at midnight and 8:00 a.m. Per the preprinted code on the MARs a 9=other/see progress notes. Resident #3's clinical record included the following progress notes. 07/03/2024 9:17 a.m., Heparin sodium injection solution 5000 UNIT/ML inject 1 ml subcutaneously every 8 hours for anticoagulation. On next pharmacy delivery run, out of stock in Omnicell. Resident and Nurse Practitioner (NP) aware. 07/03/2024 12:48 p.m., contacted pharmacy in regard to Heparin. Medication was reorder through computer on 07/02/24 & has not been received. Medication previously pulled out of Omnicell & at this time Omnicell is out of stock. Pharmacy tech states that the refill has been processed & will be sent out on night/next run. NP made aware of missed dosages of Heparin. 07/03/2024 5:03 p.m., Heparin sodium injection on next pharmacy delivery run, out of stock in Omnicell. Resident and NP aware. 07/03/2024 11:43 p.m., Heparin sodium injection Solution 5000 UNIT/ML inject 1 ml subcutaneously every 8 hours for anticoagulation awaiting medication to arrive from pharmacy. Medication not available in Omni-Cell. M.D. aware. 07/04/2024 10:49 a.m., on order waiting on pharmacy. 07/04/2024 10:56 a.m., Contacted pharmacy again to follow up on delivery of Heparin which was supposed to be sent on night delivery on 07/03/24. Overnight nurse also contacted pharmacy & pharmacy tech states that medication was out for delivery. At this time medication was not delivered. This writer called pharmacy & requested that the medication is sent to a local pharmacy due to the delay in delivery. Request has been sent in & awaiting call from local pharmacy for pick up. The facility nursing staff documented this medication had been administered on 07/04/24 at 4:00 p.m. The facility staff provided the surveyor with a copy of their policy titled, Medication Unavailability. This policy read in part, A licensed nurse discovering a medication on order that is unavailable will initiate appropriate steps to ensure medical treatment is provided as ordered. If alternate medication is ordered and is not available, the licensed nurse will activate the backup pharmacy process and procedures. On 08/20/25 at 10:45 a.m., during a meeting with the Administrator, Director of Nursing (DON), Regional Director of Clinical Services #1 and #2, and Administrator in Training the issue with the Heparin not being available for administration was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. The facility staff failed to ensure the provider ordered medications Oxycodone HCl oral tablet 5 mg and Glargine Insulin were available for administration. Resident #4's diagnoses included diabetes, muscle weakness, and open wound left lower leg. There was no completed minimum data set assessment for this resident. Resident #4 was alert and orientated. Resident #4's care plan included the focus area diabetes mellitus and at risk for pain. Interventions included administer medications as ordered. Resident #4's clinical record included provider orders for Oxycodone HCL oral tablet 5 mg give 1 tablet by mouth every 6 hours for pain. The clinical record also included an order for Insulin Glargine inject 40 units subcutaneously at bedtime for diabetes. The order date and start date were both documented as 08/14/25. A review of Resident #4's medication administration records (MARs) for August 2025 revealed that for 08/14/25 at 9:00 p.m. for Resident #4's Glargine Insulin the facility staff documented a 9. For the medication Oxycodone on 08/14/25 at 6:00 p.m. the facility nursing staff documented a 9. Per the preprinted code on the MAR a 9=other/see progress notes. Resident #4's clinical record included the following progress notes. 08/14/25 at 6:00 p.m. patient is a new admission, awaiting delivery from the pharmacy. This progress note did not identify what medication was not available. 08/14/25 at 11:18 p.m. Insulin Glargine unable to</p>		