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	03/11/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Springtree Healthcare & Rehab Center	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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interview and clinical record review, the facility staff failed to follow the comprehensive person-centered care plan for one of four residents in the survey sample, resident #1.The findings include: For resident #1 the facility staff failed to follow the comprehensive care plan that stated the resident was to be fed by staff.Resident #1's diagnoses included but were not limited to dementia, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease, diabetes, protein-calorie malnutrition, congestive heart disease, chronic kidney disease and gastroesophageal reflux disease.The annual minimum data set (MDS) assessment with an assessment reference date of 11/19/25 was reviewed. Resident #1 was assessed to have severely impaired cognitive skills for daily decision making, the resident also had little interest or pleasure in doing things, poor appetite or overeating, and feeling tired or having little energy nearly every day over the two week look back period. Resident #1 was assessed to require set up assistance or clean up assistance with meals during the lookback period. The assessment also captured a significant weight gain that was not prescribed or planned during the look back period. During the look back period, resident #1 was able to feed self, according to the MDS.The comprehensive person-centered care plan included a focus that read, the resident is at risk for weight loss or malnutrition related to chronic disease, cognitive impairment, DM (diabetes), HF (heart failure), dementia, hx (history) protein calorie malnutrition. Texture modified diet w/thickened liq. Sig (significant) wt (weight) fluctuation, most recently loss. This care plan focus was created on 10/31/2022 and revised on 12/28/25. Some of the interventions listed on the care plan were encouragement to eat, record meal % intake, supplements as ordered, and total assist for meals which had a revision date of 12/7/25, and weights as ordered.The documentation survey report which consists of the certified nursing assistant (CNA) documentation of meals and activities of daily living (ADLs) provided to resident #1 was reviewed for December 2025. The level of assistance for meals provided to resident #1 was documents as 05 which means set up assistance, and 06 which means independent for meals every day in December except 12/11/25 for the evening meal the resident was documented as being dependent. Out of 93 total meals served in the month of December resident #1 was documented as eating 76-100% for 48 meals, 51-75% for 31 meals, 26-50% for 9 meals and 0-25% for 5 meals which included 2 refusals, one on 12/25/25 and one on 12/31/25.The documentation survey report for January 2026 was reviewed. The level of assistance provided to the resident for meals was documented at independent for 3 shifts, set up or clean up assist for 5 shifts, supervision for two shifts, and dependent for 6 shifts and one refusal. The resident went to the hospital on 1/9/26 and did not return. Fourteen meals in January were documented with a meal percentage of 76-100%. Four meals were documented with a percentage of 51-75% and eight meals were documented with a percentage of 0-25%. On 3/11/26 at 1:14 PM Certified Nursing Assistant (CNA) #1 was interviewed. They stated they were very familiar with resident #1. CNA #1 stated that resident #1 was independent with meals at first but then toward the end we had to feed her. CNA #1 did not recall when staff started to feed the resident exactly but stated, I don't remember when she was put on the list, it wasn't too long before she went out to the hospital. When asked if the resident was feeding herself in December, around Christmas they stated, (continued on next page)

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Yes, I think we didn't start feeding her until after that sometime. We would take her tray in and set her up and let her try to feed herself and go back and check on her. If she wasn't eating or needed help, we would help her. When asked if that was how it was done after resident #1 got put on the feed list, CNA #1 stated, Yes, we would set her up first because sometimes she could do it. The last week or two we just fed her though, I think I can't remember for sure, but we always made sure she ate. CNA #1 stated that they have a list on the unit for residents who need to be fed and when they come to work, they are assigned certain people on the list to feed each day. On our unit, we make sure all our residents are fed and eat. On 3/11/26 at 2:22 PM CNA #2 was interviewed. When asked about resident #1 and how she ate they stated, She was supervision at first. We would set her up and let her feed herself and we'd check on her and help her if she needed it. CNA #2 stated resident #1 could drink independently, Probably about a week before she died, I had to hold the cup for her. Her appetite and desire to drink really declined fast. When asked how the staff know who to feed, they stated, We have a list. If the residents name is in bold letters we feed them, but if it isn't in bold letters, we supervise like set them up and go back and check to see if they need help. When asked if the care plan had anything on it about whether or not to feed the resident they stated they didn't know, We just go by the list. CNA #2 stated she was not sure what resident #1's care plan said about eating. On 3/11/26 at 2:31 PM the Unit Manager (UM) was interviewed. When asked if they recalled when resident #1 was put on the list to be fed, they stated, She was always on the list but was just supervision at first. She had a rapid decline, a week or so before she went out, she was up in her chair in the day room watching TV. When asked how the staff know to feed residents they stated, We have a list if the name is in bold print, they are supposed to feed that person, if it isn't in bold, they set them up and go back and check to see if they need help or not. UM could not recall the timeframe but thinks resident #1's name was in bold print. On 3/11/26 at 4:37 CNA #3 was interviewed. They stated that resident #1 occasionally refused meals and that was the case on 12/25/25 and 12/31/25. Once we started having to feed her all the time there were times when she wouldn't open her mouth or would hold the food in her mouth and not swallow it. CNA #3 stated the resident was not able to hold a drink at the end but would frequently drink better than she would eat. CNA #3 could recall the timeframe of when the resident went from being set up or supervision to being a total feed. When asked what resident #1's care plan said about whether or not to feed her they stated they weren't sure what the care plan said.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on staff interview, clinical record review and facility document review, the facility staff failed to maintain acceptable levels of nutrition and hydration status for one of five residents in the survey sample, resident #1.The findings include:For resident #1 the facility staff failed to follow the Registered Dietician recommendations for weekly weights in September 2025 and October 2025 when the resident had experienced ongoing significant weight loss and failed to feed the resident per the comprehensive care plan interventions. Resident #1's diagnoses included but were not limited to dementia, dysphagia (difficulty swallowing), chronic obstructive pulmonary disease, diabetes, protein-calorie malnutrition, congestive heart disease, chronic kidney disease and gastroesophageal reflux disease.The annual minimum data set (MDS) assessment with an assessment reference date of 11/19/25 was reviewed. Resident #1 was assessed to have severely impaired cognitive skills for daily decision making, the resident also had little interest or pleasure in doing things, poor appetite or overeating, and feeling tired or having little energy nearly every day over the two week look back period. Resident #1 was assessed to require set up assistance or clean up assistance with meals during the lookback period. The assessment also captured a significant weight gain that was not prescribed or planned during the look back period. The progress notes were reviewed. On 9/5/25 the Registered Dietician (RD) documented a weight change note that read in part, Sig (significant) wt (weight) loss likely r/t (related to) variable intake. Supplement previously decreased in Aug d/t (due to) apparent wt stability in the setting of good intake. On dysphagia mech (mechanically) altered diet, po (by mouth) intake ~75%. Receives 2.0 house supplement QD (every day). Recommend increase 2.0 supp (supplement) to BID (twice daily) and weekly weights x4 for monitoring. Discussed in wt mtg (meeting) with IDT (interdisciplinary team). The note documented the current weight to be 123 lbs. (pounds) which was a weight loss of 5% in 30 days and 7.5% in 90 days. On 10/4/25 the RD documented a weight change note that read in part, Sig wt loss noted and d/t variable intake. Nursing reports res (resident) recently not feeling well d/t respiratory illness. On dysphagia mech altered diet, po intake ~51-75% with 2.0 house suppl BID. Recommend increase of 2.0 suppl to TID (three times a day) and weekly wts x 4 for monitoring. Discussed in wt mtg w/IDT. The current weight was documented as 116 lbs. with 5% loss in 30 days, 7.5% loss in 90 days and a 10% loss in 180 days. On 11/7/25 the RD documented a weight change note that read in part, Sig wt gain appears to be some beneficial rebound from prev (previous) loss. On dysphagia mech altered diet with po intake ~75% (improved). Also receives 2.0 house suppl TID (three times a day) (increased on 10/4). BMI 21.4, WNL (within normal limits). No changes recommended at this time. Discussed in wt mtg w/IDT. The current weight was documented as 128.5 which was a 5% gain in 30 days, 7.5% gain in 90 days and 10% gain in 180 days.On 12/5 the RD documented a weight change note that read in part, Sig wt loss noted. Res with recent decline and recent oral thrush noted. Nursing reports res (resident) is now total assist for meals and is requiring cueing to swallow. Is on speech therapy caseload. On puree diet with nectar liq (liquids), po intake ~51-75% with 2.0 house suppl TID. Recommend weekly weights x 4 for monitoring. Discussed in wt mtg w/IDT. The current weight was documented as 121 lbs. which was a loss of 5% in 30 days and 10% in 180 days.On 12/26/25 the RD documented a weight change note that read in part, Sig wt loss prev (previously) addressed, but down an additional 2# (pounds). Recent diet upgrade noted, which will likely help, as well as completion of treatment for oral thrush. On dysphagia advanced diet w/ground meat and nectar thick liq. PO intake avg ~51-75%. Receives 2.0 house suppl TID (intake varies from 0-100%). Currently on weekly wts. No changes recommended at this time, just cont (continue) to monitor per protocol. Discussed in wt mtg w/IDT. The current weight was documented at 119 lbs.The weights documented in the clinical record were reviewed. There was no weight recorded for the second week of September, the third week of October, and the second week of December. The comprehensive person-centered care plan included a focus that read, the resident is at risk for weight loss or malnutrition related to chronic disease, cognitive impairment, DM (diabetes), (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	HF (heart failure), dementia, hx (history) protein calorie malnutrition. Texture modified diet w/thickened liq. Sig (significant) wt (weight) fluctuation, most recently loss. This care plan focus was created on 10/31/2022 and revised on 12/28/25. Some of the interventions listed on the care plan were encouragement to eat, record meal % intake, supplements as ordered, and total assist for meals which had a revision date of 12/7/25, and weights as ordered.The documentation survey report which consists of the certified nursing assistant (CNA) documentation of meals and activities of daily living (ADLs) provided to resident #1 was reviewed for December 2025. The level of assistance for meals provided to resident #1 was documented as 05 which means set up assistance, and 06 which means independent for meals every day in December except 12/11/25 for the evening meal the resident was documented as being dependent. Out of 93 total meals served in the month of December resident #1 was documented as eating 76-100% for 48 meals, 51-75% for 31 meals, 26-50% for 9 meals and 0-25% for 5 meals which included 2 refusals, one on 12/25/25 and one on 12/31/25. On 3/11/26 at 11:36 the Physician's Assistant (PA) who cared for resident #1 was interviewed. They stated that on 1/8/25 they, along with the facility IDT met with the family and went through the plan of care due to a decline in condition. The PA stated, Someone from the facility, I'm not sure who, had called them on the 7th and there was some sort of miscommunication about what was going on. They were made to feel like because she was a DNR (do not resuscitate), we weren't treating the decline. The family got here and saw that wasn't at all true, we had IV (intravenous) fluids going, we were doing labs and had started antibiotics for a UTI (urinary tract infection) so they were good with all we were doing. I think they did question if she should be sent to the hospital but in the end, we agreed to keep her here and treat her. On the 9th I called them again because she was profoundly dehydrated and definitely needed to go to the hospital. They questioned if the staff was feeding her and offering fluids and I know that they were. I know she was on the list to be fed by the aides. The PA stated that she was never in the room at mealtime so never saw staff feed resident #1. On 3/11/26 at 1:14 PM Certified Nursing Assistant (CNA) #1 was interviewed. They stated they were very familiar with resident #1. CNA #1 stated that resident #1 was independent with meals at first but then toward the end we had to feed her. CNA #1 did not recall when staff started to feed the resident exactly but stated, I don't remember when she was put on the list, it wasn't too long before she went out to the hospital. When asked if the resident was feeding herself in December, around Christmas they stated, Yes, I think we didn't start feeding her until after that sometime. We would take her tray in and set her up and let her try to feed herself and go back and check on her. If she wasn't eating or needed help, we would help her. When asked if that was how it was done after resident #1 got put on the feed list, CNA #1 stated, Yes, we would set her up first because sometimes she could do it. The last week or two we just fed her though, I think I can't remember for sure, but we always made sure she ate. CNA #1 stated that they have a list on the unit for residents who need to be fed and when they come to work, they are assigned certain people on the list to feed each day. On our unit, we make sure all our residents are fed and eat. On 3/11/26 at 2:22 PM CNA #2 was interviewed. When asked about resident #1 and how she ate they stated, She was supervision at first. We would set her up and let her feed herself and we'd check on her and help her if she needed it. CNA #2 stated resident #1 could drink independently, Probably about a week before she died, I had to hold the cup for her. Her appetite and desire to drink really declined fast. When asked how the staff know who to feed, they stated, We have a list. If the residents name is in bold letters we feed them, but if it isn't in bold letters, we supervise like set them up and go back and check to see if they need help. On 3/11/26 at 2:31 PM the Unit Manager (UM) was interviewed. When asked if they recalled when resident #1 was put on the list to be fed, they stated, She was always on the list but was just supervision at first. She had a rapid decline, a week or so before she went out, she was up in her chair in the day room watching TV. When asked how the staff know to feed residents they stated, We have a list if the name is in bold print, they are supposed to feed that person, if it isn't in bold, they set them up and go back and check to see if they need help or not. UM could not recall the timeframe but thinks resident #1's name was in bold print. On (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3/11/26 at 3:16 PM Licensed Practical Nurse (LPN) #1 was interviewed. When asked if resident #1 fed herself they stated, She was on the feed list. She wasn't able to feed herself at the last, for quite a while before she went out. She wasn't able to drink on her own either. I tried to make sure when I worked to keep the family updated because I knew they were concerned. The daughter did ask me during one long conversation if anyone was giving her water or feeding her, she said they had friend or somebody visiting that told them she wasn't getting fed but I told her that absolutely was not true. It could have been when they were her, she had already eaten or they hadn't gotten to her yet, but she was being fed every day.The Director of Nursing (DON) was interviewed on 3/11/26 at 4:00 PM. They stated that resident #1 had a very rapid decline. She had some weight loss we were watching closely and then bam, she needed IV's and just wasn't doing well. When asked about the weekly weights they said that resident sometimes refused care including being weighed due to pain and they would look for documentation of the missing weights or refusals. The DON was able to produce documentation of the resident refusing the December weekly weight but was unable to locate any documentation for the missing weights in September and October. The DON clarified the facility does not generally put in orders for weights but does follow RD recommendations for weights.On 3/11/26 at 4:10 PM LPN #2 was interviewed. When asked about resident #1 and if she was a feed or not, they stated, Yes the staff were feeding her and offering fluids, the last 4 months or so she was just kind of up and down. We had speech therapy in, and they changed her diet a couple times because she was having some swallowing problems but then she got some better. The last two months I would say she was dependent for eating.On 3/11/26 at 4:37 CNA #3 was interviewed. They stated that resident #1 occasionally refused meals and that was the case on 12/25/25 and 12/31/25. Once we started having to feed her all the time there were times when she wouldn't open her mouth or would hold the food in her mouth and not swallow it. CNA #3 stated the resident was not able to hold a drink at the end but would frequently drink better than she would eat. CNA #3 could recall the timeframe of when the resident went from being set up or supervision to being a total feed. The policy entitled, Weight Monitoring and Tracking with an effective date of 1/29/24 was requested and provided. The policy read in part, The center has a system in place to weigh, monitor, and track patient's weights. Weights are tracked, monitored and analyzed by the interdisciplinary team. Item #1 under procedure read, The Director of Nursing is responsible for ensuring patients are weighed in an acceptable time frame, using proper technique. Nursing staff are responsible for recording the weight in the clinical record.The Administrator, DON and Regional Director of Clinical Services were notified of the concern during a pre-exit meeting on 3/11/26 at 4:30 PM. No further information was provided prior to the exit conference.