STATEMENT OF DE AND PLAN OF COR	ICIENCIES ECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION	OMB	TED: 01/16 DRM APPRO NO: 0938-
			A BUILDIN	G	(X3) 0/	MPLETED
NAME OF PROVIDE	R OR SUPPLIED	495325	B. WING			С
				STREET ADDRESS, CITY, STATE, ZIP CODE	1	2/14/2018
	SE MUKSING &	REHAB CENTER		4356 PHEASANT RIDGE ROAD, SW		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	ROANOKE, VA 24014		
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	Comments		E 000			
12/14 compl Requi	18. The facility ance with 42 Cement for Long	nergency Preparedness d 12/12/18 through was in substantial FR Part 483.73, -Term Care Facilities. Two stigated during the survey.	F 000			
Term C investig Code so The cen 91 at the consiste closed of Resident SEG CFR(s):  §483.10( The resid self-deter access to outside the this section of the respective of the code of the c	are requirementated during the ared during the ared during the ared during the ared during the sus in this 101 at time of the sured of 19 current ared reviews.  Rights/Exercis as 3.10(a)(1)(2)(a) Resident Right and a right mination, and copersons and see facility, including the ared dignity at a manner and maintenance or of life, recognized.	certified bed facility was vey. The survey sample Resident reviews and 4 e of Rights (b)(1)(2)	F 550	Exercise of Rights  1. Resident #5 interviewed on 1/17/2019 by Regional Director of Clinical Services (RDCS) with facility Social Service Director present. Resident feels safe at the facility and feels steff treat him with dignity and respect.  2. The RDCS and UMs completed quality reviews interviews of all current residents (cognitively impaired residents' representatives were contacted) to ensure residents are provided care in a respectful and dignified manner on 1/2016.		

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 90 days 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

	T OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DA	RM APPROV NO. 0938-03 TE SURVEY MPLETED
NAME OF	200	495325	B. WING			C
INVINE OF	PROVIDER OR SUPPLIER			TREET ADDRESS	1	2/14/2018
	NT RIDGE NURSING &	181 Mars	4	STREET ADDRESS, CITY, STATE, ZIP CODE 1355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX	SUMMARY:	STATEMENT OF DEFICIENCIES				
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F 550	Continued From pag	ge 1	F 550			
	\$483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source.  §483.10(b) Exercise of Rights.  The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.  §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.  §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart.  This REQUIREMENT is not met as evidenced by:  Based on staff interview, resident interview, clinical record review, and facility document review, the facility failed to ensure resident rights and dignity were met for 1 of 23 Residents in the survey sample, Resident #5.  The findings included:  The facility staff failed to ensure the safety and dignity of Resident #5 was maintained. Another resident's family member cornered Resident #5			3. The RDCS provided the facility ED 1 to 1 re-educat the federal regulations and guidelines related to the resident's right to a dignific existence, self-determination and exercise of rights on 1/23/19. The DSS and or Ewill provide re-education to facility staff on the federal regulations and guidelines related to the Resident's Exercise of their rights by 1/28/19.  4. DCS and or ADCS will conduct random resident and their representative interview times per week for 4 weeks,	d or los	
rice s s T b b c c c c re ar s t t t t t t t t t t t t t t t t t t				weekly for 3 months, to ensure residents are provided care in dignified manner and their ab to exercise their rights is respected. Findings will be reviewed by QAPI committee monthly and Quality Monitoring updated as indicated. 5. Date of Compliance 1/28/2019.	re n a llity	

STATEMENT	RS FOR MEDICARI FOF DEFICIENCIES	E & MEDICAID SERVICES	==:	- I I - W-100	_ F(	TED: 01/16/20 DRM APPROVE NO: 0938-039
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NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		12/14/2018
PHEASA	NT RIDGE NURSING &	REHAB CENTER	1.	4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		· · · · · · · · · · · · · · · · · · ·
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	n n nc	(XS) COMPLETION DATE
F 550	- strantada i jojii pi		F 550	9		
	readmission date of but were not limited depressive disorder prostatic hyperplasion 12/13/18 at 10:4 (minimum data set) was a quarterly assigned (assessment reference of the MDS assesses Section C0500, the Resident # 5 had a mental status) score	40-year-old-male who was allity on 4/20/18, with a f 8/27/18. Diagnoses included to, hypertension, major r, anxiety disorder, and benign ia.  For Resident # 5 was reviewed 1 am. The most recent MDS assessment for Resident # 5 essment with an ARD nee date) of 9/3/18. Section C as cognitive patterns. In facility staff documented that BIMS (brief interview for 15 out of 15 which				
the contract of the contract o	The plan of care for and revised on 11/9/documented a focus resident # 5 is indefactivities, cognitive sold anxiety raumatic stress discognadriplegia, pain, pathoice, self acts in recomputer, phone, sittless dent # 5 goes by the reventions included Report resident c/o (iscomfort, breathing that interferes with the articipate in activities	area for Resident # 5 as, pendent on staff for timulation, social interaction /, depression, PTSD (post reer) limited mobility, articipating in activities of som such as TV (television), ing on porch, parties, bingo, a staff and residents. cab on community outings." I but were not limited to; complaint of) pain, difficulties or any other c/o				

FORM CMS-2587(02-99) Previous Versions Obsolets

Event ID Y3F111

Facility ID: VA0208

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JAN 24 2019

VDH/OLC

CENTER	RS FOR MEDICARE	MEDICAID SERVICES			FC	TED: 01/16/201 DRM APPROVE
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIP	LE CONSTRUCTION	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		12/14/2018
PHEASA	IT RIDGE NURSING & F	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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F 550	of care for Resident	e 3 # 5 and did not see an t # 5 made statements that	F 550			
	Resident # 5's room- interview. During the reported to the surve alleged perpetrator (f "Got in my face, yelle bathroom and wouldr	am, the surveyor was in conducting a Resident interview Resident # 5 yor that on 12/8/18, the his former roommate's sister) and at me and blocked the hit let me use the bathroom."				
	Residents that he wa the bathroom becaus bladder-retraining pro that when he got to hi perpetrator asked him and (Resident's name stated that he told the was going on and tha was talking about. Re	s socializing with and to use e he is on a gram. Resident # 5 stated is room, the alleged n "What's going on with you withheld)? Resident # 5 alleged perpetrator nothing t he did not know what she sident # 5 then stated that				
	to yell at him stating the commate told the alle Resident # 5 had been that Resident # 5 was going on. Resident # 6 alleged perpetrator the bathroom. Resident # 6 alleged perpetrator the bathroom.	n treating him differently and going to tell her what was 5 stated that he told the at he needed to use the 5 stated that the alleged ont of the bathroom door				
i t e	pathroom until she wa 5 stated that he told the 5 our room and you ar 6 get out of here." Re- alleged perpetrator con he bathroom. Resider	s done with him. Resident # e alleged perpetrator, "This re a guest here." "You need sident # 5 stated that the ntinued to block the door to nt # 5 stated that he began Resident # 5 stated, "I fett				

CENTERS FOR MEDICARE &	WILDICAID SERVICES			OMR	ORM APPROVE NO. 0938-039
ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) C	ATE SURVEY OMPLETED
	495325	B. WING			C
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ALEXANDER ST.	12/14/2018
PHEASANT RIDGE NURSING & R	St. P. Levi Salver Device Land		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	ODE	
PREFIX LEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TO DEFICIENCY	ON SHOULD BE HEAPPROPRIATE	(X5) COMPLETION DATE
the bathroom after he and stated to him, "I a when you get out became what's going on with name withheld). Reside alleged perpetrator conthrough the door while Resident # 5 stated that "She threw a fit." Resident # 5 stated that the facility. Resident # same evening other far roommate came in and Resident # 5 stated that family members sat on saying mean things to his something happens to (withheld) their asses is stated, "They made me crap." Resident # 5 stated that alleged perpetrator appreciating at a square table their room and "jerked the Resident # 5 stated that why the alleged perpetrato back into the facility after Resident # 5 stated that right to visit her family metaled that he spoke with director on Monday and	ent # 5 stated that the hally allowed him to go into had urinated on himself are going to be right here ause you are going to tell ith you and (Resident's dent # 5 stated that the ntinued to yell at him he he was in the bathroom, at he called the police at the police came and dent # 5 stated that the that evening but it would cility) if they bar her from 5 stated that later that mily members of his former 1 "intimidated" him, at his former roommate's the other side of the room him and stated, "If (Resident's name mine." Resident # 5 feel like I was a piece of ted the next day "They it was nothing." Resident # the incident that the roached him as he was in the halfway outside of he table away from me."  The beaked a staff member ator was allowed to come or what she did to him, he was told she has a nember Resident # 5 in the facility executive	F 550			

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES				, U. Alega P	NTED: 01/16/2019 FORM APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION	(X3)	B NO. 0938-0391 DATE SURVEY COMPLETED
	K- 15 1	495325	B. WING				C
NAME OF F	PROVIDER OR SUPPLIER		= 11,	\$TR	EET ADDRESS, CITY, STATE ZIP CODE		12/14/2018
PHEASA	NT RIDGE NURSING 8	REHAB CENTER			5 PHEASANT RIDGE ROAD, SW ANOKE, VA 24014		
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F 550	all handled." Resid "It handles the roor she did to me." Re- facility executive di me handle that." "I Resident # 5 then s not make any sens made me feel like I her come back in h law put her out." "I patient here I would surveyor observed became tearful. Re- happens when she you just going to pu say that settles that	ent # 5 stated that he replied, m but it doesn't handle what sident # 5 stated that the rector stated to him, "You let got 2 days to investigate that." stated to the surveyor, "It does e how she treated me." "It was worthless, and they let ere like it was nothing after the thought with me being a d be protected more." The at this time that Resident # 5 sident # 5 stated, "What attacks somebody else?" Are it people in another room and."	F	550			
	unit manager RN # allegations of abuse Unit manager RN # only know that the frand threatened him were involved."  On 12/13/18 at 10:0 interviewed the facility executive Saturday night saying the facility sa	am, the surveyor interviewed (registered nurse) about the ereported by Resident # 5.  1 stated, "I am aware briefly. I amily was acting inappropriate (Resident # 5) and the police  am, the surveyor ity executive director about buse reported by Resident # 5. director stated, "I was called ag the police had to come to ere was a yelling match with a alleged perpetrator." "We the alleged perpetrator and Monday and we spoke to # 5." The facility executive es surveyor that he was in the ting the incident and that a incident) was submitted. The actor then stated that					

STATEMENT	RS FOR MEDICARE &	MEDICAID SERVICES		State Hall Francisco		NTED: 01/16/20 FORM APPROVE
AND PLAN (	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION IG	(X3)	B NO. 0938-038 DATE SURVEY COMPLETED
NAME OF	PROVIDER OR SUPPLIER	495325	8 WING_			THE WORLD COUNTY OF
PHEASA	NT RIDGE NURSING & R			STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		12/14/2018
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ĺ	Resident # 5 had bee come back and admit was sorry. The facility stated that the nurse report the incident har perpetrator and her fanight to report the incigoing to have them be facility executive direct have any evidence. "Twitnesses." "I will be fill Monday but I can't see occurred."  On 12/13/18 at 10:15 a	an known to lie and then I to lying and saying that he I executive director also I that called him at home to I issues with the alleged I issues with the was I issues a saying the was I issues a saying the saying the surveyor observed I is and the surveyor observed I is a saying that he I is a saying tha	F 55			
	for Resident # 5 on 12, progress note was doc on medi part b total cardaily living) incontinent walker for ambulation to commate family of the nis face refusing to let be police was called due to	cumented as "Resident is re with adls (activities of of bowel and bladder uses apset due to incident with im yelling and getting into				
a R R T a po	about the allegation of a Resident # 5. The surver lesident # 5 on 12/8/18 the surveyor asked LPH in incident that occurred erpetrator and Resident fes." LPN # 1 stated the recapy room playing ga	censed practical nurse) abuse reported by eyor asked LPN # 1 if she asible for providing care to b. LPN # 1 stated, "Yes." N # 1 if she was aware of d involving the alleged at # 5. LPN # 1 stated, at Resident # 5 was in the				

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  MEDICAID SERVICES			FO.	ED: 01/16/201 RM APPROVE NO: 0938-039	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	11	2/14/2018	
PHEASAI	NT RIDGE NURSING &	REHAB CENTER	4	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
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	as Resident # 5 went perpetrator started y pinned him against the she heard the allege Resident # 5, "You're I'm not done with you # 1 if she saw the allege Resident # 5 against "No but I heard it." Lift Resident # 5 tell the sknow what you are to that she heard the all Resident # 5 again, "until I am done with y Resident # 5 came or asked her to call the police and perpetrator was yelling # 1 stated, "This was 78's husband (Resident # 5 something needs to be that the police had the after she made a scenasked LPN # 1 if she is anyone, LPN # 1 if she is anyone, LPN # 1 stated executive director at he happened. LPN # 1 stated executive director at he happened. LPN # 1 stated	the bathroom and get the hot from. LPN # 1 stated, as soon at in the room the alleged elling at Resident # 5 and the wall. LPN # 1 stated that dopen petrator state to a not going to the bathroom.  I. The surveyor asked LPN eged perpetrator pin the wall. LPN # 1 stated. PN # 1 stated. PN # 1 stated that she heard alleged perpetrator "I don't alking about." LPN # 1 stated eged perpetrator tell You can't use the bathroom ou." LPN # 1 stated that ut into the hallway crying and coolice. LPN # 1 stated, "We they came and the alleged g at the police officer." LPN witnessed by Resident # ent # 78 was not sampled) esident # 78's husband appens every night. The done." LPN # 1 stated a alleged perpetrator leave the with them. Surveyor reported this information to ed that she called the some to let him know what	F 550	DEFICIENCY)			
t s	nere." On 12/13/18 at 10:38 ; he clinical record of th campled) that LPN # 1	erm, the surveyor reviewed to Resident #78 (not reported her husband The surveyor observed			ė.		

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	(33		OMB NO	APPROVE
AND PLAN (	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE S	SURVEY
15 323	X 100	495325	B. WING	No. of the last of	C	5
NAME OF	PROVIDER OR SUPPLIER			CTOFFY ADDRESS	12/1	4/2018
DUEACA	NT DIR OF ANNUAL COLUMN		- x & 9 (	STREET ADDRESS, CITY, STATE, ZIP CCDE	1170	TO BE
PREASA	NT RIDGE NURSING & R	Albert A. Bulbers of the		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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F 550	Continued From page	e 8	F 55			
		progress notes documented	F 55	0		
	on 12/8/18 at 10 28 n	om. The progress note was	2			
	documented as "Resi	ident family member was	an upou			
	being talked to nasty	by (room number withheld)			10	
	family and was told th	nis is the worst facility and		r a Call a EV annual a constant	i	
	his wife will not be tal	cen care of because we are	100			
	the worst and miss tre	eat the residents and son to			- 1	
	sister was very rude t	o staff and resident family to				
10	where he felt uneasy.	and there comments				
	bothered him and he	could not make a statement	II 3X			
- 174	to staff after incident b	pecause he was being				
	bullied by family he ch	range his statement to loud	ġ.	ALLER TRACKS TO THE		
1	commasion (commotive	on) after he told police she	10			
	was yelling at roomma	ate and in his face and this		22 30 50		
	happened every night	to not wanting to say				30
	nothing felt very uneas	sy."			-	
	On 12/13/18 at 3:08 pt	m, the surveyor interviewed				33
i	CNA#2 (certified nurs	sing assistant) The				~
	surveyor asked CNA#	2 if she worked on the				
	evening of 12/8/18 and	if she was responsible for	_		=	. >
ŀ	providing care to Resid	dent #5. CNA # 2 stated	-	2.		100
	that she was on duty a	ind responsible for		M 11.		
- 13	providing care to Resid	dent # 5 on 12/8/18, CNA#				
	2 stated, "Resident # 5	went into his room and				
[1	within seconds, you he	ard all this velling " CNA #				100
	2 stated that she heard	the alleged perpetrator				
- 3	state," You are not goir	ng to the bathroom until t				
1	am through with you."	CNA# 2 stated, "I heard	,			
1	all this yelling and I told	I LPN #1 something is				
	going on down there." (	CNA#2 stated that	-	In 1 St. William		1
1.5	Resident # 5 came dow	vn the hallway and said he	j i			
V	wanted to call the police	e. CNA#2 stated that	] -			
	resident # 5 stated tha	t the alleged perpetrator	(()	The state of the s		
V	wouldn't let him use the	bathroom. The surveyor				
3	isked CNA if Resident	# 5 was incontinent at this	1			- 1
Į, t	ime. CNA#2 stated th	at Resident # 5 was				
	ncontinent. CNA # 2 als	so stated Resident # 5				
	vas crying and upset. (	CNA#2 stated that	1			- 1

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	¥ 18		FC	TED: 01/16/2019 DRM APPROVED NO. 0938-0391
STATEMENT AND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
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NAME OF I	PROVIDER OR SUPPLIER		(0)	IREET ADDRESS, CITY, STATE ZIP CODE		12/14/2018
PHEASA	NT RIDGE NURSING &	REHAB CENTER	43	ISS PHEASANT RIDGE ROAD, SW OANOKE, VA 24014		
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	Resident # 5 had be bladder training bed CNA # 2 stated that was outside the roo and stated that she tell Resident # 78's they will treat your work told the facility executive the surveying the survey team and staff. The surveyor a director if he stated conversation that he investigation on Mor where any abuse od director agreed to m presence of the surveyor of the surveyor and	cause he wants to go home. It another resident's husband Im and heard the commotion heard the alleged perpetrator husband "If you say anything vife bad." CNA # 2 stated. "I utive director what happened stated that he was ue."  Improve the facility administrative asked the facility executive to her in an earlier planned on closing the aday and that he did not see curred. The facility executive aking that statement in the rey team. The surveyor asked director to provide what	F 550			
	On 12/13/18 at 6:03 director provided the handwritten notes the notepad. The notes we "12/10/18 Alleged personted her out of the came in the room. The fanything happened withheld) and Reside oud. This is my home around this place and	pm, the facility executive surveyor with 4 pages of at were photocopied from a vere documented as follows:  rpetrator- she said the police le building. Resident # 5 le alleged perpetrator asked between (Resident's name int # 5. Resident # 5 she very a you are not going to go I talk about me. She wants the police call and why,			Ÿ	

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES			FC	TED: 01/16/201 DRM APPROVE
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) D	NO 0938-039 ATE SURVEY DMPLETED
		495325	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER					12/14/2018
	IT RIDGE NURSING &	REHAB CENTER	4	TREET ADDRESS, CITY, STATE, ZIP CODE 388 PHEASANT RIDGE ROAD, SW COANOKE, VA 24814		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOLE O BE	(X5) COMPLETION DATE
F 550	husband's name wi	ithheld) to write a statement.  # 5- Resident # 5 went into the	F 550			W H
	perpetrator ask is il between you and (i Resident # 5 said n	etrator waiting on him, Alleged here something wrong Resident name withheld) othing. Alleged perpetrator-i ou stopped paying attention to		×		
	(Resident name wit games with (Reside 5-It's because the w name withheld) hav not (Resident name	hheld). You are not playing ant name withheld) Resident # //ay your mom and (Resident e been treating me and I am withheld) caregiver. Alleged ou are not going to treat			8	
] 	(resident name with am not doing anythi withheld) Get out of bathroom. Alleged p me and said you are	held) this way. Resident # 5 I ng to (Resident name the way I've got to go to the respetrator stepped in front of going to talk to me. Resident				
	Alleged perpetrator; Resident # 5 this is of here you are just : Oh know this is (Res	t to use the bathroom. you can wait a minute. Dur room you need to get out a guest. Alleged perpetrator- sident name withheld) room,				
t t	ou. Resident # 5-he and said get out of m athroom. Alleged po out here waiting a	you and he will be here after e started urinating on himself hy way I have to use the erpetrator -Go head but I will and you are going to talk to				H
t h	ne she stepped out a athroom. Resident a leard her telling (Resoling to talk to me. F	of the way from blocking the # 5 was in the bathroom he sident name withheld) He is Resident waited in the		9	i	
g ti h	oing to get his food. ne bathroom when s er say I am leaving oing to deal with me	he heard her say she was Resident # 5 came out of the left. Resident # 5 heard but when I get back he is Resident # 5 called the stamily room until they got				

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

Event ID: Y3F111

Facility ID: VA0208

If continuation sheet Page 11 of 187



STATEMENT	T OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	- C		OMB	NO. 0938-0:
ND PLAN (	OF CORRECTION	DENTIFICATION NUMBER	A. BUILOIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495325	8. WING_	- 3	С	
NAME OF	PROVIDER OR SUPPLIER	CT 11 We The Th		STREET ADDRESS, CITY, STATE, ZIP CODE	1	2/14/2018
	NT RIDGE NURSING & F			4356 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OHEDSE	COMPLETE CATE
		F 55	0			
control of the second of the s	stated that they spoke of director regarding the a reported by Resident # On 12/13/18 at 6:10 pm he visitor log kept in the surveyor observed that risitor log on 12/13/18, on 12/13/18 at 6:15 pm 00 hall and 700 hall of urveyors observed that com in the bathroom. T	t 1 or CNA # 2 who both with the facility executive allegation of abuse 5.  In, the surveyor reviewed a front of the building. The no visitors had signed the content of the the facility. The two the sident # 5 was in his				

CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES  TATEMENT OF DEFICIENCIES  (X1) PROVIDERSISTERS LEDGICAL					RINTED: 01/16/201 FORM APPROVE
STATEMENT (	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER 495325	A. BUILDIN	IPLE CONSTRUCTION		MB NO. 0938-039 3) DATE SURVEY COMPLETED C
NAME OF PE	OVIDER OR SUPPLIER	498325	B. WNG			12/14/2018
PHEASAN	TRIDGE NURSING & R			STREET ADDRESS, CITY, STATE, ZIF 4355 PHEASANT RIDGE ROAD, SI ROANOKE, VA 24014		1271412010
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	(X5) COMPLETION DATE
COM to Or the	courserved sitting at a solutiside of the resident the room directly beside perpetrator was observed a resident analiway. The visitor with show the alleged perpetron 12/14/18 at 8:36 at desident # 5 again ab buse. The surveyor any contact with the alleged perpetron contact with the alleged that cocurred the table from underned the table from underned at the companient of the was in here after wait it's his family they stated, "I have the corved to his new room be honest i have stated and therapy." The sident # 5 if staying at he normally does. I se surveyor asked Reside and the room if this rmally does. Resident munito them."	e resident's room. They were square table that was square table that was st's room playing a game. In de where the alleged rived, the 2 surveyors and a visitor sitting in the as identified as Resident # dity staff stated was bullied actor.  In the surveyor interviewed out his allegations of asked Resident # 5 if he had alleged perpetrator after the on 12/8/18. Resident # 5 d on Saturday night and a Sunday and she jerked ath me." Resident # 5 ded to unit manager RN # 1 told her I couldn't believe what she did to me, and she can come visit." Resident right to be protected." The int # 5 if he has had any if perpetrator since he was a Resident # 5 stated. "No yed in my room except for	F 55			

		AND HUMAN SERVICES & MEDICAID SERVICES			FC	TED: 01/16/201 DRM APPROVE	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) D.	CMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		495328	B. WING		С		
NAME OF F	ROVIDER OR SUPPLIER	B TERTE III SET		STREET ADDRESS, CITY, STATE, ZIP CODE		12/14/2018	
PHEASAI	NT RIDGE NURSING &	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	! (EACH DEFICIE)	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRF	(XS) COMPLETION DATE	
	stated, "Yes I found social services man perpetrator called he that is how she found surveyor asked the manager what the a her. The facility soci that the alleged perpetrator told her cescorted out of the beservice manager state perpetrator told her to what happened between manager state perpetrator told her to what happened between manager state eight and that Resident # 5 attacked didn't know what happened services manager state eight and that the alleged perpetrator social services manawerbally attacking social services manawerbally serv	acility social services manager out Monday." The facility ager stated that the alleged er on Monday morning and ad out about the incident. The facility social services alleged perpetrator reported to all services manager stated petrator stated that the police on Saturday and she was building. The facility social atted that the alleged that she asked Resident # 5 ween him and (Resident's the alleged perpetrator stated arted talking loudly and that ad her verbally said that she opened. The facility social	F 550				

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES  MEDICAID SERVICES			FC	TED: 01/16/20 DRM APPROV NO. 0938-03	
ND PLAN (	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) D.	(X3) DATE SURVEY COMPLETED	
NAME OF		495326	B. WING			C	
	PROVIDER OR SUPPLIER		= ,,,210) (	STREET ADDRESS, CITY, STATE, ZIP	CODE	12/14/2018	
	NT RIDGE NURSING & I	2. J. L. Property		4385 PHEASANT RIDGE ROAD, SV ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEF'CIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE	
F v c c c c c c c c c c c c c c c c c c	The facility social sets she and the facility end she and the facility end Resident # 5 on Monsure he felt safe. The manager stated that different room on Monthat had occurred on facility social services Resident # 5 said that perpetrator to come be executive director said investigation.  On 12/14/18 at 9.23 at the unit manager RN # 1 is with Resident # 5 where about the alleged perpent to the building. Unit it with Resident # 5 where about the alleged perpent to the building. Unit it was aware and investigation was the alleged pallowed in the building. Unit manager RN # 1 is Resident # 5 that the fives a ware and investigation of the surveyor that afety checks on Resident # 5 that the fives aware and investigation of the surveyor required the surveyor required to the surveyor required	she interviewed Resident # 5.  Invices manager stated that  Invices manager stated to make  Individual services  Individual	F 55				

01/23/2019 14:06

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/16/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER A. BUILDING\_ COMPLETED C 495325 B. WNG NAME OF PROVIDER OR SUPPLIER 12/14/2018 STREET ADDRESS, CITY, STATE, ZIP CODE PHEASANT RIDGE NURSING & REHAB CENTER 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 550 Continued From page 15 F 550 interviews." The director of clinical services stated that the facility executive director and the facility social services manager did the interviews. The surveyor asked the director of clinical services if she was aware that Resident # 5 reported abuse. The director of clinical services stated, "Of course his perception is his perception." The surveyor asked the director of clinical services how long does the facility have to report suspected abuse. The director of clinical services stated, "2 hours typically." The surveyor asked the director of clinical services what is the procedure for suspected resident to resident abuse. The director of clinical services stated they are automatically separated and if needed we can do one to one. The surveyor asked the director of clinical services what was the procedure to staff to resident abuse. The director of clinical services stated that the employee is suspended pending investigation. The surveyor asked the director of clinical services what was the procedure for allegations of visitor to resident abuse. The director of clinical services stated we ask them to leave the facility until the investigation is complete. The surveyor asked the director of clinical services why the alleged perpetrator was allowed to return to the facility if the investigation into Resident # 5's allegation of abuse had not been completed. The director of clinical services stated, "There's a fine line when telling them they can't visit their loved one. They haven't had contact." The director of clinical services stated, "I wish I could give you more information but the investigation is not complete." On 12/14/18 at 11:05 am, the surveyor

interviewed the facility executive director in the presence of the survey team. The surveyor asked the facility executive director what the procedure

### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/16/2019 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED C 495325 9. WING NAME OF PROMDER OR SUPPLIER 12/14/2018 STREET ADDRESS, CITY, STATE, ZIP CODE PHEASANT RIDGE NURSING & REHAB CENTER 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG OATE DEFICIENCY Continued From page 16 F 550 was for allegations of resident to resident abuse. The facility executive director stated, "Separate and investigate." The surveyor asked the facility executive director what the procedure was for allegations of staff to resident abuse. The facility executive director stated that the employee was to be suspended pending investigation. The surveyor asked the facility executive director what was the procedure for allegations of visitor to resident abuse. The facility executive director stated, that a facility reported incident would be submitted, the incident would be investigated, and the visitor would be asked to stay away until the investigation is complete. The surveyor asked the facility executive director why the family was not asked to stay away during the investigation of the allegation of abuse reported by Resident # 5. The facility executive director stated, "Or they meet with me and the director of nursing and we determine if they can come back. I met with the family on Monday and with Resident # 5's history of 3 or 4 occasions that he has lied, the residents were separated and Resident #5 was moved to another room. I decided that the alleged perpetrator could return to the building." The surveyor asked the facility executive director how he could make that determination when the investigation had not been completed. The facility executive director stated, "I don't think it happened. Resident # 5 tells lies. In the past he has made accusations and said this happened and he comes back 3 or 4 days later and says he is sorry. I am more concerned with this nurse LPN # 1, I think she put Resident # 5 up to calling the police. It's a lot of drama involved in this with CNA # 2 and LPN # 1. They have issues with the family. My issue is more with LPN # 1 and I will deal with her after this is over." The surveyor

asked the facility executive director if he

STATEMEN	TOF DEFICIENCIES	& MEDICAID SERVICES	- (V)		OMR	ORM APPROV NO. 0938-03
NO PLAN (	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDING	PLE CONSTRUCTION  G	(X3) D	ATE SURVEY OMPLETED
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NAME OF	PROVIDER OR SUPPLIER	XIII RIESSII		STREET ADDRESS, CITY, STATE, ZIP CODE	1	2/14/2018
	NT RIDGE NURSING &	Was IVa		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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F 550 Continued From page 17  Interviewed CNA # 2. The facility exidirector stated that he did not. The executive director stated that the faservices manager interviewed CNA  On 12/14/18 at 11:20 am, unit manaprovided the surveyor with a copy of "Resident Safety Check" log for Resident Safety Check" log for Resident # 5 until 12/12/18 at 7:00 at 4 days after the initial allegation of a reported by Resident # 5, and 2 days transferred into a different room. The observed that the facility staff did no 15 minute safety checks for Resident 11:00 pm on 12/12/18 through 7:00 at 12/13/18. There were no documented checks from 11:00 pm on 12/13/18 at 11:00 am and 12/14/18 at 11:00 am and 12/14/18 at 11:47 am, two surveys the facility executive director per his facility executive director stated, "I fell how I came across about not believing always believe him. It may turn out to	2. The facility executive the did not. The facility social sterviewed CNA # 2.  10 am, unit manager RN # 1 or with a copy of the eck" log for Resident # 5. and that the facility staff did not resident safety checks for /12/18 at 7:00 am which was all allegation of abuse that was at # 5, and 2 days after he was erent room. The surveyor sility staff did not document cks for Resident # 5 from 8 through 7:00 am on an odocumented safety in on 12/13/18 through 7:00 there were no documented to 11:00 am and 11:15 am, am, two surveyors met with stor stated, "I felt bad about you not believing him. We	F 550				
s s ti b s e h b	rouldn't have done are separated them. We in surveyor stated to the hat the alleged perpet wilding on Sunday and he jerked the table from xecutive director state ere all day and no on ack and forth to the has facility executive di	nything differently. We met with the family," The facility executive director				

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	<b>医三线线</b>	and the state of t	F	ORM APPROV	
ND PLAN (	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2; MUL A. BUILDI	TIPLE CONSTRUCTION ING	(X3) D	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
NAME OF I	PROVIDER OR SUPPLIER	495325	B. WING			С	
				STREET ADDRESS, CITY, STATE, ZIF	CODE	12/14/2018	
	NT RIDGE NURSING 8	and the second of the second o	AN ENVL	4355 PHEASANT RIDGE ROAD, ST ROANOKE, VA 24014			
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	signed in as a visite facility saw the allege mother and grands in the hallway at the said the alleged per underneath him. The not respond. The succeptive director the tearful during the interest working on his toilet alleged perpetrator of the him from using the burinate on himself. The stated, "She says show," The surveyor informed the hat Resident # 5 stated that Resident # 5 stated finis room like he not coming out for meals or run into the alleged rormal behavior for Foxecutive director stated of the surveyor informed the state of the surveyor told the nat room forever and the surveyor told the surveyor told the nat she was unable to the said she was unabl	ind seeing that no one had or, 2 surveyors toured the ged perpetrator along with her on visiting with their loved one is same table that Resident # 5 petrator jerked from a facility executive director did property informed the facility hat Resident # 5 became her erview when he reported a surveyor told the facility hat Resident # 5 had been and attack that the release at an and prevented hat home causing him to the facility executive director and the facility executive director attack to the facility executive director attack to the facility executive director that Resident # 5 tells hies obligated to protect him. The part facility executive director that he isn't coming out formally does and is only because he does not want of perpetrator and this is not a resident # 5. The facility ted, "I don't know what the name withheld) has been in the doesn't want to move. To get him back to that unit." facility executive director of advise him on what to do on to protect Resident # 5.	F 5				
in	misappropriation" co	Abuse, Neglect, Exploitation ontained documentation that imited to: abuse include but are not					

STATEMENT	OF DEFICIENCIES	MEDICAID SERVICES	- A RE		ОМ	ORM APPROVE B NO. 0938-039	
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A BUILDING	PLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS CITY CTATE TO		12/14/2018	
	NT RIDGE NURSING & R	William Hillery and the second	STREET ADDRESS, CITY, STATE, ZIP CODE  4355 PHEASANT RIDGE ROAD, SW  ROANOKE, VA 24014				
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F 550	limited to: Harassing a resident Mocking, insulting, ric	diculing	F 55	0			
	Intimidate Threatening residents care or withholding a family and friends	er a resident, with intent to s, depriving a resident of resident from contact with of the center, its employees					
	services to a resident physical harm, pain, n distress Examples inc	that are necessary to avoid nental anguish or emotional clude put are not limited to: tionary measures to protect	İ				
	the health and safety of	of the resident					
	cause for disciplinary a and possible prosecuti to what actions constit Any action that may ca physical psychological	ly prohibited. Such acts are action, including dismissal on. Questions may arise as ute abuse of a resident, asse or causes actual or emotional harm, which					
	abuse. Actions such as restraining a resident in authorization, and othe seen as causing physic strictly forbidden. Acts :	mproperly or without or such acts which can be cal pain to a resident are such as teasing.					
r v n	esident may constitute with no less severely the narm. Non-action, which sychological, or physical anner as that caused action. All actions in wh	cal injury in the same by improper or excessive ich employees engage					
Į v	vith residents must hav he healthful, proper, an	e as their legitimate goal					

	OF DEFICIENCIES	MEDICAID SERVICES			OMB	DRM APPROVE NO. 0938-039	
	OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3) D	ATE SURVEY	
		495325	B. WING			6	
NAME OF	PROVIDER OR SUPPLIER	Service and American		STREET ADDRESS, CITY, STATE, ZIP CODE		12/14/2018	
DUEACAI	NT DIDGE MUDDING & A			4355 PHEASANT RIDGE ROAD, SW			
FREASA	NT RIDGE NURSING & F	REMAB CENTER	7.0	ROANOKE, VA 24014			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	PECTION		
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F 550	Continued From pag	e 20	F 55	50			
	treatment of the resid		1 00	1000 125 april 1000 1100			
	Furthermore, the Ada	ministration of the company				1001 8	
	recognizes that resid	ient abuse can be committed					
	by other residents, vi	sitors, or volunteers		1 A 100 22			
11.	Employee Obligation						
	All employees have a	a duty to respect the rights of	lille 8	INVESTMENT DATE:		T E AR	
	all residents, to treat	them with dignity and to	-=			119	
	prevent others from v	riolating their rights. Any				- d	
	employee, who witne	sses or has knowledge of an		The second secon		3-4	
	act of abuse or an ali	egation of abuse, neglect,		8		A.VII.	
	exploitation or mistre	atment, including injuries of		1			
	unknown source and	misappropriation of resident					
30	information immediate	it, is obligated to report such ely, but no later than 2 hours					
	after the allegation is	made, if the events that					
	cause the allegation i	nvolve abuse or result in					
1	serious bodily injury,	or not later than 24 hours if				8 1	
	the events that cause	the allegation do not					
	involve abuse or do n	ot result in serious bodily					
	injury, to the Administ	rator and to other officials in					
	accordance with State	law. In the absence of the					
	Executive Director, the	e Director of Clinical nated abuse coordinator.					
	oci iloco la frie design	rated abuse coordinator.		VIII 261 II II		II Ę	
	An employee shall be	deemed to have violated					
	his obligations in para	graph "1A" (above) if he	12			# 1	
	does any of the follow	ing:		l ne			
	Harasses or otherwise retaliates against any resident, employee, or other person who discloses information or participates in an						
			ĺ				
į	investigation of an act	of resident abuse		gir BH, I			
	5. Investigation						
	The Abuse Coordinato	or or his/her designee shall					
i	nvestigate all reports	or allegations of abuse.					
[ ]	neglect, misappropriat	ion and exploitation. A		1983		i	
	social Service represe	ntative may be offered in				l	
11	the role of resident adv	vocate dunng any	1			1	

DEPARTMENT OF HEALTH AN	D HUMAN	SERVICES
CENTERS FOR MEDICARE &	MEDICAID S	SERVICES
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PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN	ND PLAN OF CORRECTION (X1) PROVIDERSUPPLIERCLIA IDENTIFICATION NUMBER		(X2) MULT A BUILOII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495325	B WING_	N .		C	
PHEASA	PROVIDER OR SUPPLIER  NT RIDGE NURSING & R			STREET ADDRESS, CITY, STATE, ZIP COD 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	E	12/14/2018	
(X4) ID PREFIX TAG	LEAGH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO.	SHOULD BE	(X5) COMPLETION DATE	
F 600 SS=G	questioning of or inter Investigations will be following manner. Immediately upon the neglect, the suspect(s residents pending the allegation.  Protection Increased supervision residents."  On 12/14/18 at 2:02 pr was made aware of the No further information provided to the survey conference on 12/14/18 Free from Abuse and NCFR(s): 483.12(a)(1)  §483.12 Freedom from Exploitation The resident has the rig neglect, misappropriation and exploitation as definingled to the survey conference on 12/14/18 at 2:02 pr was made aware of the	allegation of abuse or shall be segregated from investigation resident of the of the alleged victim and the administrative team of indings as stated above.  Tregarding this incident was team prior to the exit and the to be free from abuse, on of resident property, and in this subpart. This add to freedom from voluntary seclusion and all restraint not required to ical symptoms.	F 600	F800- Free from Abus Neglect	ere 19 by nical acility s #5 & ity and with  vs residents idents' ntacted) provided dignified		

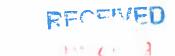
FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: Y3F111

Facility IO: VAC208

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## DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/18/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	DENTIFICATION NUMBER: A 495325 B		RIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
14 170	ROVIDER OR SUPPLIER	3 3 4 4 4 4 5 5 5 7 1	STREET ADDRESS, CITY, STATE, ZIP CODE 4356 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			12/14/2018	
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F 600	facility document in review, the facility residents were free Resident #5 and The findings included. The findings included in the findings included in the facility stall #5 was free from resident's family minimis room, verbaland caused him to Resident #5 was admitted to the facility and caused him to Resident #5 was admitted to the facility were not limited depressive disording prostatic hyperplatic hyperplatic hyperplatic hyperplatic for the MDS assessment referrof the MDS	review, resident interview, review and clinical record staff failed to ensure 2 of 23 e from abuse and neglect, Resident # 89.  ded:  If failed to ensure that Resident abuse as evidenced by another nember cornered Resident # 5 fly threatened and belittled him or urinate on himself.  a 40-year-old-male who was city on 4/20/18, with a of 8/27/18. Diagnoses included ad to, hypertension, major er, anxiety disorder, and benign sia.  If for Resident # 5 was reviewed 4.1 am. The most recent MDS to assessment for Resident # 5 sessment with an ARD rence date) of 9/3/18. Section C ses cognitive patterns. In the facility staff documented that a BIMS (brief interview for ore of 15 out of 15, which sident # 15 was cognitively	F	3. The DCS, ADCS UMs will re-educate on federal regulation guidelines for Freed Abuse, Neglect, and by 1/28/19.  4. DCS and or ADC conduct random res their representative times per week for 4 weekly for 3 months residents are provide dignified manner and to exercise their righ respected. Findings will be revie QAPI committee mo Quality Monitoring u indicated. 5. Date of Complian 1/28/2019.	facility staff as and com from I Exploitation IS will Ident and or interviews 3 weeks, then to ensure ed care in a d their ability ats is ewed by anthly and pdated as		
	The plan of care for Resident # 5 was reviewed and revised on 11/9/18. The facility staff documented a focus area for Resident # 5 as, "Resident # 5 is independent on staff for activities, cognitive stimulation, social interaction r/t (related to) anxiety, depression, PTSD (post						

		AND HUMAN SERVICES  & MEDICAID SERVICES			F	ORM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PPLE CONSTRUCTION	(X3) [	NO. 0938-0391 DATE SURVEY COMPLETED  C
nawa.		495325	B. WING_		- 10 All All	12/14/2018
	ROVIDER OR SUPPLIER  IT RIDGE NURSING &	REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE  4355 PHEASANT RIDGE ROAD, SW  ROANOKE, VA 24014			1231412010
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F 600	quadriplegia, pain, choice, self acts in computer, phone, sin music, socializes with Resident # 5 goes Interventions including "Report resident of discomfort, breathing that interferes with the participate in activiting needed)." The survey of care for Resident update that Resider are untrue.  On 12/13/18 at 7:55 Resident # 5's room interview. During the reported to the survey alleged perpetrator "Got in my face, yell bathroom and would Resident # 5 stated room to get hot choom	participating in activities of room such as TV (television), itting on porch, parties, bingo. ith staff and residents. by cab on community outings." ed but were not limited to; o (complaint of) pain, ing difficulties or any other c/o the resident's ability to ites to the nurse prn (as eyor reviewed the entire plan at # 5 and did not see an int # 5 made statements that is am, the surveyor was in a conducting a Resident e interview Resident # 5 eyor that on 12/8/18, the (his former roommate's sister) led at me and blocked the dn't let me use the bathroom." that he was going back to his colate for a group of as socializing with and to use	F6			

that Resident # 5 was going to tell her what was

CENTE	RS FOR MEDICARE 8	IND HUMAN SERVICES MEDICAID SERVICES		All the Children of the All the Children of th	FO	ED: 01/16/201 RM APPROVE NO: 0938-039	
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER	LEHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014				
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	alleged perpetrator the bathroom. Resident aperpetrator stood in finand told him he was a bathroom until she was a stated that he told to is our room and you at to get out of here." Realleged perpetrator counties to urinate on himself. awful, I cried. "Reside alleged perpetrator fir the bathroom after he and stated to him, "I awhen you get out became what's going on wham withheld). Resident #5 stated the Resident #5 stated the Resident #5 stated the facility. Resident #5 stated the facility. Resident #5 stated the facility. Resident #5 stated the facility members sat on saying mean things to something happens to withheld) their asses is stated, "They made metrap." Resident #5 stated in here like	5 stated that he told the nat he needed to use the if 5 stated that the alleged ront of the bathroom door not going to use the as done with him. Resident # he alleged perpetrator, "This are a guest here. You need esident # 5 stated that the continued to block the door to not # 5 stated that he began Resident # 5 stated that the nally allowed him to go into had urinated on himself im going to be right here ause you are going to tell ith you and (Resident's itent # 5 stated that the ntinued to yell at him in he was in the bathroom, at he called the police, at the police came and dent # 5 stated that the that evening but it would icility) if they bar her from 5 stated that later that mily members of his former d'intimidated" him. at his former roommate's the other side of the room him and stated, "If (Resident's name	F 600				

alleged perpetrator approached him as he was

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			F	ORM APPROVE
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	their room and "jerked Resident # 5 stated to why the alleged perphack into the facility. Resident # 5 stated to right to visit her familistated that he spoke director on Monday a director told Resident a different room. Resident if the facility executive directly executive dire	ble in the hallway outside of ad the table away from me," that he asked a staff member verator was allowed to come after what she did to him, that he was told she has a y member. Resident # 5 with the facility executive and the facility executive and the facility executive that the stated that the ctor stated to him, "we got it at # 5 stated that he replied, but it doesn't handle what lent # 5 stated that the ctor stated to him, "You let out 2 days to investigate that." It does now she treated me. It as worthless, and they let e like it was nothing after the uight with me being a patient cted more." The surveyor that Resident # 5 became stated. "What happens when by else?" Are you just going er room and say that settles at the surveyor interviewed (registered nurse) about the eported by Resident # 5. stated, "I am aware briefly, I nily was acting inappropriate Resident # 5) and the police	F 60C			
i	nterviewed the facility	executive director about				

#### PRINTED: 01/16/2019 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 DENTIFICATION NUMBER: COMPLETED A. BUILDING 495325 B. WING 12/14/2018 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 Ю (X5) COMPLET:ON (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRFFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 600 Continued From page 26 F 600 the allegations of abuse reported by Resident # 5. The facility executive director stated, "I was called Saturday night saying the police had to come to the facility saying there was a yelling match with Resident # 5 and the alleged perpetrator." "We had the daughters (the alleged perpetrator and her sister) come in Monday and we spoke to them and Resident # 5." The facility executive director informed the surveyor that he was in the process of investigating the incident and that a FRI (facility reported incident) was submitted. The facility executive director then stated that Resident # 5 had been known to lie and then come back and admit to lying and saying that he was sorry. The facility executive director also stated that the nurse that called him at home to report the incident had issues with the alleged perpetrator and her family and called him that night to report the incident. She asked if he was going to have them barred from the facility. The facility executive director stated, "I don't really have any evidence. There were no eye witnesses. I will be finishing this investigation by Monday but I can't see where any abuse occurred." On 12/13/18 at 10:15 am, the surveyor observed a progress note documented in the clinical record for Resident # 5 on 12/9/18 at 3:29 pm. The progress note was documented as "Resident is on medi part b total care with adls (activities of daily living) incontinent of bowel and bladder uses walker for ambulation upset due to incident with

his face."

roommate family of them yelling and getting into his face refusing to let him use the bathroom police was called due to roommate family being nasty and inappropriate by yelling and getting in

		ND HUMAN SERVICES MEDICAID SERVICES			FORM	D: 01/16/2019
STATEMENT	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE COMP	LETED
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	12/	14/2018
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	about the allegation of Resident # 5. The surveyor asked if an incident that occur perpetrator and Resident # 1 stated therapy room playing Residents. LPN # 1 stated the alleged Resident # 5 went perpetrator started ye pinned him against the she heard the alleged Resident # 5, "You're "I'm not done with you # 1 if she saw the alleged Resident # 5 against I "No but I heard it." LP Resident # 5 tell the alleged that she heard the alleged Resident # 5 again. "Yourtil I am done with you are tall that she heard the alleged Resident # 5 came ou asked her to call the poalled the police and the perpetrator was yelling # 1 stated, "This was to 78's husband (Reside LPN # 1 stated that Resident her, "This ha "Something needs to be that the police had the	d am, the surveyor (licensed practical nurse) of abuse reported by rveyor asked LPN # 1 if she consible for providing care to //18. LPN # 1 stated, "Yes."  LPN # 1 if she was aware of rred involving the alleged dent # 5. LPN # 1 stated, I that Resident # 5 was in the games with the other tated that Resident # 5 was the bathroom and get the hot om. LPN # 1 stated, as soon In the room the alleged dent # 5 and e wall. LPN # 1 stated that I perpetrator state to not going to the bathroom." I." The surveyor asked LPN ged perpetrator pin the wall. LPN # 1 stated, N # 1 stated that she heard lileged perpetrator "I don't king about." LPN # 1 stated ged perpetrator tell /ou can't use the bathroom ou." LPN # 1 stated that t into the hallway crying and oolice. LPN # 1 stated, "We hey came and the alleged g at the police officer." LPN witnessed by Resident # int # 78 was not sampled) esident # 78's husband	F	600		

CENTERS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 01/15/2 FORM APPRO
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDING	PLE CONSTRUCTION	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIEF			STREET ADDRESS, CITY, STATE, ZIP CODE	12/14/2018
PHEASANT RIDGE NURSING	& REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
PREFIX (EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
anyone. LPN # 1 executive director happened. LPN # anything about wi want APS (adult p here."  On 12/13/18 at 10 the clinical record sampled) that LPI witnessed the eve documentation in on 12/8/18 at 10:2 documented as "R being talked to nat family and was told his wife will not be the worst and miss sister was very ruc where he felt unea bothered him and to staff after incide bullied by family he commasion (comm was yelling at room happened every ni nothing felt very ur  On 12/13/18 at 3:0 CNA # 2 (certified asked CNA # 2 if s 12/8/18 and if she care to Resident # was on duty and re Resident # 5 on 12	she reported this information to stated that she called the at home to let him know what a stated, "They never do not we tell them. They don't protective services) to come in 1:38 am, the surveyor reviewed of the Resident #78 (not 1/4 1 reported her husband ints. The surveyor observed the progress notes documented 8 pm. The progress note was tesident family member was stry by (room number withheld) do this is the worst facility and taken care of because we are as treat the residents and son to let to staff and resident family to say and there comments the could not make a statement int because he was being a change his statement to loud notion) after he told police she mate and in his face and this gott to not wanting to say	F 60		

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

DEPART	MENT OF HEALTH AN	ND HUMAN SERVICES			PRINTE	D: 01/16/2019
		MEDICAID SERVICES			FOR	M APPROVED
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	E CONSTRUCTION	(X3) DAT	O. 0938-0391 E SURVEY PLETED
		495326	8 WING			С
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12	/14/2018
DUEAGAN	IT OIDOE NUODONO A DA		1	356 PHEASANT RIDGE ROAD, SW		
PHEASAN	IT RIDGE NURSING & RI	EHAB CENTER		ROANOKE, VA 24014		
(X4) (D	SUMMARY ST	ATEMENT OF DEFICIENCIES				
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F 600	Continued From page	20				
. 000	-		F 600			
	state, You are not go	ing to the bathroom until I				1 1
	all this value and the	CNA # 2 stated, "I heard				1 1
i	going on down there."	Id LPN #1 something is				f
	Resident # 5 came do	own the hallway and said he				
	wanted to call the poli	ce. CNA # 2 stated that				! I
	Resident # 5 stated th	at the alleged perpetrator				[ ]
	wouldn't let him use th	ne bathroom. The surveyor				
ł	asked CNA if Residen	t # 5 was incontinent at this				
	time. CNA # 2 stated t	that Resident # 5 was	3.5			
	incontinent. CNA#2	also stated Resident # 5	5)			
	was crying and upset.	CNA # 2 stated that				
	Nesident # 5 had beer	working really hard trying				
	CNA # 2 stated that as	ise he wants to go home. nother resident's husband	-			
	was outside the room.	and heard the commotion				
		ard the alleged perpetrator				1
ĺ	tell Resident # 78's hu	sband "If you say anything	1			
	they will treat your wife	bad." CNA#2 stated, "!	i			1
[	told the facility executive	ve director what happened				
	on Monday and he sta					1
	investigating the issue	•	1			
	On 12/13/18 at 5:45 no	n, the surveyor spoke with			2	
19	the facility executive di	rector in the presence of				
1	the survey team and th	ne facility administrative	1 1			
	staff. The surveyor ask	ed the facility executive			1	
ļ	director if he stated to l	her in an earlier	1 1		ł	
	conversation that he pl	anned on closing the				1
i	nvestigation on Monda	y and that he did not see				
1	where any abuse occur	rred. The facility executive				
19	rector agreed to make	ing that statement in the				
!!	he facility avecutive of	team. The surveyor asked			1	- 1
	he facility executive dis	rector to provide what	-			
	rvioence ne nao collec nvestigation.	red runz ist iv tve			1	ļ
	caugauon.				ĺ	
	On 12/13/18 at 6:03 pm	n, the facility executive				

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

director provided the surveyor with 4 pages of

Event ID: Y3F111

Facility ID: VA0208

If continuation sheet Page 30 of 187



		AND HUMAN SERVICES  & MEDICAID SERVICES			FC	TED: 01/16/201
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER SUPPLIER CLIA IDENTIFICATION NUMBER:	(X2) MULTIPE A BUILDING	LE CONSTRUCTION	(X3) DA	NO. 0938-039 ATE SURVEY OMPLETED
		495325	B. WING			С
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP CODE		2/14/2018
PHEASANT RIDGE NURSING & REHAB CENTER				4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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	"12/10/18 Alleged a secorted her out of came in the room." if anything happens withheld) and Residud. This is my hor around this place at to know who initiate what started it. LPN husband's name with 12/10/18 Resident # room alleged perperpertator ask is the between you and (Resident # 5 said now want to know why you (Resident name with games with (Resident name with games with held) have not (Resident name withleam not doing anythin withheld) Get out of bathroom. Alleged p	age 30 that were photocopied from a sewere documented as follows:  Derpetrator- she said the police the building. Resident # 5 The alleged perpetrator asked ad between (Resident's name fent # 5. Resident # 5 she very me you are not going to go and talk about me. She wants ad the police call and why, # 1 asked (Resident # 78 thheld) to write a statement.  # 5- Resident # 5 went into the trator waiting on him. Alleged here something wrong Resident name withheld)  Dething. Alleged perpetrator-lou stopped paying attention to anheld). You are not playing nt name withheld) Resident # ay your mom and (Resident # ay your mom and (Resident # ay your mom and (Resident # and I am withheld) caregiver. Alleged ou are not going to treat the held) this way. Resident # 5 I and to (Resident name the way I've got to go to the erpetrator stepped in front of a going to talk to me. Resident	F 600			
	#5 move, I have got Alleged perpetrator y Resident #5 this is of here you are just a Oh know this is (Resident #5 the was here before you. Resident #5-he	to use the bathroom.  you can wait a minute, our room you need to get out a guest. Alleged perpetrator- ident name withheld) room, you and he will be here after a started urinating on himself by way! have to use the				

### PRINTED: 01/16/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES **FORM APPROVED** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING B. WING 495325 12/14/2018 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 (X4) (D COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DERCIENCY) F 600 Continued From page 31 F 600 bathroom. Alleged perpetrator -Go head but I will be out here waiting and you are going to talk to me she stepped out of the way from blocking the bathroom. Resident # 5 was in the bathroom he heard her telling (Resident name withheld) He is going to talk to me. Resident waited in the bathroom a long time he heard her say she was going to get his food. Resident # 5 came out of the bathroom when she left. Resident # 5 heard her say I am leaving but when I get back he is going to deal with me. Resident # 5 called the police. He went to the family room until they got here. Resident # 5 said he felt she attacked him and it is not right. 12/10/18 Call (Resident husband's name withheld) per facility executive director. Called at 4.14 pm (Telephone number withheld) Nurse asked him about that he said he was one door out in the hall, he didn't see or hear anything if something went on it was in the room. Why happened? We are trying to investigate if something happened. He saw police. 12/10/18 Resident # 5- meeting with facility executive director and Resident # 5. Resident # 5 wants alleged perpetrator not to be able to come back in the building. The facility executive director offered Resident # 5 to move to room (room number withheld) until another semi-private room comes available. Resident # 5 agreed. But said he does not want alleged perpetrator to come back into the building." The surveyor observed that there were no statements from LPN # 1 or CNA # 2 who both

reported by Resident # 5.

stated that they spoke with the facility executive director regarding the allegation of abuse

	KS FUR MEDICARE I	& MEDICAID SERVICES			OMB I	RM APPROVE NO. 0938-039	
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	2/14/2018	
PHEASANT RIDGE NURSING & REHAB CENTER			4366 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL DEFICIENCY)	HI D BE	(XS) COMPLETION DATE	
F 600	Continued From pag	je 32	F 60				
	the visitor log kept in	pm, the surveyor reviewed the front of the building. The nat no visitors had signed the 8.					
	On 12/13/18 at 6:15 pm, 2 surveyors toured the 600 hall and 700 hall of the facility. The two surveyors observed that Resident # 5 was in his room in the bathroom. The two surveyors also observed the alleged perpetrator, her mother, and grandson visiting with their loved one in the hallway outside of the resident's room. They were observed sitting at a square table that was outside of the resident's room playing a game. In the room directly beside where the alleged perpetrator was observed, the 2 surveyors observed a resident and a visitor sitting in the hallway. The visitor was identified as Resident # 78's husband that facility staff stated was bullied by the alleged perpetrator.						
	Resident # 5 again ab abuse. The surveyor a any contact with the a incident that occurred stated, "That happene they came back in her table from underne stated, "I went and tall (registered nurse) and she was in here after versid it's his family they # 5 stated, "I have the surveyor asked Reside contact with the allege	im, the surveyor interviewed bout his allegations of asked Resident # 5 if he had alleged perpetrator after the on 12/8/18. Resident # 5 id on Saturday night and re Sunday and she jerked eath me." Resident # 5 iked to unit manager RN # 1 It told her I couldn't believe what she did to me, and she of can come visit." Resident right to be protected." The eath # 5 if he has had any d perpetrator since he was in. Resident # 5 stated, "No					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES DE CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION		E SURVEY
		495325	B. WING		4.	2/14/2018
- 1020	PROVIDER OR SUPPLIER  NT RIDGE NURSING &	REHAB CENTER	4355	EET ADDRESS CITY, STATE, ZI 6 PHEASANT RIDGE ROAD, S ANOKE, VA 24014	IP CODE	U14/2015
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 600	meals and therapy.' Resident # 5 if stay that he normally does that he normally does staying in his room normally does. Resito run into them."  On 12/14/18 at 9:02 the facility social seasked the facility so was aware of the all Resident # 5. The facility so was aware of the all Resident # 5. The facility so was aware of the all Resident # 5. The facility social services man perpetrator called he that is how she four surveyor asked the manager what the aher. The facility soci that the alleged perpetrator told her what happened between manager stay perpetrator told her what happened between withheld) and that Resident # 5 attacked idn't know what has services manager stay telephone call with that alleged perpetrator stelephone call with that alleged perpetrator stelephone call with that alleged perpetrators (Resident's name with past two weeks Reshim differently. The social services manager stay to weeks Reshim differently. The social services manager stay to weeks Reshim differently. The social services manager stay to weeks Reshim differently. The social services manager stay to weeks Reshim differently. The social services manager stay to weeks Reshim differently. The social services manager stay to weeks Reshim differently. The social services manager stay to weeks Reshim differently.	"The surveyor asked ying in his room is something bes. Resident # 5 stated, "No." de Resident # 5 why he was lifthis is not something he sident # 5 stated, "I don't want are lifthis is not something he sident # 5 stated, "I don't want are lifthis is not something he sident # 5 stated, "I don't want are lifthis is not something he sident # 5 stated, "I don't want are lifthis is not something he sident # 5 stated, "I don't want are lifthis is not something he surveyor cial services manager if she lifthig social services manager and lifthig social services alleged perpetrator reported to cial services manager stated petrator stated that the police on Saturday and she was building. The facility social	F 600			

CENTE	RS FOR MEDICARE OF DEFICIENCIES	AND HUMAN SERVICES  & MEDICAID SERVICES	e de la companya de l	eroer terms better	FC	TED: 01/18/20 DRM APPROVE NO. 0938-039
AND PLAN C	OF DEFICIENCIES  PF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
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	NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			TREET ADDRESS, CITY, STATE, ZIP CODE 155 PHEASANT RIDGE ROAD, SW OANOKE, VA 24014		12/14/2018
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NGY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	II D DE	(X4) COMPLETION DATE
i s	not. Resident # 5 in The surveyor asked manager if she interest in social services manager if she interest a statement." The services manager if she interest in social services manager if she interest in social service (Resident # 78 hust said he didn't hear a anything." The surveyorder in the facility social services manager if The facility social services manager if the facility social service in the facility social service in the said that different room on Mothat had occurred or facility social service in the service in t	age 34 nager stated, "No he would is usually very soft spoken." of the facility social services inviewed LPN # 1. The facility nager stated, "I think she wrote surveyor asked the facility nager if she interviewed shand that the facility staff witnessed the incident. The es manager stated, "I called band's name withheld) and he anything and didn't see eyor asked the facility social is he interviewed Resident # 5. ervices manager stated that executive director met with inday and wanted to make the facility social services it. Resident # 5 was moved to a binday following the incident in the previous Saturday. The is manager stated that at he didn't want the alleged back and the facility and we had to complete the if she had a conversation tere he expressed concerns repetrator being allowed back that manager RN # 1 stated that esident # 5 and he asked perpetrator still being g after what she did to him. stated that she told facility executive director	F 600			

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES			F	NTED: 01/16/20* FORM APPROVE 3 NO. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495325	8. WNG			С
NAME OF F	ROMDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD		
PHEASANT RIDGE NURSING & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DESIGNATES		4	355 PHEASANT RIDGE ROAD, SW OANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 600	could not visit her it told the surveyor safety checks on R safe. The surveyor checks.  On 12/14/18 at 9:35 the director of clinic allegation of abuse 12/8/18. The director happened on the w interviews." The director that the facility executes social services man surveyor asked the she was aware that The director of clinic his perception is his asked the director of clinic does the facility have the director of clinic typically." The surveyor allegally." The surveyor allegally." The surveyor allegally." The surveyor allegally."	leged perpetrator that she oved one. Unit manager RN # that the facility did 15-minute esident # 5 to ensure he was requested a copy of the safety  9 am, the surveyor interviewed cal services regarding the reported by Resident # 5 on or of nursing stated, "It eekend." "I didn't do any of the ector of clinical services stated cutive director and the facility larger did the interviews. The director of clinical services if Resident # 5 reported abuse. Cal services stated, "Of course is perception." The surveyor of clinical services how long the to report suspected abuse cal services stated, "2 hours ever asked the director of	F 600			
	suspected resident director of clinical se automatically separa one to one. The sur- clinical services what	at is the procedure for to resident abuse. The ervices stated they are ated and if needed we can do veyor asked the director of at was the procedure to staff				=
	to resident abuse. T stated that the empl investigation. The st clinical services wha allegations of visitor director of clinical se leave the facility unti complete. The surve clinical services why	he director of clinical services byee is suspended pending urveyor asked the director of at was the procedure for to resident abuse. The ervices stated we ask them to				

01/23/2019 14:11

		AND HUMAN SERVICES  & MEDICAID SERVICES			F	TED: 01/16/2019 ORM APPROVED	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) D	CMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		495325	8. WNG			C	
NAME OF P	ROVIDER OR SUPPLIER		THE WEST	STREET ADDRESS, CITY, STATE, ZIP COD	E	12/14/2018	
PHEASA	NT RIDGE NURSING 8	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO. (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X6) COMPLETION DATE	
	into Resident # 5's been completed. T stated, "There's a f can't visit their love contact." The direct wish I could give yo investigation is not On 12/14/18 at 11:0 interviewed the facility executive was for allegations. The facility executive was for allegations. The facility executive and investigate." The executive director wallegations of staff the executive director was to be suspended persurveyor asked the was the procedure of the visitor would be investigation is completed, that a facility submitted, the incident the visitor would be investigation is completed to stay away allegation of abuse of facility executive directors with me and the director of 3 or 4 occasions to were separated and another room. I decompetrator could reference in the surveyor asked the feature of the surveyor asked the surveyor asked the surveyor asked the	allegation of abuse had not he director of clinical services ine line when telling them they d one. They haven't had tor of clinical services stated, "I but more information but the	F 60				

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CENTER	TMENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			PRIN'	TED: 01/16/201 DRM APPROVE
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
TLE		495325	B. WING	08	С	
NAME OF P	ROMDER OR SUPPLIER			ET ADDRESS SITH SELECTION		2/14/2018
PHEASAI	NT RIDGE NURSING 8	REHAB CENTER	4355	EET ADDRESS, CITY, STATE, ZIP COU PHEASANT RIDGE ROAD, SW ANOKE, VA 24014	DE	
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	wouldn't have done separated them. V surveyor stated to that the alleged per building on Sunday she jerked the table executive directors here all day and no back and forth to the facility executive that the alleged per building because or visitor sign in log an signed in as a visito facility saw the allegementher and grands in the hallway at the sald the alleged per underneath him. The not respond. The sue executive director the tearful during the interpretation on himself. The stated, "She says shim." The surveyor's director that he stated but the facility is still surveyor informed the that Resident # 5 stated for in the allegenormal behavior for I	e anything differently. We we met with the family." The the facility executive director petrator returned to the and Resident # 5 stated that from under him. The facility stated, "No she wasn't, I was one came in. I drove staff to hotel." The surveyor asked the director if he knows for a fact petrator did not enter the in 12/13/18 after viewing the id seeing that no one had in, 2 surveyors toured the ged perpetrator along with her on visiting with their loved one is same table that Resident # 5	F 600			

	AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495325  NAME OF PROVIDER OR SUPPLIER		(X2) MULTIPLE ( A. BUILDING  B. WING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C 12/14/201	
	IT RIDGE NURSING 8		43	REET ADDRESS, CITY, STATE, ZIP CODE 65 PHEASANT RIDGE ROAD, SW DANOKE, VA. 24014	12/14/207	in the
(X4) ID PREFIX TAG	IEACH DEFICIE	' STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMP.	
	that room forever a They fought for yea The surveyor told to that she was unable but he has an oblig and all residents.  The facility policy of a Misappropriation included but was now "Mental and verb limited to. Harassing a reside Mocking, insulting, Yelling or hovering intimidate Threatening reside care or withholding family and friends Neglect is the failur or service providers services to a reside physical harm, pain distress. Examples  Failure to take precedure Acts of a residents are absolucause for disciplinal and possible prosect to what actions controlled.	ent name withheld) has been in and he doesn't want to move. Hars to get him back to that unit." he facility executive director le to advise him on what to do nation to protect Resident # 5 are "Abuse, Neglect, Exploitation" contained documentation that tot limited to: all abuse include but are not not interest in the resident, with intent to a resident from contact with the of the center, its employees a to provide goods and and that are necessary to avoid a mental anguish or emotional include put are not limited to: autionary measures to protect	F 600			
	is not caused by sin abuse. Actions such	cal or emotional harm, which nple negligence, constitutes n as striking a resident, nt improperly or without				5

PALEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	Water		OMB	RM APPROV VO. 0938-03
NO PLAN ()	F CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE C	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495325	B. WING			С
NAME OF F	PROMDER OR SUPPLIER			ECT ADDOCTOR OF A	1	2/14/2018
PHEASA	NT RIDGE NURSING & R	P.I.S. Comme		EET ADDRESS, CITY, STATE, ZIP (	SODE	
		CEMAS CENTER		PHEASANT RIDGE ROAD, SW		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		NOKE, VA 24014		
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F 600	Continued From page	- 40			10011	
	The page		F 600			
	Seen as sourcing above	ner such acts which can be				
	Strictly forbidden Asset	sical pain to a resident are				
1	strictly forbidden. Acts	s such as teasing,				
	resident may constitut	g, or intentionally ignoring a te abuse and will be dealt				
-	With no less severaly	than acts causing physical	200			
	harm. Non-action, whi	ich results in emotional,				
	psychological or phys	sical injury in the same				
	manner as that caused	d by improper or excessive	1			1_ ×
i	action. All actions in w	hich employees engage				İ
1	with residents must ha	ive as their legitimate goal,				
- 3	trie nealthful, proper, a	and humane care and				
	treatment of the reside	ent.				
	Furthermore, the Admi	inistration of the company	1 1			
4.1	recognizes that resider	nt abuse can be committed	1 1			
	by other residents, visit	tors, or volunteers.				
1	Employee Obligation				ļ	
1	All employees have a c	duty to respect the rights of			!	
18	ill residents, to treat the	em with dignity and to				
18	prevent others from vio	lating their rights Apv			20	
€	employee, who witness	ies or has knowledge of an				
a	ict of abuse or an alleg	ration of abuse members				
e	xploitation or mistreatr	ment, including injuries of	1		Ì	
l u	nknown source and m	isappropriation of resident			ĺ	
P	roperty, to a resident, i	is obligated to report such			j	
"	free the efforation is	, but no later than 2 hours			==	
0.0	fter the allegation is ma ause the allegation inv	ade, if the events that				
Se	erious bodily injury or	not later than 24 hours if				
l th	e events that cause th	te allegation do not				
in	volve abuse or do not	result in serious bodily				
in	Jury, to the Administrat	tor and to other officials in	4			
ac	cordance with State la	aw. In the absence of the				
E	recutive Director, the E	Director of Clinical				
Se	ervices is the designate	ed abuse coordinator.				
1						
Ar	employee shall be de	emed to have violeted	1		ł	

DEPARTMENT (	OF HEALTH AND HUM.	
CENTERS FOR	MEDIA	AN SERVICES
SERVICE TOR	MEDICARE & MEDICA	ID SERVICES

STATEMEN	TOF DESIGNATION	AND HUMAN SERVICES  & MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	17/2/2 5		FC	TED: 01/16/201 DRM APPROVE
HID PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A (X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DA	NO. 0938-039 ATE SURVEY
NAME OF I	PROVIDER OR SUPPLIER	496325	96325 8 WING		COMPLETED	
	NT RIDGE NURSING &	REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4356 PHEASANT RIDGE ROAD, SW	1 1	2/14/2018
(X4) ID PREFIX	SUMMARY	STATEMENT OF DEFICIENCIES	0 311	ROANOKE, VA 24014		
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t t q li fo	discloses information investigation of an action of an action. The Abuse Coordinate of the Abuse Coordinate of the Abuse Coordinate of the Abuse Coordinate of the Investigate all reports the role of resident actions of or interpretations will be actionated of the Abuse of the Investigations will be actionally upon the eglect, the suspection in investigation of the eglect, the suspection in investigation of the eglect, the suspection in investigation of the eglect, the suspection in investigation of the eglect, the suspection in investigation of the eglect, the suspection in investigation of the eglect, the suspection in investigation of the eglect, the suspection in investigation of the eglect, the suspection in investigation of the eglect.	se retaliates against any or other person who n or participates in an ot of resident abuse.  For or his/her designee shall or allegations of abuse, tion and exploitation. A tentative may be offered in typication of testiday.	F 6	000		
Inc res On	12/14/18 at 2:02 pm	of the alleged victim and the administrative team findings as stated above.				
No pro		egarding this incident was				
1	or Resident #89, fact resident was free froi misappropriation of p	ility staff failed to ensure munnecessary restraint property.	· manual substance of the substance of t			
Res 3/28 limite	ident #89 was admitte /17. Diagnoses inclued to, hemiolegia and	ad to the feature				

01/23/2019 14:12

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 01/16/2019 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING (X3) DATE SURVEY COMPLETED 495325 NAME OF PROVIDER OR SUPPLIER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 12/14/2018 PHEASANT RIDGE NURSING & REHAB CENTER 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX (EACH CORRECTIVE ACTION SHOULD BE (XS) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE TAG DATE **DEFICIENCY**) F 600 Continued From page 42 for care of tracheostomy, atherosclerotic heart F 600 disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting as her own responsible party. During an interview on 12/13/18, the resident reported being generally content with physical care received, but indicated a desire to transfer to another facility prior to the planned ban on smoking starting in February 2019. The resident reported having asked several times about progress toward the transfer, but having no timeline for the transfer. The resident also reported being sent to the hospital for tracheostomy revision the month before. The resident said she had been given no written notice of the reasons for transfer to the hospital. Clinical record review reveled that on 11/2/18, a staff member took the resident's cigarettes. The CNA and nurse on duty told the resident she could not smake as a safety concern. The resident's smoking assessment from 9/23/28 indicated the resident was safe as an independent smoker. The resident requested to leave AMA (against medical advice), signed paperwork indicating that was her intent, and started calling family and friends for a ride. Staff called the resident's father (this was not a

FORM CMS-2567(C2-99) Previous Versions Obsolete

Event ID: Y3F111

Facility ID: VA0208

If continuation sheet Page 43 of 187

DEPARTMENT OF HEALTH AND HUMAN SERVICES

AND PLAN OF	F DEFICIENCIES CORRECTION	MEDICAID SERVICES  (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II 7			TED: 01/16/ DRM APPRO	
		IDENTIFICATION NUMBER	A. BUILDI	TIPLE CONSTRUCTION	(X3) D	OMB NO. 0938-03	
NAME OF BO		495325	8. WING		COMPLETED		
	VIDER OR SUPPLIER		O. WING	The second secon		С	
PHEASANT	RIDGE NURSING & R	EULG CANA	* 1			2/14/2018	
		ENAB CENTER		4355 PHEASANT RIDGE ROAD, SW	rec III		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES		ROANOKE, VA 24014			
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	and the street of	OCCUPING INFORMATION)	TAG	(EACH CORRECTIVE ACTION SHO	OULD BE	CONPLETIO	
E 18				CROSS-REFERENCED TO THE APPLICATION SHO	ROPRIATE	DATE	
F 600 C	ontinued From page	43	-3			2016	
gt	lardianship situation	) mod have to	F 60	0		91.81	
le	ave and to get her a	psychiatric evaluation					
						2 10	
ore	der) and called an a	mbulance to take the				= 3/1/1	
1	CIRCUIT DID OF WISHING	Lhora	i				
the	resident's physician	Was notified at the			Mark Transfer		
	Andri Of High Meter A	/2c 2 Aban			6-17		
req	ulring hospitalization	a change of condition		S III II III III III	2		
In th			L 8 _				
	he hospital dischare	e summary, the hospital			2		
				14 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1			
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reside	ent had not said that	, but the nurse had).	- 1		1		
			;		- 1		
A nur	se's note dated 11/3	/18 indicated that the	- 1		į	- 1	
					1	- 1	
			- 1				
told si	ne couldn't take off h	er oxygen hecause			372	j	
	THE RESERVE OF THE PROPERTY OF	D and Man					
given	sedative medication	n instead.	Ш		3	325	
1							
Sine	a summary meeting	on 12/13/18, the	j				
	אפ מחז חו נושונטעטייי	Painink .					
					13		
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						×	
			Ì		X = 4		
			- 1			- 23	
		edged the resident signed out AMA. The dent didn't have any					
Orleani-							

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 01/16/2019 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A BUILDING COMPLETED 495325 B. WNG NAME OF PROVIDER OR SUPPLIER 12/14/2018 STREET ADDRESS CITY, STATE, ZIP CODE PHEASANT RIDGE NURSING & REHAB CENTER 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION TAG PREFIX (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 44 place to go. When asked about the resident's F 600 cigarettes being confiscated and the police being F607- Develop/implement called when the resident signed out AMA, the Abuse/Neglect, etc., Policies DCS stated she was unaware of the resident ever not being allowed to smoke when she wanted to 1. Facility submitted a FRI do so. (Facility Reportable Incident) for F 607 Develop/Implement Abuse/Neglect Policies Resident #89 on 1/21/2019. SS=D | CFR(s): 483.12(b)(1)-(3) F 607 2. The RDCS and UMs §483.12(b) The facility must develop and completed quality reviews implement written policies and procedures that: interviews of all current residents (cognitively impaired residents' §483.12(b)(1) Prohibit and prevent abuse, representatives were contacted) neglect, and exploitation of residents and misappropriation of resident property, to ensure residents are provided care in a respectful and dignified §483.12(b)(2) Establish policies and procedures manner on 1/22/19 Follow up to investigate any such allegations, and based on findings. §483.12(b)(3) Include training as required at 3. The DCS, ADCS, RDCS and paragraph §483.95, UMs will re-educate facility staff This REQUIREMENT is not met as evidenced on federal regulations and guidelines for Freedom from by: Based on resident and staff interview and Abuse, Neglect, and Exploitation clinical record review, the facility staff failed to by 1/28/19. ensure 1 of 23 residents was free from abuse by 4. DCS and or ADCS will taking property and preventing decisions conduct random resident and or important to the resident (#89). their representative interviews 3 times per week for 4 weeks, then Resident ECO#89 was admitted to the facility on weekly for 3 months, to ensure 3/28/17. Diagnoses included, but were not residents are provided care in a limited to, hemiplegia and hemiparesis following dignified manner and their ability subarachnoid hemorrhage, dysphagia, encounter to exercise their rights is for care of tracheostomy, atherosclerotic heart respected. disease, post-traumatic stress disorder, bipolar Findings will be reviewed by disorder, atherosclerotic heart disease, diabetes QAPI committee monthly and mellitus type I, and chronic obstructive pulmonary Quality Monitoring updated as heart disease. On the quarterly minimum data indicated.

5. Date of Compliance

1/28/2019.

01/23/2019 14:13

CENTERS FOR MEDICAR STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIED (SU)	(X2) MID 7	IPLE CONSTRUCTION		NTED: 01/16/2 ORM APPROV I NO: 0938-03	
	IDENTIFICATION NUMBER	A. BUILDIN	IG	(X3) (	DATE SURVEY	
	496325				OMPLETED	
NAME OF PROVIDER OR SUPPLIER		B. WING			C	
PHEASANT RIDGE NURSING 8	REHAB CENTER		STREET ADDRESS, CITY, STATE ZIP CO 4355 PHEASANT RIDGE ROAD, SW	DE	12/14/2018	
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES		ROANOKE, VA 24014			
	NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION	PREFIX TAG	PROVIDERS PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE		(XI) COMPLETIO DATE	
brief interview for massessed as lacking or behaviors affecting resident's latest safe dated 9/26/18 and in to smoke independe as her own responsition of the transfer reported being genericare received, but incompanies to smoking starting in Fireported having asked progress toward the transfer reported being sent to tracheostomy revision resident said she had notice of the reasons of the reasons of the could not smoke as a significant of the resident windependent smoker. The leave AMA (against mempaperwork indicating the started calling family an called the resident's fatinguardianship situation) is leave and to get her a pustaff requested a ECO (order) and called an aminimum and to sent the same transfer requested a ECO (order) and called an aminimum and the resident and to get her a pustaff requested a ECO (order) and called an aminimum and the started calling family and called an aminimum and the same transfer requested a ECO (order) and called an aminimum and transfer requested a ECO (order) and called an aminimum and transfer requested a ECO (order) and called an aminimum and transfer requested a ECO (order) and called an aminimum and transfer requested a ECO (order) and called an aminimum and transfer requested a ECO (order) and called an aminimum and transfer requested a ECO (order) and called an aminimum and transfer requested a ECO (order) and called an aminimum and transfer requested a ECO (order) and called an aminimum and transfer resident and transfer residen	h assessment reference date ident scored 15/15 on the ental status and was a signs of delirium, psychosis, ig self or others. The is smoking assessment was adicated the resident was able ntly. The resident was acting ble party.  In 12/13/18, the resident ally content with physical dicated a desire to transfer to be the planned ban on abruary 2019. The resident diseveral times about the hospital for the month before. The been given no written or transfer to the hospital.  In teveled that on 11/2/18, a resident's cigarettes. The viold the resident she afety concern. The assessment from 9/23/28 was safe as an he resident requested to dical advice), signed at was her intent, and diriends for a ride. Staff feer (this was not a little to the total total to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital on the said not to let her evidence to the hospital of the said not to let her evidence to the hospital of the said not to let her evidence to the hospital of the said not to let her evidence to the hospital of the said not to let her evidence to the hospital of the said not to let her evidence to the hospital of the said not to let her evidence to the hospital of the said not to let her evidence to the hospital of the said not to let her evidence to the hospital of the said not to let her evidence to the hospital of t	F 60	DEFICIENCY)			
resident to the hospital. 3-2567(02-99) Previous Versions Obsolete	here was no indication				=	

CENTERS FOR MEDICARE & MEDICAID SERVICES  STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDERS UPPLIERICLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIEDICLIA	(X2) MULTIPLE CONSTRUCTION A BUILDING		PRINTED: (FORMA) OMB NO 0	
				0	CC	MPLETED
NAME OF	PROVIDER OR SUPPLIER	495325	B. WING_	B WING		С
	NT RIDGE NURSING & R	EHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4365 PHEASANT RIDGE ROAD, SW		2/14/2018
(X4) ID PREFIX TAG	LEAGUE DEFIGENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORR  [EACH CORRECTIVE ACTION SI  CROSS-REFERENCED TO THE AP  DEFICIENCY]	1014 0 0-	(X5) COMPLETE DATE
F 607	the resident's physicia	an was notified of the	F 60			
, , , , , , , , , , , , , , , , , , ,	resident was exhibiting her to stay at the hosp Services could talk to resident's safety from the note included in history called the police and retrying to blow up the before declined to remonster interviewing the resident I hurse had).  A nurse's note dated 11 esident asked to smoke pive her cigarettes, say old she couldn't take of aturation levels might of the said to smoke the couldn't take of a turation levels might of the couldn't take of a turation levels might of the said to smoke the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of a turation levels might of the couldn't take of t	facility staff. The hospital what nursing home staff eported Resident #89 was wilding and kill residents, ove her from the building esident and her room mate had not said that, but the way and the nurse refused to and the nurse refused to any that the resident was a finer oxygen because				
SI cl for or as significant was add	or clinical services the continuous and the continuous services the continuous the policy for gned out AMA. The fact at event. No one acknows sent for ECO after significant attentions that the policy for ECO after significant and the policy for ECO after significant and the policy for ECO after significant for ECO after signific	ing on 12/13/18, the administrator, director of orporate regional director oncern with the situation record. The surveyor sllowed when a resident lility had no procedure for owledged the resident he signed out AMA. The esident didn't have any about the resident's				

PRINTED: 01/16/2019

# 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 8. WING 495325 12/14/2018 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 PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 607 Continued From page 47 F 607 not being allowed to smoke when she wanted to do so. The surveyor informed the DCS that lack F609- Reporting of Alleged of management awareness of the situation **Violations** indicated that facility policies failed to protect the resident. 1. Facility submitted a FRI for F 609 Reporting of Alleged Violations F 609 Resident #5 on 12/11/2018 CFR(s): 483.12(c)(1)(4) SS=D Facility submitted a FRI (Facility Reportable incident) for §483.12(c) In response to allegations of abuse. neglect, exploitation, or mistreatment, the facility Resident #89 on 1/21/2019 must: 2. On 1/22/2019 the Clinical Quality Specialist (CQS) §483.12(c)(1) Ensure that all alleged violations completed quality review of involving abuse, neglect, exploitation or facility reportable incidents in the mistreatment, including injuries of unknown last 30 days to ensure incidents source and misappropriation of resident property, were reported in a timely are reported immediately, but not later than 2 manner. On 1/22/19 the RDCS hours after the allegation is made, if the events and UMs completed quality that cause the allegation involve abuse or result in review/interviews of all current serious bodily injury, or not later than 24 hours if residents (cognitively impaired the events that cause the allegation do not involve residents' representatives were abuse and do not result in serious bodily injury, to contacted) to ensure residents the administrator of the facility and to other are free from abuse and neglect. officials (including to the State Survey Agency and Follow up based on findings. adult protective services where state law provides for jurisdiction in long-term care facilities) in 3. On 1/21/2019 the RDCS accordance with State law through established provided 1 on 1 re-education to procedures. the facility ED on the federal regulations and guidelines for §483.12(c)(4) Report the results of all reporting Abuse and Neglect and investigations to the administrator or his or her the Elder Justice Act. The designated representative and to other officials in ADCS and RDCS will provide reaccordance with State law, including to the State education to facility staff on the Survey Agency, within 5 working days of the

by:

incident, and if the alleged violation is verified

appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced federal regulations and

guidelines for reporting Abuse

and Neglect and the Elder Justice Act by 1/28/19.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			DATE SURVEY COMPLETED
		495325	B. WING			12/14/2018
	PROVIDER OR SUPPLIER	& REHAB CENTER	4355	EET ADDRESS, CITY, STATE, ZIP CO PHEASANT RIDGE ROAD, SW NOKE, VA 24014	ODE	12/ 14/2016
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCE	ON SHOULD BE HE APPROPRIATE	(K5) COMPLETION DATE
F 609	clinical record revireview, the facility of abuse within a line Residents in the sident # 89.  The findings included the facility start is the facility start visitor to Resident # 5.  Resident # 5 was admitted to the facility were not limited.	at interview, staff interview, lew, and facility document staff failed to report allegations timely manner for 2 of 23 urvey sample, Resident # 5 and ded:  If failed to report allegations of abuse within a timely manner as 40-year-old-male who was cility on 4/20/18, with a of 8/27/18. Diagnoses included do to, hypertension, major er, anxiety disorder, and benign	F 609	4. ED and or DCS random quality more Grievances/Concernation incidents/allegation reported timely, 3 to week for 4 weeks, for 3 months. DCS ADCS will conduct resident and or the representative interper week for 4 week weekly for 3 month residents are free for the Neglect and Exploid Findings to be representative monthly as indicated. Qualificated. Qualificated. Graphicated for the Neglect and Exploid Findings.  5. Date of Complicated 1/28/2019.	nitoring of rns to ensure is are imes per then weekly and or random ir rviews 3 times eks, then es, to ensure from Abuse, itation. orted to QAPI and updated ty monitoring based on	
	on 12/13/18 at 10: (minimum data sei was a quarterly as (assessment refer of the MDS assess Section C0500, the Resident # 5 had a mental status) sco indicated that Resi intact.  On 12/13/18 at 7.5 Resident # 5's roo interview. During ti reported to the sur alleged perpetrato "Got in my face, ye	for Resident # 5 was reviewed 41 am. The most recent MDS t) assessment for Resident # 5 sessment with an ARD ence date) of 9/3/18. Section C ses cognitive patterns. In e facility staff documented that a BIMS (brief interview for re of 15 out of 15, which ident # 15 was cognitively  55 am, the surveyor was in m conducting a Resident he interview Resident # 5 reyor that on 12/8/18, the r (his former roommate's sister) alled at me and blocked the aldn't let me use the bathroom."				

### PRINTED: 01/16/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495325 R WING 12/14/2018 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 (XS) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION! TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 609 Continued From page 49 F 609 Resident # 5 stated that he was going back to his room to get hot chocolate for a group of Residents that he was socializing with and to use the bathroom because he is on a bladder-retraining program. Resident # 5 stated that when he got to his room, the alleged perpetrator asked him "What's going on with you and (Resident's name withheld)? Resident #5 stated that he told the alleged perpetrator nothing was going on and that he did not know what she was talking about. Resident # 5 then stated that the alleged perpetrator got in his face and began to yell at him stating that Resident # 5's former roommate told the alleged perpetrator that Resident # 5 had been treating him differently and that Resident # 5 was going to tell her what was going on. Resident # 5 stated that he told the alleged perpetrator that he needed to use the bathroom. Resident # 5 stated that the alleged perpetrator stood in front of the bathroom door and told him he was not going to use the bathroom until she was done with him. Resident # 5 stated that he told the alleged perpetrator, "This is our room and you are a guest here." "You need to get out of here." Resident # 5 stated that the alleged perpetrator continued to block the door to the bathroom. Resident # 5 stated that he began to urinate on himself. Resident # 5 stated. "I felt awful, I cried." Resident # 5 stated that the alleged perpetrator finally allowed him to go into the bathroom after he had urinated on himself and stated to him, "I am going to be right here when you get out because you are going to tell me what's going on with you and (Resident's name withheld). Resident # 5 stated that the alleged perpetrator continued to yell at him through the door while he was in the bathroom.

Resident # 5 stated that he called the police.
Resident # 5 stated that the police came and

		AND HUMAN SERVICES  & MEDICAID SERVICES			FO	ED: 01/16/2019 RM APPROVED NO: 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		TE SURVEY MPLETED	
		495325	B, WNG			С	
NAME OF F	ROYDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/14/2018	
PHEASA	NT RIDGE NURSING 8	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COP (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 609	police made her le be up to "them" (the facility. Reside same evening other roommate came in Resident # 5 stated family members sa saying mean thing something happen withheld) their assistated, "They made crap." Resident # came back in here 5 stated that the da alleged perpetrator sitting at a square their room and "jer Resident # 5 stated why the alleged perpetrator is their room and "jer Resident # 5 stated why the alleged perpetrator is their room and "jer Resident # 5 stated why the facility Resident # 5 stated in the facility executive diall handled." Reside a different room. Resident # 1 stated that he spoked irector on Monday director told Reside a different room. Resident # 5 then she did to me. Resident # 5 then she did to me. Resident # 5 then should be sh	age 50 Resident # 5 stated that the ave that evening but it would be facility) if they bar her from ant # 5 stated that later that ar family members of his former and "intimidated" him. It is that his former roommate's at on the other side of the room is to him and stated, "If is to (Resident's name as is mine " Resident # 5 are feel like I was a piece of 5 stated the next day "They like it was nothing." Resident # ay after the incident that the in approached him as he was table in the hallway outside of ked the table away from me." It is that he was told she has a noily member. Resident # 5 are with the facility executive and the fac	F 609				

PRINTED: 01/16/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD			TE SURVEY MPLETED
NAME OF F	DOMEST OF COMPANS	495325	B. WING			2/14/2018
	ROVIDER OR SUPPLIER	REHAB CENTER		STREET ADDRESS, CITY, STATE, 2 4355 PHEASANT RIDGE ROAD, ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 609	Continued From pag		F	609		
	became tearful. Res happens when she a	It this time that Resident # 5 ident # 5 stated, "What attacks somebody else?" Are people in another room and				2
	unit manager RN # 1 allegations of abuse Unit manager RN # 1 only know that the fa	am, the surveyor interviewed (registered nurse) about the reported by Resident # 5. I stated, "I am aware briefly, I mily was acting inappropriate				
	were involved.  On 12/13/18 at 10:00 interviewed the facilit	ly executive director about				
	The facility executive Saturday night saying the facility saying the [Resident # 5] and [R roommate's sister." ' (referring to Resident sisters) come in Monand Resident # 5." Ti	"We had the daughters I # 5's former roommate's day and we spoke to them the facility executive director				
	of investigating the in reported incident) was executive director the had been known to list admit to lying and say facility executive dire- nurse that called him incident had issues w	or that he was in the process acident and that a FRI (facility as submitted. The facility en stated that Resident # 5 e and then come back and ying that he was sorry. The ctor also stated that the at home to report the rith Resident # 5's former	~			
	report the incident sh have them barred fro executive director sta	of called him that night to e asked if he was going to m the facility. The facility ted, I don't really have any no eye witnesses. I will be				

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

Event ID: Y3F111

Facility ID: VA0298

If continuation sheet Page 52 of 187



FORM APPROVED

#### PRINTED: 01/16/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED (X2) MULTIPLE CONSTRUCTION A. BUILDING\_

С 405225 B WING

	495325	B. WING_		12/14/2018		
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24914				
REFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CO	ER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BE ERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETI DATE	
see where any abuse executive director property of a "Facility Reported documentation that it to," Report date 12-1 Incident type Allegation as Misappropriation included but was not"7. Reporting/Resp. Any employee or conwitnesses or has known an allegation of abuse mistreatment, including source and misapproto a resident, is oblighinformation immedia after the allegation is cause the allegation serious bodily injury, the events that cause involve abuse and doinjury, to the Administiaccordance with State Executive Director, at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the executive Director at the exe	ation by Monday but I can't a occurred." The facility evided the surveyor with a sported Incident (FRI)" form. It incident form contained included but was not limited I-18, Incident date 12-8-18 on of abuse/mistreat"  "Abuse, Neglect, Exploitation contained documentation that limited to, onse itracted service provider who wledge of an act of abuse or e, neglect, exploitation or ing injuries of unknown priation of resident property, ated to report such ely, but no later than 2 hours if a the allegation do not ont result in serious bodily trator and to other officials in e law. In the absence of the not result in serious bodily trator and to other officials in e law. In the absence of the not abuse is reported, the sthe abuse coordinator, is	F6	09			

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/16/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			222, 180 200		The section of the se	O. 0938-039
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495325	B. WING		12	C 2/14/2018
NAME OF P	PROVIDER OR SUPPLIER		- 41	STREET ADDRESS, CITY, STATE, ZIP CODE	Telegraph (St. Albe	1146010
PHEASAN	PHEASANT RIDGE NURSING & REHAB CENTER			4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 609	Continued From p	age 53	F 60	9		
	provided to the sur conference on 12/2. For Resident #8 the agency that the rights and property indicated by nursir Resident #89 was 3/28/17. Diagnose limited to, hemiple subarachnoid hem for care of tracheodisease, post-traur disorder, atherosch mellitus type I, and heart disease. On set assessment wit 10/10/2018, the resident's latest sa dated 9/26/18 and to smoke independ as her own response During an interview reported being gen care received, but it	admitted to the facility on estimated to the end of the facility on the matic stress disorder, bipolar ferotic heart disease, diabetes of chronic obstructive pulmonary the quarterly minimum data the assessment reference date sident scored 15/15 on the mental status and was ag signs of delirium, psychosis, and self or others. The feromorphism of the smoking assessment was indicated the resident was acting sible party.  In on 12/13/18, the resident teally content with physical indicated a desire to transfer to				
	another facility prio smoking starting in reported having asl progress toward the timeline for the tran reported being sen- tracheostomy revis	or to the planned ban on February 2019. The resident ked several times about e transfer, but having no nsfer. The resident also				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE O	CONSTRUCTION	(X3) D/	ATE SURVEY MPLETED	
		496325	B WNG			C	
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  4385 PHEASANT RIDGE ROAD, SW  ROANOKE, VA 24014				
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X6) COMPLETION CATE	
F 609	Clinical record rev staff member took CNA and nurse on could not smoke a resident's smoking indicated the reside independent smok leave AMA (agains paperwork indicati started calling fam called the resident guardianship situal leave and to get he Staff requested a lorder) and called a resident to the host the resident's physituation or that the requiring hospitalize. In the hospital dispsychiatrist assess resident was exhibited to stay at the hospital dispsychiatrist assess resident's safety fronte included in hicalled the police at trying to blow up the Police declined to after interviewing to who said the resident's had).	iew reveled that on 11/2/18, a the resident's cigarettes. The duty told the resident she is a safety concern. The gassessment from 9/23/28 tent was safe as an ter. The resident requested to st medical advice), signed ing that was her intent, and ify and friends for a ride. Staff it's father (this was not a attion) and he said not to let her er a psychiatric evaluation. ECO (emergency commitment an ambulance to take the spital. There was no indication sician was notified of the ere was a change of condition	F 609				
	resident reported t	to staff that she felt staff was					

# DEPARTMENT OF HEALTH AND HUMAN SERVICES

		AND HUMAN SERVICES				ED: 01/16/2019 RM APPROVED
The second second second	THE RESIDENCE OF THE PROPERTY OF THE PARTY O	& MEDICAID SERVICES				NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DA	ITE SURVEY MPLETED
		495325	B. WING			C
NAME OF	PROVIDER OR SUPPLIER		V	STREET ADDRESS, CITY, STATE, ZIP CODE		2/14/2018
PHEASA	NT RIDGE NURSING &	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 610	paperwork indicating staff called police to unclear whether the remove the resider but that she would the person of her couldn't take off her couldn't take off her levels might drop as sedative medication.  During a summary surveyor reported to clinical (DCS) and for clinical services on 11/2 described in asked about the posigned out AMA. The that event. No one was sent for ECO as administrator stated place to go. When cigarettes being correctled when the resident stated of the surveyor of management awaindicated that facility resident. The facility resident. The facility allegations of staff appropriate agencies	ing intention to leave before of deal with the situation (it was a police were supposed to be to prevent her from leaving not be allowed to leave with holice). A nurse's note dated that the resident asked to se refused to give her that the resident was told she recygen because saturation and the resident was given a ministead.  Indeeding on 12/13/18, the of the administrator, director of the corporate regional director the concern with the situation on the record. The surveyor licy followed when a resident fier she signed out AMA. The lithe resident didn't have any asked about the resident's infiscated and the police being ident signed out AMA, the is unaware of the resident ever to smoke when she wanted to informed the DCS that lack areness of the situation of policies failed to protect the y failed to report the staff's and the resident's obuse of rights to the	F 603			
SS=D	CFR(s): 483.12(c)(2		F 010			

		AND HUMAN SERVICES  & MEDICAID SERVICES			FO	ED: 01/16/2019 RM APPROVED NO: 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		495325	B. WING			C 2/14/2018
NAME OF P	ROVIDER OR SUPPLIER	5. 20 STAND NEW	ST	REET ADDRESS, CITY, STATE, ZIP CODE		21 14/2010
PHEASAN	T RIDGE NURSING	REHAB CENTER		55 PHEASANT RIDGE ROAD, SW ANOKE, VA 24014		E No.
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 610	§483.12(c) In resp neglect, exploitation must:  §483.12(c)(2) Have violations are those select, exploitation investigation is in particular select, exploitation investigation is in particular select, exploitation investigation is in particular selection in particular se	e evidence that all alleged bughly investigated.  vent further potential abuse, on, or mistreatment while the progress.  out the results of all he administrator or his or her entative and to other officials in tate law, including to the State thin 5 working days of the alleged violation is venfied tive action must be taken.  NT is not met as evidenced tinterview, eview, and clinical record staff failed to thoroughly ons of abuse for 1 of 23 urvey sample, Resident # 5,	F 610	Investigate/Prevent/Corre Alleged Violations  1. Facility investigation rela Resident #5's allegation was completed by ED on 12/17/Resident #5 interviewed on 1/17/2019 by RDCS with fa SSD present. Resident fees afe at the facility and feels staff treats them with dignity respect.  2. CQS completed quality review of facility reportable incidents in the last 30 days 1/22/201 to ensure incidents thoroughly investigated. Four based on findings.  3. On 1/21/2019 the RDCS provided 1 on 1 re-education the facility ED on the federal regulations and guidelines for reporting Abuse and Neglect the Elder Justice Act. The ADCS and RDCS will provided ucation to facility staff on the federal regulations and guidelines for reporting Abuse and Neglect and the Elder Justice Act by 1/28/19.	ted to is 2018.  cility is that and on a are allow in to or a and and e re-he	

	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING 495325 B. WING		со	TE SURVEY MPLETED			
	PHEASANT RIDGE NURSING & REHAB CENTER  (XALID SLIMMARY STATEMENT OF DESIGNATIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE E APPROPRIATE	COMPLETION DATE	
F 610	and have access to Residents and the completed.  Resident # 5 was a admitted to the face readmission date of but were not limited depressive disorder prostatic hyperplass.  The clinical record on 12/13/18 at 10-4 (minimum data set was a quarterly assessment refere of the MDS assess Section C0500, the Resident # 5 had a mental status) scor indicated that Resident at the plan of care for and revised on 11/3 documented a focus "Resident # 5 is indicated."  The plan of care for and revised on 11/3 documented a focus "Resident # 5 is indicated that Resident # 5 is indicated that Resident # 5 is indicated that Resident # 5 is indicated to anxiet traumatic stress disquadriplegia, pain, choice, self acts in computer, phone, since music, socializes we resident # 5 goes to Interventions including "Report resident c/c discomfort, breathir	o Resident # 5 and other investigation had not been a 40-year-old-male who was ellity on 4/20/18, with a of 8/27/18. Diagnoses included d to, hypertension, major er, anxiety disorder, and benign	F 610	4. ED and or DCS w random quality monit Grievances/Concerns incidents/allegations reported timely, 3 tim week for 4 weeks, the for 3 months. DCS a ADCS will conduct raresident and or their representative interviper week for 4 weeks weekly for 3 months, residents are free fron Neglect and Exploitat Findings to be report committee monthly a as indicated. Quality schedule modified bafindings.  5. Date of Compliant 1/28/2019.	oring of a to ensure are es per en weekly end or endom ews 3 times to ensure en Abuse, ion. ed to QAPI end updated monitoring esed on		

		ND HUMAN SERVICES MEDICAID SERVICES		45 10		FO	ED: 01/16/2019 RM APPROVED NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILO		DNSTRUCTION	(X3) DA	TE SURVEY MPLETED
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NAME OF P	ROVIDER OR SUPPLIER			STR	EET AODRESS, CITY, STATE, ZIP CODE	11	2/14/2018
PHEASA	NT RIDGE NURSING & R	REHAB CENTER		4355	S PHEASANT RIDGE ROAD, SW ANOKE, VA 24014		100
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F 610	needed)." The survey of care for Resident are untrue.  On 12/13/18 at 7:55: Resident # 5's room interview. During the reported to the survey alleged perpetrator (foot in my face, yelle bathroom and would resident # 5 stated the toom to get hot chock Residents that he was the bathroom becaus bladder-retraining profit that when he got to he perpetrator asked him and (Resident's name stated that he told the was going on and that was talking about. Resident # 5 had been that Resident # 5 had been that Resident # 5 was going on. Resident # alleged perpetrator the bathroom. Resident # perpetrator stood in front told him he was rebathroom until she was 5 stated that he told this our room and you as	es to the nurse prn (as yor reviewed the entire plan # 5 and did not see an # 5 made statements that am, the surveyor was in conducting a Resident interview Resident # 5 yor that on 12/8/18, the his former roommate's sister) and at me and blocked the hit let me use the bathroom." That he was going back to his blate for a group of a socializing with and to use he he is on a logram. Resident # 5 stated his room, the alleged his "What's going on with you he withheld)? Resident # 5 he alleged perpetrator nothing at he did not know what she he sident # 5 then stated that for got in his face and began hat Resident # 5's former he ged perpetrator that an treating him differently and a going to tell her what was 5 stated that he told the at he needed to use the 15 stated that the alleged cont of the bathroom door	F	510			

### PRINTED: 01/16/2019 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: A. BUILDING COMPLETED 495325 B. WING 12/14/2018 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 ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION DATE PREFIX PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 610 Continued From page 59 F 610 the bathroom. Resident # 5 stated that he began to urinate on himself. Resident # 5 stated. "I felt awful, I cried." Resident # 5 stated that the alleged perpetrator finally allowed him to go into the bathroom after he had urinated on himself and stated to him, "I am going to be right here when you get out because you are going to tell me what's going on with you and (Resident's name withheld). Resident # 5 stated that the alleged perpetrator continued to yell at him through the door while he was in the bathroom. Resident # 5 stated that he called the police. Resident # 5 stated that the police came and "She threw a fit." Resident #5 stated that the police made her leave that evening but it would be up to "them" (the facility) if they bar her from the facility. Resident # 5 stated that later that same evening other family members of his former roommate came in and "intimidated" him. Resident # 5 stated that his former roommate's family members sat on the other side of the room saying mean things to him and stated. "If something happens to (Resident's name withheld) their asses is mine." Resident # 5 stated, "They made me feel like I was a piece of crap." Resident # 5 stated the next day "They came back in here like it was nothing." Resident # 5 stated that the day after the incident that the alleged perpetrator approached him as he was sitting at a square table in the hallway outside of their room and "jerked the table away from me." Resident # 5 stated that he asked a staff member why the alleged perpetrator was allowed to come back into the facility after what she did to him. Resident # 5 stated that he was told she has a right to visit her family member. Resident # 5 stated that he spoke with the facility executive director on Monday and the facility executive director told Resident # 5 they would move him to

### PRINTED: 01/16/2019 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 DENTIFICATION NUMBER: COMPLETED A. BUILDING C 495325 B. WING 12/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4386 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 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR USC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 610 | Continued From page 60 F 610 a different room. Resident #5 stated that the facility executive director stated to him, "we got it all handled." Resident # 5 stated that he replied, "It handles the room but it doesn't handle what she did to me." Resident # 5 stated that the facility executive director stated to him. "You let me handle that." "I got 2 days to investigate that." Resident # 5 then stated to the surveyor, "It does not make any sense how she treated me." "It made me feel like I was worthless, and they let her come back in here like it was nothing after the law put her out." "I thought with me being a patient here I would be protected more." The surveyor observed at this time that Resident #5 became tearful. Resident # 5 stated, "What happens when she attacks somebody else?" Are you just going to put people in another room and say that settles that." On 12/13/18 at 9:58 am, the surveyor interviewed unit manager RN # 1 (registered nurse) about the allegations of abuse reported by Resident # 5. Unit manager RN # 1 stated, "I am aware briefly, I only know that the family was acting inappropriate and threatened him (Resident #5) and the police were involved." On 12/13/18 at 10:00 am, the surveyor interviewed the facility executive director about the allegations of abuse reported by Resident #5. The facility executive director stated, "I was called Saturday night saying the police had to come to the facility saying there was a yelling match with Resident # 5 and the alleged perpetrator. We had the daughters (the alleged perpetrator and her sister) come in Monday and we spoke to them and Resident # 5." The facility executive director informed the surveyor that he was in the

process of investigating the incident and that a

		AND HUMAN SERVICES  & MEDICAID SERVICES				FO	ED: 01/16/2019 RM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		STRUCTION	(X3) OA	NO. 0938-0391 TE SURVEY MPLETED
_93.		495325	B. WING			С	
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F 610	facility executive d Resident # 5 had t come back and ad was sorry. The fac stated that the nur- report the incident perpetrator and he night to report the going to have them facility executive di have any evidence witnesses. I will be Monday but I can't occurred."	age 61 ad incident) was submitted. The irector then stated that been known to lie and then mit to lying and saying that he lility executive director also se that called him at home to had issues with the alleged or family and called him that incident. She asked if he was a barred from the facility. The rector stated. "I don't really. There were no eye or finishing this investigation by see where any abuse	F6	10			
	a progress note do for Resident # 5 on progress note was on medi part b total daily living) incontir walker for ambulati roommate family of his face refusing to police was called dinasty and inapprophis face."  On 12/13/18 at 10:2 interviewed LPN # about the allegation Resident # 5. The s was working and re Resident # 5 on 12/The surveyor asked an incident that occ perpetrator and Resident Reside	cumented in the clinical record 12/9/18 at 3:29 pm. The documented as "Resident is I care with adls (activities of lent of bowel and bladder uses on upset due to incident with them yelling and getting into let him use the bathroom ue to roommate family being riate by yelling and getting in					

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

Event ID: Y3F111

Facility ID: VA0208

If continuation sheet Page 62 of 187



STA EMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: A BUILDING		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		496325	B. WING_		12/14/2018	
	ROVIDER OR SUPPLIER T RIDGE NURSING &	REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4366 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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F 610	Residents. LPN # 1 coming out to go to chocolate from his soon as Resident # alleged perpetrator and pinned him aga that she heard the Resident # 5, "You" I'm not done with y # 1 if she saw the a Resident # 5 again "No but I heard it." Resident # 5 tell th know what you are that she heard the Resident # 5 again until I am done with Resident # 5 came asked her to call th called the police ar perpetrator was ye # 1 stated, "This w 78's husband (Res LPN # 1 stated tha stated to her, "This Something needs that the police had after she made a s asked LPN # 1 if s anyone. LPN # 1 anything about wh want APS (adult pr here."  On 12/13/18 at 10	ing 62 Ing games with the other I stated that Resident # 5 was I the bathroom and get the hot I room. LPN # 1 stated that as I 5 went in the room the I started yelling at Resident # 5 I sinst the wall. LPN # 1 stated I alleged perpetrator state to I re not going to the bathroom. I ou. "The surveyor asked LPN I stated that she heard I e alleged perpetrator pin I st the wall. LPN # 1 stated, I LPN # 1 stated that she heard I e alleged perpetrator "I don't I talking about." LPN # 1 stated I alleged perpetrator tell I "You can't use the bathroom I you." LPN # 1 stated that I out into the hallway crying and I e police. LPN # 1 stated, "We I stated the alleged I sting at the police officer." LPN I as witnessed by Resident # I dent # 78 was not sampled) I Resident # 78's husband I happens every night. I be done." LPN # 1 stated I the alleged perpetrator leave I cene with them. Surveyor I he reported this information to I stated, "They never do I at we tell them. They don't I otective services) to come in I sam, the surveyor reviewed I stated the Resident #78 (not	F 6	10		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED			
		495325				/14/2018	
	ROVIDER OR SUPPLIER	REHAB CENTER		STREET ADDRESS, CITY, STATE, Z-P CODE  4356 PHEASANT RIDGE ROAD, SW  ROANOKE, VA 24014			
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F 610	witnessed the even documentation in the non 12/8/18 at 10.28 documented as "Rebeing talked to nasifamily and was told his wife will not be state was very rudiwhere he felt uneas bothered him and his sister was very rudiwhere he felt uneas bothered him and his staff after incider bullied by family he commasion (comm was yelling at room happened every nignothing felt very uninothing fel	# 1 reported her husband Its. The surveyor observed The progress notes documented The progress note was resident family member was try by (room number withheld) This is the worst facility and taken care of because we are treat the residents and son to the to staff and resident family to say and there comments the could not make a statement to because he was being Thange his statement to loud otion) after he told police she timate and in his face and this other to not wanting to say	F 610				

PRINTED: 01/16/2019 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

From:Pheasant Ridge Nursing & Rehab 5407255735

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		ercinate (Timita)	OMB N	IO. 0938-0391	
STATEMENT	DF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING B. WING	CONSTRUCTION	cos	(X3) DATE SURVEY COMPLETED  C 12/14/2018	
MANE OF D	ROVIDER OR SUPPLIER		SI	REET ADDRESS, CITY, STATE, ZIP CO			
	IT RIDGE NURSING	REHAB CENTER	43	955 PHEASANT RIDGE ROAD, SW OANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF O (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(A5) COMPLETION DATE	
F 610	was crying and up Resident # 5 had bladder training be CNA # 2 stated the was outside their cand stated that shitell Resident # 78 they will treat your told the facility excon Monday and himestigating their investigating their conversation that investigation on National where any abuse director agreed to presence of the sithe facility execute vidence he had investigation.  On 12/13/18 at 6: director provided handwritten notes notepad. The notematical training in the room if anything happe withheld) and Reloud. This is my find the room is my thing is my first training be content of the sith facility executes notepad. The notematical facility executes the facility executes in the room if anything happe withheld) and Reloud. This is my first site was suited to the side of the si	# 2 also stated Resident # 5 set. CNA # 2 stated that been working really hard trying ecause he wants to go home. at another resident's husband from and heard the commotion the heard the alleged perpetrator to shusband "If you say anything the wife bad." CNA # 2 stated, "I ecutive director what happened the stated that he was	F 610				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495325  B. WING		PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED  C 12/14/2018
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	/EACH DEFIC	RY STATEMENT OF DEFICIENCIES RENCY MUST BE PRECEDED BY FULL Y OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 610	to know who initi what started it. I. husband's name 12/10/18 Reside room alleged perpetrator ask is between you and Resident # 5 sais want to know who (Resident name games with (Resident name withheld) not (Resident name withheld) not (Resident name am not doing an withheld) Get or bathroom. Alleged perpetra Resident # 5 this of here you are Oh know this is he was here be you. Resident # and said get out bathroom. Alleged be out here wait me she stepped bathroom. Resident # and said get out bathroom. Resident # stepped bathroom. Resident was here telling going to talk to bathroom a longoing to get his the bathroom of the stepped started in the pathroom of the bathroom of the stepped started in the bathroom of the stepped started in the bathroom of the stepped started in the bathroom of the stepped started in the bathroom of the stepped started in the bathroom of the stepped started in the bathroom of the stepped started in the bathroom of the stepped started in the stepped started in the stepped started in the	page 65 ated the police call and why. PN # 1 asked (Resident # 78 withheld) to write a statement.  Int # 5- Resident # 5 went into the repetrator waiting on him. Alleged is there something wrong did (Resident name withheld) did nothing. Alleged perpetrator-lay you stopped paying attention to withheld). You are not playing sident name withheld) Resident # 18 way your moment and (Resident have been treating ment and I am ame withheld) caregiver. Alleged no you are not going to treat withheld) this way. Resident # 5 I sything to (Resident name ut of the way I've got to go to the ed perpetrator stepped in front of u are going to talk to me. Resident e got to use the bathroom. Alter you can wait a minute. It is is our room you need to get out just a guest. Alleged perpetrator-(Resident name withheld) room, fore you and he will be here after the formy way I have to use the ged perpetrator-Go head but I will sting and you are going to talk to do out of the way from blocking the ident # 5 was in the bathroom he ging (Resident name withheld) He is me. Resident waited in the get time he heard her say she was a food. Resident # 5 came out of when she left. Resident # 5 heard waving but when I get back he is	F		

#### PRINTED: 01/16/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 495325 B. WING 12/14/2018 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 ID (XS) PREFIX (EACH CORRECTIVE ACTION SHOULD BE EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 610 Continued From page 66 F 610 going to deal with me. Resident # 5 called the police. He went to the family room until they got here. Resident # 5 said he felt she attacked him and it is not right. 12/10/18 Call (Resident husband's name withheld) per facility executive director. Called at 4:14 om (Telephone number withheld) Nurse asked him about that he said he was one door out in the hall, he didn't see or hear anything if something went on it was in the room. Why happened? We are trying to investigate if something happened. He saw police. 12/10/18 Resident # 5- meeting with facility executive director and Resident # 5. Resident # 5 wants alleged perpetrator not to be able to come back in the building. The facility executive director offered Resident #5 to move to room (room number withheld) until another semi-private room comes available. Resident # 5 agreed. But said he does not want alleged perpetrator to come back into the building." The surveyor observed that there were no statements from LPN # 1 or CNA # 2 who both stated that they spoke with the facility executive director regarding the allegation of abuse reported by Resident # 5.

visitor log on 12/13/18.

On 12/13/18 at 6:10 pm, the surveyor reviewed the visitor log kept in the front of the building. The surveyor observed that no visitors had signed the

On 12/13/18 at 6:15 pm, 2 surveyors toured the 600 hall and 700 hall of the facility. The two surveyors observed that Resident # 5 was in his room in the bathroom. The two surveyors also

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		C	(X3) DATE SURVEY COMPLETED	
The state of	4100	496325	B. WING_	CONTRACTOR OF THE PROPERTY OF		12/14/2018	
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4365 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 C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO THE DEFICIENCY	E ACTION SHOULD BE COM O TO THE APPROPRIATE		
F 610	grandson visiting at hallway outside of observed sitting at outside of the reside the room directly be perpetrator was of observed a reside hallway. The visite 78's husband that by the alleged per On 12/14/18 at 8:3 Resident # 5 again abuse. The survey any contact with thincident that occur stated, "That happy they came back in the table from und stated, "I went and (registered nurse) she was in here as aid it's his family # 5 stated, "I have surveyor asked Ricontact with the all moved to his new to be honest I have meals and therapy Resident # 5 if stithat he normally does. Reto run into them."	ted perpetrator, her mother, and with their loved one in the the resident's room. They were a square table that was dent's room playing a game. In peside where the alleged observed, the 2 surveyors int and a visitor sitting in the per was identified as Resident # facility staff stated was bullied	F6				

PRINTED: 01/16/2019

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (XI) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING \_ C 12/14/2018 **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 (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETION (EACH CORRECTIVE ACTION SHOULD BE (X4) (D PREFIX EACH DEFICIENCY MUST BE PRECEDED BY FULL DATE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 610 F 610 | Continued From page 68 asked the facility social services manager if she was aware of the allegations of abuse reported by Resident # 5. The facility social services manager stated, "Yes I found out Monday." The facility social services manager stated that the alleged perpetrator called her on Monday morning and that is how she found out about the incident. The surveyor asked the facility social services manager what the alleged perpetrator reported to her. The facility social services manager stated that the alleged perpetrator stated that the police were called for her on Saturday and she was escorted out of the building. The facility social service manager stated that the alleged perpetrator told her that she asked Resident # 5 what happened between him and (Resident's name withheld) and the alleged perpetrator stated that Resident # 5 started talking loudly and that Resident # 5 attacked her verbally said that she didn't know what happened. The facility social services manager stated that during her telephone call with the alleged perpetrator, the alleged perpetrator stated that her brother

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(Resident's name withheld) told her that for the past two weeks Resident # 5 has been treating him differently. The surveyor asked the facility social services manager if talking loudly and verbally attacking someone is a behavior that Resident # 5 would normally display. The facility social services manager stated, "No he would not. Resident # 5 is usually very soft spoken." The surveyor asked the facility social services manager if she interviewed LPN # 1. The facility social services manager stated, "I think she wrote a statement." The surveyor asked the facility social services manager if she interviewed Resident # 78's husband that the facility staff members reported witnessed the incident. The

facility social services manager stated, "I called

Facility ID: VA0208

If continuation sheet Page 69 of 187

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 496325	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C 12/14/2018	
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE  4356 PHEASANT RIDGE ROAD, SW  ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFU TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 610	(Resident # 78 hus said he didn't hear anything." The sun services manager The facility social she and the facility Resident # 5 on M sure he felt safe. The manager stated the different room on that had occurred facility social service Resident # 5 said perpetrator to come executive director investigation. The facility social services from a noter surveyor identified services manager photocopied notes director had present had been obtaillegation of abuse Resident # 5.  On 12/14/18 at 9:2 the unit manager RN is with Resident # 5 about the alleged into the building. Ushe did speak with why was the allegallowed in the build Unit manager RN is with manager RN is with why was the allegallowed in the build Unit manager RN is with m	age 69 aband's name withheld) and he anything and didn't see veyor asked the facility social if she interviewed Resident # 5. services manager stated that executive director met with onday and wanted to make the facility social services at Resident # 5 was moved to a Monday following the incident on the previous Saturday. The cas manager stated that that he didn't want the alleged e back and the facility said we had to complete the surveyor observed that the ces manager was reading and during the interview. The the notes that the social had obtained were the same that the facility executive inted previously as the evidence and in the investigation of the ethat had been Reported by  23 am, the surveyor interviewed RN # 1. The surveyor asked the # 1 if she had a conversation where he expressed concerns perpetrator being allowed back Unit manager RN # 1 stated that in Resident # 5 and he asked ed perpetrator still being ding after what she did to him. # 1 stated that she told the facility executive director	F	510		
	was aware and in	vestigating the situation but she illeged perpetrator that she		SESTIMATE S = =		

PRINTED: 01/16/2019

FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES

From:Pheasant Ridge Nursing & Rehab 5407255735

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	•		OMB I	NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED C 12/14/2018	
	ROMDER OR SUPPLIER	REHAB CENTER	4	TREET ADDRESS, CITY, STATE, ZIP CODE 1365 PHEASANT RIDGE ROAD, SW ROANOKE, VA. 24014		
(X4) ID PREFIX TAG	(EACH DEFICE		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		SHOULD BE	(XS) COMPLETION DATE
F 610	Continued From page 70 could not visit her loved one. Unit manager RN # 1 told the surveyor that the facility did 15-minute safety checks on Resident # 5 to ensure he was safe. The surveyor requested a copy of the safety checks.  On 12/14/18 at 9:39 am, the surveyor interviewed the director of clinical services regarding the allegation of abuse reported by Resident # 5 on 12/8/18. The director of nursing stated, "It happened on the weekend. I didn't do any of the interviews." The director of clinical services stated that the facility executive director and the facility social services manager did the interviews. The surveyor asked the director of clinical services if she was aware that Resident # 5 reported abuse. The director of clinical services stated, "Of course his perception is his perception." The surveyor asked the director of clinical services how long does the facility have to report suspected abuse. The director of clinical services stated, "2 hours typically." The surveyor asked the director of clinical services what is the procedure for suspected resident to resident abuse. The director of clinical services stated they are automatically separated and if needed we can do one to one. The surveyor asked the director of clinical services what was the procedure to staff to resident abuse. The director of clinical services stated that the employee is suspended pending investigation. The surveyor asked the director of clinical services what was the procedure for allegations of visitor to resident abuse. The director of clinical services stated we ask them to leave the facility until the investigation is		F 610			
	clinical services w allowed to return t	veyor asked the director of hy the alleged perpetrator was o the facility if the investigation s allegation of abuse had not				

#### PRINTED: 01/16/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B WING 12/14/2018 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 ID (X4) ID EACH CORRECTIVE ACTION SHOULD BE COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY F 610 F 610 Continued From page 71 been completed. The director of clinical services stated, "There's a fine line when telling them they can't visit their loved one. They haven't had contact." The director of clinical services stated, "I wish I could give you more information but the investigation is not complete." On 12/14/18 at 11:05 am, the surveyor interviewed the facility executive director in the presence of the survey team. The surveyor asked the facility executive director what the procedure was for allegations of resident to resident abuse. The facility executive director stated, "Separate and investigate." The surveyor asked the facility executive director what the procedure was for allegations of staff to resident abuse. The facility executive director stated that the employee was to be suspended pending investigation. The surveyor asked the facility executive director what was the procedure for allegations of visitor to resident abuse. The facility executive director stated, that a facility reported incident would be submitted, the incident would be investigated, and the visitor would be asked to stay away until the investigation is complete. The surveyor asked the facility executive director why the family was not asked to stay away during the investigation of the allegation of abuse reported by Resident # 5. The facility executive director stated, "Or they meet with me and the director of nursing and we determine if they can come back. I met with the family on Monday and with [Resident # 5]'s history of 3 or 4 occasions that he has lied, the residents were separated and [Resident # 5] was moved to another room. I decided that the

alleged perpetrator could return to the building."
The surveyor asked the facility executive director how he could make that determination when the investigation had not been completed. The facility

PRINTED: 01/16/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (XI) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495325 B. WING 12/14/2018 NAME OF PROMDER OR SUPPLIER STREET ADDRESS CITY STATE 7IP CODE 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (PACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR LISC (DENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 610 | Continued From page 72 F 610 executive director stated, "I don't think it happened. [Resident #5] tells lies. In the past he has made accusations and said this happened and he comes back 3 or 4 days later and says he is sorry. I am more concerned with this nurse LPN # 1. I think she put [Resident # 5] up to calling the police. It's a lot of drama involved in this with CNA # 2 and LPN # 1. They have issues with the family. My issue is more with LPN # 1 and I will deal with her after this is over." The surveyor asked the facility executive director if he interviewed CNA # 2. The facility executive director stated that he did not. The facility executive director stated that the facility social services manager interviewed CNA # 2. On 12/14/18 at 11:20 am, unit manager RN # 1 provided the surveyor with a copy of the "Resident Safety Check" log for Resident # 5. The surveyor observed that the facility staff did not begin documenting resident safety checks for Resident # 5 until 12/12/18 at 7:00 am which was 4 days after the initial allegation of abuse that was

5407255735

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reported by Resident # 5, and 2 days after he was transferred into a different room. The surveyor observed that the facility staff did not document 15 minute safety checks for Resident # 5 from 11:00 pm on 12/12/18 through 7:00 am on 12/13/18. There were no documented safety checks from 11:00 pm on 12/13/18 through 7:00 am on 12/14/18. Also there were no documented checks on 12/14/18 at 11:00 am and 11:15 am.

On 12/14/18 at 11:47 am, two surveyors met with the facility executive director per his request. The facility executive director stated, "I felt bad about how I came across about not believing him. We always believe him. It may turn out that it's true. I wouldn't have done anything differently. We

Event ID: Y3F111

Facility ID: VA0208

If continuation sheet Page 73 of 187

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A BUILDING		(X3) DATE SURVEY COMPLETED C			
		495325	B. WING_		12/14/2018
	PROVIDER OR SUPPLIER	REHAB CENTER		STREET ADDRESS, CITY, STATE, 2IP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
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F 610	separated them. Visurveyor stated to that the alleged perbuilding on Sunday she jerked the table executive directors here all day and no back and forth to the facility executive that the alleged perbuilding because o visitor sign in log as signed in as a visit facility saw the alleged in the hallway at the said the alleged perbuilding because on the hallway at the said the alleged perputation of the executive directors that happened. The executive directors working on his toile alleged perpetrator working on his toile alleged perpetrator in from using the urinate on himself. It stated, "She says shim." The surveyor director that he stated that Resident # 5 sof his room like he coming out for mentor run into the allegent mormal behavior for executive director.	We met with the family." The the facility executive director petrator returned to the and Resident # 5 stated that a from under him. The facility stated, "No she wasn't, I was one came in. I drove staff the hotel." The surveyor asked a director if he knows for a fact repetrator did not enter the in 12/13/18 after viewing the ind seeing that no one had or, 2 surveyors toured the ged perpetrator along with her con visiting with their loved one asame table that Resident # 5 in facility executive director did surveyor informed the facility that Resident # 5 became the surveyor told the facility that Resident # 5 had been be surveyor told the facility that Resident # 5 had been be replied at him and prevented bathroom causing him to the facility executive director she sat on the bed talking to retail that Resident # 5 tells lies it obligated to protect him. The that facility executive director stated that he isn't coming out normally does and is only als because he does not want ged perpetrator and this is not a or Resident # 5. The facility stated, "I don't know what the tent name withheld) has been in	F6	310	

#### 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 STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING R WING 12/14/2018 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 (X5) COMPLETION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE IEACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 610 F 610 Continued From page 74 that room forever and he doesn't want to move. They fought for years to get him back to that unit." The surveyor told the facility executive director that she was unable to advise him on what to do but he has an obligation to protect Resident # 5 and all residents. The surveyor made the facility executive director aware that the investigation into the allegation of abuse did not have documentation of a thorough investigation and that the investigation had not been completed within a timely manner. The facility executive director stated, "I thought I had 5 working days from the FRI" The surveyor informed the facility executive director that the investigation was to be completed within 5 working days from the time of the incident. The facility policy on "Abuse, Neglect, Exploitation & Misappropriation" contained documentation that included but was not limited to: ... "Mental and verbal abuse include but are not limited to: Harassing a resident Mocking, insulting, ridiculing Yelling or hovering over a resident, with intent to intimidate Threatening residents, depriving a resident of care or withholding a resident from contact with family and friends Neglect is the failure of the center, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress. Examples include put are not limited to: Failure to take precautionary measures to protect the health and safety of the resident. Procedure Acts of abuse directed against

From:Pheasant Hidge Nursing & Rehab 5407255735

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/16/2019 **FORM APPROVED** OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A, BUILDING	LE CONSTRUCTION	COMPLETED		
		495325	8, WNG	.5.	C 12/14/2018		
	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014				
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F 610	residents are abso cause for disciplina and possible prose to what actions con Any action that ma physical psychologis not caused by si abuse. Actions sucrestraining a reside authorization, and seen as causing platrictly forbidden. A humiliating, degrac resident may conswith no less seven harm. Non-action, psychological, or pranner as that car action. All actions with residents must the healthful, proportical that residents are recognizes that residents and recognizes that residents are considered.	dutely prohibited. Such acts are ary action, including dismissal action. Questions may arise as a stitute abuse of a resident, y cause or causes actual pical or emotional harm, which imple negligence, constitutes that as striking a resident, and improperly or without other such acts which can be hysical pain to a resident are acts such as teasing, ding, or intentionally ignoring a titute abuse and will be dealt ally than acts causing physical which results in emotional, whysical injury in the same used by improper or excessive in which employees engage at have as their legitimate goal, er, and humane care and	F 61				
	all residents, to tree prevent others from employee, who with act of abuse or an exploitation or mis unknown source a property, to a reside information immediates the allegation cause the allegation	e a duty to respect the rights of at them with dignity and to m violating their rights. Any tnesses or has knowledge of an allegation of abuse, neglect, treatment, including injuries of and misappropriation of resident dent, is obligated to report such diately, but no later than 2 hours is made, if the events that on involve abuse or result in my, or not later than 24 hours if					

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	OF DEFICIENCIES	& MEDICAID SERVICES	E 1				NO. 0938-039	
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ONSTRUCTION		ATE SURVEY OMPLETED	
		495325	B. WING				C 12/14/2018	
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADORESS, CITY, STATE, ZIP CODE			
PHEASAN	IT RIDGE NURSING 8	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014				
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F 610	the events that cau involve abuse or dinjury, to the Admir accordance with S Executive Director. Services is the des An employee shall his obligations in p does any of the foll Harasses or otherwise transfer of the resident, employee discloses information investigation of an 5. Investigation of an 5. Investigation of the Abuse Coordinate investigate all reponse to the role of resident questioning of or in Investigations will be following manner. Immediately upon the glect, the suspect residents pending that allegation.  Protection Increased supervisites and Report the results of Executive Director representative and	use the allegation do not o not result in serious bodily nistrator and to other officials in tate law. In the absence of the , the Director of Clinical signated abuse coordinator.  be deemed to have violated aragraph "1A" (above) If he	Fe	310				

Agency, within 5 working days of the incident and

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPL IDENTIFICATION NI 10 PC 10		NUMBER: A. BUILDING		(X3) DATE SURVEY COMPLETED C 12/14/2018	
	PROVIDER OR SUPPLIER  NT RIDGE NURSING & 1	REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		147.2013
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F 610	If the alleged violatic corrective action mu On 12/14/18 at 2:02	on is verified appropriate	F 616	0		
F 622 SS=D	provided to the survice conference on 12/14 Transfer and Dischat CFR(s): 483.15(c)(1) §483.15(c)(1) Facility (i) The facility must premain in the facility discharge the resident's welfare are cannot be met in the (B) The transfer or discharge the resident's on the resident's of the resident's of the resident's of the resident's of the resident's of the resident's of the resident (C) The safety of indicating of the resident (D) The health of indicating of the resident has appropriate notice, to under Medicare or Monpayment or after the Medicare or Medicair resident refuses to p	arge Requirements i)(i)(ii)(2)(i)-(iii)  and discharge- ty requirements- permit each resident to r, and not transfer or ent from the facility unless- discharge is necessary for the nd the resident's needs a facility; discharge is appropriate nt's health has improved sident no longer needs the ry the facility; dividuals in the facility is the clinical or behavioral nt; dividuals in the facility would	F 622	F622- Transfer and Requirements  1. Resident #98 disc facility on 10/22/201 #5 re-admitted to face 8/27/2018 and has readditional transfers. #89 transferred to the on 11/02/2018 and rewithin 24 hours and any additional transfers and/or discharged in days to identify if the documentation was the resident or the reparty when discharge the receiving facility, to the hospital or and by 1/25/2019. Follow on findings.	charged from 8. Resident cility on not had any Resident ne hospital returned has not had fers.  mplete quality transferred n the last 30 perequired provided to esponsible ned home, to transferred other facility	

		AND HUMAN SERVICES  & MEDICAID SERVICES			FORM	01/16/2019 1APPROVED 0938-0391
STATEMENT (	OF DEFICIENCIES . CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE : COMPI	SURVEY LETED
		495325	B. WING		17/4	
NAME OF P	ROVIDER OR SUPPLIER	08	S	FREET ADORESS, CITY, STATE, ZIP CODE	12/1	14/2018
PHEASAN	T RIDGE NURSING &	REHAB CENTER	1	656 PHEASANT RIDGE ROAD, SW OANOKE, VA 24014		
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F 622	resident only allows or (F) The facility ceas (ii) The facility may resident while the a § 431.230 of this crexercises his or her discharge notice fro 431.220(a)(3) of thi discharge or transfe or safety of the resifacility. The facility that failure to transfe facility that failure to transfe in paragraphs (c)(1) section, the facility that failure to transfer in paragraphs (c)(1) section, the facility for discharge is documedical record and communicated to the institution or provide (i) Documentation in must include:  (A) The basis for the (b) of this section.  (B) In the case of pasection, the specific be met, facility atterneeds, and the service facility to meet the resident in the communication of this section (A) The resident's pasection of this section (A) The resident's pasection of the section of this section (A) The resident's pasection of the section of this section (A) The resident's pasection of the section of this section (A) The resident's pasection of the section of this section (A) The resident's pasection of this section (A) The resident's pasection of the section of this section (A) The resident's pasection of this section of the section of the section of the section of the section of this section of the section of	ity, the facility may charge a able charges under Medicaid; sees to operate.  not transfer or discharge the ppeal is pending, pursuant to personant to right to appeal a transfer or on the facility pursuant to \$ s chapter, when a resident right to appeal a transfer or on the facility pursuant to \$ s chapter, unless the failure to er would endanger the health dent or other individuals in the must document the danger er or discharge would pose.  Insters or discharges a port the circumstances specified (i)(A) through (F) of this must ensure that the transfer amented in the resident's appropriate information is e receiving health care er.  In the resident's medical record the resident need(s) that cannot appropriate the resident ince available at the receiving need(s).  On required by paragraph (c) must be made by-hysician when transfer or ary under paragraph (c) (1)	F 622	3. The ADCS and or RDC provide re-education to Lic staff and Interdisciplinary to on federal regulations and guidelines on the transfer a discharge process to ensu when the facility transfers of discharges a resident, und of the circumstances identifiederal regulation, the facilimust ensure that the transitischarge is documented in resident's medical record appropriate information is communicated to the receipealth care institution and provided to residents where discharged home by 1/28/3.  4. DCS and or ADCS will conduct random quality monitoring of resident transidischarge documentation, times per week for 4 week weekly for 3 months. Find be reported to QAPI commonthly and updated as indicated. Quality monitorischedule modified based of findings.  5. Date of Compliance 1/28/2019.	ensed eam and re or er any fied in ity rer or or the and ving or i 2019.	

		MEDICADE BARDIDAD OFFICES				NTED: 01/16/2019 FORM APPROVED B NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER:SUPPLIER/CLIA IDENTIFICATION NUMBER:	STATE SHOWER HOLDER	IPLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED
		495325	B. WING_			C 42/44/2048
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	XOE .	12/14/2018
PHEASAN	T RIDGE NURSING 8	REHAB CENTER	Market Services	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
PREFIX TAG	EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 622	necessary under pathis section.  (iii) Information promust include a min (A) Contact information responsible for the (B) Resident representation (C) Advance Direct (D) All special instrangoing care, as a (E) Comprehensive (F) All other necession or the resident consistent with §48 any other document a safe and effective. This REQUIREME by:  Based on staff internal dimical record to provide receiving documentation where of 3 of 23 resident (Resident #98, #5).  The findings included the resident #98 was 10/15/18 and disched the entry MD Resident #98 had in not limited to diabet neuropathy and according to the resident #98 had in the resident #98 ha	en transfer or discharge is aragraph (c)(1)(i)(C) or (D) of wided to the receiving provider immum of the following: ation of the practitioner care of the resident. Sentative information including interest in the information including interest information including interest information including a truetions or precautions for propriate. As a care plan goals; is any information, including a stis discharge summary, 33.21(c)(2) as applicable, and intation, as applicable, to ensure a transition of care.  No is not met as evidenced in a resident was transferred as in the survey sample and #89).  The survey sample and #89).  The only its Set) available to review is and discharge MDS, the following diagnoses of, but ites, high blood pressure,	F 6	222		
		ecord review on 12/14/18, the hysician order dated for	M TUSII			

		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 01/16/201 RM APPROVE NO. 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		
		495325	B WING	and the same	C	
NAME OF F	PROVIDER OR SUPPLIER		S	REET ADDRESS, CITY, STATE, ZIP CODE		2/14/2018
PHEASA	NT RIDGE NURSING &	REHAB CENTER	1 .	55 PHEASANT RIDGE ROAD, SW DANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 622	(discharge) 10/22/18 another facility)." TI 10/22/18 at 10:00 at follows: "Pt daughter (without) summary & daughter to come be summary. Daughter pt."  On 12/14/18 at 11 at copies of the dischas summary for this result has been dischast summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the summary for the received when Resident #98 to show you what it is report." There was redemographics of the No further information surveyor prior to the 2. The facility staff	d. "Pt. (patient) to D/C  B to (name of the surveyor also noted that on the surveyor also noted that on the surveyor also noted that on the surveyor also noted that on the surveyor read as er d/cd (discharged) pt w/o discharged to sign discharge or return to sign papers w/o the surveyor requested arge summary/transfer sident from the director of DON stated that she would veyor.  The again requested a copy of ary/transfer summary that inving facility on 10/22/18 was discharged.  I provided the surveyor with a Report" for Resident #98. The nat's all I can do right now is cooked like when I run that no information on it except for resident.  The was provided to the exit conference on 12/14/18. The liled to ensure that plan goals were sent to the makesident #5 was	F 622			
	admitted to the facility readmission date of the	0-year-old-male who was y on 4/20/18, with a 8/27/18. Diagnoses included o hypertension, major				

97.6, 97% R/A (room air). Res (resident) c/o (complaining of) pain to sacral area with numbness to spine. Res requesting to be sent to ER (emergency room) Resident sent out 911 per Dr. (doctor) order. Res has no adverse reaction to abt (antibiotic treatment) for UTI (urinary tract

On 12/14/18 at 12:05 pm, the surveyor spoke with unit manager RN#1 (registered nurse) and requested to see documentation of what

On 12/14/18 at 1:46 pm, unit manager RN # 1 provided the surveyor with a copy of the "Nursing Home To Hospital Transfer Form" that was sent with Resident # 5. The surveyor reviewed the form and did not locate any documentation that

information was sent to the receiving facility when Resident # 5 was transferred to the hospital on

#### PRINTED: 01/16/2019 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 494325 B. WNG 12/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4365 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES (X41 JD PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC (DENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 622 Continued From page 81 F 622 depressive disorder, anxiety disorder, and benign prostatic hyperplasia. The clinical record for Resident # 5 was reviewed on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident #5 was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively intact. On 12/14/18 at 11:41 am, the surveyor reviewed the "Interdisciplinary Progress Notes" for Resident # 5. A note was documented on 8/12/18 at 2:30pm as "V/S (vital signs) 136/89, 130, 18,

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infection)."

8/12/18.

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Facility ID VA0208

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PRINTED: 01/16/2019 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\_ C 495325 B. WING 12/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION !D (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG DEFICIENCY) F 622 | Continued From page 82 F 622 supported that comprehensive care plan goals were sent to the receiving provider when Resident # 5 was transferred to the hospital on 8/12/18. On 12/14/18 at 2:02 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 12/14/18. 3. For Resident #89, facility staff failed to provide written notice of transfer when the resident was transferred to the hospital. Resident #89 was admitted to the facility on 3/28/17. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting as her own responsible party. During an interview on 12/13/18, the resident reported being generally content with physical care received, but indicated a desire to transfer to another facility prior to the planned ban on smoking starting in February 2019. The resident

reported having asked several times about

# 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 495326 B. WING 12/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 (X4) (D SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE CATE TAG DEFICIENCY) F 622 | Continued From page 83 F 622 progress toward the transfer, but having no timeline for the transfer. The resident also reported being sent to the hospital for tracheostomy revision the month before. The resident said she had been given no written notice of the reasons for transfer to the hospital. Clinical record review revaled that on 11/2/18. staff requested a ECO (emergency commitment order) and called an ambulance to take the resident to the hospital. There was no indication the resident's physician was notified of the situation or that there was a change of condition requiring hospitalization. During a summary meeting on 12/13/18, the surveyor reported to the administrator, director of clinical (DCS) and the corporate regional director F623- Notice Requirements for clinical services the concern with the situation Before Transfer/Discharge on 11/2 described in the record. Facility staff indicated that residents and families were not 1. Resident #89 transferred to routinely provided written notices including reason the hospital on 11/02/2018 and returned within 24 hours and has F 623 Notice Requirements Before Transfer/Discharge F 623 not had any additional transfers. CFR(s): 483.15(c)(3)-(6)(8) SS=E Resident #58 re-admitted to facility on 12/5/2018 and §483 15(c)(3) Notice before transfer. discharged 1/17/2019. Resident Before a facility transfers or discharges a resident, the facility must-#22 re-admitted to facility on (i) Notify the resident and the resident's 11/10/2018 and has not had any representative(s) of the transfer or discharge and additional transfers. Resident #5 the reasons for the move in writing and in a re-admitted to facility on language and manner they understand. The 8/27/2018 and has not had any facility must send a copy of the notice to a additional transfers. Resident representative of the Office of the State #55 re-admitted to facility on

Long-Term Care Ombudsman.

(ii) Record the reasons for the transfer or

discharge in the resident's medical record in

11/21/2018 and has not had any

additional transfers.

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\_ 495326 B. WING 12/14/2018 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 PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEIX FACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATIONI CROSS-REPERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2. The UMs will complete quality Continued From page 84 F 623 review of residents transferred accordance with paragraph (c)(2) of this section; and/or discharged in the last 30 days to ensure appropriate (iii) Include in the notice the items described in notification was provided to paragraph (c)(5) of this section. Resident, Resident's Representative, and Ombudsman on 1/25/2019. §483.15(c)(4) Timing of the notice. Follow up based on findings. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or 3. The ADCS and or RDCS will discharge required under this section must be provide re-education to licensed made by the facility at least 30 days before the staff and Interdisciplinary team resident is transferred or discharged on the federal (ii) Notice must be made as soon as practicable regulations/guidelines for before transfer or discharge when-(A) The safety of individuals in the facility would transfer and discharge, including be endangered under paragraph (c)(1)(i)(C) of the facility sending a copy of the this section. notice to a representative of the (B) The health of individuals in the facility would Office of the State Long-Term be endangered, under paragraph (c)(1)(i)(D) of Care Ombudsman and record this section: the reasons for the transfer or (C) The resident's health improves sufficiently to discharge in the resident's allow a more immediate transfer or discharge, medical record, by 1/28/19. under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is 4. DCS and or ADCS will required by the resident's urgent medical needs, conduct random quality under paragraph (c)(1)(i)(A) of this section; or monitoring of resident transfer (E) A resident has not resided in the facility for 30 discharge notification, 3 times days. per week for 4 weeks, then §483.15(c)(5) Contents of the notice. The written weekly for 3 months. Findings to notice specified in paragraph (c)(3) of this section be reported to QAPI committee must include the following: monthly and updated as (i) The reason for transfer or discharge: indicated. Quality monitoring (ii) The effective date of transfer or discharge; schedule modified based on (iii) The location to which the resident is findings. transferred or discharged; (iv) A statement of the resident's appeal rights. 5. Date of Compliance including the name, address (mailing and email), 1/28/2019. and telephone number of the entity which

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 01/16/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY DENTIFICATION NUMBER: A BUILDING\_ COMPLETED 495326 B WING 12/14/2018 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 (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 623 Continued From page 85 F 623 receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request: (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the malling and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally III Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as

TATEMENT OF	DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUT	IPLE CONSTRUCTION		NO. 0938-03 ATE SURVEY
ND PLAN OF C		IDENTIFICATION NUMBER	A BUILDIN	The state of the s		MPLETED
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NAME OF PRO	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		12/14/2018
PHEASANT	RIDGE NURSING &	REHAB CENTER		4356 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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we reside the state of the stat	elocation of the res 83.70(I). his REQUIREMEN y: Based on staff inter nd clinical record of provide a written esident and resider ansferred to local it ansfers to other far sample of 23 were esident #22, Resident #22, Resident #22, Resident #32, Resident #42, Resident #42, Resident #45 resident's reansfer or discharge ansfer or discharge with a modern and resident #45 resident #45 resident #45 resident #45 resident #55. After esident #55. After ansfer have ansfer red to local it esident #55. After ansfer have ansfer have and the resident and the resident and the resident and the resident and the resident and the resident and the resident and the resident and the resident and the resident and the resident and the resident #55.	the transfer and adequate idents, as required at §  IT is not met as evidenced rview, facility document review eview, the facility staff falled notice of transfer to the not representative when nospitals and failed to notify nospitalization and/or cilities. Residents effected in a Resident #89, Resident #58, dent #5, and Resident #55.	F 6	23		

	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	TIPLE CONSTRUCTION NG	сом	(X3) DATE SURVEY COMPLETED C 12/14/2018	
	PROVIDER OR SUPPLIER  NT RIDGE NURSING &	REHAS CENTER		STREET ADDRESS, CITY, STATE, Z 4355 PHEASANT RIDGE ROAD, S ROANOKE, VA 24014	IP CODE		
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1	When a center trar the center must:  "Notify the residence representative (s) of the reasons for the and manner they use a representative of Long-Term Care Of was admitted to the readmitted 12/5/18 but not limited to admitestinal disorders, stage 3, hypertensifibrillation, dementional disturbances, pressunstageable, and constageable, and constageable, and constageable, and constageable assessment reference date (AR resident with a BIM status) as 03/15. Sassessed the resident with a BIM status) as 03/15. Sassessed the resident with a BIM status) as 03/15. Sassessed the resident with a BIM status) as 03/15. Sassessed the resident with a BIM status) as 03/15. Sassessed the resident was totally dep bathing. Resident #5 11/28/18.  The surveyor intervioursing (ADON) on where notification to located. The ADON the ombudsman. Nas of today, we will	dent and resident of the transfer or discharge and of move in writing (In a language inderstand) ust send a copy of the notice to ithe Office of the State industrial and with diagnoses that included dult fallure to thrive, functional awithout behavioral awithout behavioral awithout behavioral sure ulcers bilateral heels, thronic kidney disease.  Interly minimum data set with an assessment D) of 11/7/18 assessed the S (brief interview for mental section G Functional Status ent to need extensive person for personal hygiene endent on one person for #58 was in the process of a MDS and comprehensive care is was admitted to the hospital itewed the assistant director of 12/13/18 at 11:53 a.m. about to the ombudsman was a stated, "We are not notifying lever heard we had to do that.	F	523			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A BUILDING			(X3) DATE SURVEY COMPLETED	
		495325	B. WING				C 2/14/2018
NAME OF P	ROVIDER OR SUPPLIER			STRE	ETADORESS, CITY, STATE ZIP CODE	, ,	2/14/2018
DUEAGAN	T RIDGE NURSING & RE	UAD CENTED		4355	PHEASANT RIDGE ROAD, SW		
FREMSAR	NIPOE NURSING & RE	INAD GENTER		ROA	NOKE, VA 24014		
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F 623	Continued From page	88	F	323			1
	nurse on 12/13/18 at a written transfer notifical ombudsman was not a sent to the hospital.	d the regional registered 4:29 p.m. The DON stated ation was not done and the notified when residents are the surveyor requested the g to transfers/discharge 8.					
	12/14/18 at 11:25 a.m stated he was not pro- to the resident or their admission staff stated	ved the admissions staff on . The lead admission staff viding written transfer notice representative. The lead if the resident was their (RP), whom would the fer be sent to?					
	& Right to Appeal Effer Revision Date: 3/26/2 and discharges of rest center (facility initiated according to Federal a requirements. Proced Transfer: Before Record the reaso discharge in the reside Documentation: When discharges a resident circumstances listed a that the transfer or disthe resident's medical information is communication accommunication is communication or care institution.	I) will be conducted and/or State regulatory lure: Notice Before on some some some some some some some some					
	2. The facility staff fail						

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

Event ID: Y3F111

Facility ID VA020B

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		AND HUMAN SERVICES  & MEDICAID SERVICES				F	NTED: 01/16/2019 ORM APPROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONST	TRUCTION	(X3)	3 NO. 0938-0391 DATE SURVEY COMPLETED C
		495325	B. MNG	MARIE T			12/14/2018
	ROVIDER OR SUPPLIER  IT RIDGE NURSING 8	REHAB CENTER		4355 PHI	ADDRESS, CITY, STATE, ZIP CODE EASANT RIDGE ROAD, SW IKE, VA 24014		12/14/2016
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	ombudsman when to the hospital.  The clinical record 12/12/18 through 1 admitted to the fac 10/19/18 and 11/2 included but not lin with hyperglycemia embolism of cerebic cognitive impairme cognitive impairme cognitive communicystitis without hem disorder, hypertens Resident #55's 14-with an assessmen 11/2/18 assessed the interview for menta Resident #55's curridentified the residentisk r/t (related to) a (as evidenced by) continued to the communication of 12/12/13 revision on 12/12/13 Resident #55 was a 11/12/18. The survice documentation in the paperwork and notifical through the communication in the paperwork and notifical through the communication in the paperwork and notifical sidentification in the paperwork and notification in the paperwo	ative and failed to notify the Resident #55 was transferred  of Resident #55 was reviewed 2/14/18. Resident #55 was sility 8/22/18 and readmitted 1/18 with diagnoses that nited to type 2 diabetes mellitus at cerebral infarction due to ral artery, dysphagia, mild nt, lack of coordination, cation deficit, aphasia, acute naturia, anxiety, bipolar femia, major depressive sion, and migralnes.  day minimum data set (MDS) to reference date (ARD) of the resident with a BIMS (brief I status) as 15/15.  Tent comprehensive care plan and to be at nutrition/hydration suffered nutrient utilization AEB diagnoses include DM2  with poorty controlled serum what (hemoglobin A1C) at erventions included to obtain gnostic work as ordered. D (medical doctor) and follow ate initiated 8/27/18 and	F	523			

		AND HUMAN SERVICES  E & MEDICAID SERVICES			FC	TED: 01/16/201 PRM APPROVE NO: 0938-039	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING			
		495325	B. WING		С		
NAME OF P	ROMDER OR SUPPLIER			EET ADDRESS, CITY, STATE, ZIP CODE		12/14/2018	
PHEASAI	NT RIDGE NURSING	& REHAB CENTER	4355	S PHEASANT RIDGE ROAD, SW ANOKE, VA 24014			
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F 623	Continued From p	page 90	F 623			3	
	The suppoyer inte	rviewed the assistant director of					
	nursing (ADON) o	n 12/13/18 at 11:53 a.m. about				Ш	
	where notification	to the ombudsman was					
		ON stated, "We are not notifying					
	As of today, we w	Never heard we had to do that: ill start notifying."					
	The surveyors me	et with the administrator, the					
	director of nursing	, and the regional registered					
		at 4:29 p.m. The DON stated					
		tification was not done and the not notified when residents are					
		The surveyor requested the					
		aining to transfers/discharge					
		viewed the admissions staff on a.m. The lead admission staff					
		providing written transfer notice					
		their representative. The lead					
		sted if the resident was their					
		arty (RP), whom would the					
	written notice of tra	ansier be sent to?					
	The policy titled "T	ransfer/Discharge Notification					
		Effective Date: 09/23/2017					
		26/2018" read in part "Transfer					
		residents, initiated by the ated) will be conducted					
		ral and/or State regulatory					
		cedure: Notice Before					
	Transfer: Before a	center transfers or discharges					
	a resident the cent						
		dent and resident	3.3				
		of the transfer or discharge and emove in writing (in a language					
	and manner they u						
		ust send a copy of the notice to					

AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:  A05205  A05205  A BUILDING		(X3) DATE SURVEY COMPLETED		
	495326	B. WING	10 (12) (12)	12/14/2018	
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE NURSING & REHAB CENTER  PHEASANT RIDGE NURSING & REHAB CENTER  ROANOKE, VA 24014				12/14/2010	
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discharge in the reside Documentation: Whe discharges a resident circumstances listed that the transfer or disthe resident's medical information is communicated information is communicated information in communicated information in communicated information is communicated information exit conference on 12 3. For Resident #89, written notice of transtransferred to the hose Resident #89 was add 3/28/17. Diagnoses is limited to, hemiplegial subarachnoid hemorr for care of tracheostor disease, post-traumated disorder, atherosclero mellitus type I, and che heart disease. On the set assessment with a 10/10/2018, the reside brief interview for mer assessed as lacking sor behaviors affecting resident's latest safe sed dated 9/26/18 and indices to smoke independent as her own responsible.	the Office of the State budsman cons for the transfer or lent's medical record. In the center transfers or a under any of the above the facility will ensure scharge is documented in a record and appropriate unicated to the receiving or provider."  It was provided prior to the 2/14/18, facility staff failed to provide fer when the resident was pital.  In the facility on included, but were not and hemiparesis following hage, dysphagia, encounter my, atherosclerotic heart disease, diabetes pronic obstructive pulmonary equarterly minimum data assessment reference date ent scored 15/15 on the intal status and was signs of delirium, psychosis, self or others. The smoking assessment was able thy. The resident was acting	F 623			

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM APPROV OMB NO. 0938-03	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUP		(X1) PROMDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULT A BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495325	B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	12/14/2018	
PHEASAN	IT RIDGE NURSING &	REHAB CENTER	de	4355 PHEASANT RIDGE ROAD, ST ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A) CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE COMPLETION DATE DATE	
F 623	another facility pric smoking starting in reported having as progress toward the timeline for the transported being sent tracheostomy revise resident said she had notice of the reason. Clinical record revistaff requested a corder) and called a resident to the host the resident's physituation or that the requiring hospitalize During a summary surveyor reported to clinical (DCS) and for clinical services on 11/2 described indicated that the opposite a written notify the ombudent services on the resident #22 was transferred to notify the ombudent services on the resident #22 is a soriginally admitted a readmission date included, but were acute kidney failure diabetes, and compare the resident and compare the resident services on the resident #22 is a soriginally admitted a readmission date included, but were acute kidney failure diabetes, and compare the resident services on the residen	indicated a desire to transfer to or to the planned ban on February 2019. The resident ked several times about e transfer, but having no insfer. The resident also to the hospital for it on the month before. The lad been given no written ins for transfer to the hospital.  Ewe reveled that on 11/2/18, CO (emergency commitment in ambulance to take the pital. There was no indication ician was notified of the ere was a change of condition.	F6	223		

#### PRINTED: 01/16/2019 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 C 495325 R WING 12/14/2018 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 PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 623 Continued From page 93 F 623 on 12/13/18 at 8:00 am. The most recent MDS (minimum data set) assessment for Resident #22 was a quarterly assessment with an ARD (assessment reference date) of 10/03/18. In Section C0500, the facility staff documented that Resident #22 had a BIMS (brief interview for mental status) score of 15 out of 15. On 12/13/18 the surveyor reviewed Resident #22's progress notes. The clinical record contained a progress note dated 11/07/18 at 7:30 pm that read in part, "Resident continues to have large amount of dark brown coffee ground emesis, After speaking to the Resident multiple times throughout the shift Resident has agreed to go to the ED (emergency department) for evaluation ... The surveyor could not locate documentation in Resident #22's clinical record that indicated that Resident #22 was given a written copy of the transfer agreement upon transfer to the emergency room on 11/07/18. On 12/13/18 at 4:31 pm during end of day meeting with the executive director, the DON (director of nursing), and the regional nurse consultant. The administrative team was asked by the survey team how and if they notify the ombudsmen of transfers. The executive director voiced they do not notify the ombudsman of transfers to the hospital. The DON also agreed the ombudsman was not notified of transfers. The surveyor asked the administrative team if the Resident or responsible party were provided with a written transfer agreement at the time of transfer. The DON voiced that transfer

agreements were not provided in writing at the time of transfer. The DON stated "We notify over

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3)	OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		495325	8. WNG		С		
NAME OF F	PROMDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		12/14/2018
PHEASAI	NT RIDGE NURSING 8	REHAB CENTER		4355	PHEASANT RIDGE ROAD, SW ANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFID TAG	(	PROWDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	10ULD BE	COMPLETION DATE
F 623	the phone and make a note but they are not given in writing".  On 12/14/18 at 11:26 am, the surveyor spoke with DON (director of nursing) and it was clarified that the facility staff did not give transfer agreement in writing to Resident #22 upon transfer to the local hospital on 11/07/18.  The administrative team was made aware of issue during a meeting with survey team on 12/14/18 at 2:00 pm.  No further information regarding this issue was provided to the survey team prior to the exit conference on 12/14/18.  5. The facility staff failed to provide written notification to the resident and the resident representative and the ombudsman when		Fe	523			
	Resident #5 was tra 8/12/18.  Resident #5 was a admitted to the facili readmission date of but were not limited depressive disorder prostatic hyperplasi The clinical record on 12/13/18 at 10:4 (minimum data set) was a quarterly ass (assessment refere of the MDS assesses Section C0500, the Resident #5 had a mental status) score	anmsferred to the hospital  40-year-old-male who was lity on 4/20/18, with a f 8/27/18. Diagnoses included I to, hypertension, major r, anxiety disorder, and benign					

	OF CORRECTION CONTROL (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DENTIFICATION NUMBER:  A BUILDING		(X3) DATE SURVEY COMPLETED C				
		495325	B. WING		12/14/2018		
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
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F 623	director of nursing nurse on 12/13/18 written transfer no ombudsman was sent to the hospita facility policy perta notification on 12/13. The policy titled "T & Right to Appeal Revision Date: 3/2 and discharges of center (facility initia according to Federequirements. Pro Transfer. Before a a resident the cent "Notify the resi representative (s) the reasons for the and manner they to "The Center ma representative of Long-Term Care O"Record the redischarge in the redischarges a reside circumstances liste that the transfer or	t with the administrator, the , and the regional registered at 4:29 p.m. The DON stated tification was not done and the not notified when residents are it. The surveyor requested the ining to transfers/discharge 14/18.  Transfer/Discharge Notification Effective Date: 09/23/2017 26/2018" read in part "Transfer residents, initiated by the ated) will be conducted ral and/or State regulatory icedure: Notice Before a center transfers or discharges ter must: dent and resident of the transfer or discharge and a move in writing (in a language inderstand) ust send a copy of the notice to f the Office of the State	F 623				
	the resident's med information is com health care institut On 12/14/18 at 2:0	ical record and appropriate municated to the receiving					

		AND HUMAN SERVICES			PRINTED: 01/16/201	
STATEMENT	ENTERS FOR MEDICARE & MEDICAID SERVICES  TEMENT OF DEFICIENCIES OPLAN OF CORRECTION  (X1) PROVIDER'S UPPLIER'CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A. BUILDING		ONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
		495325	B. WING		С	
NAME OF P				REET ADDRESS, CITY, STATE, ZIP CODE	12/14/2018	
PHEASAN	NT RIDGE NURSING 8	REHAB CENTER	436	5 PHEASANT RIDGE ROAD, SW ANOKE, VA 24014		
(X4) (D PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION ATE DATE	
F 623	Continued From pa	age 96	F 623			
	No further inflorma exit conference on	tion was provided prior to the				
F 624 SS≖D		fe/Orderly Transfer/Dschrg	F 624			
	discharge. A facility must provous preparation and orisafe and orderly trafacility. This orientation and manner thunderstand. This REQUIREMED by: Based on resident clinical record review provide for a safe a residents (89).	ide and document sufficient ientation to residents to ensure ansfer or discharge from the ation must be provided in a nat the resident can  NT is not met as evidenced interview, staff interview, and ow, the facility staff failed to and orderly transfer for 1 of 23 admitted to the facility on sincluded, but were not		F624- Preparation for Safe/Orderly Transfer/Discharge  1. Resident #89 transferred the hospital on 11/02/2018 a returned within 24 hours and not had any additional transfer transferred and/or discharged in the last 30 day ensure appropriate documentation is in the resident's medical record by	ind I has iers. /s to	
	limited to, hemipleg subarachnoid hemo for care of tracheos	ia and hemiparesis following orrhage, dysphagia, encounter stomy, atherosclerotic heart		1/25/2019. Follow up based findings.  3. The ADCS and or RDCS v	vill	
	disorder, atheroscle mellitus type I, and	natic stress disorder, bipolar erotic heart disease, diabetes chronic obstructive pulmonary the quarterly minimum data		provide re-education to licens staff and Interdisciplinary tea on federal regulations and guidelines for discharge and	sed m	
	set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting			transfer, including the facility providing and documenting sufficient preparation and orientation to residents to ensafe and orderly transfer or discharge from the facility, by 1/28/2019.	sure	