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	05/23/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 42353 Based on observation, staff interview, and facility document review, the facility staff failed to ensure a clean and sanitary homelike environment for 1 of 27 current sampled residents, Resident #1. The findings included: For Resident #1, on three separate days of the survey, a large area of multiple dried, brown, drips were observed on the wall to the left of the resident's bed. Resident #1's diagnosis list indicated diagnoses, which included, but not limited to Dementia, Bipolar II Disorder, Chronic Obstructive Pulmonary Disease, Type 2 Diabetes Mellitus, and Congestive Heart Failure. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 2/22/24 assigned the resident a brief interview for mental status (BIMS) summary score of 4 out of 15 indicating the resident was severely cognitively impaired. During initial survey rounding on 5/21/24 at 3:49 PM, surveyor observed a large area of multiple, dried brown drips on the wall to the left of Resident #1's bed. Surveyor made additional observations of Resident #1's room on 5/22/24 at 1:30 PM, 5/23/24 at 8:31 AM, 5/23/24 at 10:22 AM, and 5/23/24 at 3:38 PM with no changes in the appearance of the dried drips on the wall. On 5/23/24 at 3:42 PM, surveyor spoke with the Housekeeping Supervisor (HS) and requested they visualize the wall in Resident #1's room. The drips remained and the HS stated they would get a housekeeping cart and clean the wall. Surveyor requested and received the facility policy titled, Daily Resident/Patient Room Cleaning which read in part .spot clean all necessary areas . On 5/23/24 at 5:02 PM, the survey team met with the Administrator, Assistant Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of the soiled wall in Resident #1's room. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/23/24.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Encode each resident’s assessment data and transmit these data to the State within 7 days of assessment. 28567 Based on staff interview and clinical record review, the facility staff failed to electronically transmit minimum data set (MDS) assessments for 2 of 3 residents reviewed for the Resident Assessment task, Resident's #8 and #92. The findings included: 1. For Resident #8, the facility staff failed to electronically transmit a discharge MDS assessment. Resident #8's diagnoses included, but were not limited to, metabolic encephalopathy, muscle weakness, and diabetes. Resident #8's clinical record included a discharge MDS assessment with an assessment reference date (ARD) of 02/15/24. During the survey process the Resident Assessment task triggered for an MDS over 120 days old for this resident. On 05/23/24 at 11:50 a.m., Licensed Practical Nurse (LPN) #5 and Registered Nurse (RN) #2 was asked to review the MDS submissions for this resident. On 05/23/24 at 12:30 p.m., RN #2 confirmed that Resident #8's discharge MDS assessment with an ARD of 02/15/24 had not been transmitted prior to today and it had now been transmitted. On 05/23/24 at 5:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Administrator in Training, and Regional Nurse Consultant, the issue with the MDS not being transmitted was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Resident #92, the facility staff failed to electronically transmit a discharge MDS assessment. Resident #92's diagnoses included, but were not limited to, diabetes, muscle weakness, and chronic obstructive pulmonary disease. Resident #92's clinical record included a discharge MDS assessment with an ARD of 12/27/23. During the survey process the Resident Assessment task triggered for an MDS over 120 days old for this resident. On 05/23/24 at 11:50 a.m., Licensed Practical Nurse (LPN) #5 and Registered Nurse (RN) #2 were asked to review the MDS submissions for this resident. (continued on next page)

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F 0640 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 12:30 p.m., RN #2 confirmed that Resident #92's discharge MDS assessment with an ARD of 12/27/23 had not been transmitted prior to today and it had now been transmitted. On 05/23/24 at 5:00 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Administrator in Training, and Regional Nurse Consultant, the issue with the MDS not being transmitted was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. 28169 Based on staff interviews and clinical record review facility staff failed to accurately complete minimum data set (MDS) assessments for 2 of 32 residents. (Resident #5 and #107) The findings were: 1. The facility staff failed to accurately code Resident #5's physical restraint status. The MDS read Resident #5 used physical restraints (bedrails) daily when the resident did not have physical restraints. Resident #5's diagnoses included but were not limited to, hereditary and idiopathic neuropathy, paranoid schizophrenia, major depressive disorder, recurrent bipolar II disorder, heart failure, type 2 diabetes mellitus, and chronic obstructive pulmonary disease. Section C (cognitive patterns) of Resident #5's quarterly MDS assessment with an assessment reference date of 05/13/2024 coded a brief interview for mental status score of 14 out of 15. In Section P (restraints and alarms) Resident #5 was coded as using a physical restraint (bedrails) daily. The resident's clinical record contained a document titled, Device Assessment - V 3 dated 05/13/24 which read the device used was assist bars x2 to help with bed mobility and transfers and the device was not considered to be restrictive. On the morning of 05/22/24, this surveyor met Resident #5 in the resident's room. The surveyor observed the resident in bed with assist bars attached to the bed on both sides. No side rails were present. After speaking with the director of nursing (DON) and regional director of clinical services (regional nurse) about Resident #5's MDS assessment showing restraints in the form of bedrails used daily, on 05/23/24 at 9:20 a.m. both the DON and regional nurse reported they had just observed the resident's side rails and determined they were assist bars and not restrictive. The regional nurse acknowledged the MDS was coded incorrectly. On 05/23/24 at 9:32 a.m. the MDS coordinator (RN #5) who coded Resident #5 as using physical restraints daily was interviewed. The coordinator stated he may have coded it incorrectly since the MDS assessment listed bedrails as a physical restraint option but did not list assist bars as an option. RN #5 reported being aware the device assessment read the assist bars were not restrictive. On 05/23/24 in the afternoon, a different MDS coordinator (RN #2) provided a modified MDS which documented in Section P (restraints and alarms) that Resident #5 had no physical restraints. On 05/23/24 at 5:03 p.m., during a meeting with the administrator, DON, and regional nurse, Resident #5's physical restraint versus assist bars and how the MDS was coded and modified was discussed. No further information was provided prior to the exit conference. 28567 (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. For Resident #107, the facility staff failed to accurately code a discharge minimum data set (MDS) assessment. The facility staff coded the discharge MDS assessment as if the resident was discharged to a short-term general hospital. Resident #107 was in fact discharged home. Resident #107's diagnoses included, but were not limited to, malignant neoplasm of breast, cognitive communication deficit, and muscle weakness. Resident #107's clinical record included a discharge MDS assessment with an assessment reference date (ARD) of 02/23/24. This MDS assessment was coded as if Resident #107 was discharged to a short-term general hospital. The clinical record included a progress note documented by the Activities Director that read in part, Patient discharged to home 2/23/24 . On 05/22/24 at 4:20 p.m., the surveyor reviewed this MDS assessment with Licensed Practical Nurse (LPN) #5. This staff stated they would review this information. On 05/23/24 at 8:25 a.m., the Regional Nurse Consultant stated the MDS assessment had been corrected to indicate the resident discharged home. On 05/22/24 at 4:35 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Administrator in Training, and Regional Nurse Consultant the issue with the MDS was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed develop and implement a comprehensive person-centered care plan for 2 of 32 sampled residents, Resident #18 and Resident #35. The findings include: 1. For Resident #18 (R18) the facility staff failed to develop a comprehensive person-centered activity care plan to address the resident's activity preferences, interests, and psychosocial needs. R18's diagnosis list indicated diagnoses that included, but were not limited to, Major Depressive Disorder, History of Falling, Bipolar Disorder, Schizophrenia, Dementia, Cognitive Communication Deficit, and Anxiety Disorder. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 5/13/24 assigned the resident a brief interview for mental status (BIMS) summary score of 9 out of 15, indicating R18 was moderately impaired in cognitive skills for daily decision making. A review of R18's clinical record on 5/21/24 revealed an Activities-Admission Review assessment dated , 9/16/2015 that revealed, .Use this data to design an activities program that meets the residents needs and preferences. Update the care plan on completion . A review of the most recent Activities Reassessment dated [DATE], revealed, .Residents Activity-Related Focus(es) including Needs, Strengths and Preferences: a. Activity-Related focuses remain appropriate/current as per current care plan .Goals were met . Interventions/approaches have been effective in reaching goals . Surveyor reviewed R18's comprehensive care plan and was unable to locate documentation of an activity person-centered focus or goal. One activity intervention with a created date of 02/12/2024 read, Activities of resident choice. On 5/22/24 at 11:25 AM, surveyor interviewed Activity Director (AD). Surveyor informed AD that an activity care plan could not be located in the clinical record for R18. AD stated the corporate consultant does audits and if an activity care plan was missed, she (corporate consultant) would have let her know and she could not believe R18 would not have an activity care plan. AD stated she would look and see if she had one. On 5/22/24 at 2:03 PM, AD brought surveyor a copy of R18's care plan that revealed one activity intervention that was highlighted, with a created date of 02/12/2024 and read, Activities of resident choice. AD agreed R18 should have an activity person-centered care plan in place. This concern was discussed at an end of day meeting on 5/22/24 at 4:35 PM and at the pre-exit meeting on 5/23/24 at 5:02 PM, with the administrator, assistant administrator, director of nursing and the regional director of clinical services. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received a facility policy titled, Recreation .Care Plan . that revealed, .Recreation staff will actively participate in the development of an individualized care plan for each patient .to support patients in their choice of activities, use the information gathered through the assessment process to develop the activities component of the comprehensive care plan which is individualized to match the skills, abilities, interests and preferences of each patient .Care plan focuses and/or goals .include measurable objectives and time frames, focus on desired outcomes, and describe the services that are to be furnished to attain or maintain the patient's highest practicable physical, mental and psychosocial well-being .View the other disciplines' focuses and goals and add appropriate activity interventions . No further information was provided to the survey team prior to exit. 21227 2. Resident #35's comprehensive person-centered activity care plan did not address the resident's activity preferences and interests. Resident #35's most recent Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 5/2/24. Resident #35 was assessed as being able to make self understood and as being able to understand others. Resident #35's Brief Interview for Mental Status (BIMS) summary score was documented as a 11 out of 15; this indicated moderate cognitive impairment. Resident #35's care plan included a focus area, created on 7/13/23, of Alteration of prior leisure routines to continue life-long interests and preferences as conditions allow. This focus area included the following two (2) interventions dated as being created on 7/13/23: (a) Honor patient's preferences of leisure activities and (b) Offer leisure materials such as . No specific leisure materials were detailed as part of this care plan. Resident #35's ACTIVITIES REassessment dated [DATE] included the following activity information: - The resident reported it was somewhat important to listen to music they like. - The resident reported it was somewhat important to be around animals/pets. - This assessment indicated it was important for the resident to spend time with friends, watch TV, and explore the building. The resident was assessed as having a very social personality. On 5/23/24 at 2:40 p.m., the Activity Director (AD) reviewed Resident #35's care plan. The AD stated the activities care plan was incomplete. Resident #35's activities care plan was revised on 5/23/24 to include the following interventions: (a) Honor patient's preferences of leisure activities such as interest in music, socials, visiting, and sitting outside in the courtyard and occasionally church and (b) Offer leisure materials such as magazines, newspapers and other materials as requested. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The following information was found in a facility policy titled Care Planning (with an effective date of 11/1/19): A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. The survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical services on 5/23/24 at 5:04 p.m. The surveyor discussed Resident #35's incomplete activities care plan during this meeting.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. 21227 Based on staff interview, clinical record review, and facility document review, the facility staff failed to review and revise the comprehensive person-centered care plan for 1 of 32 sampled residents (Resident #37). The findings included: Resident #37's comprehensive person-centered care plan was not revised to address: (a) a change in the resident's code status and (b) the implementation of comfort care measures. Resident #37's most recent Minimum Data Set (MDS) assessment had an Assessment Reference Date (ARD) of 3/1/24. Resident #37 was assessed as being able to make self understood and as usually being able to understand others. Resident #37's Brief Interview for Mental Status (BIMS) summary score was documented as a nine (9) out of 15; this indicated moderate cognitive impairment. On 5/23/24 at 9:00 a.m., Resident #37's care plan included the focus of The resident has an advanced directive of Full Code. Resident #37's care plan did not address the resident receiving comfort care measures. Resident #37's medical provider orders included: (a) an order for COMFORT CARE: no hospitalization s, no labs, no weights, no TF (tube feeding), no IVFs (intravenous fluids) with a revised date of 5/13/24 and (b) an order for DNR (Do Not Resuscitate) with a revised date of 5/14/23. On 5/23/24 at 9:06 a.m., the surveyor asked the Director of Nursing (DON) and the Regional Director of Clinical Services (RDCS) about Resident #37's care plan not addressing the DNR and Comfort Care orders. On 5/23/24 at 9:13 a.m., the RDCS confirmed the care plan did not address the DNR and Comfort Care. The RDCS reported Resident #37's care plan was being updated. Resident #37's updated care plan indicated the focus of The resident has an advanced directive of DNR was revised on 5/23/24. This focus included the following intervention which was documented as being revised on 5/23/24: COMFORT CARE: no hospitalization s, no labs, no weights, no TF, no IVFs. The following information was found in a facility policy titled Care Planning (with an effective date of 11/1/19): - A licensed nurse, in coordination with the interdisciplinary team, develops and implements an individualized care plan for each patient in order to provide effective, person-centered care, and the necessary health-related care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being of the patient. - Care plans will be updated on an ongoing basis as changes in the patient occur, and [sic] reviewed quarterly with the quarterly assessment. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The survey team met with the facility's Administrator, Director of Nursing, and Regional Director of Clinical services on 5/23/24 at 5:04 p.m. The surveyor discussed Resident #37's comprehensive care plan not being revised to address the residents code status change and the implementation of comfort care measures.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 47299 Based on observation, staff interview and clinical record review, the facility staff failed to provide care and services as ordered by the primary care physician for one (1) of 32 residents in the survey sample (Resident # 46). The findings include: For resident # 46, the facility staff failed to ensure water flushes were delivered according to the physician's order through the PEG (percutaneous endoscopic gastrostomy) tube. Resident # 46's diagnoses include but are not limited to dysphagia following a cerebrovascular accident, hemiplegia, hemiparesis, unspecified protein-calorie malnutrition, and unspecified heart failure. Resident # 46's minimum data set (MDS) assessment with an assessment reference date of 3/26/24 indicated that resident was severely cognitively impaired and is rarely or never understood. On 5/21/24 at 4:14 PM this surveyor observed resident lying in bed with tube feeding pump at bedside. Surveyor noted that the pump was running and was set to deliver 250 milliliters (mls) of water every 4 hours. Resident # 46 was not interviewable. The medical record was reviewed, and a physician's order was located that was dated 3/24/24 and read, Free Water: 200 cc via PEG (percutaneous endoscopic gastrostomy) Q 4 hours. The Medication Administration Record (MAR) was reviewed and did include an entry for this order that was signed off as administered each day this month. On 5/21/24 at 5:45 PM this surveyor asked Licensed Practical Nurse (LPN) # 2 if they knew how much water resident # 46 was supposed to be getting through their tube. They stated, I believe it's 200 mls every four (4) hours but let me check to be sure. After checking the orders they stated, Yes, (resident # 46) gets 200 mls every 4 hours. This surveyor asked LPN # 2 to check the pump. LPN # 2 asked LPN # 3 to come as well. Surveyor asked LPN #3 what the pump was set for and they stated 250 mls every 4 hours, what is it supposed to be? LPN # 2 stated, The order is for 200. LPN # 3 changed the setting to 200 mls every 4 hours. Surveyor asked LPN # 3 if they agreed that the pump setting was incorrect and they stated, Yes, it should have been set for 200 mls every 4 hours. On 5/22/24 8:59 AM this surveyor observed resident # 46 lying in bed with tube feeding running and pump was set to deliver water flushes at 200 mls every 4 hours. On 5/23/24 at 5:03 PM the survey team met with the Administrator, Assistant Administrator, Director of Nursing, and Regional Director of Clinical Services. This concern was reviewed with them at that time. No further information was provided to the survey team prior to the exit conference.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. 49622 Based on observation, resident interview, clinical record review and facility document review, the facility staff failed to administer oxygen according to the attending medical provider's orders for 1 of 32 sampled residents, Resident #44. The findings include: For Resident #44 (R44) the facility staff failed to administer oxygen per the medical provider orders at 4 liters per minute via nasal cannula. Diagnoses for R44 included but were not limited to, heart failure, acute and chronic respiratory failure with hypoxia, obstructive sleep apnea, and morbid severe obesity due to excess calories. The most recent minimum data set (MDS) assessment with an assessment reference date of 5/7/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15, indicating intact cognition. On 05/21/24 at 4:30 PM, surveyor observed R44 in a wheelchair in the dining room receiving oxygen (02) with a nasal cannula via a portable 02 tank that was observed to be on three (3) liters of oxygen. On 05/22/24 at 1:17 PM, surveyor observed R44 lying in bed and observed resident to be receiving 02 from a nasal cannula via a 02-concentrator set on 3 liters. Surveyor asked R44 how many liters of oxygen she is supposed to be on and R44 stated she is on 3 liters of oxygen. On 5/22/24 at 1:59 PM, surveyor observed R44 up in her wheelchair receiving 02 from a nasal cannula with a portable O2 tank set on 3 liters and resident stated, I am on 3 liters. R44's current physician's orders included an active order dated 1/17/24, that read in part, Oxygen at 4 (four) liters per minute via nasal cannula every day and night shift . A review of the medication administration record (MAR) for May 2024 read that R44's 02 was administered as ordered. A review of R44's comprehensive care plan revealed a focus statement that read in part, RESPIRATORY: the resident is at risk for respiratory complications secondary to Acute & Chronic Respiratory Failure . and an intervention statement that read in part, .administer oxygen as ordered . This concern was discussed at an end of day meeting on 5/22/24 at 4:35 PM with the administrator, assistant administrator, director of nursing and the regional director of clinical services. On 5/23/24 at 10:42 AM, surveyor observed R44 lying in bed with 02 being administered via nasal cannula from a 02-concentrator set on 4 liters. R44 stated they told her this morning that she is supposed to be on 4 liters of oxygen. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor requested and received a facility policy titled, .Physician's Orders ., that revealed, . Orders-medication and treatment orders must include .Right dosage . Surveyor also requested and received a facility policy titled, .Respiratory Care & Oxygen Equipment ., that revealed, .Follow provider's order including; .Flow rate .For continuous oxygen therapy, verify and document in the medical record each shift and PRN . This concern was discussed at the pre-exit meeting on 5/23/24 at 5:02 PM, with the administrator, assistant administrator, director of nursing and the regional director of clinical services. No further information was provided to the survey team prior to exit.

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 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. 28567 Based on resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure provider ordered medications were available for administration for 1 of 27 current sampled residents, Resident #94 and failed to ensure nursing staff correctly implemented the facility scheduled/control monitoring system for 1 of 6 medication carts, the 400-hall medication cart. The findings included: 1. The facility staff failed to ensure Resident #94's provider ordered narcotic pain medication Oxycodone was available for administration. Resident #94's clinical record included the diagnoses, malignant neoplasm of bronchus of lung, chronic obstructive pulmonary disease, muscle weakness, and cirrhosis of liver. Section C (cognitive patterns) of Resident #94's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/12/24 included a brief interview for mental status (BIMS) score of 15 out of a possible 15 points. Resident #94's comprehensive care plan included the focus area at risk for pain. Interventions included administer medications as ordered. Resident #94's clinical record included a provider order dated 01/11/24 for the pain medication Oxycodone 1 tablet 3 times a day for pain hold for sedation or lethargy. A review of Resident #94's clinical record revealed that the facility nursing staff documented that for the narcotic pain medication Oxycodone on 04/20/24 this medication was unavailable, 04/29/24 on order from pharmacy, and on 05/05/24 awaiting delivery from pharmacy. On 05/21/24 at 5:06 p.m., the surveyor interviewed Resident #94 regarding their Oxycodone medication not being available for administration. Resident #94 stated they had run out of it one time and they had to reorder it from the pharmacy, but it wasn't an issue they just needed it at bedtime. On 05/22/24 at 11:20 a.m., Registered Nurse (RN) #1 was interviewed regarding the procedure for unavailable medications. RN #1 stated they would notify the provider, call the pharmacy, and try to get the medication as soon as possible. When asked about the backup supply at the facility RN #1 stated sometimes the medications were available and sometimes not. On 05/22/24 at 12:05 p.m., the Director of Nursing (DON) and Regional Nurse Consultant were made aware of the issue regarding Resident #94's medication not being available for administration. The surveyor requested a list of medications in the facility stat box (back up box). (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 05/23/24 at 8:30 a.m., the Regional Nurse Consultant provided the surveyor with a copy of the stat box list. A review of this list revealed that this medication would not have been available onsite for administration. The facility policy titled, Medication Unavailability with an effective date of 01/29/24 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. 1. A licensed nurse will notify the provider of the unavailability of medication and discuss an alternative order, if necessary . On 05/22/24 at 4:35 p.m., during an end of the day meeting with the Administrator, Director of Nursing, Administrator in Training, and Regional Nurse Consultant the issue with the unavailability of the Oxycodone was reviewed. No further information regarding this issue was provided to the survey team prior to the exit conference. 42353 2. The Controlled Drug Administration Record for Resident #313's Gabapentin 600 mg did not reconcile with the actual amount of Gabapentin 600 mg tablets available in the medication cart. Resident #313's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Infarction, Alzheimer's Disease, Type 2 Diabetes Mellitus, and Bilateral Foot Calcaneal Spurs. Resident #313's current medical provider orders included an order for Gabapentin 600 mg by mouth every 12 hours for neuropathy scheduled to be administered at 8:00 AM and 8:00 PM. On 5/23/24 at 10:42 AM, the surveyor and Director of Nursing (DON) reconciled the resident's documented Gabapentin count with the actual amount available for administration in the medication cart and a discrepancy of one tablet was identified. According to Resident #313's Controlled Drug Administration Record Tablet, the medication cart should contain a bubble pack with 14 tablets and a bubble pack of 28 tablets for a total of 42 Gabapentin 600 mg tablets. The surveyor and the DON observed a bubble pack of 13 tablets and a bubble pack of 28 tablets of Gabapentin 600 mg present in the medication cart. According to Resident #313's Controlled Drug Administration Record Tablet, the last Gabapentin 600 mg tablet was signed out as being administered on 5/22/24 at 9:00 PM. However, Resident #313's May 2024 Medication Administration Record (MAR) indicated Gabapentin 600 mg was administered on 5/23/24 at 8:00 AM. Surveyor requested and received the facility policy titled, Administration Procedures for All Medications which read in part .IV. Administration .7. After administration, return to cart .document administration in the MAR or TAR and the controlled substance sign out record, if necessary . (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/24 at 5:02 PM, the survey team met with the Administrator, Assistant Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of the discrepancy in Resident #313's Gabapentin count. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/23/24.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure residents are free of significant medication errors for 2 of 32 sampled residents, Resident #314 and #62. The findings included: 1. For Resident #314, the facility staff failed to follow medical provider orders for the administration of the medications, Diltiazem, Metoprolol Tartrate, and Midodrine on 2/15/24 and 2/16/24. Diltiazem and Metoprolol Tartrate are antihypertensives and Midodrine is used to treat low blood pressure. Resident #314's diagnosis list indicated diagnoses, which included, but not limited to Pneumonia, Generalized Muscle Weakness, Protein Calorie Malnutrition, Essential Hypertension, and Gastro-Esophageal Reflux Disease. Resident #314's minimum data set (MDS) with an assessment reference date (ARD) of 1/17/24 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. The resident's provider orders included orders dated 2/09/24 for Diltiazem 60 mg by mouth one time a day and hold for systolic blood pressure (SBP) less than 110 and Metoprolol Tartrate 12.5 mg two times a day and hold dose for SBP less than 110. A review of Resident #314's February 2024 Medication Administration Record (MAR) revealed Diltiazem and Metoprolol Tartrate were each administered on 2/15/24 at 9:00 AM with a SBP of 97 and 2/16/24 at 9:00 AM with a SBP of 95. Metoprolol Tartrate was administered again on 2/16/24 at 5:00 PM with a SBP of 95. Resident #314's provider orders included an order dated 2/09/24 to administered Midodrine 10 mg every 8 hours as needed for hypotension if SBP was less than 105. According to the order, Midodrine should have been administered on 2/15/24 at 9:00 AM due to a SBP of 97, 2/16/24 at 9:00 AM due to a SBP of 95, and 2/16/24 at 5:00 PM due to SBP of 95. According to the resident's MAR, Midodrine was not administered as ordered on 2/15/24 and 2/16/24. On 5/23/24 at 8:55 AM, surveyor spoke with registered nurse (RN) #3 who administered the Diltiazem and Metoprolol Tartrate and failed to administer the Midodrine. RN #3 reviewed the resident's MAR and stated, appears I made a med error. Surveyor requested and received the facility policy titled, Administration Procedures for All Medications which read in part .III .1. Prior to removing the medication package/container from the cart/drawer .d. Check for vital signs or other tests to be done during or prior to medication administration . (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/23/24 at 5:02 PM, the survey team met with the Administrator, Assistant Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of staff failing to follow Resident #314's provider orders. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/23/24. 2. For Resident #62, the facility staff failed to follow the physician's order for the administration of Insulin Glargine, a long-acting insulin. Resident #62's diagnosis list indicated diagnoses, which included, but not limited to Type 2 Diabetes Mellitus, Asthma, Chronic Obstructive Pulmonary Disease, Emphysema, and Essential Hypertension. The most recent minimum data set (MDS) with an assessment reference date (ARD) of 4/04/24 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. Resident #62's current comprehensive person-centered care plan included a focus area stating The resident is at risk for complications and blood glucose fluctuations related to diagnosis of diabetes mellitus with insulin use with an intervention to administer insulin as ordered. The resident's current provider orders included an order dated 10/03/23 for Insulin Glargine 100 unit/ml inject 40 units subcutaneously every 12 hours and hold if blood glucose below 140. A review of Resident #62's May 2024 Medication Administration Record (MAR) revealed Insulin Glargine 40 units was administered on 5/23/24 at 8:00 AM. In the area on the MAR provided for documentation of the blood sugar, NA was entered by the nurse. Surveyor reviewed the clinical record and was unable to locate documentation of a blood sugar immediately prior to the administration of the insulin. The most recently documented blood sugar of 181 was obtained at 6:24 AM earlier that morning. Surveyor requested and received the facility policy titled, Administration Procedures for All Medications which read in part .III .1. Prior to removing the medication package/container from the cart/drawer .d. Check for vital signs or other tests to be done during or prior to medication administration . On 5/23/24 at 5:02 PM, the survey team met with the Administrator, Assistant Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of staff failing to follow Resident #62's provider orders for the administration of insulin. No further information regarding this concern was presented to the survey team prior to the exit conference on 5/23/24.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 42353 Based on observation and staff interview, the facility staff failed to ensure safe and secure storage of medications and/or blood collection tubes for 3 of 6 medication carts (200 Hall, 400 Hall, and 500 Hall) and 1 of 2 medication storage rooms (Unit 2). The findings included: 1. The 500 Hall medication cart contained three used insulin pens which were not labeled with a resident's name or date of opening. The 400 Hall medication cart contained an insulin pen without a clearly identifiable resident name, an expired box of Levothyroxine 75 mg tablets, and a half full vial of Insulin Glargine with a dispense date of 2/14/24 and a beyond use date of 5/13/24. On 5/23/24 at 9:43 AM, surveyor observed Registered Nurse (RN) #3 drawing insulin out of an insulin pen into an insulin syringe. RN #3 stated they did not have any pen needles in the medication cart. The insulin pen being used by RN #3 was Basaglar Insulin and was not labeled with a resident's name or in a labeled bag. RN #3 discarded the insulin syringe. Surveyor immediately notified the Unit Manager (UM) of the observation. On 5/23/24 at 10:00 AM, surveyor notified the Director of Nursing (DON) of the observations. The DON stated insulin pens are delivered from the pharmacy with multiple pens in a labeled bag and stated when staff remove a pen from the bag the nurse should write the resident's name on the pen. Surveyor returned to the UM at 10:08 AM and the UM stated they removed a total of four unlabeled insulin pens from the 500 Hall medication cart. The unlabeled insulin pens included two used Basaglar Insulin pens, a used Fiasp Insulin Aspart pen and a new unused Fiasp Insulin Aspart pen. The UM stated they were running a report to determine which resident the insulin pens belonged to. When asked how they could determine which residents had used the pens, the UM stated they would throw out the Basaglar pens and obtain new ones but only one resident was prescribed Fiasp Insulin Aspart. On 5/23/24 at 10:24 AM in the presence of the DON, the surveyor observed the 400 Hall medication cart. The cart contained a Levemir Insulin pen without an identifiable resident name, smeared pen ink was visible on the label, an opened box of Levothyroxine 75 mg with an expiration date of 8/2023, and a vial of Insulin Glargine with a dispense date of 2/14/24 and a sticker which read: Beyond Use Date: 5/13/24. Based on several other opened medications, at times staff were writing the open date on the Beyond Use Date sticker, therefore, surveyor was unable to determine when the vial was opened. The survey team met with the Administrator, Assistant Administrator, DON, and Regional Nurse Consultant (RNC) on 5/23/24 at 11:15 AM and discussed the concern of the unlabeled used insulin pens available in the medication carts and the expired medications. The RNC stated they would dispose of the unlabeled insulin pens and obtain new ones. RNC stated insulin pens should be labeled with a resident's name. The RNC returned at 11:45 AM and stated the unlabeled insulin pens were in the possession of management and would be discarded. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor requested and received the facility policy titled, Storage of Medications which read in part III. Expiration Dating (Beyond-Use Dating) .8. All expired medications will be removed from the active supply and destroyed in accordance with facility policy, regardless of amount remaining . No further information regarding this concern was presented to the survey team prior to the exit conference on 5/23/24. 47299 2. On 5/22/24 at 8:40 AM during a medication pour and pass observation, this surveyor observed Registered Nurse (RN) # 1 leave 6 (six) medication cards on top of the medication cart unsecured while administering medications to a resident. There were other staff in the hallway where the medication cart was left. The cart was out of RN # 1's line of sight for 4 minutes. No staff or residents approached the cart during that time. The medications left unattended included clopidogrel 75 mg tablets, lisinopril 20 mg tablets, hydralazine 10 mg tablets, Lasix 40 mg tablets, finasteride 5 mg tablets, and Flomax 0.4 mg capsules. When RN # 1 Returned to the medication cart this surveyor asked if they typically leave medications unattended on the cart and they stated, No, I never do that. On 5/23/24 at 10:40 AM this surveyor performed a check of the 500 hall medication cart with RN # 3. In the second drawer of the cart, this surveyor observed an opened box of bisocodyl 10 mg suppositories with two suppositories remaining. The suppositories were house stock and did not have a resident name on the box. The expiration date stamped on the box was 12/2023. RN # 3 would not answer surveyors questions and did not comment, they walked away and stated, Lock the cart when you are done. There were multiple other staff observing this interaction. This surveyor discussed this concern with Licensed Practical Nurse (LPN) # 3. LPN # 3 took the medication and agreed that the expiration date was 12/2023. They stated they would destroy the medication. This surveyor requested and received the policy entitled Administration Procedure for all Medications with an effective date of 09-2018 that read in part, I. Security All medication storage areas (carts, medication rooms, central supply) are locked at all times unless in use and under the direct observation of the medication nurse/aide. A second policy entitled, Storage of Medications with an effective date of 09-2018 that read in part, under the heading Policy, Medications and biologicals are stored safely, securely, and properly, following manufacturer's recommendations or those of the supplier. The medication supply is accessible only to licensed nursing personnel, pharmacy personnel, or staff members lawfully authorized to administer medications. Under the heading of General Guidance the policy read in part, 8. Outdated, contaminated, or deteriorated medications and those in containers that are cracked, soiled, or without secure closures are immediately removed from inventory, disposed of according to procedures for medication disposal, and reordered from the pharmacy if a current order exists. This concern was reviewed with the Administrator, Assistant Administrator, Director of Nursing and the Regional Director of Clinical Services on 5/23/24 at 5:03 PM. No further information was provided to the survey team prior to the exit conference. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	28169 3. All of the blood collection tubes in the medication room on Unit 2 had expired. On 05/23/24 at 10:17 a.m., the surveyor completed an observation of the medication room on Unit 2 accompanied by the infection preventionist (IP), a licensed practical nurse, LPN #14. There were multiple types of blood collection tubes (i.e. blue tops, red/black tops, green tops, and purple tops). All the blood collection tubes were observed as having expired in various months in 2023. Of the over 100 tubes found, there were no blood collection tubes that were not expired. The IP acknowledged all the blood collection tubes had expired. The IP reported facility staff do not collect laboratory samples, they call a laboratory service for blood collection needs at any time, 24 hours/day. The IP acknowledged the expired blood collection tubes had been available for use and gathered the expired tubes to remove from the medication room. On 05/23/24 at 4:37p.m., the regional nurse was interviewed and reported that although there was no written policy with guidance about keeping the medication rooms with current products, it was the responsibility of central supply and nursing administration. On 05/23/24 at 5:03 p.m., the administrator, regional nurse, and DON were informed of the expired products found in Unit 2's medication room. The regional nurse reported facility staff do not collect their own blood samples and, instead call a laboratory service whenever a blood sample needed to be collected. No further information was provided prior to the exit conference.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. 42353 Based on staff interview, clinical record review, and facility document review, the facility staff failed to provide laboratory services to meet the needs of the resident for 1 of 32 sampled residents, Resident #314. The findings included: For Resident #314, the facility staff failed to obtain a urinalysis as ordered by the medical provider on 2/13/24. Resident #314's diagnosis list indicated diagnoses, which included, but not limited to Pneumonia, Generalized Muscle Weakness, Protein Calorie Malnutrition, Essential Hypertension, and Gastro-Esophageal Reflux Disease. Resident #314's minimum data set (MDS) with an assessment reference date (ARD) of 1/17/24 assigned the resident a brief interview for mental status (BIMS) summary score of 14 out of 15 indicating the resident was cognitively intact. Resident #314 was assessed by the facility family nurse practitioner (FNP) on 2/13/24, the progress note read in part .[adult child] reports last night patient showing signs of UTI [urinary tract infection] and was reportedly hallucinating today, patient denies acute issues when asked about dysuria, patient states slight but reports nowhere near discomfort [he/she] has had in the past with recurrent UTIs .Assessment and Plan . UA [urinalysis] with CS [culture and sensitivity] . A provider order for a urinalysis with reflex culture and sensitivity via an in and out catheterization was ordered to be obtained between 2/13/24 and 2/16/24. Surveyor was unable to locate results of the urinalysis or evidence that a urine sample was obtained for testing. On 5/22/24 at 9:30 AM, surveyor spoke with the FNP who stated they saw Resident #314 at the family's request for signs and symptoms of a UTI, but the resident denied having any issues and they ordered a CBC (complete blood count) and a UA. FNP stated the labs were obtained but the urine was not collected. FNP stated there was no documentation from nursing addressing why the urine was not collected. Surveyor requested and received the facility policy titled, Laboratory/Diagnostic Testing which read in part .1. A licensed nurse will obtain laboratory, radiology, or other diagnostic services to meet the needs of its patients as ordered by the provider. 2. A licensed nurse will monitor and track all provider ordered laboratory, radiology, and other diagnostic tests; ensure that tests are completed as ordered and communicate results to the provider . On 5/22/24 at 4:35 PM, the survey team met with the Administrator, Assistant Administrator, Director of Nursing, and the Regional Nurse Consultant and discussed the concern of staff failing to obtain a urinalysis for Resident #314. (continued on next page)

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this concern was presented to the survey team prior to the exit conference on 5/23/24.

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F 0776 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. 49622 Based on staff interview, clinical record review, and facility document review, the facility staff failed to meet the needs of a resident in regard to the timeliness of providing radiology services for 1 of 32 sampled residents, Resident #44. The findings include: For Resident #44 (R44) the facility staff failed to obtain radiology services timely, per the medical providers orders, on 1/19/24 and on 2/13/24. Diagnoses for R44 included but were not limited to, heart failure, acute and chronic respiratory failure with hypoxia, obstructive sleep apnea, and morbid severe obesity due to excess calories. A review of R44's clinical record revealed physician's orders that included an order dated, 1/19/24, that read in part, .cxr (chest x-ray) d/t (due to) worsening cough. [sic] s/p (status post) treatment for PNA (Pneumonia) 1/19 [sic] .end date 1/22/24 . A physician's order dated, 2/13/24, revealed, .CXR 2/13 [sic] .end date 2/16/24 . A review of R44's Radiology Result Reports revealed the chest x-ray that was ordered on 1/19/24 was not completed until 1/23/24 and a Radiology Result Report could not be located in the clinical record for the x-ray that was ordered on 2/13/24. This concern was discussed with the director of nursing (DON) and regional director of clinical services during an interview on 5/23/24. The DON informed surveyor the x-ray ordered on 1/19/24 for R44, was not obtained until 1/23/24 at 6:00 AM and there was no order for the x-ray. DON also informed surveyor that the x-ray ordered on 2/13/24 was missed and the NP (nurse practitioner) was made aware, and an x-ray was ordered and completed on 2/20/24. This concern was discussed at the pre-exit meeting on 5/23/24 at 5:02 PM, with the administrator, assistant administrator, director of nursing and the regional director of clinical services. Surveyor requested and received a facility policy titled, .Physician's Orders ., that revealed, .Orders . treatment orders must include .Right time .Follow-up Appointments, as necessary .Other orders as indicated by patient's condition with specific directions . No further information was provided to the survey team prior to exit.

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	05/23/2024

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 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs. 49622 Based on observation, resident interview, staff interview, and facility document review, the facility staff failed to support the nutritional well-being for 4 of 27 current samples residents (R 89, R 76, R 411, R 412), of the facility with a nourishing, well-balanced diet. The findings include: The facility staff failed to support the nutritional well-being for residents of the facility with a nourishing well-balanced diet, by not serving an adequate amount of ham salad as indicated on the corporate recipe. On 5/21/24 at 5:43 PM, Resident #89 (R 89), asked surveyor to look at her ham salad sandwich on her dinner tray. R 89 removed the top slice of bread from the sandwich and surveyor observed a minimal amount of ham salad on the bottom slice of bread. The ham salad appeared as a flat smear that was approximately the size of a teaspoon. R 89 stated she didn't think it was even a teaspoon amount. Surveyor asked R89's roommate, Resident #76 (R 76), if she could observe her ham salad sandwich. R 76' s' ham salad sandwich was observed to have a minimal amount of ham salad on the bottom slice of bread. The ham salad appeared as a flat smear that was approximately the size of a teaspoon. On 5/21/24 at 5:45 PM, surveyor asked the administrator (ADM) to accompany her to the room of R89 and R76. R89 and R76 showed ADM their ham salad sandwiches. ADM offered both residents another sandwich. On 5/21/24 at 5:55 PM, surveyor interviewed regional director of operations (RDO) for contracted dietary services. Surveyor asked RDO what the serving size for the ham salad sandwiches should be and RDO stated it just said, 1(one) whole on the diet guide. RDO stated ADM had made him aware of the problem with the ham salad sandwiches for dinner this evening and he currently had two dietary staff out on the floor offering residents a second sandwich. On 5/22/24 at 8:25 AM, surveyor interviewed RDO. RDO stated he was not sure which scoop the cook used for the ham salad sandwiches served at dinner on 5/21/24, but stated the cook should have used a #(number) 24 (twenty-four) scoop. Surveyor requested to see a #24 scoop and RDO could not locate a #24 scoop. RDO located a #30 (thirty) scoop and stated that was the closest to a #24 they had. RDO agreed if the cook used the #30 scoop, there would have been more ham salad on the bread than what was served and he stated he agreed one hundred percent, the sandwiches served on 5/21/24, did not have an adequate amount of ham salad. On 5/22/24 at 9:10 AM, surveyor interviewed Resident #412 (R412) and Resident #411 (R411). Surveyor asked R412 if she had a ham salad sandwich for dinner last evening (5/21/24) and resident stated yes, but there could not have been more than a teaspoon of ham salad as she pointed to a plastic teaspoon on her over-the-bed table. R411 stated there couldn't have been more than a teaspoon of ham salad in the middle of the bread. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0800 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 5/22/24 at 11:48 AM, surveyor interviewed dietary cook #1 (DC#1). Surveyor asked DC#1 about the ham salad sandwiches that were served for dinner on 5/21/24. DC#1 stated she looked at the chart and the chart said, red scoop #24. DC#1 stated she couldn't find a red scoop, so she used a blue scoop #16 (sixteen). DC#1 stated she used the blue scoop on all the sandwiches, but she did add a little more (ham salad) on some of the sandwiches. Surveyor asked DC#1 the protocol for not having the red scoop (#24) and she stated she didn't think to ask the RDO for the best option, but she knows now to ask, and she apologized for the error. DC#1 agreed she should have used the #30 scoop when a #24 scoop could not be located. This concern was discussed at an end of day meeting on 5/22/24 at 4:35 PM and at the pre-exit meeting on 5/23/24 at 5:02 PM, with the administrator, assistant administrator, director of nursing and the regional director of clinical services. Surveyor requested and received a facility document titled, Corporate Recipe-Number 21 (twenty-one) Soft Ham Salad Sandwich, which revealed, .Spread One #24 Scoop of Filling Between 2 (two) Slices of Bread . No further information regarding this issue was provided to the survey team prior to the exit.