

September 26, 2016

Mr. Rodney Miller Office of Licensure and Certification Division of Long Term Care Services 9960 Mayland Drive, Suite 401 Richmond, Va. 23233-1485

Dear Mr. Miller,

Enclosed is our Plan of Correction for Pheasant Ridge. The Plan of Correction will serve as the Facility's allegation of substantial compliance. Should you have any questions, please do not hesitate to call me at 540-725-8210.

Sincerely,

Mason Layne

Administrator

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PHEASANT RIDGE NURSING & REHAB CENTER

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

495325

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

> C 08/24/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

B. WING

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 000 INITIAL COMMENTS

An unannounced Medicare/Medicaid standard survey was conducted 8/22/16 through 8/24/16. Six complaints were investigated during the survey. The facility was not in compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 101 certified bed facility was 93 at the time of the survey. The survey sample consisted of 17 current Resident reviews (Residents #1 through #16 and #20) and 3 closed record reviews (Residents #17 through #19).

F 155 483.10(b)(4) RIGHT TO REFUSE; FORMULATE SS=D ADVANCE DIRECTIVES

> The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section.

> The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.

F 000

Preparation and submission of the Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or correctness of the conclusions set forth on the statement of deficiencies, the Plan of Correction is prepared and submitted solely because of the requirements under state and federal laws.

The facility kindly requests that the Plan of Correction serve and be accepted as the Facility's allegation substantial compliance.

F 155

- 1. For Resident #8, the Responsible Party and the Physician were notified and an Advanced Directive document was completed to include the necessary areas checked indicating the residents individual capacity as well as signatures from the RP and the physician. For Resident # 5, the most current code status has been determined and the physician's order for the resident's code status has been clarified.
- 2. For current residents residing in the center, a review has been completed of Advanced Directive documents and physician's orders for code status by the DCS/Designee to ensure that necessary/required areas on the document are completed, necessary/required signatures are present on the document,

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by deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ner safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days lowing 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 ys following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

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Event ID: GCK411

Facility ID: VA0208

If continuation sheet Page 1 of 109

(X6) DATE

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(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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08/24/2016

NAME OF PROVIDER OR SUPPLIER

PHEASANT RIDGE NURSING & REHAB CENTER

495325 B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

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(X5) COMPLETION DATE

F 155 Continued From page 1

This REQUIREMENT is not met as evidenced by:

Based on clinical record review and staff interview the facility staff failed to ensure a complete and accurate Virginia Department of Health DDNR (durable do not resuscitate) form for 2 of 20 Residents, Residents #8 and #5 and failed to accurately determine code status for 1 of 20 Residents, Resident #5.

The findings included:

1. For Resident #8 the facility staff failed to accurately complete the Virginia Department of Health DDNR form.

Resident #8 was admitted to the facility on 02/22/15 and readmitted on 03/14/16. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, aphasia, cerebrovascular accident, dementia, respiratory failure, and dysphagia.

The most recent MDS (minimum data set) with and ARD (assessment reference date) of 08/02/16 coded the Resident as 0 of 15 in section C, cognitive patterns. This is an annual MDS.

Resident #8's clinical record was reviewed on 08/23/16. It contained a Virginia Department of Health DDNR form which read in part:
"I further certify (must check 1 or 2)
[] 1. The patient is CAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment.
(Signature of patient is required)

F 155

current code status has been determined, and the physician's order accurately reflects the most current code status..

3. Education has been provided by the DCS/Designee to the Social Services Director and the Licensed Nurses regarding ensuring that necessary/required areas on the Advanced Directives document are completed and that required signatures have been obtained and are on the document. The education also included the requirement that the most current code status be accurately determined and the physician's order accurately reflect code status. A review of Advanced Directives documents and physician's orders for code status will be completed by the DCS/Designee for (5) residents per week for (12) weeks to ensure that necessary/required areas on the

Advanced Directives document have been completed, that required signatures are present, the most current code status has been determined, and the most current physician's order accurately reflects code status.

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Event ID: GCK411

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PHEASANT RIDGE NURSING & REHAB CENTER (X4] ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 155 Continued From page 2 [] 2. The patient is INCAPABLE of making an informed decision, not to make a rational evaluation of the risks and benefits of alternative to that decision. If you checked 2 above, check A, B, or C below. If A While capable of making an informed decision, the patient has executed a written advanced directive which direct that life-prolonging procedures be withheld for withdrawn. [] B. While capable of making an informed decision, the patient has executed a written advanced directive which direct which alphorits a "Person Authorized to Consent of the Patient's is required.)" [] C. The patient has not executed a written advanced directive which direct which appoints a "Person Authorized to Consent of the Patient's is required.)" No boxes had been checked in either area of the DDNR. Surveyor spoke with the RNC (regional nurse) SIMEET ADDRESS, CITY, SATE ZIP CODE 4355 PHEASANT RIDGE ROAD, 24314 4355 PHEASANT RIDGE ROAD, 242044 RESULTS AND ROAD AND CORRECTION ROAD AND CORRECTION ROAD AND CORRECTION ROAD AND COMPLETE AND OF COMPLETE			495325	B. WING		01	
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[] 2. The patient is INCAPABLE of making an informed decision about providing, withholding, or withdrawing a specific medical treatment because he/she is unable to understand the nature, extent or probable consequences of the proposed medical decision, or to make a rational evaluation of the risks and benefits of alternative to that decision. If you checked 2 above, check A, B, or C below. [] A. While capable of making an informed decision, the patient has executed a written advanced directive which direct that life-prolonging procedures be withheld for withdrawn. [] B. While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf" with the authority to direct that life-prolonging procedures be withheld or withdrawn. (Signature of "Person Authorized to Consent of the Patient's is required.) [] C. The patient has not executed a written advanced directive Wind appoints a "Person Authorized to Consent of the Patient's is required.) [] C. The patient has not executed a written advanced directive (living will or durable power of attorney for health care). (Signature of "Person Authorized to Consent of the Patient's Behalf is required)" No boxes had been checked in either area of the DDNR. Surveyor spoke with the RNC (regional nurse	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREF!	X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	SHOULD BE	COMPLETION
regarding the incorrect DDNR. RNC stated that the DDNR form was incomplete.		informed decision al withdrawing a speci- he/she is unable to or probable consequence medical decision, or of the risks and benedecision. If you checked 2 about the decision. If you checked 2 about the decision, the patient advanced directive wife-prolonging proces withdrawn. [] B. While capable of decision, the patient advanced directive withdrawn. [] B. While capable of decision, the patient advanced directive withdrawn. [] B. While capable of decision, the patient advanced directive with the authority to oppose with the authority to oppose with the authority to oppose with the authority of "Person Authorized to Conservedured.) [] C. The patient has advanced directive (I attorney for health can advanced directive (I attorney for health can advanced directive) No boxes had been of DDNR. Surveyor spoke with a consultant) on 08/24/regarding the incorrections.	INCAPABLE of making an bout providing, withholding, or ific medical treatment because understand the nature, extent uences of the proposed romake a rational evaluation efits of alternative to that ove, check A, B, or C below: of making an informed thas executed a written which direct that edures be withheld for of making an informed thas executed a written which appoints a "Person ent on the Patient's Behalf' direct that life-prolonging eld or withdrawn. (Signature and to Consent of the Patient's not executed a written living will or durable power of are). (Signature of "Person of the Patient's Behalf is checked in either area of the the RNC (regional nurse 16 at approximately 1330 oct DDNR. RNC stated that	4. 1	Results of the reviews conduby the Director of Clinical Sewill be reviewed at the Quali Performance Improvement (Meeting each month for (three The QAPI Committee will meeting to the plan as in substantial compliance. Once determines that the problem for the review will be comple	ervices/Desty Assurance Committee ee) months. ake recommidicated to see the QAPI no longer e	ce mendations sustain I Committee xists

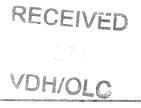
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The concern of the incomplete DDNR was discussed with the administrative staff during a

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	No further information 2. For Resident #5, complete a Virginia (durable do not resu accurately determinatatus. The record review repeatment of the properties of the properti	ge 3 6 at approximately 1630. on was provided prior to exit. the facility failed to accurately Department of Health DDNR uscitate) order and failed to e the Residents current code evealed that Resident #5 had the facility on 07/15/16. but were not limited to, s, morbid obesity, heart obstructive pulmonary status) of the Resident's nimum data set) assessment reference date) of BIMS (brief interview for e of 12 out of 15 points. ent was cognitively intact. cal record included a //16) POS (physician order the Residents code status	F 1	55	

However, the front of the Residents clinical record

included a DDNR order form that had been signed by the physician and the Residents POA (power of attorney). The date on this DDNR was documented as 07/21/16.

Under section 1 this DDNR read in part, "I further certify [must check 1 or 2]:

- 1. The patient is CAPABLE of making an informed decision...
- 2. The patient is INCAPABLE of making an

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08/24/2016

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HEASANT RIDGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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(X5) COMPLETION DATE

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informed decision..."

The boxes beside #1 and #2 had been left blank.

Under section 2 the DDNR box B had been checked. "While capable of making an informed decision, the patient has executed a written advanced directive which appoints a "Person Authorized to Consent on the Patient's Behalf' with authority to direct that life-prolonging procedures be withheld or withdrawn....

The bottom of this DDNR order form was signed by the physician and the POA (power of attorney).

The Residents CCP (comprehensive care plan) included the focus area "Resident has advanced directive r/t (related to) DNR."

The administrative staff were notified of the incomplete DDNR and inconsistencies in the Residents code status during an end of the day meeting with the survey team on 08/24/16 at approximately 3:20 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 241 483.15(a) DIGNITY AND RESPECT OF SS=D INDIVIDUALITY

> The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

This REQUIREMENT is not met as evidenced by:

F 155

F 241

1. For Resident #1, there were no adverse effects. The physician and the responsible party have been notified. LPN #1 has received education regarding maintaining resident dignity during treatment administration. An observation has also been conducted by the DCS/Designee for

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F 241 Continued From page 5

Based on observation, staff interview and clinical record review, the facility staff failed to maintain dignity during wound care for 1 of 20 residents (Resident #1).

The findings included:

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating, dressing and personal hygiene.

The surveyor observed wound care being performed on 8/24/16 at approximately 10 a.m. Resident #1's pressure ulcer was located on the resident's sacral area. After would care was performed by LPN #1, the nurse applied an occlusive dressing to the area. The nurse proceeded to write the date that the wound care was performed and signed her initials while the dressing was on the pressure ulcer on the Resident's sacral area.

LPN #1 was interviewed after the nurse had exited the room by the surveyor. The surveyor asked the nurse was it appropriate for her to date

F 241

LPN #1 during treatment administration to ensure that dignity is maintained during the procedure.

- 2. LPN #1 has received education regarding maintaining resident dignity during treatment administration. An observation has also been conducted by the DCS/Designee for LPN #1 during treatment administration to ensure that dignity is maintained during the procedure. For resident's currently residing in the facility with pressure ulcers, a treatment observation has been completed by the DCS/Designee to ensure that dignity is maintained during the treatment.
- 3. Education has been completed by the DCS/Designee with currently employed Licensed Nurses regarding maintaining dignity during resident treatment administration to include dating and signing the new dressing before applying the dressing to the resident. Treatment observations will be conducted by the DCS/Designee with (3) Licensed Nurses per week for (12) weeks to ensure that dignity is maintained during the treatment including signing and dating the new dressing before it is applied to the resident.

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F 24	The regional nurse of documented observed during wound care. That 's a dignity issue with that nurse right. The administrator, redirector of nursing with the documented findings that education had a concerning this matter.	dressing once it was applied N #1 stated, "No, it wasn't. I do that." was notified of the above ation made by the surveyor The regional nurse stated, "ue and we will do education now." egional nurse and interimere notified of the above the regional nurse stated aready begun with all nurses er.	F 24	4. Results by the Designed Assura Commit (three) will made revision sustain su	nce/Performand ittee Meeting ea	nical Services/ wed at the Quality ce Improvement ch month for API Committee ations for indicated to pliance. Once etermines that
F 252 SS=D	483.15(h)(1)	n was provided to the exit conference on 8/24/16. ORTABLE/HOMELIKE	F 252	5. 10/4/201	basis.	Ampleted on a
	The facility must prov comfortable and home the resident to use his to the extent possible.	elike environment, allowing s or her personal belongings		the shower i cleaned duri	Resident #10's coroom on Unit 1 wing the survey part of removing the	was Process.

This REQUIREMENT is not met as evidenced by:

Based on observation, resident and family interview, and in the course of a complaint investigation, the facility staff failed to ensure a clean and comfort homelike environment for 3 of 20 residents (Resident #10, #3 and #16).

The findings included:

This included removing the cotton balls from the floor, picking up and sanitizing the (4) handheld water sprayers from the floor, removing the (3) bottles of shampoo from the floor, and cleaning the red/brown material from the commode. For Resident #3,

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PHEASANT RIDGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

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(X5) COMPLETION DATE

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1. Resident #10 verbalized to the surveyor that the "hole" (referring to the shower room) was dirty and he would not take a shower in there.

Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident 's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 6 out of 15. Resident #10 requires set up help only for dressing and bathing.

During the resident interview with Resident #10 on 8/24/16 at approximately 1 pm, the surveyor asked the resident if he liked to take showers or preferred to wash off in his room. The resident stated, "Have you been down there to the hole where they take us for a shower? I would rather not take one if I had to take one in there." The surveyor asked the resident if the "hole" that he was referring to was the shower room. The resident stated, "Yes." The surveyor verbalized to the resident that the surveyor would go down to the shower room to make an observation. The resident stated "I wish you would."

The surveyor went to the shower room and was accompanied by Licensed Practical Nurse #2. Upon observation of the shower room, the surveyor noted the following: cotton balls were on the floor wet and observed randomly throughout the shower room, 4 hand held water sprayers were noted to be in the floor with the water still running, there were 3 bottles of shampoo in the floor and in the commode in the shower room was a reddish-brown dried

- the room and the bathroom were cleaned during the survey process.

 The urine odor was eliminated, the red/brown substance was cleaned off of the back of the commode, lint was removed from the floor underneath the window. The pieces of paper and the 2x2 gauze were also removed from the floor. For Resident # 16, the resident room was also cleaned during the survey process. Resident #16 no longer resides in the center.
 - 2. Facility rounds including shower rooms, resident rooms and bathrooms have been conducted by the ED/Designee to identify other environmental concerns. Further identified concerns were corrected as indicated by the results of the facility rounds.
 - 3. Education has been conducted by the ED/Designee with current employees regarding identification of and notification to the appropriate persons regarding environmental concerns to include shower rooms, resident rooms, and bathrooms. Education also included keeping these areas clean. Facility rounds /observations including the shower rooms, resident rooms, and resident

M CMS-2567(02-99) Previous Versions Obsolete

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PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CONSTRUCTION	(X3) DATE SURVEY
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		B. WING		08/24/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	TOOTE TIZOTO
PHEASANT RIDGE NURSING	3 & REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW	
			ROANOKE, VA 24014	
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	Y MUST BE PRECEDED BY FULL	PREF		(1/2)
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F 252 Continued From page 8

substance. LPN #2 stated "This shower room has been busy all day. Someone should had cleaned up after they were finished." The surveyor asked LPN #2 if this room appeared to be inviting and clean to the residents that used this shower room. LPN #2 stated "No, it doesn't."

The interim administrator, regional nurse and interim director of nursing were notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference.

THIS IS A COMPLAINT DEFIENCY.

2. For Resident #3, the facility staff failed to ensure a clean and comfortable homelike environment in the resident's room and bathroom.

The record review revealed that Resident #3 had been admitted to the facility 05/29/10. Diagnoses included, but were not limited to, mild intellectual disabilities, dysphagia, peripheral vascular disease, hypothyroidism, and convulsions.

Section C (cognitive patterns) of the Residents significant change in status MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/08/16 had included a BIMS (brief interview for mental status) summary score of 4 out of a possible 15 points.

On 08/23/16 at approximately 1:55 p.m. the surveyor completed an observation of the resident's bathroom. The bathroom was noted to have a strong odor of urine. The commode had been flushed and the resident did not have a roommate.

F 252

bathrooms will be conducted by the ED/Designee weekly for (12) weeks to identify environmental concerns as well as to ensure that cleaning is occurring.

- 4. The results of the facility rounds /observations will be discussed by the ED/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for (3) months. The committee will recommend revisions to the plan to sustain substantial compliance.
- 5. 10/4/2016

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1	OF DEFICIENCIES	WIEDICAID SERVICES			OMB NO. 0938-039
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		& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	1 00/24/2016
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2 gauze lying in the floor.

On 08/25/16 at approximately 9:30 a.m. the surveyor completed a second observation of the resident's bathroom. The surveyor was able to observe a large amount of a brownish/reddish substance on the back of the commode. The bathroom still had a pervasive odor of urine. Upon exiting the bathroom and walking toward the resident's window the surveyor was able to observe lint on the floor underneath the window, pieces of paper scattered on the floor, and a 2 X

During a group interview held with the residents of the facility on 08/24/16 at approximately 10:00 a.m. Resident #12 verbalized to surveyor #2 that she had to wait three days once to have her room cleaned. No problems were noted with Resident #12's room during the survey. Resident #12's BIMS score on their most recent MDS (07/14/16) was 15 out of 15 indicating the Resident was cognitively intact.

On 08/25/16 at approximately 9:05 a.m. the surveyor interviewed HKS (housekeeping staff) #1. HKS verbalized to the surveyor that the Resident rooms were cleaned daily. When asked if they were able to get their work completed HKS #1 stated yes, pretty much. When asked about any complaints regarding rooms not being clean HKS #1 stated not about me but that they had heard things about other staff not cleaning properly.

The administrative staff were notified of the above issues in Resident #3's room during a meeting with the survey team on 08/25/16.

No further information regarding this issue was

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PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENC	IES
ND PLAN O	F CORRECTION	N

NAME OF PROVIDER OR SUPPLIER

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A BUILDING

(X3) DATE SURVEY COMPLETED

495325

B WING

08/24/2016

PHEASANT RIDGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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provided to the survey team prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY

3. For Resident #16, the facility staff failed to ensure the Residents room was cleaned daily.

The record review revealed that Resident #16 was admitted to the facility 07/25/16. Diagnoses included, but were not limited to, acute kidney failure, cellulitis lower limb, anxiety, lymphedema, and heart failure.

Section C (cognitive patterns) of the Residents initial MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/01/16 included a BIMS (brief interview for mental status) score of 15 out of a possible 15 indicating the Resident was cognitively intact

During an observation of Resident #16's room on 08/24/16 at approximately 1:20 p.m. the surveyor was able to observe an odor of urine in the room and several wet and dry pieces of napkins/tissues laying about in the floor beside the Residents bed.

During a second observation during the morning hours of 08/25/16 the surveyor was again able to observe debris such as napkins scattered throughout the floor next to the Residents bed, linen piled onto a chair that fell over into the floor, this was removed from the room by a staff person. There was also a moderate amount of a white substance on the table and in the floor of the room.

During a group interview held with the Residents

F 252

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DEPAR CENTE	RTMENT OF HEALTH	HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 09/16/20 FORM APPROV DMB NO. 0938-03
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495325	B. WNG		08/24/2016
NAME OF	PROVIDER OR SUPPLIER		I	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/24/2016
PHEAS	ANT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
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F 252	a.m. Resident #12 she had to wait thre cleaned. No probler #12's room during the BIMS score on their was 15 out of 15 index cognitively intact. On 08/25/16 at appropriately interviewed #1. HKS verbalized Resident rooms were if they were able to get #1 stated yes, pretty any complaints regard HKS #1 stated not a heard things about of properly. During an interviewed 08/25/16 at approxime #16 was asked if how daily. Resident #16 where room was cleaned.	24/16 at approximately 10:00 verbalized to surveyor #2 that the days once to have her roomms were noted with Resident he survey. Resident #12's most recent MDS (07/14/16) dicating the Resident was roximately 9:05 a.m. the d HKS (housekeeping staff) to the surveyor that the re cleaned daily. When asked get their work completed HKS much. When asked about arding rooms not being clean about me but that they had other staff not cleaning with Resident #16 on mately 10:15 a.m. Resident usekeeping cleaned her room verbalized to the surveyor that the devery other day.	F 2	52	

No further information regarding this issue was provided to the survey team prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY. F 272 483.20(b)(1) COMPREHENSIVE SS=D ASSESSMENTS

F 272

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER PHEASANT RIDGE NURSING	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
PRÉFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	/ TOTAL STATE ACTION SHO	ULD BE COMPLETION
a comprehensive, a	ge 12 nduct initially and periodically occurate, standardized sment of each resident's	F 2	1. Resident #11, #6, and Res	

A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following:

Identification and demographic information;

Customary routine;

Cognitive patterns;

Communication;

Vision:

Mood and behavior patterns;

Psychosocial well-being;

Physical functioning and structural problems;

Continence;

Disease diagnosis and health conditions;

Dental and nutritional status;

Skin conditions:

Activity pursuit;

Medications;

Special treatments and procedures;

Discharge potential;

Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and

Documentation of participation in assessment.

- Resident #11, #6, and Resident #7
 Section V of the Care Area Assessment
 (CAA) Summary have had the location and date of the CAA documentation of where the supportive information could be found has now been added to the V0200 Location and Date of the CAA documentation.
- 2. The facility had reviewed section V of resident's who still reside in the facility and the location and date of the supportive CAA documentation will be added to the location and date summary column as it appears on the individual CAT worksheets
- 3. The Regional MDS consultant has completed education with the facility MDSC on section V and the RAI rules along with F tag F272. Going forward the facility will add the location and date of supportive documentation on the CAA summary

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/16/2016

		& MEDICAID SERVICES			FORM APPROVE MB NO. 0938-039
AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495325	B. WING		C 08/24/2016
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2 1/2 0 1 0
PHEASAN	T RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES			
PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION

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This REQUIREMENT is not met as evidenced

Based on staff interview and clinical record, the facility staff failed to ensure an accurate comprehensive MDS (Minimum Data Set) for 3 of 20 residents (Resident #11, #6 and #7).

The findings included:

1. The facility staff failed to ensure an accurate comprehensive MDS assessment for Resident #11.

Resident #11 was admitted to the facility on 10/2/15 with the following diagnoses of, but not limited to high blood pressure, thyroid disorder. seizures, depression, schizophrenia and severe intellectual disabilities. The resident was coded on the MDS with an AR (Assessment reference Date) of 6/15/16 as having a BIMS (Brief Interview for Mental Status) score of 1 out of a possible score of 15, in Section C, Cognitive Patterns.

The surveyor also reviewed Section V, Care Area Assessment (CAA) Summary. The facility staff did not identify the location and date of the CAA documentation of where it could be found. The only documentation noted in this area stated " CAA WS (worksheet) dated 6/20/16.

The MDS coordinator was interviewed on 8/24/16 at 2 pm. The MDS Coordinator stated that this was how she was taught to document in this area.

The administrator, regional nurse and the interim director of nursing were notified of the above documented findings on 8/24/16 at 4:30 pm.

F 272

column for comprehensive assessments. The facility DCS/Designee will review\ five (5) comprehensive assessments section V. Care Area Assessment (CAA) monthly to ensure the location and date of the supportive documentation is located on the V. CAA Location and date column.

- 4. The results of the review will be discussed by the DCS/Designee monthly for three (3) months at the **Quality Assurance Performance** Improvement Committee meeting. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
- 5. 10/4/2016

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PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

CENTER:	S FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED
		495325	B. WING		C 08/24/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PHEASAN	T RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORREC X (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION

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F 272

Np further information was provided to the surveyor prior to the exit conference.

2. For Resident #6 the facility staff failed to ensure an accurate comprehensive MDS (minimum data set) assessment.
Resident #6 was admitted to the facility on 05/25/12 and readmitted on 09/01/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia, dementia, dysphagia, hypothyroidism and psychotic disorder.

The most recent comprehensive MDS with and ARD (assessment reference date) of 02/20/16 coded the Resident as 3 of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was "see CAA WS dated 02/26/16".

The MDS coordinator was interviewed on 08/23/16 at approximately 1015. She stated that is how she had always done it. The administrative staff was notified of the findings during a meeting on 08/23/16 at approximately 1630.

No further information was provided prior to exit.

3. For Resident #7 the facility staff failed to ensure an accurate comprehensive MDS assessment.

Resident #7 was admitted to the facility on06/18/15 and readmitted on 11/25/15. Diagnoses included but not limited to anemia, urinary tract infection, Alzheimer's disease, dementia, malnutrition, anxiety, depression,

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FATEMENT OF DEFICIENCIES VD PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED C

495325

B WING

08/24/2016

VAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE PHEASANT RIDGE NURSING & REHAB CENTER

4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES /EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

(X5) COMPLETION DATE

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dysphagia, coronary artery disease and hip fracture.

The most recent comprehensive MDS with an ARD of 12/02/15 coded the Resident as 12 out of 15 in Section C, cognitive patterns. Section V, Care Area Assessment (CAA) Summary was also reviewed. The facility staff had not identified the date and location of the CAA information used to determine the care plan. The only documentation was "see CAA WS dated 12/03/15" The MDS coordinator was interviewed on 08/23/16 at approximately 1015. She stated that is how she had always done it The administrative staff was notified of the findings during a meeting on 08/23/16 at approximately 1630.

No further information was provided prior to exit. F 309 483.25 PROVIDE CARE/SERVICES FOR SS=E HIGHEST WELL BEING

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical. mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

This REQUIREMENT is not met as evidenced

Based on Resident interview, staff interview. facility document review, clinical record review. and in the course of a complaint investigation, the facility staff failed to provide the necessary care and services to attain or maintain the highest practicable wellbeing for 16 of 20 residents. Residents #3, #5, #12, #16, #20, #6, #7, #8, #1,

F 272

F 309

1. -For Resident #3, the physician and the responsible party have been notified. -For Resident #5, the physician and the responsible party have been notified. -For Resident #12, the physician and the responsible party have been notified. -For Resident #16, the (physician's order for allegra transcribed to the MAR??). Resident #16 no longer resides in the center. The physician and the responsible party have been notified. -For Resident #20, the physician's and the responsible party have been notified. The physician was contacted for further intervention.

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROV
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		495325	B. WING		C - 08/24/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	
PHEAS	ANT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE RO ROANOKE, VA 24014	DAD, SW
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) E ACTION SHOULD BE COMPLET D TO THE APPROPRIATE DATE DIENCY)
F 309	Continued From pa	ge 16	F 3	-09	
	#10, #11, #13, #15,	#2, #9, and #14.		For Resident #6, the	
	The findings include	ed.		responsible party hav	ve been notified.
	administer the Resiphysicians orders a facility bowel protoc The record review rebeen admitted to the	the facility staff failed to (A) dents medications per the nd failed to (B) follow the ol. evealed that Resident #3 had a facility 05/29/10. Diagnoses ot limited to, mild intellectual	- 1	(The fall mats have bedside as indicated. function if being mon For Resident #7, the state party Therapy has evaluate or half side rail and be seen to the control of the c	Wander-guard nitored. physician and have been notified.
	disabilities, dysphag	ia, peripheral vascular dism, and convulsions.	-]	For Resident #8, the party l	physician and
	Section C (cognitive significant change in set) assessment with reference date) of 08 interview for mental out of a possible 15 status) was coded (3 required extensive a for toilet use. Section coded (1/1) to indica occasionally incontin	patterns) of the Residents status MDS (minimum data n an ARD (assessment 8/08/16 had a BIMS (brief status) summary score of 4 points. Section G (functional 8/3) to indicate the Resident ssistance of two plus persons n H (bladder and bowel) was te the Resident was ent.	F -I c -I an -I c	Antihypertensive med currently being monit ohysician's order. For Resident #1, bowe currently being monit For Resident #10, bowe re currently being monit for Resident #11, bowe currently being monit	dications are tored per the el movements are tored and documented. Wel movements onitored and documente wel movements are tored and documented. Wel movements are tored movements are
	plan) included the for	nt CCP (comprehensive care cus areas of-		urrently being monit For Resident #15, bow	ored and documented. vel movements

Has impaired skin integrity due to dandruff and at risk for altered bowel and bladder elimination

history of constipation and irritable bowel syndrome.

(A) When reviewing the Residents MAR's (medication administration records) for July and August 2016 it was noted that the facility nursing staff had documented that the Residents depakote (seizure medication) was not available

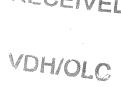
Facility ID: VA0208

documented.

are currently being monitored and

-For Resident #2, bowel movements

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PHEASANT RIDGE NURSING & REHAB CENTER

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

	495325	B. WING
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION
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(X3) DATE SURVEY COMPLETED

> C 08/24/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE
4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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for administration on 08/17/16 at 5:00 p.m. A review of the stat box list provided to the surveyor by the facility staff indicated that this medication would have been available in the stat box for administration.

Further review of the clinical record indicated that there was no documentation on the Residents MAR's (medication administration records) for July and August 2016 indicating the following medications and nutritional supplement had not been administered per the physician orders.

July 2016. Prostat July 13 at 9:00 a.m. Levothyroxine and Omeprazole on July 25 at 6:30 a.m.

For August 2016.

Levothyroxine and Omeprazole for August 1 and 2 at 6:30 a.m.

Hydrocodone August 3 at 6:00 a.m. and 2:00 p.m. Depakote August 11, 12, 14, 15, and 21 at 9:00 p.m.

Depakote and Loratadine on August 14 at 5:00 p.m.

Docusate and Ferrous Sulfate August 20 at 5:00 p.m.

Dilantin, Keppra, Vimpat, and Loratadine on August 21 at 9:00 p.m.

Hydrocodone on August 21 at 10:00 p.m. Mighty Shakes August 20, 21, and 22 at 5:00 p.m.

A review of the Residents TAR's (treatment administration records) for August 2016 indicated that the facility staff had not documented that they applied the Residents dandruff shampoo twice a week as ordered by the physician on August 1, 8,

F 309

are currently being monitored and documented.

- -For Resident #9, bowel movements are currently being monitored and documented.
- -For Resident #14, bowel movements are currently being monitored and documented.
- 2. For current residents residing in the facility, a review of the Medication Administration Record, Treatment Administration Record, and bowel movement documentation for the previous (30) days has been conducted by the Director of Clinical Services/Designee to identify further concerns regarding medication administration and parameters per physician's order including heart rate and blood pressure, treatment intervention implementation including fall mats, wander-guard, side rails and hip abductors, oxygen saturation levels per physician's order, bowel movement documentation and physician notification/intervention in the instance of no bowel movements within (3) days.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

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PHEASANT RIDGE NURSING & REHAB CENTER

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

495325

B. WING

C 08/24/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

F 309 Continued From page 18 11, 15 and the 18.

The facility did supply the surveyor with copies of the narcotic sheets referencing the hydrocodone. Indicating the nursing staff had removed the hydrocodone from the narcotic drawer on August 3 at 6:00 a.m. and 2:00 p.m. and on August 21 at 9:00 p.m.

Prior to the exit conference on 08/25/16 the facility staff did not provide the survey team with any evidence to indicate the above medications, treatments, and/or nutritional supplements were provided and administered per the physician orders and/or plan of care.

THIS IS A COMPLAINT DEFICIENCY.

1(b). The Residents ADL (activity of daily living) tracking form for July 2016 indicated that Resident #3 had BMs (bowel movements) on July 9, 14, 22, 29 and 30.

A review of the Residents current physician orders indicated the Resident was receiving Docusate Sodium (colace) 100 mg 1 cap twice daily for constipation.

The facility staff provided the survey team with a copy of their policy/procedure titled "Bowel Movement Assessment." This policy/procedure read in part. "...The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident's last bowel movement and identifies the need for additional interventions. If the resident had not had a bowel movement by the third day, he/she is given a laxative or suppository, depending on the circumstances and physicians orders. The nurse checks the

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3. Education has been provided by the DCS/Designee to the Licensed Nurses regarding administration of medications per the physician's orders, monitoring parameters for medications including heart rate and blood pressure and documentation of parameters per the physician's orders, treatment intervention implementation documentation including fall mats, wander-guard, side rails, hip abductors, oxygen saturation levels obtained per physician's orders, and bowel movement documentation including physician notification/intervention in the instance of no bowel movement within (3) days. A review will be conducted by the

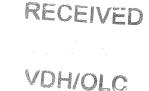
DCS/Designee of the medical record,
Medication Administration Record,
Treatment Administration Record,
and bowel movement records (2) times
per week for (3) months to ensure
that medications are administered per
the physician's order, parameters
including heart rate and blood pressure
are monitored per the physician's order,
treatment interventions are documented
per the physician's order including fall

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

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If continuation sheet Page 19 of 109



PRINTED: 09/16/2016 FORM APPROVED OMB NO 0938-0391

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1	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			OATE SURVEY OMPLETED
		495325	B WING			C 08/24/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC	DE	
PHEASAI	NT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH CORRECTIVE ACTION S	ER'S PLAN OF CORRECTION (X5 RRECTIVE ACTION SHOULD BE COMPLE ERENCED TO THE APPROPRIATE DAT DEFICIENCY)	
F 309	Continued From pa	ge 19	F	309		

resident's order sheet making sure there is a laxative or suppository order."

During a meeting with the administrative staff on 08/24/16 at approximately 3:20 p.m. the surveyor asked if the facility had any further information regarding the Residents BM's.

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #5, the facility staff failed to administer medications and obtain oxygen saturations as ordered by the physician.

The record review revealed that Resident #5 had been readmitted to the facility on 07/15/16. Diagnoses included, but were not limited to, sepsis, osteoarthritis, morbid obesity, heart failure, and chronic obstructive pulmonary disease.

Section C (cognitive status) of the Resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/22/16 included a BIMS (brief interview for mental status) score of 12 out of 15 points. Indicating the Resident was cognitively intact

The Residents clinical record included a physician signed (08/__/16) POS (physician order sheet) that included the orders O2 (oxygen) saturation every shift.

The Residents TAR (treatment administration record) read O2 sat (saturation) every shift as needed for SOB (shortness of breath)/change in condition. The TAR did not include any O2

matts, wander-guard, side rails, hip abductors, oxygen saturation levels per the physician's order, and bowel movements are documented with intervention as indicated per the physician's order.

- 4. Results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee (QAPI) meeting monthly for (3) months. The committee will recommend revisions \ to the plan as indicated to sustain substantial compliance.
- 5. 10/4/2016

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If continuation sheet Page 20 of 109 KEULIVED



EPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/16/2016 ROVED 38-0391

ENTERS FOR MEDICAL	RE & MEDICAID SERVICES		FORM APPROV	
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
	495325	B. WING		08/24/2016
AME OF PROVIDER OR SUPPLIE	R		STREET ADDRESS, CITY, STATE, ZIP CODE	
HEASANT RIDGE NURSIN	G & REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW	
	- was a summary of the I V		ROANOKE, VA 24014	

SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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saturations for the entire month of August 2016.

There was no documentation on the Residents MAR's (medication administration records) for August 2016 indicating the following medications had been administered per the physician orders. Potassium (KCL) August 14 at 9:00 p.m. and August 17 at 2:00 p.m. Diltiazen August 10 at 9:00 a.m. Oxycodone August 8 at 6:00 a.m.

A review of the narcotic sheet for August 8 indicated that the facility nursing staff had documented they had removed the Oxycodone from the narcotic drawer at 6:00 a.m.

The administrative team were notified of the above issues during a meeting with the survey team on 08/25/16.

Prior to the exit conference on 08/25/16 the facility staff did not provide the survey team with any evidence to indicate the above medications, treatments, and/or nutritional supplements were provided and administered per the physician orders and/or plan of care.

THIS IS A COMPLAINT DEFICIENCY

3. For Resident #12, the facility staff failed to administer the Residents medications as ordered by the physician.

The record review revealed that Resident #12 was admitted to the facility 10/25/12. Diagnoses included, but were not limited to, multiple sclerosis, abnormal posture, hyperlipidemia, atrial fibrillation, and hypertension.

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Event ID: GCK411

Facility ID: VA0208

If continuation sheet Page 21 of 109





		AND HUMAN SERVICES			PRINTED: 09/16/201 FORM APPROVEI OMB NO. 0938-039
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495325	B. WING		C 08/24/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PHEASA	NT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
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F 309	annual MDS (miniman ARD (assessme included a BIMS (br score of 15 out of a Resident was cogni During an interview 08/25/16 at approximal 412 verbalized to the months ago she had medications and the evenings. There was no docur MAR's (medication and July and August 201 medications/treatment per the physician or July 2016-Metoprolol Tartrate Atorvastatin on July Eucerin calming creation the 3-11 shift.	e patterns) of the Residents num data set) assessment with the reference date) of 07/14/16 rief interview for mental status) 15 points. Indicating the tively intact. With Resident #12 on mately 8:20 a.m. Resident e surveyor that a couple of d a problem with getting her at this mostly happened in the mentation on the Residents administration records) for 6 indicating the following ents had been administered ders. July 10 at 5:00 p.m. 10 at 9:00 p.m. am on July 9, 10, 22, and 29 3, 9, 10, 15, and 29 on the	F3		

Diltiazem on August 9 at 9:00 a.m.

The administrative team were notified of the above issues during a meeting with the survey team on 08/25/16.

Prior to the exit conference on 08/25/16 the facility staff did not provide the survey team with any evidence to indicate the above medications or treatments were provided and administered

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

Facility ID: VA0208

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	B. WING		C 08/24/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PHEASANT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
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F 309 Continued From page	na 22		0.0	

ontinued From page 22 per the physician orders and/or plan of care. F 309

THIS IS A COMPLAINT DEFICIENCY.

4. For Resident #16, the facility staff failed to transcribe an order for allegra onto the Residents MAR (medication administration record) which resulted in the Resident not receiving the medication per the physician order.

The record review revealed that Resident #16 was admitted to the facility 07/25/16. Diagnoses included, but were not limited to, acute kidney failure, cellulitis lower limb, anxiety, lymphedema, and heart failure.

Section C (cognitive patterns) of the Residents initial MDS (minimum data set) assessment with an ARD (assessment reference date) of 08/01/16 included a BIMS (brief interview for mental status) score of 15 out of a possible 15 points indicating the Resident was cognitively intact

The Residents clinical record included a physician order dated 08/19/16 for "Allegra 24 hr 60 mg tab one po (by mouth) daily X 10 days-allergies."

During the record review the surveyor was unable to locate this order on the Residents current MAR.

On 08/25/16 at approximately 6:35 a.m. the surveyor asked LPN (licensed practical nurse) #1 to review the order and MAR. After reviewing the MAR LPN #1 verbalized to the surveyor that the order for the allegra was not on the MAR.

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Event ID: GCK411

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DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 09/16/2016

CENTER	S FOR MEDICARE	& MEDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
TATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495325	B. WING_		C 08/24/2016
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PHEASAN	NT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	JLD BE COMPLETIO

F 309 Continued From page 23

On 08/25/16 at approximately 10:20 a.m. the surveyor asked LPN #2 about the allegra. LPN #2 verbalized to the surveyor that she had not given Resident #16 any allegra. When asked to check and see if the pharmacy had sent any to the facility LPN #2 verbalized to the surveyor that the allegra was a stock medication and would not have come from the pharmacy.

The administrative team were notified of the above issues during a meeting with the survey team on 08/25/16.

The facility policy/procedure titled "Physician Orders" read in part "A Clinical Nurse shall transcribe and review all physician orders in order to effect their implementation...The order must then be transcribed to all appropriate areas (MAR...)."

No further information regarding the allegra was provided to the survey team prior to the exit conference.

THIS IS A COMPLAINT DEFICIENCY.

5. For Resident #20, (A) administer the Residents medications per the physicians orders and failed to (B) follow the facility bowel protocol.

The record review revealed that Resident #20 was admitted to the facility 09/07/09. Diagnoses included, but were not limited to, dementia, dysphagia, atrial fibrillation, anemia, and hypertension.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of

F 309

DEFICIENCY

PRINTED: 09/16/2016 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF GORRECTION PROVIDER OR SUPPLIER PHEASANT RIDGE NURSING & REHAB CENTER PRESS PHEASANT RIDGE NURSING & REHAB CENTER REQUISITED WITH REPORT OF DETERMINES PROVIDED BY PRESS PROVIDERS PLAY OF CORRECTION PRESS PROVIDER OF CORRECTION PRESS PROVI	CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0	391
NAME OF PROVIDER OR SUPPLIER PHEASANT RIDGE NURSING & REHAB CENTER SIMMARY STATEMENT OF DETICIONORS REGILATORY OR A SCIENTIFICATION OF DETICIONORS FREETY REDIVERS NAME OF TOTAL OR THE PROVIDER SHAN OF CORRECTION FREETY TAG FROM Continued From page 24 O7711/16 included a BIMS (brief interview for mental status) score of 2 out of a possible 15 points. Section 6 (functional status) was coded (32) to indicate the Resident required extensive arisistance of one person for toller use. Section H (bladder and bowel) was coded (22/2) to indicate the Resident required extensive and bladder. (A) When reviewing the Residents MAR's (medication administration records) for August 2016 the surveyor was unable to find any documentation to indicate the following medications and/or nutritional supplements had been administrated per the physicians order. Gabapentin and Mirtazapine for August 1 and 5 at 9:00 p.m. UTI Stat August 16 at 12 p.m. Med pass August 16 at 120 p.m. Med pass August 16 at 120 p.m. Prior to the exit conference on 08/25/16 the facility staff cition to provide the survey team with any evidence to indicate the above medications, treatments, and/or nutritional supplements were provided and administered per the physician orders. THIS IS A COMPLAINT DEFICIENCY. 5(b). The Residents current CCP (comprehensive care plan) included the focus area at risk for altered elimination related to history of chronic constipation, history of colon cancer with partial colectomy, and history of laxative abuse.				1		(X3) DATE SURVEY	
PHEASANT RIDGE NURSING & REHAB CENTER (XA) ID SUMMARY STATEMENT OF DEPICIENCY SEPTICE. TAG PROPERTY RECORD BY FULL REGULATORY OR LSO IDENTEYING INFORMATION) FROM Continued From page 24 O7/11/18 included a BIMS (brief interview for mental status) score of 2 out of a possible 15 points. Section G (functional status) was coded (3/2) to indicate the Resident required extensive assistance of one person for tolder use. Section H (bladder and bowel) was coded (2/2) to indicate the Resident was frequently incontinent of bowel and bladder. (A) When reviewing the Residents MAR's (medication administration to indicate the following medications and/or nutritional supplements had been administered per the physicians order. Gabapentin and Mirtazapine for August 1 and 5 at 9:00 p.m. Magic Cup August 16 at 12 p.m. Med pass August 16 at 12 p.m. Med pass August 16 at 12 p.m. Med pass August 16 at 19 p.m. Prior to the exit conference on 08/25/16 the facility staff did not provide the survey team with any evidence to indicate the above medications, treatments, and/or nutritional supplements were provided and administered per the physician orders and/or plan of care. THIS IS A COMPLAINT DEFICIENCY. 5(b). The Residents current CCP (comprehensive care plan) included the focus area at risk for altered elimination related to history of chronic constipation, history of colon cancer with partial colectomy, and history of laxative abuse.			495325				3
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) F 309 Continued From page 24 07/11/16 included a BIMS (brief interview for mental status) score of 2 out of a possible 15 points. Section G (functional status) was coded (3/2) to indicate the Resident required extensive assistance of one person for totilet use. Section H (bladder and bowel) was coded (1/2) to indicate the Resident was frequently incontinent of bowel and bladder. (A) When reviewing the Residents MAR's (medication administration records) for August 2016 the surveyor was unable to find any documentation to indicate the following medications and/or nutritional supplements had been administered per the physicians order. Gabapentin and Mirtazapine for August 1 and 5 at 9:00 p.m. UTI Stat August 16 at 1:00 p.m. Med pass August 16 at 1:00 p.m. Prior to the exit conference on 08/25/16 the facility staff did not provide the survey team with any evidence to indicate the above medications, treatments, and/or nutritional supplements were provided and administered per the physician orders and/or plan of care. THIS IS A COMPLAINT DEFICIENCY. 5(b). The Residents current CCP (comprehensive care plan) included the focus area at risk for altered elimination related to history of chronic constipation, history of colon cancer with partial colectomy, and history of laxative abuse.			& REHAB CENTER		4355 PHEASANT RIDGE ROAD	ZIP CODE	Philippin de de la companya del companya del companya de la compan
07/11/16 included a BIMS (brief interview for mental status) score of 2 out of a possible 15 points. Section G (functional status) was coded (3/2) to indicate the Resident required extensive assistance of one person for toilet use. Section H (bladder and bowel) was coded (2/2) to indicate the Resident was frequently incontinent of bowel and bladder. (A) When reviewing the Residents MAR's (medication administration records) for August 2016 the surveyor was unable to find any documentation to indicate the following medications and/or nutritional supplements had been administered per the physicians order. Gabapentin and Mirtazapine for August 1 and 5 at 9:00 p.m. UTI Stat August 16 at 9:00 a.m. Magic Cup August 16 at 12 p.m. Med pass August 16 at 1:00 p.m. Prior to the exit conference on 08/25/16 the facility staff did not provide the survey team with any evidence to indicate the above medications, treatments, and/or nutritional supplements were provided and administered per the physician orders and/or plan of care. THIS IS A COMPLAINT DEFICIENCY. 5(b). The Residents current CCP (comprehensive care plan) included the focus area at risk for altered elimination related to history of chronic constipation, history of colon cancer with partial colectomy, and history of laxative abuse.	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFI:	X (EACH CORRECTIVE AC CROSS-REFERENCED TO	TION SHOULD BE COMPLE THE APPROPRIATE DATE	TION
The Resident was currently receiving		07/11/16 included a mental status) score points. Section G (fi (3/2) to indicate the assistance of one p (bladder and bowel) the Resident was from and bladder. (A) When reviewing (medication administered pure documentation to insert administered pure documentation and Mir 9:00 p.m. UTI Stat August 16 and Magic Cup August 16 and Magic Cup August 16 and Magic Cup August 16 and Magic Staff did not pany evidence to indicate treatments, and/or any evidence to indicate and adminitional and magic Cup August 16 and adminitional and a	BIMS (brief interview for e of 2 out of a possible 15 unctional status) was coded Resident required extensive erson for toilet use. Section H was coded (2/2) to indicate equently incontinent of bowel the Residents MAR's stration records) for August was unable to find any dicate the following nutritional supplements had per the physicians order. It at 9:00 a.m. 6 at 12 p.m. at 1:00 p.m. Berence on 08/25/16 the provide the survey team with cate the above medications, utritional supplements were stered per the physician force. NT DEFICIENCY. Current CCP (comprehensive the focus area at risk for elated to history of chronic of colon cancer with partial ry of laxative abuse.	F 3	09		

polyethylene glycol powder daily and senexon-s

EPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/16/2016 FORM APPROVED IO. 0938-0391

ENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-03
TEMENT OF DEFICIENCIES PLAN OF CORRECTION	IDENTIFICATION NUMBER:		ILTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	495325	B. WING		C 08/24/2016
ME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
			4355 PHEASANT BINGE BOAD SW	

HEASANT RIDGE NURSING & REHAB CENTER

ROANOKE, VA 24014

SUMMARY STATEMENT OF DEFICIENCIES X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION RÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY)

F 309 Continued From page 25 twice a day for constipation.

F 309

The Residents ADL (activity of daily living) tracking form for July 2016 indicated that Resident #20 had BMs (bowel movements) on July 3, 4, 7, 8, 13, 14, 29, and 30.

The facility staff provided the survey team with a copy of their policy/procedure titled "Bowel Movement Assessment." This policy/procedure read in part. "... The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident's last bowel movement and identifies the need for additional interventions. If the resident had not had a bowel movement by the third day, he/she is given a laxative or suppository, depending on the circumstances and physicians orders. The nurse checks the resident's order sheet making sure there is a laxative or suppository order."

The administrative team were notified of all the above issues during a meeting with the survey team on 08/25/16.

No further information regarding this issue was provided to the survey team prior to the exit conference.

6. For Resident #6 the facility staff failed to follow physician's orders for the administration of the thyroid medication Levothyroxine and acetaminophen and for the treatments fall mats at bedside, and check wanderquard function.

Resident #6 was admitted to the facility on 05/25/12 and readmitted on 09/01/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia,

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/16/20

CENTERS FOR ME	EDICARE	& MEDICAID SERVICES				M APPROVE
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		495325	B. WING			C
PHEASANT RIDGE N	NURSING 8			STREET ADDRESS, CITY, STATE, ZII 4355 PHEASANT RIDGE ROAD, S ROANOKE, VA 24014	P CODE	8/24/2016
PREFIX (EACH D	DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETIO DATE
F 309 Continued	From pag	e 26	F 30	D9		A

dementia, dysphagia, hypothyroidism and psychotic disorder.

The most recent comprehensive MDS with and ARD (assessment reference date) of 02/20/16 coded the Resident as 3 of 15 in Section C. cognitive patterns.

Resident #6's clinical record was reviewed on 08/23/16. It contained a signed POS (physician's order summary) dated 04/01/16 which read in part "Levothyroxine 175mcg tablet for levothyroxine sodium-take 1 tab by mouth every day for hypothyroidism" and "acetaminophen 325mg tablet for Tylenol 2 tabs (650mg) by mouth twice daily for pain". The Resident's clinical record also contained an MAR (medication administration record) which read in part "Levothyroxine 175mcg tablet for levothyroxine sodium-take 1 tab by mouth every day for hypothyroidism". This entry had not been initialed as having been administered on the following days: 04/10-14, 04/19-20, 04/22-26, and 04/28-29. The MAR also contained an entry which read in part "acetaminophen 325mg tablet for Tylenol 2 tabs (650mg) by mouth twice daily for pain". This entry had not been initialed as having been given on 04/11-12 at 5pm.

Resident #6's clinical record contained a signed POS dated 08/01/16 which contained the following entries: "Wanderguard-check function and expiration every shift and as needed" and "fall mats to floor when in bed". The Resident's TAR (treatment administration record) for the months of May, June, and July contained entries which read in part "wanderguard-check function and expiration every shift and as needed" and "fall mats to floor when in bed". The entry for the wanderguard had not been initialed as having

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

Facility ID: VA0208

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495325	B. WING			ns	C 3/24/2016
	PROVIDER OR SUPPLIER	& REHAB CENTER		43	REET ADDRESS, CITY, STATE, ZIP CODE 55 PHEASANT RIDGE ROAD, SW DANOKE, VA 24014	T CO	112412016
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	been checked on th 05/25, 05/27, 06/19 shift. The entry for f as having been don 05/4-5, 05/25, 05/27 and 06/20, 06/23-24 07/29-30 on 11-7 sh. The concern of the medication and trea brought to the attent during a meeting on 1630. The RNC (reg that they could not contain the strength of the they could not contain the strength of the they could not contain the strength of the stren	e following dates: 05/4-5, -20, 06/27-29, all for 3-11 all mats had not been initialed e on the following dates: 7, 06/02, 06/4-5 for 3-11 shift 1, 06/27-29, 07/11, 07/25, and ift. missing documentation of tment administration was ion of the administrative staff 08/23/16 at approximately tional nurse consultant) stated	FS	09			
	No further information	n was provided prior to exit.					
	physician's orders fo trazodone and ativar hydrocodone and ibu mouthwash, the supp	uprofen, and peri-dex plements magic cup, uti-stat, n gelatin and the treatments					
	06/18/15 and readmin included but not limite infection, Alzheimer's	depression, dysphagia,					
	an ARD (assessment	(minimum data set) with reference date) of 05/25/16 s 12 of 15 in section C,					

cognitive patterns. This is a quarterly MDS.

PRINTED: 09/16/20° FORM APPROVE OMB NO. 0938-039

				21/10 140. 0330=038
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X3) DATE SURVEY COMPLETED
	495325	B. WING _		C 08/24/2016
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0012112010
PHEASANT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION

F 309

F 309 Continued From page 28

Resident #7's clinical record was reviewed on 08/23/16. It contained a signed POS (physician's order summary) dated 08/01/16 which read in part "lorazepam 0.5mg tablet for Ativan-take 1/2 tab (0.25.mg) by mouth every morning", "Peri-Dex mouthwash 15cc q8 (every 8 hours) x 7 days", trazodone 50mg tablet for Desyrel U-D-take 1/4 tab (12.5mg) by mouth every

evening (4pm) for depression/anxiety", "lorazepam 0.5mg....take 1 tab by mouth every evening for anxiety",

hydrocodone-acetaminophen 5-325mg tablet for Norco-take 1 tab by mouth every 6 hours for pain", ibuprofen 400mg tablet for Motrin-take 1 tab by mouth every 6 hours for pain", trazodone hol 50mg....take 1/2 tab (25mg) by mouth at bedtime for depression/sundowning", "uti-stat 30cc (1oz) by mouth twice daily", protein gelatin twice daily as supplement for weight loss", "magic cup by mouth three times daily with meals", "medpass: take 90ml (3oz) four times daily as supplement for weight loss" and "1/2 bed side rails for increased bed mobility".

Resident #7's MAR (medication administration record) for the month of July was reviewed and contained the following entry which read in part "trazodone 50mg tablet...take 1/4 tab by mouth every evening..." This entry had not been initialed as having been administered on 07/4 or 07/21. The MAR contained an entry which read in part "hydrocodone-acetaminophen 5-325mg tablet...take 1 tab by mouth every 6 hours for pain". This entry had not been signed as having been administered on 07/19-21 at 12pm, 07/29 at 6am or 12am. The MAR contained an entry which read in part "ibuprofen 400mg tablet...take 1 tab by mouth every 6 hours for pain". This entry had

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OLIVILIA	3 FOR MEDICARE	& MEDICAID SEKVICES			OWR M	O. 0938-039 1
STATEMENT (AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		ATE SURVEY OMPLETED
		495325	B. WING		0:	C 8/24/2016
	T RIDGE NURSING	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP 4355 PHEASANT RIDGE ROAD, S ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
	Continued From pa	ge 29	F3	309		

not been initialed as having been administered on 07/21 at 12pm, 07/29 at 6am or 12am. The MAR contained an entry which read in part "trazodone hcl 50mg....take 1/2 tab (25mg) by mouth at bedtime...". This entry had not been signed as having been administered on 07/10. The MAR contained an entry which read in part "ativan 0.25mg 1 po q9A for anxiety". This entry had not been signed as having been administered on 07/28. The MAR contained an entry which read in part "ativan 0.25mg take 2 tabs po q5pm for anxiety". This entry had not been signed as having been administered on 07/18. The MAR contained an entry which read in part "Peridex mouthwash 15cc q8 hours x 7 days". This entry had not been initialed as having been administered on 07/28-29 at 6am, 07/27-29 at 2pm or 07/29 at 10pm. The MAR contained an entry which read in part "Magic Cup by mouth three times a day with meals". This entry had not been signed as having been administered on 07/28 and 07/30 at 9am and 1pm, and 07/06 and 0710 at 5pm. The MAR contained an entry which read in part "UTI-Stat 30cc (1oz) by mouth twice daily". This entry had not been signed as having been administered on 07/28 at 9am and 07/04, 07/06, 07/20-31 at 9pm. The MAR contained an entry which read in part "Medpass: Take 90ml (3oz) four times daily as supplement for weight loss". This entry had not been signed as having been administered on 07/28 at 9am or 1pm, 07/30 at 1pm, 07/06 and 07/10 at 5pm or 9pm, and 07/31 at 9pm. The MAR contained an entry which read in part "Protein gelatin twice daily as supplement for weight loss". This entry had not been signed as having been administered on 07/28 at 9am, 07/06 and 07/10 at 5pm.

Resident #7's TAR (treatment administration

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ENTER		. 0938-039				
	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING		1, ,	(X3) DATE SURVEY COMPLETED		
		495325	B, WING		08.	C / 24/2016
	ROVIDER OR SUPPLIER	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	DE	
K4) ID REFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(HOULD BE	(X5) COMPLETION DATE
C 000						

F 309 Continued From page 30

record) contained an entry which read in part" 2 1/2 side rails for increased bed mobility". This entry had not been signed on 07/23, 07/29 and 07/30 for 7-11, 07/5-6, 07/08-10, 07/ 23-24, and 07/29 for 3-11, and 07/28-30 for 11-7. The TAR contained an entry which read in part "hip abductor in place at all times". This entry had not been signed as having been done on 07/10-11 on 7-3, 07/05, 07/08-11 on 3-11, and 07/04, 07/08-11 on 11-7.

The concern of the missing documentation of medication and treatment administration was brought to the attention of the administrative staff during a meeting on 08/23/16 at approximately 1630. The RNC (regional nurse consultant) stated that they could not confirm that the medications/treatments had been completed as ordered.

No further information was provided prior to exit.

8. For Resident #8 the facility staff failed to follow physician's orders for the antihypertensive medications lisinopril and metoprolol, cholesterol medication atorvastatin, Ultram, Eliquis, aspirin and lisinopril and for monitoring for the antihypertensive medication diltiazem.

Resident #8 was admitted to the facility on 02/22/15 and readmitted on 03/14/16. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, aphasia, cerebrovascular accident, dementia, respiratory failure, and dysphagia.

F 309

1 CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

Facility ID: VA0208

If continuation sheet Page 31 of 109



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CENIE	RS FOR MEDICARE	& MEDICAID SERVICES	·	-	OMB NO. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495325	B. WING		C 08/24/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PHEAS	ANT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW	
				ROANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		LD BE COMPLETION
F 309	and ARD (assessm 08/02/16 coded the	ge 31 DS (minimum data set) with ent reference date) of Resident as 0 of 15 in section s. This is an annual MDS.	F3	809	
	08/23/16. It contains order summary) dat part "aspirin 81mg t every day for proph 180mg cap ER 24-t for hypertension-hol pressure) 110 or 15 mg tablet-take 1 tahypertension", "tram 1 tab by mouth ever "atorvastatin 40mg to bedtime for hyperlip ER 24hr-take 1 tab hypertension", " met 24hr-take 1 tab by hypertension" and "I</td <td>ablet-take 1 tab by mouth at idemia" "metoprolol 50mg tab by mouth every morning for oprolol 25mg tab ER nouth every evening for Eliquis 2.5mg tablet-take 1 tab of for hx (history of) CVA</td> <td></td> <td></td> <td></td>	ablet-take 1 tab by mouth at idemia" "metoprolol 50mg tab by mouth every morning for oprolol 25mg tab ER nouth every evening for Eliquis 2.5mg tablet-take 1 tab of for hx (history of) CVA			
	record) for the monti reviewed. The MAR which read in part "o ER 24-take 1 cap by hypertension-hold fo pressure) 110 or H<br were no recorded BR dates: 07/01-03, 07/ HR's on 07/07-08, 0 The MAR contained "atorvastatin 40mg to bedtime for hyperlipi	s (medication administration hs of July and August were for July contained an entry liltiazem 24hr CD 180mg cap mouth every day for r SBP (systolic blood IR (heart rate) <55". There P's or HR's on the following 16, or 07/30 and no recorded 7/11, 07/16, 7/22, or 07/27. an entry which read in part ablet-take 1 tab by mouth at demia". This entry had not ng been administered on			

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

PRINTED: 09/16/2016

DATE

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	-		FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495325	B. WING		C 08/24/2016
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
PHEASAN	IT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO-	LD BE COMPLETION

F 309 Continued From page 32

07/06-07or 07/09. The MAR contained an entry which read in part "Ultram 50mg 1po (by mouth) q8h (every 8 hours) for pain". This entry had not been signed as having been administered on 07/11, 07/13, and 07/29 at 6am. The MAR contained an entry which read in part "Eliquis 2.5mg tablet-take 1 tab by mouth twice daily for hx CVA". This entry had not been signed as having been administered on 07/03 at 9am and 07/02, 07/05, 07/07, 07/10, 07/14, 07/18-19, 07/25, and 07/27-28 at 5pm.

The MAR for the month of August contained an entry which read in part "aspirin 81mg -take 1 tab by mouth every day for prophylaxis'. This entry had not been signed as having been given on 08/09/16. The MAR contained an entry which read in part "metoprolol 25mg tab ER 24hr-take 1 tab by mouth every evening for hypertension". This entry had not been signed as having been administered on 08/21/16. The MAR contained an entry which read in part "metoprolol 50mg tab ER 24hr- take 1 tab by mouth every morning for hypertension". This entry had not been signed as having been given on 08/08/09/16. The MAR contained an entry which read in part "diltiazem 24hr CD 180mg cap ER 24-take 1 cap by mouth every day for hypertension-hold for SBP (systolic blood pressure) </110 or HR (heart rate) <55". There were no recorded BP's or HR's for the following dates: 08/21 and 08/23-24 and no recorded HR's on 08/09 and 0812-20. The MAR contained an entry which read in part "lisinopril 5mg tablet-take 1 tab by mouth every day for hypertension". This entry had not been signed as having been administered on 08/09/16.

The concern of the missing documentation of medication and treatment administration was

F 309

CROSS-REFERENCED TO THE APPROPRIATE

DEFICIENCY)

DEPAR'	TMENT OF HEALTH	AND HUMAN SERVICES					D: 09/16/2016 M ADDROVER
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES					M APPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTR	(X3) D	(X3) DATE SURVEY COMPLETED	
		495325	B. WING			0	C 8/24/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADI	DRESS, CITY, STATE, ZIP CO	ODE	
PHEASA	NT RIDGE NURSING	& REHAB CENTER			SANT RIDGE ROAD, SW E, VA 24014	1	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(E	PROVIDER'S PLAN OF COR ACH CORRECTIVE ACTION SS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	during a meeting or 1630. The RNC (reg that they could not comedications/treatment ordered. No further information of the facility staff is movements for Res Resident #1 was orion 7/20/16. The resinto the facility on 7/diagnoses of, but not disease, high blood disease, neurogenic quadriplegia, depressamputation and presergion. The resident was concept to be a set of 6/27/16 with Mental Status) score of 15. The resident of totally dependent on dressing and person.	on was provided prior to exit. failed to monitor bowel ident #1. Iginally admitted to the facility sident was readmitted back (8/16 with the following or limited to coronary artery pressure, peripheral vascular bladder, wound infection, esion, bilateral above the knee issure ulcer of the sacral and the MDS (Minimum and MRD (Assessment Reference in a BIMS (Brief Interview for even a 15 out of a possible score was also coded as being it as free in a lygiene.	F3	09			
		Activities of Daily Living) of July, 2016. There was no					

bowel movement documentation noted for the following days: 7/2/16, 7/3/16. 7/4/16, 7/5/16, 7/6/16, 7/8/16, 7/11/16. 7/12/16. 7/13/16, 7/16/16,

7/17/16, 7/18/16, 7/19/16, 7/20/16, 7/25/16, 7/26/16, 7/27/16, 7/28/16, 7/30/16 and 7/31/16.

PHEASANT RIDGE NURSING & REHAB CENTER

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

495325

B. WING

C 08/24/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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Record) was also reviewed by the surveyor. The resident was ordered "Glycolax Dissolve 1 packet in liquid and take by mouth every day for constipation."

The interim director of nursing was interviewed on 8/24/16 and stated that this was the only way that bowel movements were being monitored.

The surveyor received a copy of the policy and procedure titled "Bowel Movement Assessment." The policy stated "...The Clinical Nurse checks the Bowel Movement Worksheet or ADL sheet for the date of the resident's last bowel movement and identifies the need for additional interventions. If the resident has not had a bowel movement by the third day, he/she is given a laxative or suppository, depending upon the circumstances and physician orders. The nurse checks the resident's order sheet making sure there is a laxative or suppository order."

The administrative team was notified of the above documented findings on 8/24/16 at 4:30 pm.

No further information was provided to the surveyor prior to the exit conference.

10. The facility staff failed to monitor bowel movements or Resident #10.

Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident 's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of

F 309

		HAND HUMAN SERVICES				FORM APPROVED
	RS FOR MEDICARE T OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	T _{(X2) MU}	TIPLE	O CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:			ECONSTRUCTION	COMPLETED
	!	495325	B. WING	·		C 08/24/2016
NAME OF	PROVIDER OR SUPPLIER	Ĺ		ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/2-7/2010
PHEASA	ANT RIDGE NURSING	& REHAB CENTER		1	55 PHEASANT RIDGE ROAD, SW OANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	DE COMPLETION
F 309	Continued From page 6 out of 15. Reside	age 35 ent #10 requires set up help	F:	309		
	only for dressing an					
	along with the ADL (sheets for the month bowel movement do following days: 7/1/7/6/16, 7/8/16, 7/11/7/18/16, 7/25/16, 7/27/24/16, 7/25/16, 7/2 The July MAR (Med Record) was also reresident was ordere mouth twice daily for The interim director 8/24/16 and stated to	dication Administration eviewed by the surveyor. The ed "Senekot-S Take 2 tabs by				
	procedure titled "Bo" The policy stated checks the Bowel Manager for the date of movement and ident interventions. If the movement by the thi laxative or supposito circumstances and p	red a copy of the policy and lowel Movement Assessment. "The Clinical Nurse flovement Worksheet or ADL fithe resident's last bowel tifies the need for additional resident has not had a bowel ind day, he/she is given a bry, depending upon the physician orders. The nurse 's order sheet making sure suppository order."				

The administrative team was notified of the above documented findings on 8/24/16 at 4:30 pm.

No further information was provided to the surveyor prior to the exit conference.

PRINTED: 09/16/2016

		& MEDICAID SERVICES				APPROVED
STATEMEN"	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	LTIPLE CONSTRUCTION DING	(X3) DATE	0938-0391 E SURVEY PLETED
		495325	B. WING	5		24/2016
NAME OF	PROVIDER OR SUPPLIER		->-	STREET ADDRESS, CITY, STATE, ZIP CODE		
PHEASA	NT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		JLD BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 36	F:	309		
	11. The facility staff movements for Res	f failed to monitor bowel ident #11.				
	10/2/15 with the following limited to high blood seizures, depression intellectual disabilities on the MDS with an Date) of 6/15/16 as Interview for Mental	dmitted to the facility on owing diagnoses of, but not I pressure, thyroid disorder, n, schizophrenia and severe es. The resident was coded AR (Assessment reference having a BIMS (Brief Status) score of 1 out of a i, in Section C, Cognitive				
	along with the ADL (sheets for the month bowel movement do following days: 7/1/7/6/16, 7/8/16, 7/18/	vas reviewed by the surveyor Activities of Daily Living) of July, 2016. There was no ecumentation noted for the 16, 7/3/16, 7/4/16, 7/5/16, 16, 7/19/16, 7/20/16, 7/21/16, 27/16, 7/29/16, 7/30/16 and				
	Record) was also re-	cation Administration viewed by the surveyor. The diffusion Senekot-S Take 2 tabs by constipation.				
	8/24/16 and stated the	of nursing was interviewed on nat this was the only way that ere being monitored.				
	procedure titled " Bo " The policy stated	ed a copy of the policy and owel Movement Assessment. "The Clinical Nurse ovement Worksheet or ADL				

sheet for the date of the resident 's last bowel movement and identifies the need for additional

PHEASANT RIDGE NURSING & REHAB CENTER

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING ____

(X3) DATE SURVEY COMPLETED

495325

B. WING

08/24/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 309 Continued From page 37

interventions. If the resident has not had a bowel movement by the third day, he/she is given a laxative or suppository, depending upon the circumstances and physician orders. The nurse checks the resident's order sheet making sure there is a laxative or suppository order."

The administrative team was notified of the above documented findings on 8/24/16 at 4:30 pm.

No further information was provided to the surveyor prior to the exit conference.

12. The facility staff failed to monitor bowel movements for Resident #13.

Resident #13 was originally admitted to the facility on 6/29/11 and then readmitted on 6/18/14 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure, Alzheimer's disease and dementia. Resident #13 was coded in the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/15/16 as having a BIMS (Brief Interview for Mental Status) score of 1 out of a possible score of 15.

The clinical record was reviewed by the surveyor along with the ADL (Activities of Daily Living) sheets for the month of July, 2016. There was no bowel movement documentation noted for the following days: 7/1/16, 7/2/16, 7/4/16, 7/5/16, 7/6/16, 7/7/16, 7/8/16, 7/18/16, 7/19/16, 7/20/16, 7/21/16, 7/25/16, 7/26/16, 7/27/16, 7/29/16, 7/30/16 and 7/31/16.

The interim director of nursing was interviewed on 8/24/16 and stated that this was the only way that bowel movements were being monitored.

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	LTIPLE CONSTRUCTION DING	(X3) DATE SURVEY COMPLETED
	495325	B. WING		C 09/24/2046
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/24/2016
DIE GALLE DIDOC ALLE			4355 PHEASANT RIDGE ROAD, SW	
PHEASANT RIDGE NURSING	& REHAB CENTER		ROANOKE, VA 24014	
PREFIX (EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		JLD BE COMPLETION
F 309 Continued From pag	ge 38	F3	809	
procedure titled "Be" The policy stated checks the Bowel M sheet for the date of movement and ident interventions. If the movement by the thi laxative or supposite circumstances and p checks the resident there is a laxative or The administrative to documented findings No further information surveyor prior to the 13. The facility staff movements for Resident #15 was ad 3/2/15 with the follow limited to anemia, Mulanxiety, dysphagia ar resident was coded of Set) with an ARD (As of 8/10/16 as having a Mental Status) score of 15. Resident #15 is staff members for drebathing.	earn was notified of the above on 8/24/16 at 4:30 pm. In was provided to the exit conference. failed to monitor bowel dent #15. mitted to the facility on ing diagnoses of, but not all tiple Sclerosis, malnutrition,			

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along with the ADL (Activities of Daily Living) sheets for the month of July, 2016. There was no

documentation noted for the following days:

Event ID: GCK411

Facility ID: VA0208

If continuation sheet Page 39 of 109

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PRINTED: 09/16/2016

		E& MEDICAID SERVICES					MAPPROVED 0.0938-0391
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		E CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER		***************************************	S	TREET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
PHEASA	ANT RIDGE NURSING	& REHAB CENTER			355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
	7/8/16, 7/17/16, 7/1 7/21/16, 7/25/16, 7/1 7/30/16 and 7/31/16 The interim director 8/24/16 and stated to bowel movements with the surveyor receive procedure titled "B" The policy stated checks the Bowel M sheet for the date of movement and iden interventions. If the movement by the the laxative or supposite circumstances and public circumstan	16, 7/5/16, 7/6/16, 7/7/16, 8/16, 7/19/16, 7/20/16, 26/16, 7/27/16, 7/29/16, 5. If of nursing was interviewed on that this was the only way that were being monitored. If dealy of the policy and owel Movement Assessment. IfThe Clinical Nurse lovement Worksheet or ADL of the resident 's last bowel tifies the need for additional resident has not had a bowel ind day, he/she is given a bory, depending upon the ohysician orders. The nurse 's order sheet making sure suppository order." The am was notified of the above on 8/24/16 at 4:30 pm. In was provided to the exit conference. If ailed to monitor bowel		309	DEFICIENCY)		
	8/17/15 with diagnos disease, aphasia, Gu hypertension, diabete coronary artery disea	mitted to the facility on les of end stage renal uillian -Barre syndrome, es, insomnia, depression, ase, stroke, urinary tract r disease, and chronic		٠			

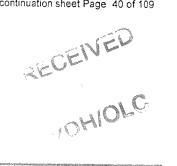
FORM CMS-2567(02-99) Previous Versions Obsolete

The current quarterly Minimum Data Set (MDS)

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 309 Continued From page 40

with a reference date of 5/30/16 assessed the resident with a cognitive score of "11" of "15". The resident was able to communicate with with gestures. The resident was assessed requiring total assistance of 1-2 persons for bed mobility. transfers, dressing, eating, toileting, hygiene, and bathing. The resident was assessed to have bowel and bladder incontinence.

The clinical record was reviewed. The bowel and bladder report was provided by the acting director of nursing (DON). The report contained daily documentation by the certified nursing assistants(CNAs) for bowel movements. The report for June 2016 contained the resident had no bowel movements for 6/16 through 6/28. The report for July 2016 was blank for 7/4, 7/13,7/27, and 7/28. The forms completed by the CNAs for July and kept in the clinical record were blank for 7/4,7/5, 7/7,7/9,7/10,7/11, 7/13, and from 715 through 7/29.

The DON stated this was the only way bowel function was monitored. The DON provided the facility policy for monitoring bowel function. The policy stated the resident should have interventions done when no bowel movement for 3 days with either oral or a suppository given. The policy also stated no blanks on the form and a zero to be noted when no bowel movement.

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m.

15. The facility staff failed to monitor bowel movements for Resident #9.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 309	Continued From page	ge 41	F 30	09			
	4/12/13 with diagno	mitted to the facility on ses of dementia, anxiety, bulbar affect, arthritis, mia.					
	with a reference dat resident with a cogn resident was assess assistance of 1 pers dressing, eating, toil	y Minimum Data Set (MDS) e of 7/26/16 assessed the itive score of "0" of "15". The sed requiring extensive on for bed mobility, transfers, eting, bathing, and hygiene, sessed to be incontinent for					
	bladder report was p of nursing (DON). The documentation by the assistants (CNAs) for report for June 2016 no bowel movements form completed by the 6/5, 6/6, 6/9, 6/11, 6/ July documented no	r bowel movements. The contained the resident had s for 6/8 through 6/14. The ne CNAs was blank for 6/4, 12, and 6/13. The report for bowel function for 6/19 port for July 2016 was blank 7/28 and no bowel					
	function was monitor facility policy for mon policy stated the residenterventions done will days with either orapolicy also stated no	was the only way bowel ed. The DON provided the itoring bowel function. The dent should have nen no bowel movement for all or a suppository given. The blanks on the form and an no bowel movement.					

The administrator, DON, and corporate nurse

PHEASANT RIDGE NURSING & REHAB CENTER

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

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B. WING

 \mathbf{C} 08/24/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 309 Continued From page 42

consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m.

16. The facility staff failed to monitor bowel movements for Resident #14.

Resident #14 was admitted to the facility on 8/10/15 with diagnoses of chronic constipation. depression, Vitamin B12 deficiency, hypertension, hearing loss, hypothyroidism, anxiety, stroke, congestive heart failure, and gastro-esophageal reflux disease.

The current significant change Minimum Data Set (MDS) with a reference date of 2/29/16 assessed the resident with a cognitive score of "11" of "15". The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers. dressing, toileting, bathing, and hygiene. The resident was assessed to have occasional incontinence.

The comprehensive care plan was reviewed. The resident had a problem listed for altered bowel and bladder elimination with interventions listed to monitor incontinent briefs every two hours and change as needed.

The clinical record was reviewed. The resident had physician orders for medications for constipation for Miralax17 gms every other day. Biscodyl 10mg daily, Milk of Magnesia 45ml every other day, and a stool softner 200mg twice daily.

The August ADL tracking form was reviewed. The form was blank for 8/6, 8/7, 8/19, and 8/21. The staff documented the resident did not have a bowel movement 8/17, 8/18, 8/19, 8/20, and 8/21,

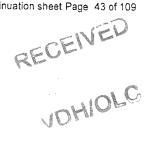
F 309

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PHEASANT RIDGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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(X5) COMPLETION DATE

F 309 Continued From page 43

These included blanks.

The DON stated this was the only way bowel function was monitored. The DON provided the facility policy for monitoring bowel function. The policy stated the resident should have interventions done when no bowel movement for 3 days with either oral or a suppository given. The policy also stated no blanks on the form and a zero to be noted when no bowel movement

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m.

F 312 483.25(a)(3) ADL CARE PROVIDED FOR SS=E DEPENDENT RESIDENTS

A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.

This REQUIREMENT is not met as evidenced by:

Based on resident interview, family interview, group of resident's review, staff interview, and clinical record review, and in the course of a complaint investigation, the facility staff failed to provide activities of daily living (ADLs) for bathing for 10 of 20 residents (Resident# 2, #9, #7, #12, #20, #3, #10, #11, #13, and #15).

The findings include:

1. The facility staff failed to provide daily bathing

F 309

F 312

- 1. Resident #2 is currently being bathed.
 Resident #9 is currently being bathed.
 Resident #7 is currently being bathed.
 Resident #3 is currently being bathed.
 Resident #12 is currently being bathed.
 Resident #20 is currently being bathed.
 Resident #10 is currently being bathed.
 Resident #11 is currently being bathed.
 Resident #13 is currently being bathed.
 Resident #15 is currently being bathed.
- 2. For current resident's residing in the facility, interviews have been conducted by the DCS/Designee to establish resident preference regarding bathing. Bathing schedules have been revised as indicated by the interviews.
- 3. Education has been provided by the e DCS/Designee to the nursing staff

Facility ID: VA0208

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FATEMENT OF DEFICIENCIES VD PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495325

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

08/24/2016

NAME OF PROVIDER OR SUPPLIER

PHEASANT RIDGE NURSING & REHAB CENTER

B. WING

STREET ADDRESS, CITY, STATE, ZIP CODE

4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 312 Continued From page 44 for Resident #2.

Resident #2 was admitted to the facility on 8/17/15 with diagnoses of end stage renal disease, aphasia, Guillian-Barre syndrome, hypertension, diabetes, insomnia, depression, coronary artery disease, stroke, urinary tract infection, peptic ulcer disease, and chronic osteomyelitis.

The current quarterly Minimum Data Set (MDS) with a reference date of 5/30/16 assessed the resident with a cognitive score of "11" of "15". The resident was able to communicate with with gestures. The resident was assessed requiring total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing. The resident was assessed to have bowel and bladder incontinence. The resident was transported to dialysis via stretcher.

Two certified nursing assistants (CNAs) were interviewed on initial tour of the facility conducted 8/22/16 at 6:00 p.m. CNA#1 stated he was not always able to get his assigned bathing completed on the evening shift. The other CNA (CNA#2) stated she would stay late to get her work completed.

The resident was interviewed on 8/24/16 at 8:30 a.m. The resident was asked if he got his baths and he gestured with a thumbs down motion that he did not.

The ADL tracking form for July 2016 was reviewed. The resident was documented to receive a partial bath on 7/2, 7/3, and 7/6. The rest of the form for July 1 through July 31 was incomplete or blank. The computerized bathing

F 312

regarding resident bathing and documentation of resident bathing preferences. The DCS/Designee will conduct a review for five (5) residents per week for three (3) months to ensure that baths are being completed and documented per the residents' preference.

- 4. The results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated necessary to sustain substantial compliance.
- 5. 10/4/2016

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F 312 Continued From page 45

report provided by the acting director of nursing (DON) was blank for 7/4, 7/8, 7/13, 7/17, 7/27, 7/28, and 7/30. The resident was noted to receive 1 shower for the month on 7/20.

The DON stated this was the only method the facility had to document bathing.

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m.

2. The facility staff failed to provide bathing for Resident #9.

Resident #9 was admitted to the facility on 4/12/13 with diagnoses of dementia, anxiety, depression, pseudobulbar affect, arthritis, dysphagia, and anemia.

The current quarterly Minimum Data Set (MDS) with a reference date of 7/26/16 assessed the resident with a cognitive score of "0" of "15". The resident was assessed requiring extensive assistance of 1 person for bed mobility, transfers, dressing, eating, toileting, bathing, and hygiene.

The ADL tracking form for July 2016 was reviewed. The resident was documented to receive a partial bath on 7/6. and a bed bath on 7/30 and a shower on 7/30. The rest of the form for July 1 through July 31 was incomplete or blank. The computerized bathing report provided by the acting director of nursing (DON) was blank for 7/4,7/8, 7/17, 7/28, and 7/30. The resident was noted to receive 1 shower for the month on 7/30.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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08/24/2016

NAME OF PROVIDER OR SUPPLIER

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PHEASANT RIDGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
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ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

F 312 Continued From page 46

The DON stated this was the only method the facility had to document bathing.

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/24/16 at 1:30 p.m.

3. For Resident #7 the facility staff failed to provide ADL (activities of daily living) assistance for bathing.

Resident #7 was admitted to the facility on 06/18/15 and readmitted on 11/25/15. Diagnoses included but not limited to anemia, urinary tract infection, Alzheimer's disease, dementia, malnutrition, anxiety, depression, dysphagia, coronary artery disease, and hip fracture.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/25/16 coded the Resident as 12 of 15 in section C, cognitive patterns. Section G, function status coded the Resident as 3 of 3 in the area of bathing, which is equivalent to "extensive assistance two person physical assist". This is a quarterly MDS.

Surveyor interviewed the Resident on 08/23/16 at 1400. Surveyor asked Resident #7 if she received her baths/showers as scheduled and she stated that she did not. She also stated that she "might get one a week if the girls have time". Resident stated that she had a bath the previous day due to having a doctor appointment this AM. Surveyor observed at the time of interview that Resident was neatly dressed in street clothes and appeared to be clean.

Resident #7's ADL sheets for bathing were

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F 312	Continued From pa	age 47	F 3	12			
	that the Resident of and one bed bath fit partial baths from 0 bath and two bed b four partial baths ar	116. The ADL sheets indicated only received one partial bath from 06/02/16-06/07/16, five 06/09/16-06/28/16, one partial baths from 06/30/167/05/16, and three bed baths from and three partial baths and 07/22/16-07/31/16.					
	discussed with the a meeting on 08/23/16 RNC (regional nurse facility had changed ADL care to paper of "agency staff" at the	providing ADL care was administrative staff during 6 at approximately 1630. The se consultant) stated that the d from electronically charting charting due to the number of e facility. RNC stated that they nat ADL's had been completed.					
	4. For Resident #3, t	on was provided prior to exit. the facility staff failed to ies of daily living) care in the					
	been admitted to the included, but were no disabilities, dysphagi	evealed that Resident #3 had e facility 05/29/10. Diagnoses not limited to, mild intellectual ria, peripheral vascular dism, and convulsions.					
	significant change in set) assessment with reference date) of 08 (brief interview for me	patterns) of the Residents status MDS (minimum data h an ARD (assessment 8/08/16 included a BIMS ental status) summary score a 15 points. Section G					

persons.

(functional status) was coded (3/2) for personal hygiene extensive assistance of one person and (3/3) for bathing extensive assistance of 2 +

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

495325

B. WING

C 08/24/2016

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION DATE

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Resident #3's ADL tracking form indicated that Resident #3 had only received partial baths on July 2, 3, 6, 29, and 30 and a bed bath on July 9.

On 08/24/16 at approximately 11:10 a.m. RN (registered nurse) #3 verbalized to the survey team that they had hired a shower aide due to concerns from Residents and family members that the Residents of the facility were not getting their showers.

During a meeting with the administrative staff on 08/24/16 at approximately 3:20 p.m. the surveyor asked if the facility had any further information on the Residents bathing status.

No further information regarding this issue was provided to the survey team prior to the exit conference.

5. For Resident #12, the facility staff failed to provide ADL (activities of daily living) care in the area of bathing.

The record review revealed that Resident #12 was admitted to the facility 10/25/12. Diagnoses included, but were not limited to, multiple sclerosis, abnormal posture, hyperlipidemia, atrial fibrillation, and hypertension.

Section C (cognitive patterns) of the Residents annual MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/14/16 included a BIMS (brief interview for mental stats) summary score of 15 out of a 15 points. Indicating the Resident was cognitively intact. Section G (functional status) was coded (3/2) for personal hygiene extensive assistance of one

F 312

ORM CMS-2567(02-99) Previous Versions Obsolete

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Facility ID: VA0208

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PRINTED: 09/16/2016 EPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** ENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY DIPLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING C B. WING 495325 08/24/2016 AME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW HEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 312 Continued From page 49 F 312 person and (3/3) for bathing extensive assistance of 2 + persons. Resident #12's ADL tracking form indicated that Resident #12 had received partial baths on July 2, 3, 5 and 9. A bed bath on July 10 and a shower on July 14. On 08/24/16 at approximately 11:10 a.m. RN (registered nurse) #3 verbalized to the survey team that they had hired a shower aide due to concerns from Residents and family members that the Residents of the facility were not getting their showers. During an interview with Resident #12 on 08/24/16 at approximately 2:15 p.m. Resident #12 verbalized to the surveyor that she received one bath a week if at all. When asked if she was okay with that she stated not really. The administrative staff were notified of the above in a meeting with the survey team on 08/24/16 at approximately 3:20 p.m.

No further information regarding this issue was provided to the survey team prior to the exit

6. For Resident #20, the facility staff failed to provide ADL (activities of daily living) care in the area of bathing.

The record review revealed that Resident #20 was admitted to the facility 09/07/09. Diagnoses included, but were not limited to, dementia, dysphagia, atrial fibrillation, anemia, and hypertension.

conference.

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	LTIPLE CONSTRUCTION DING	(X3) DATE SURV COMPLETE	
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	PROVIDER OR SUPPLIER NT RIDGE NURSING	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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F 312	quarterly MDS (min with an ARD (asses 07/11/16 included a mental status) sum possible 15 points. was coded was code and bathing indicate extensive assistance. Resident #20's ADI for July 2016 Reside bath on July 2, 29, and 14 and a bed both on July 2, 29, and 14 and a bed both on July 2, 29, and 14 and a bed both on July 2, 29, and 14 and a bed both on July 2, 29, and 14 and a bed both on July 2, 29, and 14 and a bed both on July 2, 29, and 14 and a bed both on July 2, 29, and 14 and a bed both on July 2, 29, and 14 and a bed both on July 2, 29, and 14 and a bed both on July 2, 29, and 14 and a bed both on Series of the residents of the residents of the exit con 7. The facility staff for Resident #10 was a 10/28/15 with the folimited to heart failudiabetes, stroke, dedepression. On the Data Set) with an A	e patterns) of the Residents alimum data set) assessment reference date) of a BIMS (brief interview for a BIMS (brief interview for a Section G (functional status) ded (3/2) for personal hygiene ing the Resident required be of one person. Litracking form indicated that lent #20 had received a partial and 30. A shower on July 4, 7, both on July 15. Proximately 11:10 a.m. RN #3 verbalized to the survey hired a shower aide due to idents and family members of the facility were not getting staff were notified of the above the survey team on 08/25/16.	F3	312		

DADTMENT OF HEALTH AND HIMAN SERVICES

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ENTERS FOR M		EDICAID SERVICES			FORM APPROVE OMB NO. 0938-039
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		495325	B. WING		C 08/24/2016
AME OF PROVIDER OF	R SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE	
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F 312 Continued From page 51

BIMS (Brief Interview for Mental Status) score of 6 out of 15. Resident #10 requires set up help only for dressing and bathing.

A clinical record review was conducted by the surveyor on 8/23/16. The ADL (Activities of Daily Living) from for July, 2016 were also reviewed. The resident was documented as to not have had a shower or bath from August 1 through August 14. However, the resident did receive a partial bath on 8/8/16.

On 8/24/16 at 4:30 pm, the administrative team was notified of the above documented findings. The regional nurse stated, "We had to go to paper charting in July because of the number of complaints that we were receiving of residents not getting their baths. I honestly cannot tell you if they received them or not. "

No further information was provided to the provided to the surveyor prior to the exit conference.

8. The facility staff failed to provide daily bathing for Resident #11.

Resident #11 was admitted to the facility on 10/2/15 with the following diagnoses of, but not limited to high blood pressure, thyroid disorder, seizures, depression, schizophrenia and severe intellectual disabilities. The resident was coded on the MDS with an AR (Assessment reference Date) of 6/15/16 as having a BIMS (Brief Interview for Mental Status) score of 1 out of a possible score of 15, in Section C, Cognitive Patterns.

The ADL tracking form for July, 2016 was reviewed. Resident #11 was documented as to F 312

₹M CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

Facility ID: VA0208

If continuation sheet Page 52 of 109



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		AND HUMAN SERVICES & MEDICAID SERVICES					APPROVED 0.0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DA	TE SURVEY MPLETED	
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	dates in the month had "8" in the book did not occur. The director of nurse only way that bathin facility. The director had to switch to panumber of complair receiving their baths if they received their constructions of the service of the servic	ower on 7/6/16. All the other of July were either left blank or xes which means the activity sing stated that this was the ng was being tracked in the r also stated that they have per charting in July due to the nts that residents were not s. "I honestly cannot tell you r baths or not." pm, the administrative team above documented findings. on was provided to the exit conference. failed to provide daily bathing riginally admitted to the facility a readmitted on 6/18/14 with uses of, but not limited to pressure, heart failure, se and dementia. Resident the MDS (Minimum Data Set) is ment Reference Date) of BIMS (Brief Interview for exit of 1 out of a possible score new was performed by the	F3	312			
	the resident received	DL tracking form July. 2016, d 2 partial baths. One was on one was 7/14/16. All of the					

other dates were left blank or had an "8" documented which means that the activity did not

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F 312 Continued	H From page 5	3	F:	312			

F 312 Continued From page 53 occur for this resident.

The director of nursing stated that this was the only way that bathing was being tracked in the facility. The director also stated that they have had to switch to paper charting in July due to the

number of complaints that residents were not receiving their baths. "I honestly cannot tell you if they received their baths or not."

On 8/24/16 at 4:30 pm, the administrative team was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference.

10. The facility staff failed to provide daily bathing for Resident #15.

Resident #15 was admitted to the facility on 3/2/15 with the following diagnoses of, but not limited to anemia, Multiple Sclerosis, malnutrition, anxiety, dysphagia and gastrostomy. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/16 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #15 is totally dependent on 2 staff members for dressing, personal hygiene and bathing.

A clinical review of Resident #15's clinical record was reviewed by the surveyor. The ADL tracking form was also reviewed at this time. There were only 2 dates in July, 2016 that it was documented that the resident received 2 partial baths. The rest of the month, the boxes were either blank or had an "8" documented which means that the

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F 312	Continued From paractivity did not occur	=	F 3′	12	
	only way that bathi facility. The director had to switch to particular number of complain receiving their bath if they received the				
		pm, the administrative team above documented findings.			
F 314 SS=D	surveyor prior to the 483.25(c) TREATM		F 31	14	
,	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.			1. For Resident, #8, the and the responsible been notified of the on the Treatment Ac Record for the mont and July 2016 as we initials on the Medic Administration Recomonth of June 2016.	party have missing initials dministration th of May, June, ll as the missing cation ord for the
	by: Based on clinical reand in the course of facility staff failed to	NT is not met as evidenced ecord review, staff interview f a complaint investigation the provide services to prevent 1 of 20 Residents, Resident			

The findings included:

PARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

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	ROVIDER OR SUPPLIER	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
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F 314 Continued From page 55

For Resident #8, the facility failed to follow physician's orders to prevent/treat pressure ulcers.

Resident #8 was admitted to the facility on 02/22/15 and readmitted on 03/14/16. Diagnoses included but not limited to atrial fibrillation, coronary artery disease, congestive heart failure, hypertension, gastroesophageal reflux disease, diabetes mellitus, aphasia, cerebrovascular accident, dementia, respiratory failure, and dysphagia.

The most recent MDS (minimum data set) with and ARD (assessment reference date) of 08/02/16 coded the Resident as 0 of 15 in section C, cognitive patterns. Section M, skin conditions coded the Resident as being at risk for developing pressure ulcers, having unhealed pressure ulcers, having two stage 3 pressure ulcers not present on admission. This is an annual MDS.

Resident #8's clinical record was reviewed on 08/23/16. It contained a signed POS (physician's order summary) dated 05/04/16 which read in part "Sureprep to bilateral heels every shift". The clinical record also contained a TAR (treatment administration record) for the month of May 2016 which read in part "Sureprep to bilateral heels every shift". The MAR had not been initialed as completed on the following dates: 05/12 for 7-3, 05/18 for 7-3 or 3-11, 05/21-22 for 7-3 or 3-11, 05/23-25 for 3-11, and 05/31 for 7-3 or 3-11.

Resident #8's clinical record contained a signed physician's order dated 06/21/16 which read in part "moon boots on bil (bilateral) feet when in

F 314

- 2. For current residents residing in the center, the DCS/Designee has conducted a review of Medication Administration Records and Treatment Administration Records for the previous thirty (30) days to identify other interventions/medications that may have not been initialed off on the MAR/TAR. The physician and responsible party have been notified.
- 3. Education has been provided by the DCS/Designee to the Licensed Nurses regarding the six rights of medication and treatment administration including documentation of the administration. MARs and TARs

will be reviewed by the DCS/Designee to identify potential medications /interventions not administered as well as to ensure that documentation has been completed appropriately three (3) times weekly for three (3) months.

Facility ID: VA0208

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F 314 Continued From p	age 56	F	314	

bed, clean R (right) lat (lateral) ankle c (with) N/S (normal saline), apply Duoderm-change q (every) 3 days and prn (as needed), clean sacrum c NS apply Maxorb and cover c Optifoam q 3 days and as needed, Sureprep to (R) heel qd (every day) as preventative, clean (L) heel c NS apply Santyl oint c gauze dressing, wrap c Kling bid (twice daily), and air mattress to bed". The Resident's TAR for June 2016 contained entries which read in part "moon boots on bil (bilateral) feet when in bed, clean R (right) lat (lateral) ankle c (with) N/S (normal saline), apply Duoderm-change q (every) 3 days and prn (as needed), clean sacrum c NS apply Maxorb and cover c Optifoam q 3 days and as needed, Sureprep to (R) heel qd (every day) as preventative, clean (L) heel c NS apply Santyl oint c gauze dressing, wrap c Kling bid (twice daily), and air mattress to bed". There were multiple areas on the MAR which had not been initialed as the treatments having been completed. The TAR for the month of July contained an entry which read in part "cleanse L heel c NS pat dry apply Maxorb cover c dry dressing QD". This entry had not been initialed at any time as having been completed.

The surveyor spoke with the RNC (regional nurse consultant) on 08/23/16 at approximately 1050, regarding Resident #8. RNC stated that she could not confirm that the treatments had been completed as ordered.

The concern of the treatments not being completed was discussed with the administrative staff during a meeting on 08/23/16 at approximately 1630.

No further information was provided prior to exit. This is a complaint deficiency.

- 4. Results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
- 5. 10/4/2016

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

TATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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B. WING

08/24/2016

NAME OF PROVIDER OR SUPPLIER

PHEASANT RIDGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

F 315 483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility staff failed to provide services as ordered by the physician on 1 of 20 residents (Resident#1).

The findings included:

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating,

F 315

- 1. For Resident #1, an appointment was scheduled to have the suprapubic catheter changed.
- 2. For residents currently residing in the facility with catheters, a review has been conducted by the DCS/Designee to ensure that catheters have been changed as ordered by the physician.
- 3. Education has been provided by the DCS/Designee to Licensed Nurses regarding ensuring that catheters are changed as ordered by the physician. The DCS/Designee will conduct a review for (3) residents per week for three (3) months to ensure that catheters have been changed as ordered by the physician.
- 4. The results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months.

 The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
- 5. 10/4/2016

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

Facility ID: VA0208

If continuation sheet Page 58 of 109



DEPARTMENT OF HEALTH AND HUMAN SERVICES

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1 010	dressing and perso	-	1 0	15		
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	of Resident #1 's r physician order wa dated for 7/1/16 thr Suprapubic tube	rmed a clinical record review nedical record. The following is noted on the Plan of Care ough 7/31/16 which stated, "to be changed monthly by eveyor could not find had been done.				
	On 8/24/16 at 4:30 was notified of the	pm, the administrative team above findings.				
	the surveyor, "We documentation that The nurses are ma	m, the regional nurse stated to cannot find any this has been done either. king arrangements to have if to urology clinic to have it				
	surveyor prior to the	ion was provided to the e exit conference. ENT/CARE FOR SPECIAL	F 3	128		
	The facility must en proper treatment an special services: Injections; Parenteral and enter	stomy, or ileostomy care; ;	1	ie U s F is	exygen concentrator filters dentified as dirty on Unit 1 Unit 2 were corrected during urvey process including roof or Resident #15, the tube for being administered as ord y the physician.	g the om 410. eeding

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F 328 Continued From page 59

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility documents review, clinical record review, and in the course of a complaint investigation the facility staff failed to perform routine maintenance in regards to oxygen concentrators and failed to provide an enteral feeding as ordered by the physician for 1 of 20 Residents, Resident #15.

The findings included.

1. The facility staff failed to clean oxygen concentrators filters used by the residents of the facility.

On 08/24/16 at approximately 10:35 a.m. LPN (licensed practical nurse) #5 was interviewed regarding the changing/cleaning of oxygen filters. LPN #5 verbalized to the surveyor that the filters were changed as needed and she had been told that they had new filters so they didn't need to wash them anymore.

On 08/25/16 at approximately 6:05 a.m. the surveyor asked LPN #1 how often the filters on the oxygen concentrators were cleaned/changed. LPN #1 verbalized to the surveyor that they were cleaned every Sunday.

On 08/25/16 at approximately 6:10 a.m. LPN #3 verbalized to the surveyor that the oxygen filters were usually cleaned/changed on Sunday nights.

When interviewing an agency nurse working at the facility on 08/25/16 at approximately 6:15 a.m. agency nurse #1 verbalized to the surveyor that the filters on the back of the concentrators were cleaned every 30 days.

- 2. Residents currently residing in the facility that utilize oxygen have had the filters on their oxygen concentrators cleaned. Residents that reside in the facility with tube feeding have had their physician's orders reviewed.

 Observations of residents with tube feeding have been conducted by the DCS/Designee to ensure that tube feeding is provided as ordered by the physician.
- 3. Education has been provided by the DCS/Designee to Licensed Nurses regarding maintaining clean filters on oxygen concentrators as well as administering tube feeding as ordered by the physician. Observations will be conducted by the DCS/Designee three (3) times per week for three (3) months for three (3) residents to ensure that oxygen filters are clean and that tube feeding is being administered as ordered by the physician.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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B. WNG

08/24/2016

NAME OF PROVIDER OR SUPPLIER

PHEASANT RIDGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE

F 328 Continued From page 60

In the morning of 08/25/16 the surveyor and the director of clinical services did a random check of oxygen filters. Of the three filters checked on unit 1-one was found to have a moderate amount of lint present. Of the three filters checked on unit 2-two were found with lint present. The filter in room 410 was observed with a large amount of lint

On 08/25/16 at approximately 9:00 a.m. the surveyor attempted to check the oxygen filters in room 404 and 202 all of the filters had been removed from the concentrators. One of the residents in room 404 stated that the facility staff had removed the filters for cleaning.

On 08/25/16 at approximately 9:10 a.m. the surveyor interviewed RN (registered nurse) #3 regarding the missing filters. RN #3 verbalized to the surveyor that she had removed the filters for cleaning. When asked how they looked RN #3 stated the ones on the 200/300 hall looked like they had been cleaned. She then stated the ones on the 400 hall did not look like they had been cleaned. RN #3 was then asked the cleaning schedule for the filters RN #3 stated the filters should be rinsed weekly and one time a month a representative should come to the facility and clean the filters. RN #3 then added she wasn't sure when the representative came in and cleaned the filters.

The facility staff provided the surveyor with a copy of the service manual for the oxygen concentrators used at the facility. In regards to cleaning or replacing cabinet filters the manual did not specify a specific cleaning schedule but did read "Clean or replace gross particle (cabinet)

- 4. The results of the observations will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
- 5. 10/4/2016

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		495325	B. WING		08/24/2016
	PROVIDER OR SUPPLIER NT RIDGE NURSING	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP C 4355 PHEASANT RIDGE ROAD, SV ROANOKE, VA 24014	
i) ID EFIX AG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO	N SHOULD BE COMPLETION
328	filters on both sides Perform this proced upon the environme in"	age 61 s of the cabinet NOTE: dure as needed depending ent the concentrator is used staff were notified of the above	F 3	28 [·]	
	on 08/25/16 prior to	the exit conference.			
		ion regarding the oxygen was provided to the survey kit conference.			
	THIS IS A COMPLA	AINT DEFICIENCY.			
	2. The facility staff feeding system to F	failed to restart the enteral Resident #15.			
	3/2/15 with the follor limited to anemia, Manxiety, dysphagia resident was coded Set) with an ARD (A of 8/10/16 as havin Mental Status) scor of 15. Resident #15	admitted to the facility on owing diagnoses of, but not Multiple Sclerosis, malnutrition, and gastrostomy. The don the MDS (Minimum Data Assessment Reference Date) g a BIMS (Brief Interview for re of 14 out of a possible score 5 is totally dependent on 2 dressing, personal hygiene and	·		
	approximately 6:20 Resident #15 's root the feeding the dray not connected to the asked the resident feeding tube had not #15 stated, " Ever stated approximately 10 to	e facility on 8/22/16 at pm, the surveyor went into pm. The surveyor observed ped over the IV pole but was e resident. The Surveyor how long has it been that the pot been restarted. Resident since I took my bath at 2 pm ve told different ones but it			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 09/16/2016

		E & MEDICAID SERVICES				FORM APPROVE 28-039 DMB NO	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(VO) MUU:	TIDI E		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILD		CONSTRUCTION	COMPLETED	
		495325	B. WING			C 08/24/2016	
NAME OF	PROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE		
PHEASA	NT RIDGE NURSING	& REHAB CENTER			55 PHEASANT RIDGE ROAD, SW DANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION	
F 328	Continued From pa	age 62	F 3	28			
	resident 's room to had been restarted	veyor went back into the observe if the feeding tube. The surveyor noted the same location as documented					
	the resident's room	veyor once again, went into m and observed the feeding anner in which it had been on ions.					
	went into the reside	oximately 8 am, the surveyor ent's room. The resident was ling tube was infusing by IV					
	the resident's roor	0 am, the surveyor returned to m and the resident stated, " nect my feeding tube until 9:20					
	Resident #15. On the had ordered the following	wed the clinical record of the Plan of Care, the physician lowing: "Tube feed 2 CAL at daily via (by) peg tube"					
		team was notified of the above gs at the end of the day /16.					
	No further informati surveyor prior to the 483.25(m)(2) RESII SIGNIFICANT MED	DENTS FREE OF	F 3	33 1.	For Resident #2, the physi	ician and	
	The facility must en any significant med	sure that residents are free of ication errors.			responsible party have be regarding the omitted ini-	en notified	

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

FD/01/4	
	(X3) DATE SURVEY COMPLETED
B. WING	C 08/24/2016
STREET ADDRESS, CITY	, STATE, ZIP CODE
4355 PHEASANT RIDG ROANOKE, VA 240	, -
Y FULL PREFIX (EACH CORRE MATION) TAG CROSS-REFERE	S PLAN OF CORRECTION (X5) CTIVE ACTION SHOULD BE COMPLETION NCED TO THE APPROPRIATE DATE DEFICIENCY)
	B. WING STREET ADDRESS, CITY 4355 PHEASANT RIDG ROANOKE, VA 240: ES ID PROVIDER'S Y FULL PREFIX (EACH CORRE MATION) TAG CROSS-REFERE

= 333 Continued From page 63

This REQUIREMENT is not met as evidenced by:

Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 4 of 20 residents (Resident #2, #4, #6, and #8) were free from significant medication error.

The findings include:

1. The facility staff failed to administer insulin per the physician order for Resident #2.

Resident #2 was admitted to the facility on 8/17/15 with diagnoses of diabetes, end stage renal disease, aphasia, Guillian -Barre syndrome, hypertension, insomnia, depression, coronary artery disease, stroke, urinary tract infection, peptic ulcer disease, and chronic osteomyelitis.

The current quarterly Minimum Data Set (MDS) with a reference date of 5/30/16 assessed the resident with a cognitive score of "11" of "15". The resident was able to communicate with with gestures. The resident was assessed requiring total assistance of 1-2 persons for bed mobility, transfers, dressing, eating, toileting, hygiene, and bathing. The resident was assessed to have bowel and bladder incontinence.

The clinical record was reviewed. The physician ordered accuchecks (blood sugar monitoring) every 6 hours and also a sliding scale insulin schedule every 6 hours of Novolog 2 units for blood sugar(BS) of 200-249, 4 units for for BS 250-299, 6 units for BS 300-349, 8 units for BS 350-399, and greater than 399 12 units. The

F 333

Levemir insulin on 7/10/16, 7/12/16, 7/13/16, 7/14/16, 7/15/16, 7/26/16, 7/28/16, and 7/30/16. The physician and RP have also been notified regarding omitted initials for accu-checks for Resident #2 on 7/12/16 and 7/29/16. The physician and responsible party have been made aware of the medication variance for sliding scale insulin on 7/12/16 and 7/28/16.

For Resident #4, the physician \and responsible party have been notified regarding Novolg insulin that was held on 8/18/16 for a blood glucose level of 88 as well as Novolog with-held on 8/21/16 for a blood glucose level of 41 and the omitted blood glucose recheck as ordered by the physician. The physician and responsible

party have also been notified of the blood glucose levels of 500 and 503 on 7/8/16. The physician and RP were also made aware of the omitted initials for Levemir insulin on 7/26/16.

1 CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

Facility ID: VA0208

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CENTERS	FUR MEDICARE	& MEDICAID SERVICES		O	MB NO. 0938-039
STATEMENT OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495325	B. WING		C 08/24/2016
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	
PHEASANT	RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION

F 333 Continued From page 64

order was to call the physician for BS less than 60 or greater than 500. The physician also ordered to Levemir insulin 10 units every 12 hours.

The medication administration record (MAR) for July 2016 was reviewed. The facility staff failed to administer the Levemir insulin on 7/10, 7/12, 7/13,7/14,7/15, 7/26, and 7/29 at 9:00 p.m. The facility staff also failed to administer the Levemir at 9:00 a.m. on 7/26,7/28, and 7/30.

The facility staff also failed to obtain accuchecks on 7/12 at noon, and 7/29 at 6:00 a.m. and 12 midnight. The facility staff failed to administer the appropriate sliding scale insulin on 7/12 at noon, and at 6:00 a.m. and midnight on 7/28.

The director of nursing (DON) provided the survey team with copies of the facility policy on "Insulin Administration". The policy stated the "clinical nurse was to administer insulin subcutaneously per the physician order".

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m. There was no further information provided by the facility prior to exit

2. The facility staff failed to follow physician orders for insulin administration for Resident #4.

Resident #4 was admitted to the facility on 2/18/15 and re-admitted on 5/24/16 with diagnoses of diabetes, paraplegia, urinary retention, malnutrition, chronic pulmonary embolism, hypertension, psychosis, anemia, gastro esophageal reflux disease, right above the knee amputation, pressure ulcers, and deep vein

F 333

For Resident #6, the physician and Responsible Party have been notified regarding the omitted initials for Novolog insulin on 6/2/16, 6/18/16, 6/28/16, 7/22/16, 7/25/16, 7/2/16, 7/18/16, and 7/29/16. The physician and the RP have also been notified regarding the medication variance on 7/10/16 as well as the omitted accuchecks on 6/2/16, 6/18/16, and 7/14/16.

For Resident #8, the physician and the Responsible Party have been notified regarding the omitted initials for Novolog sliding scale on 6/5/16, 6/7/16, 6/14/16, 6/15/16, 6/16/16, 6/17/16, 6/20/16, 6/21/16, 6/22/16, 6/23/16, 6/27/16, 6/28/16, 6/29/16, 6/30/16, 7/6/16, 7/9/16, 7/15/16, 7/18/16 7/26/16, 7/28/16,

7/29/16, 8/8/16, and 8/9/16. The physician and responsible party have also been notified regarding omitted initials for Lantus Solostar insulin on 6/12/16, 6/14/16, 6/22/2016, 6/27/16, 7/15/16, 7/18/16, 7/23/16, 8/8/16, 8/9/16, 8/10/16, and 8/22/16.

DEPARTMENT OF HEALTH AND HIMAN SERVICES

		& MEDICAID SERVICES			FORM APPROVI MB_NO. 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
		495325	B. WNG		C 08/24/2016
	ROVIDER OR SUPPLIER T RIDGE NURSING	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE

F 333 Continued From page 65 thrombosis.

> The current admission Minimum Data set (MDS) with a reference date of 5/31/16 assessed the resident with a cognitive score of "10" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility. transfers, dressing, toileting, bathing, and hygiene.

> The clinical record was reviewed. The physician ordered accuchecks before meals and at bedtime and to administer Novolog insulin 3 units for blood sugar(BS) 200-299, 6 units for BS 300-399. 9 units for BS 400-499 and to call the physician for BS less than 50 or greater than 500.

The comprehensive care plan was reviewed. The care plan contained a problem listed the resident was at risk for metabolic complications related to diabetes with interventions listed to administer medications as ordered and notify the physician as indicated.

The medication administration record (MAR) for August 2016 was reviewed. The nurse documented on the back of the MAR on 8/18 at 5:00 p.m., "Novolog 8 units sq held-res BS 88". There was no notation in the nursing notes and no physician orders the physician had been informed of the nurse deciding to hold the insulin. A nurse also documented on 8/21/16 at 11:30 a.m. the Novolog had been held for a BS of 41 with a note to recheck. Again there was no documentation the physician had been informed and no recheck of the BS done.

The July 2016 MAR was reviewed. The nurse documented a BS at 11:30 a.m. on 7/8 of 503 and F 333

The physician and the RP were also notified of omitted initials for accu-checks on 6/12/16, 6/14/16, 6/22/16, 6/27/16, 7/2/16, 7/6/16, 7/15/16, 7/28/16, and 7/29/16.

- 2. For residents currently residing in the center with physician's orders for insulin and accu-checks, the DCS/Designee has conducted a review of the Medication Administration Record for the previous thirty (30) days to identify further concerns regarding administration of insulin and completion of accu-checks per the physician's 1 order. The review also included verification of physician notification of blood glucose parameters per the physician order. The physician and the responsible party will be notified as indicated by the reviews.
- 3. Education has been provided by the DCS/Designee regarding following physician's orders for administering and documenting insulin, and completing and documenting accu-

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA **IDENTIFICATION NUMBER:**

495325

(X2) MULTIPLE CONSTRUCTION A. BUILDING

(X3) DATE SURVEY COMPLETED

B WING

C 08/24/2016

NAME OF PROVIDER OR SUPPLIER

PHEASANT RIDGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY

(X5) COMPLETION DATE

F 333 Continued From page 66

a BS of 500 at 9:00 p.m. There was no evidence the nurse notified the physician as ordered. The nurse documented administration of 9 units of Novolog insulin at 11:30 a.m. The amount documented at 9:00 p.m. was illegible.

The nurse failed to administer Levemir insulin 20 units as ordered by the physician every 12 hours at 9:00 p.m. on 7/26.

The MAR for June 2016 also was reviewed. The failed to administer Levemir 18 units at 9:00 p.m. on 6/6, 6/10, 6/11, 6/17, and 6/20.

The director of nursing (DON) provided the survey team with copies of the facility policy on "Insulin Administration". The policy stated the "clinical nurse was to administer insulin subcutaneously per the physician order".

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/23/16 at 4:30 p.m. There was no further information provided by the facility prior to exit.

3. For Resident #6 the facility staff failed accurately monitor BS (blood sugar) levels and failed to accurately administer insulin per the physician's orders.

Resident #6 was admitted to the facility on 05/25/12 and readmitted on 09/01/15. Diagnoses included but not limited to anemia, congestive heart failure, hypertension, peripheral vascular disease, diabetes mellitus, hyperlipidemia, dementia, dysphagia, hypothyroidism and psychotic disorder.

The most recent comprehensive MDS with and ARD (assessment reference date) of 02/20/16

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checks. The education also included notification to the physician as ordered regarding blood glucose readings and following physician orders to hold insulin as well as documentation of such physician notification.

A review will be conducted for three

- (3) residents per week for three
- (3) months to ensure that insulin has been administered per the physician's order, accu-checks have

been completed with physician notification of the blood glucose results per the physician's order, and these have been documented.

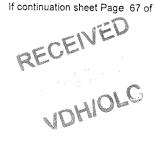
- 4. The results of the review will be discussed by the DCS/Designee at the Quality Assurance Performance **Improvement Committee meeting** monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
- 5. 10/4/2016

ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

Facility ID: VA0208

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OLIVIERO I OR MILDICAL	VE & MEDICAID SEKVICES		(DMB NO. 0938-03	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495325	B. WING		C 08/24/2016	
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0012412010	
PHEASANT RIDGE NURSING & REHAB CENTER			4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIC ((EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ACTION SHOULD BE COMPLETIC DATE	
					

F 333 Continued From page 67

coded the Resident as 3 of 15 in Section C, cognitive patterns. This is significant change MDS.

Resident #6's clinical record was reviewed on 08/23/16. It contained a signed POS (physician's order summary) dated 08/01/16 which read in part "Novolog Flex Pen Pref Syr (prefilled syringe) sliding scale 0-200= 0 u (units) 201-250=2u 251-300= 4u 301-350= 6u 351-400=8u 401-450=10u 451-500=12u >500=12u", "Novolog mix 70-30 units/1ml vial-inject 27 units subcutaneously every day-DM (diabetes mellitus)", "Novolog Mix 70-30 units/1ml vial-inject 8 units subcutaneously every day-DM", and "Accuchecks twice daily".

Resident #6's MAR's (medication administration record) for the months of June and July 2016 were reviewed. The MAR's contained an entry which read in part "Novolog Flex Pen Pref Syr (prefilled syringe) sliding scale 0-200= 0 u (units) 201-250=2u 251-300= 4u 301-350= 6u 351-400=8u 401-450=10u 451-500=12u >500=12u". This entry had not been signed as having been completed on 07/22 at 5pm and 07/25 at 5pm. On 07/10/16 the Resident's BS was recorded as 251 at 8am and the amount of insulin administered was recorded as 2u. The MAR's contained an entry which read in part "Novolog mix 70-30 units/1ml vial-inject 27 units subcutaneously every day-DM (diabetes mellitus)". This entry had not been signed as having been administered on 06/02, 06/18, 07/02 or 07/18. The MAR's contained an entry which read in part "Novolog Mix 70-30 units/1ml vial -inject 8 units subcutaneously every day-DM". This entry had not been signed as having been administered on 06/28 or 07/29. The MAR's

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				MB NO	<u>. 0938-0391</u>
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495325	B. WING			08	C /24/2016
NAME OF PROVIDER OR SUPPLIER PHEASANT RIDGE NURSING & REHAB CENTER			4355	ET ADDRESS, CITY, STATE, ZIP CODE PHEASANT RIDGE ROAD, SW NOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
	signed as having be 8am or 5pm, 06/18 The concern of the insulin administration brought to the attenduring a meeting or 1630. The RNC (registration that they could not a medications/treatment ordered. No further information of the securately monitor accurately administration orders. Resident #8 was ad 02/22/15 and readminoluded but not limic coronary artery dise hypertension, gastrodiabetes mellitus, and accident, dementia, dysphagia. The most recent MD and ARD (assessme 08/02/16 coded the C, cognitive patterns Resident #8's clinical Residen	which read in part daily". This entry had not been een completed on 06/02 at at 8am, and 07/14 at 5pm. missing documentation of the on and accuchecks was tion of the administrative staff of 08/23/16 at approximately gional nurse consultant) stated	F 3	33			
		ed 08/01/16 which read in					

part "Novolog Flex Pen Pref Syr (prefilled syringe)

PHEASANT RIDGE NURSING & REHAB CENTER

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

STAT	EMENT OF	DEFICIENCIES
AND	PLAN OF C	ORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

08/24/2016

С

495325 B. WING

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

F 333 Continued From page 69

100unit/1ml insulin pen-inject subcutaneously per sliding scale as follows: 200-250=2u, 251-300=4u, 301--350=6u, 351-400=8u, 401-450=10u, 451-500=12u-call MD if <50 or >500 for DM (diabetes mellitus)", "accuchecks before meals and a bedtime for DM", and "Lantus Solostar 100uni/1ml insulin pen-inject 20 units subcutaneously at bedtime for DM". Resident #8's MAR (medication administration record) for June 2016 contained an entry which read in part "Novolog Flex Pen Pref Syr (prefilled syringe) 100unit/1ml insulin pen-inject subcutaneously per sliding scale as follows: 200-250=2u, 251-300=4u, 301--350=6u, 351-400=8u, 401-450=10u, 451-500=12u-call MD if <50 or >500 for DM (diabetes mellitus)". This entry had not been signed as having been administered on 06/16-17, 06/20, 06/23, or 06/28-30 at 11:30am, 06/05, or 06/29 at 4:30pm, and 06/07, 06/14-15, 06/17, 06/21-22, 06/27 or 06/29 for 9pm. The MAR contained an entry which read in part "accuchecks before meals and at bedtime for DM". This entry had not been signed as having been completed on 06/12, 06/14, 06/22 or 06/27 at 9p and no BS (blood sugar) had been recorded on 06/20 at 11:30am or 06/13 at 4:30pm. The MAR contained an entry which read in part "Lantus Solostar 100uni/1ml insulin pen-inject 20 units subcutaneously at bedtime for DM". This entry had not been signed as having been administered on 06/12, 06/14, 06/22, or 06/27.

The MAR for July contained an entry which read in part "Novolog Flex Pen Pref Syr (prefilled syringe) 100unit/1ml insulin pen-inject subcutaneously per sliding scale as follows: 200-250=2u, 251-300=4u, 301--350=6u, 351-400=8u, 401-450=10u, 451-500=12u-call MD if <50 or >500 for DM (diabetes mellitus)". This

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ORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

Facility ID: VA0208

If continuation sheet Page 70 of 109



PRINTED: 09/16/20 FORM APPROVE OMB NO. 0938-039

					UNID N	10. 0938-031	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ł	MULTIPLE CONSTRUCTION IILDING		(X3) DATE SURVEY COMPLETED	
		495325	B. WING			C 08/24/2016	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
PHEASANT RIDGE NURSING & REHAB CENTER				4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	X (EACH CORRECTIVE ACTION	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETI CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 333	Continued From pa	ge 70	F 3	33			

entry had not been signed as having been administered on 0728-29 at 6:30am, 07/26 at 11:30am, 07/09, 07/15, or 07/26 at 4:30, and 07/06, 07/09, 07/15, 07/18, or 07/26 at 9pm. The MAR contained an entry which read in part "accuchecks before meals and at bedtime for DM". This entry had not been signed as completed on 07/29 at 6:30am, 07/06 or 07/15 at 9pm and no BS had been recorded for 07/28 at 6:30am or07/02 at 11:30am. The MAR contained an entry which read in part "Lantus Solostar 100uni/1ml insulin pen-inject 20 units subcutaneously at bedtime for DM". This entry had not been signed as having been administered on 07/15, 07/18, or 07/23.

The MAR for August contained an entry which read in part "Novolog Flex Pen Pref Syr (prefilled syringe) 100unit/1ml insulin pen-inject subcutaneously per sliding scale as follows: 200-250=2u, 251-300=4u, 301--350=6u, 351-400=8u, 401-450=10u, 451-500=12u-call MD if <50 or >500 for DM (diabetes mellitus)". This entry had not been signed as having been administered on 08/08 at 9pm or 08/09 at 11:30am. The MAR contained an entry which read in part "Lantus Solostar 100unit/1ml insulin pen-inject 20 units subcutaneously at bedtime for DM". This entry had not been signed as having been administered on 08/08-10 or 08/22.

The Resident's clinical record contained telephone order dated 08/23/16 which read in part "Hold Novolog sliding scale until insulin is received from pharmacy. The time of the order was 1740. Surveyor spoke with the RNC (regional nurse consultant) on 08/24/16 at approximately 0915 regarding the Novolog insulin. RNC stated that the insulin had arrived from the pharmacy,

EPARTMENT OF HEALTH AND HUMAN SERVICES

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ENTE	<u>RS FOR MEDICARE</u>	& MEDICAID SERVICES		0	MB NO. 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495325	B. WING		C 08/24/2016
	PROVIDER OR SUPPLIER NT RIDGE NURSING	& REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
X4) ID REFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE COMPLETION
F 333	The concern of the insulin administration brought to the attenduring a meeting or 1630. The RNC (rethat they could not a second to the second	missing documentation of the on and accuchecks was tion of the administrative staff n 08/23/16 at approximately gional nurse consultant) stated	F3	33	
F 369 SS=D	483.35(g) ASSISTIVEQUIPMENT/UTENTHE facility must proposed and utensils for residuant utensils for residuant experiments. This REQUIREMENTHS by: Based on observator record review, the fathe correct feeding of Resident #20.	ovide special eating equipment dents who need them. IT is not met as evidenced fon, staff interview, and clinical acility staff failed to provide utensils for 1 of 20 Residents,	F3	 Resident #20 was provided plastic silverware during t survey process. Residents currently residin the facility requiring altern silverware/eating utensils I the potential to be affected review has been conducted DCS/Designee for current residing in the facility requality 	the Ig in native have . A by the
	The findings include	d.		alternative "	ırıng

The Residents CCP (comprehensive care plan) indicated the Resident was to use plastic silverware at meals. The Resident was observed by the surveyor to be using regular utensils.

The record review revealed that Resident #20 was admitted to the facility 09/07/09. Diagnoses included, but were not limited to, dementia, dysphagia, atrial fibrillation, anemia, and

- alternative silverware/eating utensils to ensure that required silverware/eating utensils are provided as indicated.
- 3. Education has been provided to the employees in the dietary department by the ED/Designee regarding provision of alternative silverware/eating utensils as indicated during mealtime.

		AND HUMAN SERVICES & MEDICAID SERVICES				F(1ED: 09/16/201 DRMAPPROVE NO. 0938-039
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- 369	provided to the sur	age 73 ion regarding this issue was vey team prior to the exit	F3	369	9		
F 387 SS=D	conference. 483.40(c)(1)-(2) FF OF PHYSICIAN VI	REQUENCY & TIMELINESS SIT	F3	381	7		
	The resident must	he seen by a physician at least		1	. Resident #10 currently ha	.S	

once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

This REQUIREMENT is not met as evidenced by:

Based on staff interview and clinical record review, the facility staff failed to ensure timely physician visits for 1 of 20 residents. (Resident #10)

The findings included:

Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident 's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 6 out of 15. Resident #10 requires set up help only for dressing and bathing.

During the clinical record review on 8/23/16, it was noted by the surveyor that there were 2

- been seen by the physician and visits are timely.
- 2. Current residents residing in the facility have the potential to be affected. A review has been conducted by the DCS/Designee regarding physician's visits.
- 3. Education has been provided to the physician(s) regarding timeliness of visits. A review will be conducted by the DCS/Designee weekly for three (3) residents to ensure that physician visits are conducted on a timely basis.
- 4. The results of the reviews will be discussed by the DCS/Designee\ at the Quality Assurance Performance **Improvement Committee meeting** monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
- 5. 10/4/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION TATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: ND PLAN OF CORRECTION A. BUILDING B. WING 495325 08/24/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION ID (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) F 387 F 387 Continued From page 74 progress notes that could not be found in the clinical record. There was a progress note dated for 3/28/16 and another one for 8/8/16. On 8/23/16 at 4:30 pm, the administrative team was notified of the above documented findings. No further information was provided to the surveyor prior to the exit conference. F 425 483.60(a).(b) PHARMACEUTICAL SVC -F 425 SS=E ACCURATE PROCEDURES, RPH 1. For Resident #5, the physician and The facility must provide routine and emergency responsible party have been notified drugs and biologicals to its residents, or obtain them under an agreement described in that Fentanyl was unavailable on 8/1/16. §483.75(h) of this part. The facility may permit For Resident #20, the physician and the unlicensed personnel to administer drugs if State responsible party have been notified law permits, but only under the general supervision of a licensed nurse. that mirtazapine was unavailable A facility must provide pharmaceutical services on 8/2/16. For Resident #2, the physician and (including procedures that assure the accurate acquiring, receiving, dispensing, and the responsible party have been administering of all drugs and biologicals) to meet notified that Norco was unavailable the needs of each resident. on 8/15/16 and 8/16/16. For Resident #13, the physician and The facility must employ or obtain the services of a licensed pharmacist who provides consultation the responsible party have been notified on all aspects of the provision of pharmacy that Fentanyl was unavailable on 8/18/16 services in the facility. and 8/19/16. For Resident #15, the physician and the responsible party have been notified This REQUIREMENT is not met as evidenced that Valium was unavailable on 7/19/16. by: For Resident #1, the physician and the

Based on staff interview, facility document

review, and clinical record review the facility staff

responsible party have been notified

that Doxepin was unavailable on 8/8/2016.

FORM APPROVED OMB NO. 0938-0391

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F 425		ge 75 sician ordered medications	-	425 2. For current residents	residing	g in

failed to ensure physician ordered medications were available for administration for 6 of 20 Residents, Residents #5, #20, #2, #1, #13, and #15

The findings included.

1. For Resident #5, the facility failed to ensure the physician ordered medication fentanyl was available for administration.

The record review revealed that Resident #5 had been readmitted to the facility on 07/15/16. Diagnoses included, but were not limited to, sepsis, osteoarthritis, morbid obesity, heart failure, and chronic obstructive pulmonary disease.

Section C (cognitive status) of the Resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/22/16 included a BIMS (brief interview for mental status) score of 12 out of 15 points. Indicating the Resident was cognitively intact.

The Residents clinical record included a physician signed (08/_/16) POS (physician order sheet) that included an order for the pain medication fentanyl duragesic patch apply 1 patch topically every 72 hours.

When reviewing the Residents MAR's (medication administration records) it was noted that the facility nursing staff had documented that on 08/01/16 at 9:00 a.m. the Residents fentanyl patch was not available for administration. The Resident did have scheduled oxycodone ordered every 6 hours and a prn (as needed) order for oxycodone for pain.

- 2. For current residents residing in the center, a review has been conducted of the physicians orders and the Medication Administration Record for the previous thirty (30) days by the DCS/Designee to identify medication availability concerns. The physician and the responsible party have been notified as indicated by the results of the review.
- 3. Education has been provided by the DCS/Designee to the Licensed Nurses regarding the process for acquiring medications and ensuring that medications are available as ordered by the physician. The DCS/Designee will conduct a weekly review for three (3) residents per week for three (3) months to ensure that medications are available for administration as ordered by the physician.
- 4. The results of the reviews will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
- 5. 10/4/2016

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

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F 425 Continued From page 76

F 425

During a meeting with the survey team on 08/24/16 at approximately 3:20 p.m. the administrative staff were notified that Resident #5's fentanyl patch was not available for administration on 08/01/16.

The facility policy/procedure titled "Medication Shortages/Unavailable Medications." read in part "...Upon discovery that Facility has as inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy..."

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. For Resident #20, the facility failed to ensure the physician ordered medication mirtazapine was available for administration.

The record review revealed that Resident #20 was admitted to the facility 09/07/09. Diagnoses included, but were not limited to, dementia, dysphagia, atrial fibrillation, anemia, and hypertension.

Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/11/16 included a BIMS (brief interview for mental status) score of 2 out of a possible 15 points.

Resident #20 had a physician order for mirtazapine 7.5 mg by mouth at bedtime for depression/appetite stimulation.



PRINTED: USI 10/20 16 **EPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED **ENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X3) DATE SURVEY EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495325 B. WING 08/24/2016 VE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW EASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (4) ID 1D (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE REFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 425 Continued From page 77 F 425 When reviewing the Residents MAR's (medication administration records) it was noted that the facility nursing staff had documented on 08/02/16 at 9:00 p.m. that the medication was not available for administration and would be delivered. The surveyor did not find any documentation that this medication had been delivered to the facility and administered to the Resident on 08/02/16. The administrative team was notified of the above during a meeting with the surveyors on 08/25/16. The facility policy/procedure titled "Medication Shortages/Unavailable Medications." read in part "...Upon discovery that Facility has as inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy..." No further information regarding this issue was provided to the survey team prior to the exit conference. 3. The facility staff failed to ensure the pain medication, Hydrocodone-Acetaminophen

(Norco) 7.5/325 mg, was available for administration for Resident #2.

Resident #2 was admitted to the facility on 8/17/15 with diagnoses of diabetes, end stage renal disease, aphasia, Guillian -Barre syndrome, hypertension, insomnia, depression, coronary artery disease, stroke, urinary tract infection, peptic ulcer disease, and chronic osteomyelitis.

The current quarterly Minimum Data Set (MDS) with a reference date of 5/30/16 assessed the

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F 425	resident was able to gestures. The resid total assistance of transfers, dressing,	itive score of "11" of "15". The communicate with with ent was assessed requiring I-2 persons for bed mobility, eating, toileting, hygiene, and it was assessed to have	F	425				
	ordered Norco 7.5-3	was reviewed. The physician 325 mg 1 tablet given via very 4 hours with a start date						
	record was reviewe evidence the nurse Norco had not been The nurse documer waiting for pharmac documented at 4:00	edication administration d. The record contained had circled initials noting the given at 8:00 p.m. on 8/15. Ited on the back of the MAR y arrival. The nurse p.m. on 8/15/16 and 8/16/16 available pharmacy called".						
	consultant were info meeting with the su p.m. There was no by the facility prior to 4. The facility staff	OON, and corporate nurse ormed of the findings during a rvey team on 8/23/16 at 4:30 further information provided to exit. Failed to ensure the physician fentanyl was available for						
	on 6/29/11 and then the following diagno anemia, high blood Alzheimer's diseas #12 was coded in th with an ARD (Asses	riginally admitted to the facility readmitted on 6/18/14 with ses of, but not limited to pressure, heart failure, e and dementia. Resident e MDS (Minimum Data Set) sment Reference Date) of BIMS (Brief Interview for						

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 425 Continued From page 79

TAG

Mental Status) score of 1 out of a possible score of 15.

During the clinical record review, the surveyor noted on Resident #13 's MAR (Medication Administration Record) for the month of August, 2016 that it contained documentation that the fentanyl patch was not available from pharmacy on 8/18/16 and 8/19/16. There was no documentation in the clinical record that the resident had been experiencing pain nor where there any behavior problems during this time.

The regional nurse was notified of the above documented findings on 8/25/16. The regional nurse stated, "There is a plan in place for this, someone just dropped the ball. "

The facility policy titled " Medication Shortages/Unavailable Medications " read in part "...Upon discovery that Facility has an inadequate supply of a medication to administer to a resident, Facility staff should immediately initiate action to obtain the medication from Pharmacy ... "

The administrative team was notified of the above documented findings on 8/25/16.

No further information was provided to the surveyor prior to the exit conference.

5. The facility staff failed to ensure that the physician ordered medication Valium was available to administer to Resident #15.

Resident #15 was admitted to the facility on 3/2/15 with the following diagnoses of, but not limited to anemia, Multiple Sclerosis, malnutrition, F 425

RM CMS-2567(02-99) Previous Versions Obsolete

Event ID: GCK411

Facility ID: VA0208

If continuation sheet Page 80 of 109



		AND HUMAN SERVICES & MEDICAID SERVICES			FORMAPPROVED OMB NO. 0938-0391
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- 425	Continued From pa		F	425	
	resident was coded Set) with an ARD (a of 8/10/16 as havin Mental Status) scoro of 15. Resident #1 staff members for a bathing. During the clinical rechart, the surveyor 2016 MAR (Medicathat on "7/19/16 a on the way from RX receives Valium by There was no docusupport what time to the pharmacy. The regional nurse documented finding nurse stated, "The someone just drop! The facility policy to Shortages/Unavailation."Upon discovery inadequate supply to a resident, Facility				

The administrative team was notified of the above documented findings on 8/25/16.

No further information was provided to the surveyor prior to the exit conference.

6. The facility staff failed to ensure the physician

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	ordered medication administrated to Re Resident #1 was or on 7/20/16. The resident facility on 7/diagnoses of, but not disease, high blood disease, neurogenic quadriplegia, depresamputation and presegion. The resident was conducted bate of 6/27/16 with Mental Status) score of 15. The resident totally dependent on dressing and person the clinical record and (Medication Administion of August 2016 was On the back of the All was documented "8 (milligram) po (by medication in the regional nurse with documented findings nurse stated, "The resomeone just dropped into the regional part of the regional nurse with the regional nurs	Doxepin was available to be sident #1. iginally admitted to the facility sident was readmitted back /8/16 with the following of limited to coronary artery pressure, peripheral vascular cobladder, wound infection, ssion, bilateral above the kneessure ulcer of the sacral and which was also coded as being a 1 staff member for eating, and hygiene. Is well as the resident 's MAR tration Record) for the month reviewed by the surveyor. Jugust MAR, the following 3/8/16 9 pm Doxepin 10 mg outh) not available. " Jugust MAR, the following south) not available. "	F 4	25	
,	'Upon discovery th	le Medications " read in part			

to a resident, Facility staff should immediately

IEASANT RIDGE NURSING & REHAB CENTER

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

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A. BUILDING

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4355 PHEASANT RIDGE ROAD, SW

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F 425 Continued From page 82

initiate action to obtain the medication from Pharmacy ... "

The administrative team was notified of the above documented findings on 8/25/16.

No further information was provided to the surveyor prior to the exit conference.

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.

The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to

F 431

F 425

1. The bottle of metoclopramide was removed from the counter on Unit 1 during the survey process by LPN #3. The card of omeprazole and the card

of lisinopril were also removed from the top of the medication cart on the 400 hall of Unit 1 during the survey process by LPN #3. There were no residents adversely affected.

- 2. Facility rounds/observations have been conducted by the DCS/Designee to ensure that no further medications were left unattended or out of view.
- 3. Education has been provided to the Licensed Nurses by the DCS/Designee regarding ensuring that medications are not left unattended or out of view and that medications remain secured. The DCS/Designee will conduct weekly observations on each unit for three (3) months to ensure that medications are secured and not left unattended or left out of the Licensed Nurses' view.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 431 Continued From page 83

abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

This REQUIREMENT is not met as evidenced by:

Based on observation, and staff interview, the facility staff failed to ensure medications were properly stored on 1 of 2 units, unit I.

The findings included.

The facility nursing staff left the medications metoclopramide, omeprazole, and lisinopril unattended and out of view.

On 08/25/16 at approximately 6:10 a.m. the surveyor observed a 16 ounce bottle of metoclopramide (reglan) unattended on top of the counter at the unit I nurses station. There were six female Residents in their wheelchairs sitting at this same nursing station.

The surveyor sat down at the nurse's station and when turning around the surveyor noted the medication was no longer on top of the counter.

Upon approaching the medication cart on the 400 hall (unit I) the surveyor was able to observe two cards of medication turned upside down on top of the cart. The surveyor flipped the cards over one card contained thirty tabs of omeprazole and the other card contained thirty tabs of lisinopril. The surveyor was able to observe one female Resident in the vicinity sitting in her wheelchair. The nursing staff on this hall was in a Residents

F 431

- 4. The results of the observations will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan to sustain substantial compliance.
- 5. 10/4/2016

PRINTED: 09/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY 1D PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495325 B. WING 08/24/2016 VAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F 431 Continued From page 84 room.

F 431

When LPN (licensed practical nurse) #3 returned to the medication cart the surveyor asked them if they had removed the bottle of metoclopramide from the top of the nursing station to which they replied they had. When asked about the medication on top of the cart LPN #3 verbalized to the surveyor that the medications were in the wrong cart and they had removed them to put in the other cart. LPN #3 acknowledged that the medication should not have been left out of the medication cart.

The surveyor requested from the facility their policy/procedure on medication storage. This policy/procedure read in part "...Facility should ensure that all medications and biologicals...are securely stored in a locked cabinet/cart or locked medication room that is inaccessible by residents and visitors..."

The administrative staff were notified of the improperly stored medications during a meeting with the survey team on 08/25/16.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 441 483.65 INFECTION CONTROL, PREVENT SS=E SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

F 441

1. Ice scoop holders have been placed on the outside of the ice chest so that the ice scoop can be stored appropriately in between filling resident water

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F 441 Continued From page 85

(a) Infection Control Program
The facility must establish an Infection Control
Program under which it -

- (1) Investigates, controls, and prevents infections in the facility;
- (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
- (3) Maintains a record of incidents and corrective actions related to infections.
- (b) Preventing Spread of Infection
- (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
- (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
- (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.
- (c) Linens

Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility documents review and clinical record review, the facility staff failed to follow standard infection control guidelines on 1 of 2 units (unit II) and failed to follow infection control policies and procedures for 3 of 20 Residents, Residents #1,

F 441

pitchers. Gloves are no longer worn during distribution of ice on ice pass.

For Resident #1, education \
has been provided to LPN #1
regarding maintaining appropriate
infection control practices
during treatment administration
including changing gloves and
washing hands when transitioning
from dirty to clean surfaces.

There were no negative effects to Resident #1.

For Resident #15, the tubing was \ changed and the tube feeding was reconnected to the resident \ during the survey process. There were no negative effects to Resident #15. For Resident #8, education has been provided to RN #1 regarding maintaining appropriate infection control practices during treatment administration including changing gloves and washing hands when transitioning from dirty to clean surfaces as well as sanitizing scissors appropriately during treatment administration. There were no negative effects to Resident #8.

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F 441 Continued From page 86 #15, and #8.

The findings included.

1. The facility staff filled the water pitchers on unit II with ice in a manner that could increase the risk for the ice to be contaminated.

On 08/24/16 at approximately 6:40 a.m. the surveyor observed CNA (certified nursing assistant) #1 pass ice to the Residents on unit II. CNA #1 was observed by the surveyor to enter the Residents room obtain the Residents water pitcher bring it out into the hallway and fill the ice pitcher with ice from an ice chest. After filling up the ice pitcher to the Residents room.

After the CNA left the ice chest and returned to the Residents room the surveyor opened the ice chest and observed the ice scoop laying over in the ice and water. The handle of the ice scoop was observed to be touching the ice and water.

When CNA #1 returned to the ice chest the surveyor interviewed them regarding their procedure of passing ice/water. When asked about the ice scoop CNA #1 stated to the surveyor "It's nasty." I have complained about it several times we should have something on the side to put the ice scoop in. CNA #1 stated she tried to put the ice scoop in the ice with the handle facing up.

CNA #1 was observed by the surveyor to wear gloves. However, CNA #1 was observed entering several Resident rooms and was not observed to change her gloves, wash her hands, or perform any hand hygiene between Residents and/or

F 441

- 2. Residents currently residing in the facility requiring treatment administration have the potential to be affected. The DCS/Designee has conducted random treatment observations on Unit 1 and Unit 2 to ensure that Licensed Nurses follow appropriate infection control practices during treatment administration including appropriate donning/changing of gloves, handwashing when transitioning between soiled and clean surfaces, and sanitizing scissors prior to, during, and after treatment administration as appropriate. Facility rounds/observations have also been conducted by the DCS/Designee to ensure that there were no further infection control concerns during distribution of i
- 3. Education has been provided by the DCS/Designee to the Licensed Nurses regarding maintaining appropriate infection control practices including donning /changing gloves, handwashing when transitioning between soiled and clean surfaces, and sanitizing scissors prior to, during, and after treatment administration as appropriate. Education has also been

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F 441 Continued From page 87 Resident rooms.

The administrative staff were notified of the infection control issue regarding the ice scoop in a meeting with the survey team on 08/24/16 at approximately 3:20 p.m.

The facility policy/procedure titled "Standard Precautions" read in part "...Remove gloves promptly after use, before touching non-contaminated items and environmental surfaces and before going to another resident. IMMEDIATELY wash hands after removing gloves..."

No further information regarding this issue was provided to the survey team prior to the exit conference.

2. The facility staff failed to follow infection control policy during a wound care dressing change on Resident #1.

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating, dressing and personal hygiene.

F 441

provided to the nursing staff regarding maintaining appropriate infection control practices during ice distribution including storing the ice scoop separately from the ice and sanitizing hands appropriately between residents when distributing ice. The DCS/Designee will conduct observations for three (3) Licensed **Nurses completing treatment** administration/dressing changes weekly for three (3) months to ensure that appropriate infection control practices are followed including appropriate donning/changing of gloves, handwashing when transitioning between soiled and clean surfaces, and sanitizing scissors prior to, during, and after treatment administration as appropriate. Facility rounds/observations will be conducted by the DCS/Designee three (3) times per week for three (3) months during facility ice distribution/ice pass to ensure that appropriate infection control practices are being followed including storing the ice scoop separately from

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F 441 Continued From page 88

The surveyor observed Licensed Practical Nurse (LPN) #1 perform wound care on Resident #1. The surveyor made the following observation:

- LPN #1 put on a pair of gloves and removed old dressing then discarded gloves appropriately.
- LPN #1 went into bathroom and washed her hands.
- LPN #1 then placed another pair of gloves on and cleaned the wound bed with gauze soaked in saline.
- LPN #1 proceeded to take the new dressing supplies out of the packaging and applied it to the wound on the resident's sacral wound.
- · She then removed her gloves and washed her hands.

After LPN #1 had left the room, the surveyor asked LPN #1 if she could remember anything that she would have done differently during the wound care. LPN #1 stated, "I don't believe so. You have made me so nervous." When the surveyor explained to LPN #1 that she had gloves on that had been used to clean the wound bed, LPN #1 stated, "I should had changed my gloves between going from dirty to clean."

The regional nurse and unit manager #1 were notified of the above documented observations that the surveyor had made during wound care on 8/24/16. The regional nurse stated, "Yes, they are to wash their hands after they clean the wound and put on new gloves to apply the new dressing to the area."

On 8/24/16 at 4:30 pm, the administrative team was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference.

F 441

- the ice and handwashing/hygiene appropriately between residents during ice distribution.
- 4. The results of the observations will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
- 5. 10/4/2016

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= 441 Continued From page 89

F 441

3. The facility staff failed to follow infection control in regards to the tube feeding for Resident #15.

Resident #15 was admitted to the facility on 3/2/15 with the following diagnoses of, but not limited to anemia, Multiple Sclerosis, malnutrition, anxiety, dysphagia and gastrostomy. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/16 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #15 is totally dependent on 2 staff members for dressing, personal hygiene and bathing.

On initial tour of the facility on 8/22/16 at approximately 6:20 pm, the surveyor went into Resident #15 's room. The surveyor observed the feeding tubing was draped over the IV pole but was not connected to the resident. The tip end of the feeding tube was not covered. The Surveyor asked the resident how long has it been that the feeding tube had not been restarted. Resident #15 stated, " Ever since I took my bath at 2 pm this afternoon. I have told different ones but it hasn 't got done."

At 7:30 pm, the surveyor went back into the resident's room to observe if the feeding tube had been restarted. The surveyor noted the feeding tube in the same location as documented above, with the end of the feeding tube uncovered.

At 8:30 pm, the surveyor once again, went into the resident's room and observed the feeding tube in the same manner in which it had been on

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	the first 2 observation	<u>-</u>					
	went into the reside	oximately 8 am, the surveyor nt 's room. The resident was ing tube was infusing by IV					
	asked to give this s	and director of nursing were urveyor a copy of the policy cerning feeding tubes and how d if not in use.					
		ream was notified of the above s at the end of the day /16.					
	surveyor, "We can what you were askir	ector of nursing stated to the not find a policy regarding ng for. But if it had been me, I I the tip of the tube so that any get in there. "					
	No further information	on was provided to the exit conference.					
	established infectior dressing change by	he facility staff failed to follow n control procedures during a placing gloved hand in pocket and taking scissors into					
	02/22/15 and readm included but not limi coronary artery dise hypertension, gastro diabetes mellitus, ap	mitted to the facility on itted on 03/14/16. Diagnoses ted to atrial fibrillation, ase, congestive heart failure, resophageal reflux disease, chasia, cerebrovascular respiratory failure, and					

dysphagia.

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F 441 Continued From page 91

F 441

The most recent MDS (minimum data set) with and ARD (assessment reference date) of 08/02/16 coded the Resident as 0 of 15 in section C, cognitive patterns. Section M, skin conditions coded the Resident as being at risk for developing pressure ulcers, having unhealed pressure ulcers, having two stage 3 pressure ulcers not present on admission. This is an annual MDS.

The surveyor observed dressing change being completed on Resident #8's stage III heel/ankle decubitus ulcers by RN (registered nurse) #1 on 08/23/16 at approximately 0755. RN #1 washed hands, and then donned clean gloves. RN #1 then reached into pocket of scrub top, removed scissors and used them to remove old dressing from Resident's left foot, without cleaning them. RN #1 placed soiled dressing and gloves into trash receptacle. RN# 1 washed hands, donned fresh gloves, and cleaned the wound. RN #1 removed soiled gloves, washed hands and donned fresh gloves. RN #1 applied treatment to wound, applied bandage to wound, then applied Kling dressing to wound, using same scissors to cut dressing. RN #1 removed gloves and washed hands. RN #1 donned fresh gloves and using scissors, removed old dressing from Resident's right foot. RN #1 placed soiled dressing and gloves into trash receptacle. RN #1 washed hands, taking scissors into bathroom with her. RN #1 donned fresh gloves, placed scissors on barrier, cleaned wound, removed soiled gloves and washed hands. RN #1 donned clean gloves, applied treatment to Resident's R ankle, applied bandage, and applied Kling dressing, using scissors to cut. RN #1 removed soiled gloves, placed in trash receptacle, tied and removed

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1 771	•	-	ור ו	171		
	trash bag, then was	siled fiallus.				
	RNC (regional nurs approximately 0830 should not have pla	d wound care observation with se consultant) on 08/23/16 at 0. RNC stated that RN #1 aced hand in pocket to retrieve ng, nor should have taken boom.				
	was discussed with	breech in infection control the administrative staff during 3/16 at approximately 1530.				
F 456 SS=E		ion was provided prior to exit NTIAL EQUIPMENT, SAFE DITION	F 4	456		
		aintain all essential cal, and patient care operating condition.			1. Residents residing in the were placed on increase The maintenance direct facility rounds/observat	ed supervision. tor conducted ions of call
	This REQUIREMENT by:	NT is not met as evidenced			bells for residents curre in the facility to ensure	•
	Based on observa	tion and staff interviews, the pensure a proper working call 2 units.			light outside the resider were functional. The cal	ll bell
	The findings include	ed:			system has been repaire 2. Residents residing in the	e facility were
	there were 3 survey	the facility on 8/22/16 at 6 pm, yors that were checking on the its and did they work properly.			placed on increased sup maintenance director c rounds/observations of	onducted facility call bells for
	station on Unit 1 arrandomly picked ro	rveyors stood at the nurses ' and 1 surveyor went into a om and activated the call bell veyors at the nurses ' station			residents currently resi facility to ensure that the the residents' rooms' w The call bell system has	he light outside vere functional.

The call bell system has been repaired.

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08/24/2016

NAME OF PROVIDER OR SUPPLIER

PHEASANT RIDGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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F 456 Continued From page 93

could hear the call bell system alarming but the box at the nurses 'station that has buttons with room numbers on them did not work.

On 8/23/16 at 8 am, the surveyor was sitting on Unit 1 at the nurses' station and observed the call bell system alarming but the room numbers on the box in the nurses' station would randomly light up. At the nurses' station, there were 3 ceiling lights that the surveyor observed being turned on when the call bell system was alarming on the 400 hallway showing which direction the call bell alarm was coming from. All three hallways had the lights in the ceiling at the beginning of the hallways but only the one for the 400 hallway worked.

The surveyor asked unit manager #1 if the call bell system had been working properly. Unit Manager #1 started, "They were here 2 weeks ago but I haven't seen a change in it." The surveyor requested that the maintenance director be paged to come to unit 1 to discuss the call bell system.

At 8:15 am, the director of nursing was at the nurses' station and the call bell system alarmed. Once again, the light in the ceiling for the 400 hallway came on and the light beside the resident's door came on but the box in the nurses' station did not light up to show the room number that the call bell was ringing from. The surveyor asked the DON how the call bell was suppose to work. The DON stated, "I'll have to go and get the maintenance director to help you out with that."

At 8:25 am, the regional nurse came back to the nurses' station and asked if there was a problem

F 456

- 3. Education has been provided to current employees regarding responding to call bells and monitoring for lights outside the resident rooms. The education also included maintaining increased supervision via increased frequency of rounds to identify potential resident needs. The ED/Designee will conduct random rounds on both units totaling ten (10) residents per week for three (3) months to monitor call bell function.
- (3) months to monitor call bell function4. The results of the observations will be discussed by the ED/Designee at the Quality Assurance Performance
 - Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
- 5. 10/4/2016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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F 456		age 94 stem. The surveyor notified of the above documented	F 45	66			
	unit 1 nurses 'stat him how the call be maintenance direct it works." The su maintenance was p system. The maintenance	intenance director came to the ion and the surveyor asked ell system worked. The cor stated, "I don't know how reyor asked if periodic performed on the call bell tenance director stated, "I don't know when a bulb burns out I."	;				
	of an email for the system for the enti- also stated, "We I minute round chec	brought to the surveyor a copy approval of a new call bell re facility. The regional nurse have put everyone on 15 ks until the new system has a have also educated all the lure."					
	were on unit 2 obse	oximately 6 pm, 2 surveyors erving the call bell system. nat occurred on unit 1 occurred	<i>:</i>				
		pm, the administrative team above documented findings.		1.	The facility currently permanent Administ	rator/Execu	
F 490 SS=E	surveyor prior to th 483.75 EFFECTIVE		F 49	90	Director employed e The facility also has and the amount of a has been reduced.	a DCS emp	loyed
		dministered in a manner that a resources effectively and		2.	The facility currently permanent Administ		ıtive

efficiently to attain or maintain the highest

Director employed effective 9/19/2016.

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	PROVIDER OR SUPPLIER NT RIDGE NURSING	& REHAB CENTER	4355 F	TADDRESS, CITY, STATE, ZIP CODE PHEASANT RIDGE ROAD, SW NOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 490	This REQUIREME by: Based on survey residents and nursing staff to facility were able to highest practicable well-being. The facility had two survey, both no long the current acting corporate office. The director of nurcurrent acting director of	al, mental, and psychosocial resident. NT is not met as evidenced results it was determined the on failed to use its' resources of ensure the residents in the ormaintain or attain their ephysical and/or emotional of administrators since the last ager employed at the facility, administrator was from the sing had resigned and the ctor of nursing was the	4.	The facility also has a Dand the amount of agend has been reduced. Education has been condomored. Regional Director of Clip/Designee regarding the prequirement that a facility administered in a mannit to use its resources effective of the practicable phy and psychosocial well-bresident. The RDCS/Deassurance Performance Committee meeting proceed for three (3) months to a reas identified out of coreviewed. The ED/Designing implement a Family Coquarterly for twelve (12) identify further performing the ED/Designee will residentified as out of commast the facility Quality A Performance Improvement Meeting monthly for the The committee will receive to the plan as indicated substantial compliance.	ducted by the inical Services regulation lity must be ter that enables fectively and maintain the sical, mental, being of each esignee will almore are gnee will also uncil Meeting months to mance ties. Eview areas pliance as well a for these areas assurance tent Committee ree (3) months. Ommend revision to sustain
	F315, F328, F333		5.	10/4/2016	

EPARTMENT OF HEALTH AND HUMAN SERVICES

ENTERS FOR MEDICARE & MEDICAID SERVICES

TEMENT OF DEFICIENCIES PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION A. BUILDING

OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

PRINTED: 09/16/2016 FORM APPROVED

C

495325

B. WING

08/24/2016

AME OF PROVIDER OR SUPPLIER

HEASANT RIDGE NURSING & REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

(X5) COMPLETION

F 502 483.75(j)(1) ADMINISTRATION SS=D

The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

This REQUIREMENT is not met as evidenced

Based on staff interview and clinical record review the facility staff failed to obtain a physician ordered lab for 1 of 20 Residents, Resident #5.

The findings included.

The facility staff failed to obtain the physician ordered lab albumin.

The clinical record review revealed that Resident #5 had been readmitted to the facility on 07/15/16. Diagnoses included, but were not limited to, sepsis, osteoarthritis, morbid obesity, heart failure, and chronic obstructive pulmonary disease.

Section C (cognitive status) of the Resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/22/16 included a BIMS (brief interview for mental status) score of 12 out of 15 points. Indicating the Resident was cognitively intact.

The clinical record review revealed that Resident #5's physician had ordered an albumin and prealbumin lab test on 08/04/16.

Further review of the clinical record revealed that the facility staff had obtained the prealbumin on 08/05/16. The clinical record did not include any

F 502

- 1. For Resident #5, the physician and responsible party have been notified regarding the albumin level.
- 2. Residents currently residing in the facility with physician's orders for labs have the potential to be affected. A review has been conducted by the DCS/Designee for the previous thirty (30) days for residents with

physician's orders for labs to ensure that labs have been obtained per the physician's order.

- 3. Education has been provided by the DCS/Designee to the Licensed Nurses regarding obtaining labs as ordered by the physician. The DCS/Designee will conduct a review for three (3) residents per week for three (3) months to ensure that labs have been obtained per the physician's order.
- 4. The results of the reviews will be discussed by the DCS/Designee at the Quality **Assurance Performance Improvement** Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.
- 10/4/2016 5.

racility ID: VA0208

If continuation sheet Page 97 of 109

PRINTED: 09/16/2016 PARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 NTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **EMENT OF DEFICIENCIES** COMPLETED IDENTIFICATION NUMBER: PLAN OF CORRECTION A. BUILDING 495325 B. WING 08/24/2016 STREET ADDRESS, CITY, STATE, ZIP CODE ME OF PROVIDER OR SUPPLIER 4355 PHEASANT RIDGE ROAD, SW

IEASANT RIDGE NURSING & REHAB CENTER

ROANOKE, VA 24014

PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)

F 502 Continued From page 97 results for the albumin lab.

(4) ID

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The unit manager was asked about the missing lab but was unable to locate the results.

The administrative staff were notified that the facility staff failed to obtain a physician ordered lab for Resident #5 prior to the exit conference on 08/25/16.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 505 483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN SS=D OF LAB RESULTS

> The facility must promptly notify the attending physician of the findings.

This REQUIREMENT is not met as evidenced

Based upon staff interview and clinical record review, the facility staff failed to report abnormal laboratory results to the physician for 1 of 20 residents in the survey sample. (Resident #1)

The findings included:

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

F 502

F 505

F 505:

- 1. For Resident #1, the physician and the responsible party have been notified of the results of the Basic Metabolic Panel from 7/1/2016.
- 2. Residents residing in the facility with physician's orders for labs have the potential to be affected. A review has been conducted by the DCS/Designee for labs obtained within the previous thirty (30) days to ensure that the physician has been notified regarding lab results.

PRINTED: 09/16/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION **FATEMENT OF DEFICIENCIES** COMPLETED IDENTIFICATION NUMBER: VD PLAN OF CORRECTION A. BUILDING 08/24/2016 B. WING 495325 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES 1D (EACH CORRECTIVE ACTION SHOULD BE COMPLETION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 505 F 505 Continued From page 98 The resident was coded on the MDS (Minimum 3. Education has been provided by the Data Set) with and ARD (Assessment Reference DCS/Designee to Licensed Nurses Date) of 6/27/16 with a BIMS (Brief Interview for regarding ensuring that the physician Mental Status) score of 15 out of a possible score is notified of lab results. The DCS/Designee of 15. The resident was also coded as being totally dependent on 1 staff member for eating, will review to ensure that the dressing and personal hygiene. physician has been notified of lab results for three (3) residents per week for During the clinical record review of Resident #1 ' s clinical record, it was noted that on 7/1/16, a three (3) months. Basic Metabolic Panel was obtained from the 4. The results of the review will resident and the blood was sent to a laboratory to obtain results. The following lab results were be discussed by the DCS/Designee noted to be abnormal per laboratory reference at the Quality Assurance Performance ranges for Resident #1 on 7/1/16: "Glucose H (high) 110Reference Range for Improvement Committee meeting this test was 70-99 mg/dl (milligram per deciliter) monthly for three (3) months. The ...Sodium was L (low) Reference Range for this committee will recommend revisions test was 135-145 and Creatinine L (low) 0.48 Reference Range for this test was 0.5-1.4 mg/dl. to the plan as indicated to sustain

On 8/24/16, unit manager #1 was notified of the above documented findings. "Let me look into this and I will get back to you.

At 3:55 pm, unit manager #1 returned to the surveyor and stated, "These were not called to the physician. I cannot find any documentation that states these were communicated."

At 4:30 pm, the administrative team was notified of the above documented findings.

F 514 483.75(I)(1) RES

SS=E RECORDS-COMPLETE/ACCURATE/ACCESSIB

The facility must maintain clinical records on each

F 514

5. 10/4/16

substantial compliance.

TRANSACTION REPORT

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CHARTING FOR 9/24/1	THROUG		Talashana Ne	······	DE 1 OF 5 Medical Record No.

PRINTED: 09/16/2016 FORM APPROVED 'ARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 ITERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA MENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILDING LAN OF CORRECTION C 08/24/2016 B. WING 495325 STREET ADDRESS, CITY, STATE, ZIP CODE E OF PROVIDER OR SUPPLIER 4355 PHEASANT RIDGE ROAD, SW EASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE ÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 514 514 Continued From page 99 resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and 1. For Resident #5, an entry systematically organized. was made by the DCS/Designee The clinical record must contain sufficient clarifying the resident's status information to identify the resident; a record of the regarding clostridium difficile. resident's assessments; the plan of care and For Resident #16, the resident's services provided; the results of any preadmission screening conducted by the State; baths are currently being documented. For Resident #1, the resident's weights and progress notes. are currently being documented. This REQUIREMENT is not met as evidenced For Resident #10, a) the resident's weights are currently being documented Based on Resident interview, staff interview, and b) a clarification order has been entered clinical record review, the facility staff failed to into the medical record clarifying maintain a complete and accurate clinical record for 9 of 20 Residents, Residents #5, #16, #1, #10, the dates in which therapy was #13, #15, #6, #4, and #9. provided for Resident #10. For Resident #13, the physician and The findings included. the responsible party have been 1. For Resident #5, the facility staff documented notified regarding the omitted in the Residents clinical record that the Resident initials on 8/14/2016 for the Mighty Shake. was being treated for clostridium difficile when in For Resident #15, the weights are currently fact they were not. being documented in the medical record.

The clinical record review revealed that Resident #5 had been readmitted to the facility on 07/15/16. Diagnoses included, but were not limited to, sepsis, osteoarthritis, morbid obesity, heart failure, and chronic obstructive pulmonary disease.

Section C (cognitive status) of the Resident's admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/22/16 included a BIMS (brief interview for

medical record.

For Resident #6, the (2) lab reports

for other residents residing in the

facility were removed from the

For Resident #4, vital signs

PRINTED: 09/16/2016 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: ID PLAN OF CORRECTION A. BUILDING 08/24/2016 B. WING 495325 STREET ADDRESS, CITY, STATE, ZIP CODE VAME OF PROVIDER OR SUPPLIER 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) F 514 F 514 Continued From page 100 mental status) score of 12 out of 15 points. Indicating the Resident was cognitively intact have been obtained and documented in the resident's medical record. On 08/18/16 the nursing staff documented in the Residents clinical record that Resident #5 Weights are currently continued antibiotic for c-diff (clostridium difficile) documented in the medical record also. with no adverse reactions. For Resident #9, vital signs have been obtained and are documented When interviewing the unit manager about the nursing entry on 08/18/16 regarding the c-diff. in the medical record. Weights The unit manager verbalized to the surveyor that are currently documented in the the Resident did not have c-diff and the nurse medical record also. had charted in error. The surveyor was unable to locate any further 2. Residents currently residing in information in the clinical record regarding the the facility have the potential c-diff. to be affected. The following The administrative staff were notified of the reviews have been conducted inaccurate record during a meeting with the by the DCS/Designee: survey team on 08/24/16 at approximately 3:20 a) A review has been conducted by the DCS/Designee for the No further information regarding this issue was previous thirty (30) days to provided to the survey team prior to the exit ensure that residents currently conference. residing in the center do not 2. For Resident #16, the facility staff failed to have inappropriate notations document that they had provided ADL (activities regarding clostridium of daily living) care in regards to bathing. difficile in their medical record. The clinical record review revealed that Resident #16 was admitted to the facility 07/25/16.

lymphedema, and heart failure.

Diagnoses included, but were not limited to, acute kidney failure, cellulitis lower limb, anxiety,

Section C (cognitive patterns) of the Residents initial MDS (minimum data set) assessment with

PRINTED: 09/16/2016 PARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 NTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA MENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: LAN OF CORRECTION A. BUILDING B. WING 08/24/2016 495325 STREET ADDRESS, CITY, STATE, ZIP CODE E OF PROVIDER OR SUPPLIER 4355 PHEASANT RIDGE ROAD, SW ASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 (X5) COMPLETION PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE ĖFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG ٩G DEFICIENCY)

514 : Continued From page 101

an ARD (assessment reference date) of 08/01/16 included a BIMS (brief interview for mental status) score of 15 out of a possible 15 points indicating the Resident was cognitively intact

The record review revealed that the facility staff had documented that Resident #16 had received partial baths on August 2, 4, 5, 8, 10, 18, 19, 20, 21, and 23. Bed baths were documented on August 3 and 22.

During an interview with Resident #16 on 08/25/16 at approximately 10:20 a.m. the Resident verbalized to the surveyor that she received her shower/baths and was due to get one today.

The administrative staff were notified of the incomplete documentation regarding bathing on 08/25/16 prior to the exit conference.

No further information regarding this issue was provided to the survey team prior to the exit conference.

3. For Resident #1, the facility staff failed to document weights in the clinical record.

Resident #1 was originally admitted to the facility on 7/20/16. The resident was readmitted back into the facility on 7/8/16 with the following diagnoses of, but not limited to coronary artery disease, high blood pressure, peripheral vascular disease, neurogenic bladder, wound infection, quadriplegia, depression, bilateral above the knee amputation and pressure ulcer of the sacral region.

The resident was coded on the MDS (Minimum Data Set) with and ARD (Assessment Reference F 514

- b) A review has been conducted by the DCS/Designee for the previous thirty (30) days to ensure that baths have been documented.
- c) A review has been conducted by the DCS/Designee for the previous thirty (30) days to ensure that Vital Signs and Weights have been documented in the medical record.
- d) A review has been conducted by the DCS/Designee for the previous thirty (30) days to ensure that therapy orders are accurate on the Physician's Order Sheet (POS) regarding therapy services and therapy notes are present on the medical record.
- e) A review has been conducted by the DCS/Designee for the previous thirty (30) days of the Medication Administration

Facility ID: VA0208

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING	(X3) DATE SURVEY COMPLETED
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EASANT RIDGE NURSING & REHAB CENTER

4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

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PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**)

(X5) COMPLETION

514 Continued From page 102

Date) of 6/27/16 with a BIMS (Brief Interview for Mental Status) score of 15 out of a possible score of 15. The resident was also coded as being totally dependent on 1 staff member for eating, dressing and personal hygiene.

During the clinical record review conducted by the surveyor, it was noted that no weights were documented in the clinical record.

On 8/24/16 at approximately 1:30 pm, the surveyor asked the interim director of nursing where the weights on the residents could be found in the clinical record. The interim DON stated, "They aren't. We just had to look for someone else and we found them in the director of nursing 's office.

A copy of Resident #1 's weights was given to the surveyor.

The administrative team was notified of the above documented findings on 8/24/16.

No further information was provided to the surveyor prior to the exit conference.

4a. The facility staff failed to maintain a complete and accurate medical record for Resident #10.

Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident 's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 6 out of 15. Resident #10 requires set up help

F 514

Record to identify further omitted medications including but not limited to Mighty Shakes. The physician and the responsible party will be notified as indicated by the findings of the review.

- f) A review of the medical record has been completed by the DCS/Designee for current residents residing in the facility for the previous thirty (30) days to identify medical records that may contain information for other residents including but not limited to lab reports.
- 3. Education has been provided as follows:
 - a) Education has been provided by the DCS/Designee to the Licensed Nurses regarding ensuring that notations in the resident's medical record are accurate regarding medical conditions including clostridium difficile.
 - b) Education has been provided by the DCS/Designee to nursing staff regarding ensuring that baths that are given are documented as given.

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

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495325
E OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

EASANT RIDGE NURSING & REHAB CENTER

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG

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PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5) COMPLETION DATE

514 Continued From page 103 only for dressing and bathing.

A clinical record review was conducted by the surveyor on 8/23/16. It was noted by the surveyor that there were no weights documented in the clinical record.

The interim director of nursing was asked where weights should be kept in the medical record. The interim DON stated, "There should be a form that they fill out for weights." This form could not be found in the clinical record by the surveyor or interim DON.

A copy of Resident #1 's weights was given to the surveyor. The interim DON stated that they found the weights in the director of nurses ' office.

The administrative team was notified of the above documented findings on 8/24/16.

No further information was provided to the surveyor prior to the exit conference.

4b. The facility staff failed to maintain a complete and accurate clinical record for Resident #10.

Resident #10 was admitted to the facility on 10/28/15 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes, stroke, dementia, anxiety and depression. On the resident's MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 7/19/16 coded the resident as having a BIMS (Brief Interview for Mental Status) score of 6 out of 15. Resident #10 requires set up help only for dressing and bathing.

F 514

- c) Education has been provided by the DCS/Designee to the Licensed Nurses regarding ensuring that vital signs and \ weights are documented in the medical record.
- d) Education has been provided by the DCS/Designee to the Licensed Nurses and the \
 Therapy Department regarding ensuring that current orders for therapy services are accurate on the Physician's Order Sheet (POS) as well as ensuring that there are therapy notes present on the medical record for therapy services provided.
 - e) Education has been provided by the DCS/Designee to the Licensed Nurses regarding ensuring that medications are administered as ordered by the physician, and that medications administered are documented as administered on the Medication Administration Record i.e. Mighty Shakes.

During the chart review by the surveyor, it was

PRINTED: 09/16/2016 EPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 ENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA TEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: A. BUILDING PLAN OF CORRECTION C 08/24/2016 495325 STREET ADDRESS, CITY, STATE, ZIP CODE ME OF PROVIDER OR SUPPLIER 4355 PHEASANT RIDGE ROAD, SW HEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE REFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) TAG

F 514 Continued From page 104

noted that on the August 2016 Plan of Care, the physician had ordered the following to be performed: "PT (Physical Therapy) 5 x (times)/ week x 30 days ...OT (Occupational Therapy) 5 x /week x 30 days ...

At 9 am, the physical therapist #1 came and spoke to the surveyor concerning Resident #10 receiving therapy services. The surveyor also verbalized to physical therapist #1 that there were no notes in the chart.

At 10:30 am, the physical therapist #1 came back to the surveyor and gave a copy of the an order to discontinue PT and PT services on 11/18/15 but " nursing never took that off of the plan of care. The resident never received services past this date. "

On 8/24/16 at 4:30 pm, the administrative team was notified of the above documented findings.

No further information was provided to the surveyor prior to the exit conference.

5. The facility staff failed to maintain a complete and accurate clinical record for Resident #13.

Resident #13 was originally admitted to the facility on 6/29/11 and then readmitted on 6/18/14 with the following diagnoses of, but not limited to anemia, high blood pressure, heart failure, Alzheimer 's disease and dementia. Resident #12 was coded in the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 5/15/16 as having a BIMS (Brief Interview for Mental Status) score of 1 out of a possible score of 15.

F 514

Education has been provided by the DCS/Designee to the Licensed Nurses as well as the Medical Records Coordinator regarding ensuring that information present on the medical record is accurate and they there is not information for multiple residents filed in resident medical records.

A review will be completed by the DCS/ Designee for three (3) residents per week for three months and will include the following areas:

- a) There is not inappropriate notation regarding Clostridium Difficile in the residents' medical record.
- b) Baths have been completed and documented in the medical record.
- c) Vital Signs and weights have been obtained and are documented in the medical record.
- d) Current physician's orders including the Physician's Order Sheet are accurate regarding therapy services and there are current therapy notes on the medical record for therapy services being provided.

Facility ID: VA0208

PRINTED: 09/16/2016 FORM APPROVED OMB NO. 0938-0391

MENT OF DEFICIENCIES LAN OF CORRECTION

4) ID

EFIX

^AG

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

495325

(X2) MULTIPLE CONSTRUCTION
A. BUILDING

(X3) DATE SURVEY COMPLETED

08/24/2016

TE OF PROVIDER OR SUPPLIER

EASANT RIDGE NURSING & REHAB CENTER

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

B. WING

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

STREET ADDRESS, CITY, STATE, ZIP CODE

4355 PHEASANT RIDGE ROAD, SW

ROANOKE, VA 24014

(X5) COMPLETION DATE

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Clinical record reviews was conducted by the surveyor and it was noted on the August, 2016 MAR (Medication Administration Record) that on 8/14/16 at 9 am and again at 1 pm there was no documentation of medication being given. The boxes were left blank and nothing was documented on the back of the MAR to state why the medicine was not given. The medication that was to be administered was Mighty Shakes by mouth three times a day as ordered by the physician.

6. The facility staff failed to maintain a complete and accurate clinical record for Resident #15.

Resident #15 was admitted to the facility on 3/2/15 with the following diagnoses of, but not limited to anemia, Multiple Sclerosis, malnutrition, anxiety, dysphagia and gastrostomy. The resident was coded on the MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 8/10/16 as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score of 15. Resident #15 is totally dependent on 2 staff members for dressing, personal hygiene and bathing.

A clinical record review was conducted by the surveyor on 8/25/16. It was noted by the surveyor that there were no weights documented in the clinical record.

The interim director of nursing was asked where weights should be kept in the medical record. The interim DON stated, "There should be a form that they fill out for weights." This form could not be found in the clinical record by the surveyor or interim DON.

F 514

- e) Medications including Mighty
 Shakes are being administered
 as ordered by the physician and
 are documented on the medical record.
- f) There is only information for the correct resident filed on each resident's medical record and there is no other resident's information misfiled i.e. lab reports.
- 4. The results of the reviews

will be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly for three (3) months. The committee will recommend revisions to the plan as indicated to sustain substantial compliance.

5. 10/4/2016

		HAND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 09/16/2016 FORM APPROVED DMB NO. 0938-0391	
ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` '	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED		
		495325	B. WING	AND 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 - 180 -	08/24/2016	
IAME OF I	PROVIDER OR SUPPLIER		<u>′ </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		
PHEASA	NT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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F 514	Continued From pa	age 106	F 5	514		
	the surveyor. The	#15's weights was given to interim DON stated that they in the director of nurses'				
	The administrative documented finding	team was notified of the above gs on 8/25/16.				
	No further informat surveyor prior to the	ion was provided to the e exit conference.				
	7. For Resident #6 ensure an accurate	, the facility staff failed to e clinical record.		,		
	05/25/12 and readi included but not lin heart failure, hyper disease, diabetes redementia, dysphage psychotic disorder. The most recent con ARD (assessment)	dmitted to the facility on mitted on 09/01/15. Diagnoses nited to anemia, congestive tension, peripheral vascular mellitus, hyperlipidemia, gia, hypothyroidism and emprehensive MDS with and reference date) of 02/20/16 t as 3 of 15 in Section C,				
:		cal record was reviewed on led two laboratory reports for ents of the facility.			RECEIVE	
:	person on 08/23/16 regarding the misfil don't know why tho be filed anywhere to signed by the phys	e with the medical records at approximately 0855 ed reports and she stated "I se are in there, they shouldn't because they haven't been ician". She then took the them in a folder for the			RECEIVE	

physician to sign.

PRINTED: 09/16/2016 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495325 B. WING 08/24/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 514 Continued From page 107 F 514 The concern of the misfiled reports was brought to the attention of the administrative staff during a meeting on 08/23/16 at approximately 1630. No further information was provided prior to exit. 8. The facility staff failed to ensure a complete and accurate clinical record for Resident #4. Resident #4 was admitted to the facility on 2/18/15 and re-admitted on 5/24/16 with diagnoses of diabetes, paraplegia, urinary retention, malnutrition, chronic pulmonary embolism, hypertension, psychosis, anemia. gastro esophageal reflux disease, right above the knee amputation, pressure ulcers, and deep vein thrombosis. The current admission Minimum Data set (MDS) with a reference date of 5/31/16 assessed the resident with a cognitive score of "10" of "15". The resident was assessed requiring extensive assistance of 1-2 persons for bed mobility.

The clinical record was reviewed. The record did not contain vital signs or weights recorded for Resident #4.

transfers, dressing, toileting, bathing, and

The unit manager (RN#2) was asked on 8/23/16 at 9:00 a.m. for the current weights for Resident #4. RN#2 stated the clinical record should contain a form for recording of vital signs and weights. Resident #4's clinical record did not contain the form. The director of nursing was able to find 3 weights obtained for Resident #4 on the 24 hour reports.

hygiene.



CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY		
			A. BUILD	DING		COMPLETED	
		495325	B. WING			C 09/24/2040	
NAME OF	PROVIDER OR SUPPLIER		1	STREET ADDRESS, CITY, STATE, ZIP COD	<u></u> E	08/24/2016	
PHEAS	ANT RIDGE NURSING			4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD I	RE COMPLETE	NC
F 514	Continued From page 108		F 5	14			
	consultant were info meeting with the sur	OON, and corporate nurse rmed of the findings during a vey team on 8/24/16 at 1:30 urther information provided o exit					
	9. The facility staff fa	illed to ensure complete and ord for Resident #9.					
	4/12/13 with diagnos	mitted to the facility on es of dementia, anxiety, oulbar affect, arthritis, nia					
	with a reference date resident with a cognit resident was assesse assistance of 1 perso	Minimum Data Set (MDS) of 7/26/16 assessed the tive score of "0" of "15". The ed requiring extensive on for bed mobility, transfers, tring, bathing, and hygiene.					
	not contain recorded The resident was reco Cup, Mighty shakes, a weight loss. No weigh	as reviewed. The record did vital signs or weights. eiving supplements of Magic and med pass twice daily for its were recorded in the /26/16. The resident had the eigh monthly.					

by the facility prior to exit.

The administrator, DON, and corporate nurse consultant were informed of the findings during a meeting with the survey team on 8/24/16 at 1:30 p.m. There was no further information provided