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PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/12/17 through 9/14/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CRF Part 483 Requirements for Federal Long Term Care facilities. The Life Safety Code survey/report will follow. The census in this 102 certified bed facility was 92 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents #1 through #16) and 5 closed record review (Residents # 17-21).	F 000	**Preparation and submission of this 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 law.** **This Plan of Correction will serve as the Facility's allegation of substantial compliance**	
F 167 SS=C	483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE (g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and (g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and	F 167	**F 167 C:** 1. The most recent Life Safety Code results were placed in the binder designated to contain the survey results on 9/14/2017 by the Administrator/Designee. A notice of where the survey results for the last three preceding years' surveys along with the corresponding plans of correction can be located has been posted by the Administrator/Designee as well on 9/14/2017. 2. A review has been conducted by the	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mason Jayne — TITLE: Executive Director — (X6) DATE: 10-12-17

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

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F 167	Continued From page 1 (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by. Based on observation and staff interview, the facility staff failed to post the results of the most recent life safety code survey and failed to post a notice of the availability of the last three preceding year's survey results and their corresponding plan of corrections The findings included During the initial tour of the facility on 9/12/17 beginning at 1 00 p m , the surveyor observed a sign on a bookcase in the front lobby informing staff, visitors, and residents of the facility that the current survey results were available in a binder in the front lobby for review. However, upon checking this binder the surveyor was unable to locate the most recent life safety code survey report There was no posting or notification indicating the last three preceding year's survey results were available for review On 9/13/17 at 10 00 a m , a group meeting was held with nine residents of the facility During this meeting the residents verbalized to the surveyor conducting the group that they were aware of where the current survey results were kept The administrative staff were notified of the missing life safety code survey report and the missing notice of the availability of the three	F 167	Administrator/Designee to ensure that the survey results from required survey agencies including but not limited to Life Safety Survey are present in the designated binder. 3. Re-education has been provided to the Administrator and the Director of Clinical Services by the Regional Director of Clinical Services/Designee on or before 10/17/2017 regarding ensuring that required survey results including but not limited to Life Safety Survey are present for examination in the binder designated for survey results as well as ensuring that there is a notice posted detailing where survey results for the last three preceding years surveys along with the corresponding plans of correction can be located. The Administrator/Designee to conduct observations on a weekly basis to ensure that the survey results from required regulatory agencies	

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F 167	Continued From page 2 preceding year's reports during a meeting with the survey team on 9/14/17 at 11:00 a.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 167	are posted/present in the binder designated and there is a notice posted detailing where survey results for the last three preceding years surveys along with the corresponding plans of correction can be located for the purpose of examination of survey results. 4. The results of the weekly observations to be discussed by the Administrator/Designee at the monthly Quality Assurance Performance Improvement Committee Meeting. The Interdisciplinary Team to recommend revisions to the plan as indicated necessary to sustain substantial compliance. Quality review schedule modified based on findings as well. 5. 10/17/2017	
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. 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, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following. (k) Pain Management The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that	F 309	**F 309 D:** 1. For Resident #3, the physician/physician extender and the responsible party	

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F 309	Continued From page 3 residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to follow physician orders for 1 of 21 Residents in the sample survey, Resident #3. The Findings Included For Resident #3 the facility staff administered Namenda XR 28 on 9/7/17, after the Namenda was discontinued by the physician on 9/6/17. Resident #3 was a 98 year old female who was originally admitted on 5/25/12 and readmitted on 9/1/15. Admitting diagnoses included, but were not limited to: diabetes mellitus, affective mood disorder, dementia with behaviors, congestive heart failure, hypothyroidism, hypertension and peripheral vascular disease. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS assessment with an Assessment Reference Date (ARD) of 7/11/17. The facility staff coded that Resident #3 had a Cognitive Summary Score of 00. The facility staff also coded that Resident #3 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's). On September 13, 2017 the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced a physician telephone	F 309	have been notified and a physician clarification order was obtained and was placed on the Medication Administration Record for September by the Director of Clinical Services/Designee. There were no adverse effects to the resident. 2. A quality review conducted by the Director of Clinical Services/Designee of physician's orders and Medication Administration Records for current residents for the month of September for correct transcription of physician orders to Medication Administration Record and administration of medications. 3. Re-education has been provided to Licensed Nurses by the DCS/Designee regarding the process for accurately transcribing orders to the Medication Administration Record and administering medications as ordered by the	

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F 309	Continued From page 4 order dated 9/6/17. The order read ... "Pt (patient) refuses < Discontinue Namenda XR 28 q-am (every morning). Discontinue Ativan 0.5mg po (by mouth) qd (every day) prior to blood draw. Discontinue Melatonin 3 mg qHS (every night at bedtime). + Continue Ativan gel 0.5mg topically q-6hr PRN (every 6 hours as needed)." (sic) Further review of the clinical record produced the September 2017 MAR's. Review of the September 2017 MAR's documented that the facility staff did not discontinue the Namenda XR 28 on the MAR's, and in fact received the Namenda 28 mg on September 7, 2017 at 10 a.m. On September 13, 2017 at 11:45 a.m. the surveyor notified the Director of Nursing (DON) that the facility staff had administered Namenda XR 28 on 9/7/17 when in fact the Namenda was discontinued on 9/6/17. The surveyor reviewed the clinical record with the DON. The surveyor pointed out the physician telephone order to discontinue the Namenda on 9/6/17. The surveyor and DON walked down the hall to the medication cart to review the September 2017 MAR's for Resident #3. The medication Nurse, who was a Licensed Practical Nurse (#1), was standing in the hallway near Resident #3's room at the medication cart. The surveyor, DON and LPN (#1) reviewed the September 2017 MAR's. The surveyor pointed out that whoever had gotten the physician telephone order on 9/6/17 to discontinue the Namenda had not transcribed the order correctly and that the order for the Namenda was still on the September 2017 MAR's. The surveyor also pointed out that the Namenda had been administered on 9/7/17 at 10 a.m. LPN (#1) stated that Resident #3 had only	F 309	physician/physician extender. The DCS/Designee to conduct a quality review/comparison of the physician's orders to the Medication Administration Record for three (3) residents per week. Follow up to be completed as necessary based on findings. 4. The results of the review/comparison to be discussed by the DCS/Designee at the monthly Quality Assurance Performance Improvement Committee Meeting. The IDT to recommend revisions to the plan as indicated necessary to sustain substantial compliance. Quality review schedule modified based on findings as well. 5. 10/17/2017	

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taken her medications a few times in the past few months and that she, LPN (#1), was the nurse who administered the Namenda to Resident #3 on 9/7/17.

On September 13, 2017 at 4:15 p.m. the survey team met with the Administrator (Adm) and DON. The surveyor notified the Administrative Team (AT) that the facility staff failed to follow physician orders for Resident #3. The surveyor explained that Resident #3 had a physician telephone order dated 9/6/17 to discontinue Namenda XR 28. The surveyor notified the AT that the order had not been removed from the September 2017 MAR's and, in fact, Resident #3 received the Namenda on 9/7/17.

No additional information was provided prior to exiting the facility as to why the facility staff failed to follow physician orders on Resident #3. The facility staff administered Namenda XR 28 on 9/7/17. The Namenda XR 28 was discontinued by the physician on 9/6/17.

F 323 SS=G — 483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

F 323 — Past Non Compliance 10/9/16 R2R

(d) Accidents.
The facility must ensure that -

(1) The resident environment remains as free from accident hazards as is possible; and

(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility

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must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility document review, clinical record review, and in the course of a complaint investigation, the facility staff failed to ensure a safe transfer, which resulted in injury, for 1 of 21 residents (Resident #20). This is a past non-compliance.

The findings included:

Resident #20 sustained a mildly comminuted, mildly displaced and angulated transverse right proximal humeral neck fracture (right shoulder) and an L1 (lumbar) compression fracture while being transferred with a mechanical lift on 10/8/16. C.N.A. #1 transferred Resident #20 using a Sara Lift (sit to stand lift) by herself. The resident slid from the sit to stand lift and injured the right shoulder and the L1 vertebrae. Resident #20's comprehensive care plan directed that two people were required to transfer the resident as well as the facility policy on lifts.

The surveyor reviewed Resident #20's clinical record 9/13/17 and 9/14/17. Resident #20 was

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admitted to the facility 10/25/12 with diagnoses that included but not limited to multiple sclerosis, abnormal posture, hyperlipidemia, atrial fibrillation, joint contracture, pain in right lower leg, pain in left thigh, muscle weakness, gastroesophageal reflux disease, glaucoma, insomnia, folate deficiency anemia, hypertension, and dysphagia.

Resident #20's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/24/16 assessed the resident with a cognitive summary score of 15 out of 15. Resident #20 was not coded to have behaviors, psychosis, or delirium. Bed mobility and transfer ability was coded as 3/3 (extensive assistance of two+ people). Walk in room and walk in corridor were coded as 8/8 (activity did not occur). Resident #20 required extensive assistance of one person for personal hygiene and extensive assistance of two+ persons for bathing. Resident #20's balance and walking were assessed as follows: Not steady only able to stabilize with staff assistance when moving from seated to standing position, moving on and off toilet, and from surface to surface (transfer between bed and chair or wheelchair). Walking and turning around did not occur.

Resident #20's current comprehensive care plan initiated 4/20/16 and revised 6/28/16 identified the resident as a potential for injury r/t (related to) Multiple Sclerosis, bilateral LE (lower extremities) contractures, moderately impaired vision with readers-diagnosis glaucoma, osteoarthritis (OA). Interventions: Mechanical Lift-SARA-LIFT 2 person transfer, ensure that the resident is wearing appropriate footwear when ambulating or mobilizing in w/c (wheelchair). The "Nurse Tech

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Information Kardex" kept at the nurse's station for certified nurse's aides to review included Resident #20's transfer assist which was marked "Sit to stand lift-TL (transfer lift) and transfers (assist of 2)."

In the clinical record, the surveyor noted a "Quarterly Data Collection" dated 7/14/16. Section A Safety had documentation that the resident was non-ambulatory, no history of falls, difficulty with trunk control and balance is currently on medications which would require safety precautions, and was visually challenged. Fall Risk Evaluation scored Resident #20 with a score of 15. Total score of 10 or above deems the resident to be at risk for falls. Resident #20 had no documentation of falls within the past 6 months.

On 10/8/16 12pm, a nurse (licensed practical nurse #1) documented "Res (resident) slid out of lift stand. Res's (resident's) knees buckled staff reported that resident slid out. 2 C.N.A.s witnessed fall. Notified supervisor. Res states Right and Left shoulder hurts. X-rays ordered. Notified RP (responsible party) to call us back on A/M (answering machine). No answer. Res states pain level is 10. Pain med (medication) given. Res ref (refused) shower, provides d/t (due to) pain (sic). Res doesn't want staff messing with her she stated. Res didn't hit head staff said."

10/8/16 6 pm, L.P.N. #1 documented "I heard from another C.N.A. that 2 C.N.A.s weren't present when resident fell. Res told me personally about it. I notified supervisor. Res states she was on floor when 2nd C.N.A. responded not at time of transfer. Res states she

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didn't hit head. Daughter present when resident told me this. I notified supervisor, DON (director of nursing) and unit manager of incident. I was not notified of resident on floor when occurred. When I had arrived from lunch C.N.A. had told me about fall. Res was in bed when I was called about incident at 4pm (? Time). I immediately checked resident for injuries. I observed shoulders swollen and painful to touch. Pain med given."

10/8/16 9 pm, L.P.N. #1 documented "Notified unit manager and supervisor that x-ray had been contacted 4 x's and had not come yet. Daughter upset. Supervisor and I asked daughter of she wanted her sent out. Daughter stated no, she would wait on x-ray."

10/8/16 11 pm, L.P.N. #1 documented "Asked daughter again if she wanted her to go out. Res RP daughter stated yes she wanted her to go. Dr. (name omitted) but will be referred to as other #3 said 911 would be ok."

10/8/16 11:20 pm, L.P.N. #1 documented "911 arrived. RP went with her mom."

10/9/16 6:30 a.m., registered nurse #2 documented "Returned from ED (emergency department) with right arm in sling."

The surveyor reviewed the emergency department visit notes dated 10/9/16 3:08 a.m. The discharge notes read "83 yo (year old) F (female) with right shoulder pain after fall from Hoyer loft. XR (x-ray) with proximal humerus fracture. L1 compression fx (fracture) indeterminate age. Provided arm immobilizer, ortho (orthopedics) f/u (follow-up). Non

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ambulatory at baseline. Agrees d/c (discharge). Return as needed. Clinical Impression Primary Impression: Proximal humerus fracture. Secondary Impression: Compression fracture of L1 lumbar vertebrae."

The surveyor discussed the complaint with the director of nursing on 9/13/17 at 3:05 p.m. The DON stated the facility had completed a plan of correction for the incident on 10/8/16. The DON provided the facility "Investigative Report" dated 10/14/16. The report gave a detailed description of the incident: resident was being assisted to transfer for shower and lost balance/became weak and slid out of the sit to stand lift to the floor. 2 C.N.A.s then assisted her from the floor to the bed. Injury occurred (proximal humeral fracture). RP, MD, APS, Ombudsman, and VDH notified as well as Department of Health Professions. Details of the investigation read: Investigation initiates interviews conducted with employees involved- C.N.A. #1 and C.N.A. #2. Sequence of events retraced with return demonstration as well conducted. Res was being assisted with transfer in room to shower-lost balance, knees buckled, and res became weak and slid to the floor during the transfer. 2 C.N.A.s then assisted her up from the floor to the bed. Outcome of investigation: see attached POC, see below for system intervention. Transfer education will be heightened during orientation. Return demonstrations for transfers ongoing. Employee was educated at the time of hire regarding lift/safety requirements-we were not able to anticipate that this employee would make this decision.

The DON stated certified nursing assistant #1 informed the DON that Resident #20's knees

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buckled when she was being transferred. C.N.A. #1 was the only C.N.A. involved in the transfer. The DON stated the facility policy on mechanical lifts require 2 people. The DON stated C.N.A. #1 did not transfer the resident per the facility policy and the careplan. The DON stated the facility determined the incident was an unavoidable accident. The DON provided the "Determination of Unavoidable Accident" form dated 10/8/16 at approximately 11:30 a.m. The DON stated the facility could not have anticipated that this employee (C.N.A. #1) would have made the decision she made, therefore, the event was unavoidable. This employee was educated upon hire regarding lift/safety education. The employee will no longer be employed for the facility. 5 pt (point) POC (plan of correction) implemented."

The DON provided the surveyor with C.N.A. #1's corrective action form and witness statement as well as other staff involved in the occurrence on 10/8/16 that involved Resident #20. The form dated 10/10/16 read in part "Used lift without assistance of 2 staff members. Rsd subsequently fell. Also, staff member put rsd back in bed without a nurse assessment." Witness statement dated 10/8/16 by C.N.A. #1 read "Rst (resident) was in a standing position on lift "sit to stand" and knees began to buckle. Rst slid out from lift and slid on floor. I had assisted from other employee. Nurse notified. Neuro checks stat. Did not hit head. VS. C.N.A. #2 "Witness Employee." Witness statement dated 10/10/16 as told to registered nurse #2 read "Got her up with lift by myself. She sat on side of bed strap on her locked. Looked down the hall to see if anyone was coming to help. There was no one to help. Got her up, pulled the chair around and

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she was in the floor. Had on brown shoes. She just started coming out of the lift and sat down in the floor. I went out and got L.P.N. #1. L.P.N. #1 was at the desk. No not right before the nurse got in the room, we got her back to bed. I didn't even have her. I didn't have any help. I didn't use the lift on anyone else. I know I have been educated that there has to be 2 people for lifts. I've never had her. I never meant for this to happen. Didn't use lift to get her back to bed. C.N.A. #2 and I got under her arms and lifted her back into bed. I didn't know I was supposed to use a hoyer lift to get her back to bed." C.N.A. #1 was no longer working at the facility so an interview was unable to be completed.

The agency C.N.A. (#2) corrective action form dated 10/9/16 was reviewed. The form read "Rsd had fall and was put back to bed prior to a nurse assess rsd. Education on proper use of mech (mechanical lifts.) witnessed statement was reviewed." C.N.A. #2's witnessed statement read "I C.N.A. #2 was called to help assist the lady (Resident #20) to get off the floor. I asked her did she notify a nurse to check her so then I went ahead and help sit her up then get on the bed. I was only a witness to seeing her already in the floor when I entered the room. I asked the girl did a nurse see her said yes so I went ahead and helped her get her up. I didn't see a nurse but I assumed she had already had a nurse see her. Then after that she came back with a paper and vital signs. This happened while the lunch trays was on the unit. I asked the cna did she need help before she went into the room with the lift, she told me no so I assumed she had found someone to help her. If I knew she was in there by herself I would have went in the room with her and helped. I also would have not touched the

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resident if I knew that a nurse was not notified and checked the patient first. I would have done things different if I knew different." C.N.A. #2 was not available for an interview by the surveyor.

The DON stated immediately after the incident, C.N.A. #1 was suspended. The DON stated both C.N.A. #1 and the agency C.N.A. #2 were terminated from working at the facility.

The DON stated C.N.A. #1 was asked to return to the facility for a demonstration of transfers. The observation occurred 10/10/16 and read "1. Knows to have 2 people. 2. Knows to have brakes on. 3. Knows to have nurse assess rsd prior to putting back to bed 4. Knows to use hoyer lift for rsds who fall not to lift under arms."

The DON stated C.N.A. #1 made a bad decision. She had the education/demonstration. She admitted she should have used 2 people to transfer Resident #20.

The DON provided the "5 Point Plan of Correction" dated 10/8/2016 for Resident #20.

1. The employee was suspended pending investigation. Vital signs were obtained by nurse. MD and the RP were notified. New orders were given. The resident was medicated per the physician's order. The resident was transferred to the hospital for evaluation.
2. The employee was suspended and did not provide care/assistance to any other resident after the occurrence. No other residents were affected. The lift utilized was removed from service, locked and tagged out and not to be utilized until the manufacturer comes out to assess the lift for appropriate function. Other lifts

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were checked by the maintenance staff for appropriate function.
3. Nursing staff will be educated by the DCS (director of clinical services)/Nurse Manager/Designee regarding transfers, appropriate utilization of the lift, and where to find the appropriate information for individual resident transfers.
a) Transfer assessments will be completed for residents residing in the facility.
b) Resident Kardex will be updated on or before 10/12/2016 with the results of the transfer assessments.
c) Resident careplans will be updated on or before 10/12/2016 to correspond with transfer assessments and Kardex's.
d) The DCS/Nurse Manager/Designee will observe a transfer for nursing employees to ensure that appropriate transfer technique is being demonstrated during resident transfers. As of 10/12/2016, nurses and c.n.a.'s will be required to demonstrate a transfer successfully before they can work another shift. Nursing staff on shift on 10/9/16, demonstrated transfer technique prior to conducting any further transfers.
e) Random weekly observations of transfers will be conducted by DCS/Nurse Manager/Designee for three (3) employees to ensure that appropriate transfer technique is being sustained by nursing staff during resident transfers.
4. An in-prompt QA/PI meeting was held 10/9/2016--10/10/2016 to discuss the plan of correction and corrective measures. Results of random weekly observation will be discussed at the monthly QA/PI meeting for three (3) months to sustain substantial compliance.
5. 10/12/2016.

Attached to the 5 Point Plan of Correction was

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the QA/PI committee meeting with staffing signatures. The DON provided the surveyor the lift evaluations for the residents residing in the facility 10/9/16 and completed 10/10/16, weekly staff transfer technique observation from 10/2016 through 11/23/16, staff education on lifts dated 10/9/16 and 10/10/16, lift inspection sheet of 8 facility lifts dated 10/9/2016, the operating and maintenance instructions for the SARA Lift by Arjo, the Stand Up Patient Lift by Invacare, and the Steady Aid 3500/4500/7500 Series by "tollos".

Resident #20's "Transfer/Mobility Status Criteria" dated 10/10/16 documented the resident was assessed to be a "SST-Sit-to-stand with 2 people."

The surveyor reviewed C.N.A. #1's orientation checklist. C.N.A. #1's orientation occurred 9/6/16 and included "Proper Lifting Techniques (S-305) and Ten Commandments of Body Mechanics (N-902)."

The DON also stated all new hires receive orientation on the floor. Therapy now spends 30 minutes educating new hires on transfer education/demonstration. Therapy now completes the transfer assessment of each resident.

The surveyor reviewed the facility policy on transfers on 9/13/17. The policy titled "Transfer/Mobility Evaluation Low Lift" revised 11/30/2014 read in part "3. Two staff members are required when using a mechanical lift."

The surveyor also reviewed the facility policy titled "Low Lift Program" effective date 11/30/2014. The policy read in part "The Care Center is

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committed to providing the equipment and resources to achieve, as much as practicable, a lift free environment for both Residents and Staff. Procedure 1. Residents are evaluated on admission and with a significant change in condition using the Transfer/Mobility Status Criteria. 2. Identification of the residents lift status will be located: a. Resident's Care Plan b. Internal QA Nurse tech Kardex c. Using an identification system on the resident's door at each resident's nameplate that identifies the lift status."

The surveyor interviewed certified nursing assistant #3 on 9/14/17 at 7:20 a.m. When asked where the resident's transfer status was located, the C.N.A. stated on a kardex at the nurse's station or ask another C.N.A. C.N.A. #3 stated she was observed doing transfers.

The surveyor interviewed certified nursing assistant #4 on 9/14/17 at 7:21 a.m. She was also asked where the resident's transfer status was located. C.N.A. #4 stated at the nurse's desk. C.N.A. #4 stated she was observed doing transfers.

The surveyor interviewed the certified occupational therapy assistant (COTA) other #4 on 9/14/17 at 9:00 a.m. Other #4 stated Resident #20 had been on caseload prior to the fall from 9/10/16 through 9/29/16. Other #4 stated she was seen for pain and decreased range of motion in her left knee. Other #4 stated resident #20 did well and was discharged from therapy with recommendations to use the sit to stand lift. Other #4 stated Resident #20 was very specific on how she wanted things done. Other #4 stated restorative nursing was not a recommendation.

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F 323	Continued From page 17 Resident #20 was no longer a resident of the facility; therefore, an observation of the sit to stand lift could not be observed with her. The surveyor did observe a sit-to-stand transfer on Resident #1 on 9/13/17 at 1:40 p.m. with C.N.A. #5 and C.N.A. #6. The surveyor id not observe any areas of concern with the transfer from the wheelchair to the bed. The surveyor informed the administrator and the director of nursing of the above findings on 9/14/17 at 11:00 a.m. The DON stated C.N.A. #1 made a bad decision when Resident #20 was transferred incorrectly. This is a past non-compliance and a complaint deficiency	F 323		
F 329 SS=D	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 329	**F 329 D:** 1. For Resident #15, the physician/physician's extender and the responsible party have been notified. The Licensed Nurse responsible for the documentation of the blood glucose reading has received re-education regarding appropriately obtaining and documenting blood glucose readings per the physician's order. There was no adverse effect to the resident.	

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(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.

483.45(e) Psychotropic Drugs.
Based on a comprehensive assessment of a resident, the facility must ensure that--

(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record;

(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs;
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 1 of 21 residents (Resident #15) was free of an unnecessary drug.

The findings included:

The facility staff failed to ensure Resident #15 was free of unnecessary medications. The facility staff failed to follow physician ordered parameters in regards to blood sugars and insulin for Resident #15.

The clinical record of Resident #15 was reviewed 9/14/17. Resident #15 was admitted to the facility 9/11/17 with diagnoses that included but not limited to type 2 diabetes mellitus, acute

2. The DCS/Designee have completed a review of physicians orders compared with the Medication Administration Record for September for diabetic residents for obtaining blood glucose reading(s) documentation of blood glucose monitoring per physician orders. Follow up to be completed as necessary based on findings.
3. Re-education has been provided to the Licensed Nurses by the DCS/Designee regarding obtaining and documenting blood glucose readings per the physician's order. The DCS/Designee to complete a quality review weekly for five (5) diabetic residents. The review to compare physician's orders to the Medication Administration Record to ensure that blood glucose readings are being obtained and documented per the physician's order.

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F 329	Continued From page 19 respiratory failure with hypoxia, acute respiratory failure with hypercapnia, sepsis, hypertension, acute on chronic diastolic heart failure, chronic obstructive pulmonary disease, encephalopathy, moderate protein calorie malnutrition, osteoarthritis, and atrial fibrillation. Resident #15's admission minimum data set (MDS) assessment had not yet been completed The September 2017 admission physician order sheets were reviewed. Resident #15 had orders that read "AC & HS Accuchecks (before meals and at bedtime blood sugar checks) and Humalog S/S (sliding scale): 201-250=2 unit; 251-300=4 units; 301-350= 6 units; 351-400=8 units; 401-500=10 units; 501-600=12 units Call MD (medical doctor) if below 50 or above 500." A review of the September 2017 medication administration records (MAR) revealed the following dates and times when there were no documented results for blood sugars. 9/12/17 6:30 a.m. The surveyor reviewed the 9/12/17 skilled nursing note/progress note. The 9/12/17 progress note did not reveal evidence the blood sugar was obtained on 9/12/17 at 6:30 a.m. The surveyor informed the unit 2 manager registered nurse #1 of the above issue with the 9/12/17 6:30 a.m. blood sugar results. After reviewing the September 2017 MARs, the	F 329	4. The results of the reviews to be discussed by the DCS/Designee at the monthly Quality Assurance Performance Improvement Committee Meeting. The IDT to recommend revisions to the plan as indicated necessary to sustain substantial compliance. Quality review schedule modified based on findings as well. 5. 10/17/2017	

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F 329	Continued From page 20 progress notes, the skilled nursing note, and the 24-hour report, the unit manager R.N. #1 sated the blood sugar was not done at 6:30 a.m. on 9/12/17. The surveyor informed the administrator and the director of nursing of the above concern in a meeting on 9/14/17 at 11:00 a.m. The surveyor had requested the facility policy on diabetic management from the director of nursing on 9/14/17 at 10:45 a.m. The facility provided the surveyor the policy titled "Diabetic Coma" on 9/14/17. The policy read in part "Clinical Nurses are responsible for recognizing signs/symptoms of diabetic coma. Neglect of therapy, stress, illness, and/or increased carbohydrate ingestion can cause diabetic coma." No further information was provided prior to the exit conference on 9/14/17.	F 329		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:	F 356	**F 356 C:** 1. The Daily Staffing Sheet identified on 9/14/2017 was corrected to reflect current information upon notification by the DCS/Designee. 2. A review of current Daily Staffing Sheet(s) conducted for reflecting current staffing information. 3. Re-education has been provided to the Administrator/Director of	

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F 356	Continued From page 21 (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility staff posted the daily nurse-staffing information already filled out, for all shifts, at the beginning of each day during the	F 356	Clinical Services by the Regional Director of Clinical Services on or before 10/17/2017 to reflect the accurate process for posting the daily nurse staffing. The DCS/Designee to complete observations weekly to ensure that requirements are met regarding posting the daily nurse staffing. 4. The results of the observations to be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee Meeting. The IDT to recommend revisions to the plan as indicated necessary to sustain substantial compliance. Quality review schedule modified based on findings as well. 5. 10/17/2017	

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F 356	Continued From page 22 survey. The findings included: During the survey on 9/12/17, 9/13/17, and 9/14/17, the daily nurse-staffing sheet was observed in the lobby. However, the daily nurse-staffing sheet was observed to be already filled out for all three shifts each day of the survey, even though some shifts had not yet started. On 9/14/17 at approximately 10:45 a.m., an interview was conducted with the administrator and the director of nursing. The administrator stated that daily nurse-staffing sheets were filled out at the beginning of the day but if a staff member had not shown up to work for any reason, that would be reflected on the daily nurse staffing sheet. The facility administration was informed of the findings during a briefing on 9/14/17 at approximately 11:00 a.m. The facility did not present any further information about the findings.	F 356		
F 387 SS=D	483.30(c)(1)(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT (c) Frequency of Physician Visits (1) The residents must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 thereafter. (2) 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	F 387	**F 387 D:** 1. For Resident #1, he has currently been seen by the physician/physician's extender and visits are timely. 2. A review has been conducted for the last (90) days by the DCS/Designee regarding physician's/physician extender visits. Follow up to be completed as necessary based on findings.	

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by:
Based on staff interview and clinical record review, the facility staff failed to ensure the physician visited every 60 days with a 10-day grace period for 1 of 21 residents (Resident #1).

The findings included:

The facility staff failed to ensure Resident #1 was seen by the physician at least every 60 days with a grace period of 10 days. The physician did not visit Resident #1 for 85 days between 4/10/17 and 7/5/17.

The clinical record of Resident #1 was reviewed 9/13/17. Resident #1 was admitted to the facility 5/29/10 and readmitted 9/18/13 with diagnoses that included but not limited to unspecified intellectual disabilities, abnormal posture, epilepsy, convulsions, peripheral vascular disease, dysphagia, gastroesophageal reflux disease, hypothyroidism, chronic embolism and thrombosis of vein, and iron deficiency anemia.

Resident #1's annual minimum data set (MDS) assessment with an assessment reference date (ARD) of 7/19/17 assessed the resident with a cognitive summary score of 9 of 15.

The surveyor reviewed the physician progress notes. Resident #1 was seen on 4/10/17. The next physician note found was dated 7/5/17. The surveyor was unable to locate any physician visits between 4/10/17 and 7/5/17. The surveyor requested the thinned chart from medical records (other #1) on 9/13/17.

The surveyor reviewed the thinned record but was unable to locate any additional physician

3. Re-education has been provided to the physician(s)/physician extender regarding timeliness of visits. A quality review to be conducted by the DCS/Designee weekly for three (3) residents to ensure that physician/physician extender visits are conducted on a timely basis.
4. The results of the reviews to be discussed by the DCS/Designee at the Quality Assurance Performance Improvement Committee meeting monthly. The committee to recommend revisions to the plan as indicated to sustain substantial compliance. Quality review schedule modified based on findings as well.
5. 10/17/2017

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	495325	A. BUILDING _____ B. WING _____	C 09/14/2017

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	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 387	Continued From page 24 visits between 4/10/17 and 7/5/17. The surveyor informed the administrator and the director of nursing of the above concern regarding timeliness of physician visits on 9/14/17 at 11:00 a.m. The DON stated the facility staff was unable to locate a physician visit between 4/10/17 and 7/5/17. No further information was provided prior to the exit conference on 9/14/17.	F 387		
F 504 SS=D	483.50(a)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN (a) Laboratory Services (2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to obtain a physician order prior to obtaining a laboratory test for Resident #3. The Findings Included: For Resident #3 the facility staff obtained a Urinalysis and a Culture and Sensitivity on 8/22/17 without having a physician order. Resident #3 was a 98 year old female who was originally admitted on 5/25/12 and readmitted on	F 504	**F 504 D:** 1. For Resident #3, a physician clarification order was obtained for the urinalysis. The physician/physician extender and the responsible party have been notified. 2. A review has been completed by the DCS/Designee for the last thirty (30) days of labs obtained including urinalysis to ensure that there was a physician's order provided to obtain the lab/urinalysis. Follow up to be completed as necessary based on findings of review. 3. Re-education has been provided by the DCS/Designee to Licensed Nurses regarding	

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9/1/15. Admitting diagnoses included, but were not limited to: diabetes mellitus, affective mood disorder, dementia with behaviors, congestive heart failure, hypothyroidism, hypertension and peripheral vascular disease.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS assessment with an Assessment Reference Date (ARD) of 7/11/17. The facility staff coded that Resident #3 had a Cognitive Summary Score of 00. The facility staff also coded that Resident #3 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's).

On September 13, 2017 the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced the results of a Urinalysis and a Culture and Sensitivity obtained on 8/22/17.

Continued review of the clinical record failed to produce a physician order to obtain the Urinalysis and Culture and Sensitivity.

On September 13, 2017 at 11:15 a.m. the surveyor notified the Unit Manager (UM), who was a Registered Nurse (RN), that Resident #3 had the results of a Urinalysis and Culture and Sensitivity obtained on 8/22/17 in her clinical record. The surveyor notified the UM that a physician order to obtain the Urinalysis and Culture and Sensitivity could not be located in the clinical record. The surveyor reviewed the clinical record with the UM. The surveyor specifically pointed out the Urinalysis and Culture and Sensitivity results dated 8/2217. The UM reviewed the clinical record and could not find a physician order to obtain the Urinalysis and

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ensuring that urinalysis are obtained with a physician order. The DCS/Designee to complete a review for three (3) residents per week to ensure that urinalysis/labs are obtained as ordered by physician.

4. The results of the review to be discussed by the DCS/Designee at the Quality Assurance Performance Improvement/QAPI Committee Meeting monthly. The interdisciplinary team to recommend revisions to the plan as necessary to sustain substantial compliance. Quality review schedule modified based on findings as well.
5. 10/17/2017

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F 504	Continued From page 26 Culture and Sensitivity. The UM stated she would look in her office and in the thinned record to see if she could locate a physician order. On September 13, 2017 at 1 p.m. the UM approached the surveyor and told the surveyor that she, the UM, had not been able to locate a physician order to obtain the Urinalysis and Culture and Sensitivity. On September 13, 2017 at 4:15 p.m. the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that the facility staff obtained a Urinalysis and Culture and Sensitivity on 8/22/17 without having a physician order. No additional information was provided prior to exiting the facility as to why the facility staff failed to obtain a physician order prior to obtaining a Urinalysis and Culture and Sensitivity on 8/22/17	F 504		
F 514 SS=D	483.70(i)(1)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized	F 514	**F 514 D:** 1. For Resident #3, the physician/physician extender and the responsible party have been notified and the physician clarification order was obtained and order transcribed on the Medication Administration Record for September by the Director of Clinical Services/Designee. There	

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(5) The medical record must contain-

(i) Sufficient information to identify the resident;

(ii) A record of the resident's assessments;

(iii) The comprehensive plan of care and services provided;

(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;

(v) Physician's, nurse's, and other licensed professional's progress notes; and

(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50
This REQUIREMENT is not met as evidenced by:
Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate clinical record for 1 of 21 Residents in the sample survey, Resident #3.

The Findings Included:

For Resident #3 the facility staff failed to ensure complete and accurate September 2017 Medication Administration Records (MAR's).

Resident #3 was a 98 year old female who was originally admitted on 5/25/12 and readmitted on 9/1/15. Admitting diagnoses included, but were not limited to: diabetes mellitus, affective mood disorder, dementia with behaviors, congestive heart failure, hypothyroidism, hypertension and

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were no adverse effects to the resident.

2. A quality review has been conducted by the Director of Clinical Services/Designee of physician's orders and Medication Administration Records for current residents for the month of September for physician order transcription and administration of medication based on physician order.
3. Re-education has been provided to Licensed Nurses by the DCS/Designee regarding the process for accurately transcribing physician orders to the Medication Administration Record and administering medications as ordered by the physician/physician extender. The DCS/Designee to conduct a quality review/comparison of the physician's orders to the Medication

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peripheral vascular disease.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Significant Change MDS assessment with an Assessment Reference Date (ARD) of 7/11/17. The facility staff coded that Resident #3 had a Cognitive Summary Score of 00. The facility staff also coded that Resident #3 required extensive (3/3) to total nursing care (4/3) with Activities of Daily Living (ADL's).

On September 13, 2017 the surveyor reviewed Resident #3's clinical record. Review of the clinical record produced a physician telephone order dated 9/6/17. The order read . "Pt (patient) refuses < Discontinue Namenda XR 28 q-am (every morning). Discontinue Ativan 0.5mg po (by mouth) qd (every day) prior to blood draw. Discontinue Melatonin 3 mg qHS (every night at bedtime). + Continue Ativan gel 0.5mg topically q-6hr PRN (every 6 hours as needed)." (sic)

Further review of the clinical record produced the September 2017 MAR's. Review of the September 2017 MAR's documented that the facility staff did not discontinue the Namenda XR 28 on the MAR's, and in fact received the Namenda 28 mg on September 7, 2017 at 10 a.m.

On September 13, 2017 at 11:45 a.m. the surveyor notified the Director of Nursing (DON) that Resident #3's September 2017 MAR's were incorrect. The surveyor reviewed the clinical record with the DON. The surveyor pointed out the physician telephone order to discontinue the Namenda on 9/6/17. The surveyor and DON walked down the hall to the medication cart to

Administration Record for three (3) residents per week. Follow up to be completed as necessary based on findings.

4. The results of the review/comparison to be discussed by the DCS/Designee at the monthly Quality Assurance Performance Improvement Committee Meeting. The IDT to recommend revisions to the plan as indicated necessary to sustain substantial compliance. Quality review schedule modified based on findings as well.
5. 10/17/2017

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review the September 2017 MAR's for Resident #3. The medication Nurse, who was a Licensed Practical Nurse (#1), was standing in the hallway near Resident #3's room at the medication cart. The surveyor, DON and LPN (#1) reviewed the September 2017 MAR's. The surveyor pointed out that whoever had gotten the physician telephone order on 9/6/17 to discontinue the Namenda had not transcribed the order correctly and that the order for the Namenda was still on the September 2017 MAR's. The surveyor also pointed out that the Namenda had been administered on 9/7/17 at 10 a.m. LPN (#1) stated that Resident #3 had only taken her medications a few times in the past few months and that she, LPN (#1), was the nurse who administered the Namenda to Resident #3 on 9/7/17.

On September 13, 2017 at 4:15 p.m. the survey team met with the Administrator (Adm) and DON. The surveyor notified the Administrative Team (AT) that the facility staff failed to ensure complete and accurate September 2017 MAR's for Resident #3. The surveyor explained that Resident #3 had a physician telephone order dated 9/6/17 to discontinue Namenda XR 28. The surveyor notified the AT that the order had not been removed from the September 2017 MAR's and, in fact, Resident #3 received the Namenda on 9/7/17.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure complete and accurate September 2017 MAR's for Resident #3. The facility staff failed to remove/discontinue the Namenda from the September 2017 MAR's.