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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X.5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 624 Continued From page 97 F 624 as her own responsible party. 4. DCS and or ADCS will conduct random quality During an interview on 12/13/18, the resident monitoring of resident transfer reported being generally content with physical discharge documentation, 3 care received, but indicated a desire to transfer to times per week for 4 weeks, then another facility prior to the planned ban on weekly for 3 months. Findings to smoking starting in February 2019. The resident be reported to QAPI committee reported having asked several times about monthly and updated as progress toward the transfer, but having no indicated. Quality monitoring timeline for the transfer. The resident also schedule modified based on reported being sent to the hospital for findings. tracheostomy revision the month before. The 5. Date of Compliance resident said she had been given no written 1/28/2019. 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 smoke 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 guardianship situation) and he said not to let her leave and to get her a psychiatric evaluation. 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. In the hospital discharge summary, the hospital psychiatrist assessment dated 11/2/18 said the resident was exhibiting no symptoms, but wanted

her to stay at the hospital until Adult Protective

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behavior or symptoms.

behaviors before calling police. Facility staff were unable to locate documentation of any record of

The surveyor discussed the 11/2 incident with the Business office director, who obtained the ECO order. She stated she was working on 11/2/18

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 (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION 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 (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR USC IDENTIFYING INFORMATIONS TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F 624 Continued From page 99 F 624 and came in after dinner and the police were there. Staff told her that the resident wanted to smoke. She had returned from the doctor's office saying she was cleared to smoke. Staff told the Business Office Manager the resident was smoking outside hours and getting upset when they told her she couldn't. Staff said the roommate was upset and wouldn't go in the room in case the resident smoked. The Business Office Manager never saw the resident or talked to the room mate. The Business Office Manager called the administrator who told her he had been dealing with the situation for hours. He told her to go downtown to get a TDO (called ECO above). The Business Office Manager took some statements from a supervisor and a CNA to the magistrate for a TDO (ECO). There was no transfer summary or assessment in the medical record for that date. The director of nursing was unable to locate any transfer documentation, assessments, or written notification of the reason for transfer given to the resident, a family member, or hospital staff. During a summary meeting on 12/13/18, the surveyor reported to the administrator, director of clinical (DCS) and the corporate regional director for clinical services the concern with the situation on 11/2 described in the record. Staff did not record any assessment or complete a transfer assessment or contact the resident's physician prior to the transfer. F 625 Notice of Bed Hold Policy Before/Upon Trasfr F 625 SS=E | CFR(s): 483.15(d)(1)(2)

§483.15(d) Notice of bed-hold policy and return-

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 496325 A. WING 12/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS CITY STATE ZIP CODE 4356 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES (X4) IO PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREEIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 625 | Continued From page 100 F 625 §483.15(d)(1) Notice before transfer. Before a F625-Notice of Bed Hold nursing facility transfers a resident to a hospital or Policy Before/Upon Transfer the resident goes on therapeutic leave, the nursing facility must provide written information to 1. Resident #89 transferred to the resident or resident representative that the hospital on 11/02/2018 and specifiesreturned within 24 hours and has (i) The duration of the state bed-hold policy, if not had any additional transfers. any, during which the resident is permitted to return and resume residence in the nursing Resident #90 discharge from facility: facility on 12/29/2018. Resident (ii) The reserve bed payment policy in the state #58 re-admitted to facility on plan, under § 447.40 of this chapter, if any; 12/5/2018 and has not had any (iii) The nursing facility's policies regarding additional transfers. Resident bed-hold periods, which must be consistent with #22 re-admitted to facility on paragraph (e)(1) of this section, permitting a 11/10/2018 and has not had any resident to return; and additional transfers. Resident #5 (iv) The information specified in paragraph (e)(1) re-admitted to facility on of this section. 8/27/2018 and has not had any §483.15(d)(2) Bed-hold notice upon transfer. At additional transfers. Resident the time of transfer of a resident for #55 re-admitted to facility on hospitalization or therapeutic leave, a nursing 11/21/2018 and has not had any facility must provide to the resident and the additional transfers. Lead resident representative written notice which Admissions re-educated on specifies the duration of the bed-hold policy facility bed hold policy and described in paragraph (d)(1) of this section. procedure on 1/21/2019. This REQUIREMENT is not met as evidenced by: 2. The UMs will complete quality Based on staff interview, facility document review review of residents transferred and clinical record review, the facility staff failed and/or discharged in the last 30 to provide written information about the bed hold days to ensure appropriate policy to the resident or the resident's documentation is in the representative prior to and upon transfer to the resident's medical record that hospital or therapeutic leave. This information resident or resident must be provided to all facility residents. representative had been given regardless of their payment source and include information pertaining to bed

the duration of the state bed-hold policy, if any, during which the resident is permitted to return

and resume residence in the nursing facility; the

holds on 1/25/2019. Follow up

based on findings.

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 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 (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 625 Continued From page 101 F 625 reserve bed payment policy in the state plan, and 3. The ADCS and or RDCS will the nursing facility's policies regarding bed-hold provide re-education to licensed period permitting a resident to return. This staff and Interdisciplinary team failure effected six of 23 residents (Resident #89. on the federal regulations and Resident #90, Resident #58, Resident #22. guidelines for the notice of bed Resident #5, and Resident #55). hold by 1/28/2019. The findings included: 4. DCS and or ADCS will conduct random quality 1. The facility staff failed to provide written bed monitoring of resident transfer hold notice information when residents were discharge documentation to transferred to the hospital-Resident #58. ensure resident or resident representative have been given Six residents were identified to have been information pertaining to bed transferred to local hospitals (Resident #89. holds, 3 times per week for 4 Resident #90, Resident #58, Resident #22, weeks, then weekly for 3 Resident #5, and Resident #55). After reviewing months. Findings to be reported the clinical record, none of the six had to QAPI committee monthly and documentation that the resident or resident updated as indicated. Quality monitoring schedule modified representative had been given information pertaining to bed holds. based on findings. 5. Date of Compliance 1/28/2019. Resident #58's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 11/7/18 assessed the resident with a BIMS (brief interview for mental status) as 03/15. Section G Functional Status assessed the resident to need extensive assistance of one person for personal hygiene and was totally dependent on one person for bathing. Resident #58 was in the process of a significant change MDS and comprehensive care plan. Resident #58 was admitted to the hospital 11/28/18.

The surveyor interviewed the admissions staff on 12/14/18 at 11:25 a.m. The lead admissions staff stated the facility does not offer a bed hold due to the facility always having beds available. The lead

		NO HUMAN SERVICES MEDICAID SERVICES			FC	FED: 01/16/2019 PRM APPROVED NO: 0938-0391	
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	VIDER OR SUPPLIER	REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW				
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and significant with a significa	traight back to the sindisturbed. The lea We don't even pack to some coming back to the dissions staff information on the bend/or provided in the acket. The surveyed hold policy. The surveyor reviewed ffective Date 03/01/11/2017 on 12/14/11 Resident or resident of the hospital or the	ed if a resident was coming same room that room was left d admissions staff stated, the bags. I didn't think it er a bed hold because they he same room." The lead med the surveyor that ad hold policy was given a resident's admission or requested a copy of the ed the policy titled "Bed Hold 2015 Revision Date. 8. The policy read in part representative will be and at the time of transfer rapeutic leave) of the bed and to Federal and/or State dure: 2. At the time of all or therapeutic leave, the copy of notification of bed the time of transfer is met if it the notice is sent with other gither resident to the different and of the day meeting the end of the day meeting the end of the day meeting the regarding this issue was y team prior to the exit	F 625				

		AND HUMAN SERVICES & MEDICAID SERVICES			FC	TED: 01/16/2019 ORM APPROVED
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	12/12/18 through 1 admitted to the fact 10/19/18 and 11/2 included but not lin with hyperglycemia embolism of cerebic cognitive impairme cognitive impairme cognitive communicystitis without her disorder, hyperlipid disorder, hyperlipid disorder, hypertens Resident #55's 14-with an assessment 11/2/18 assessed the interview for mental Resident #55's curridentified the resident fire the resident for the resident for the resident places levels, Hgb 13.2% 8/18/18. Interview for mental resident places levels, Hgb 13.2% 8/18/18. Interview for mental fire part results to Mill up as indicated. Darevision on 12/12/18 Resident #55 was a 11/12/18. The surved documentation in the paperwork and notificating manager licensed principles.	of Resident #55 was reviewed 2/14/18. Resident #55 was illity 8/22/18 and readmitted 1/18 with diagnoses that hited to type 2 diabetes mellitus a cerebral infarction due to rail artery, dysphagia, mild nt, lack of coordination, cation deficit, aphasia, acute haturia, anxiety, bipolar lemia, major depressive sion, and migraines. Iday minimum data set (MDS) at reference date (ARD) of the resident with a BIMS (brief at status) as 15/15. Interest comprehensive care plan and to be at nutrition/hydration altered nutrient utilization AEB diagnoses include DM2 I) with poorfy controlled serum A1c (hemoglobin A1C) at enventions included to obtain gnostic work as ordered. In (medical doctor) and follow attein initiated 8/27/18 and 3. Idmitted to the hospital eyor was unable to find a clinical record of required fication and informed the unit ractical nurse #2 on 12/13/18.	F 62			
		ewed the admissions staff on				

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NAME OF F	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		12/14/2018	
PHEASA	NT RIDGE NURSING 8	REHAB CENTER		4355 F	PHEASANT RIDGE ROAD, SW NOKE, VA 24014			
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F 625	stated the facility of the facility always if admissions staff st straight back to the left undisturbed. The "We don't even pack was necessary to care coming back to	age 104 loes not offer a bed hold due to having beds available. The lead lated if a resident was coming lead same room, that room was he lead admissions staff stated, lik the bags. I didn't think it lifter a bed hold because they he same room." The lead formed the surveyor that	F	625				
	information on the I and/or provided in the packet. The surve bed hold policy. The surveyor review Effective Date 03/0 11/1/2017 on 12/14 "Resident or resident provided in the packet in the provided in the	wed the policy was given the resident's admission yor requested a copy of the wed the policy titled "Bed Hold 1/2015 Revision Date: 1/18. The policy read in part the representative will be an, and at the time of transfer						
	(to the hospital or the hold policies, according requirements. Proc transfer to the hospicenter will provide a hold. Requirement at the resident's copy of the hold.	ding to Federal and/or State edure: 2. At the time of the time of the time of open of notification of bed at the time of transfer is met if of the notice is sent with other nog the resident to the						
]	director of nursing a	ed the administrator, the nd the regional registered the end of the day meeting p.m.					i i	
	provided to the surve conference on 12/14 3. For Resident #89,	on regarding this issue was bey team prior to the exit 1/18. facility staff falled to provide written notice of transfer.		2				

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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FLILL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 625 Continued From page 105 F 625 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 clinical record indicated the resident was hospitalized 11/2-11/3/18. On 12/14/18 the surveyor interviewed the unit manager about the transfer paperwork. The unit manager attempted to locate the transfer summary and order summary and said she would find out if anyone gave the resident or representative a written notice of the reason for transfer and the bed hold policy. The administrator and director of clinical services were notified of the concern during a summary meeting on 12/14/18. No transfer summary for the receiving facility, written notice of transfer for the resident and representative, or bed hold policy were found for the 11/2/18 hospitalization. 4. For Resident #90, facility staff falled to provide bed hold policies or written notice of transfer. Resident #90 was admitted to the facility on 6/12/18 and readmitted on 12/6/18 with

diagnoses including chronic respiratory failure.

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 (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 ID PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (XS) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATIONS TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 625 Continued From page 106 F 625 toxic encephalopathy, dysphagia, end stage renal disease with hemodialysis, hypertension, type 2 diabetes mellitus, and dysphagia. On the quarterly minimum data set assessment with assessment reference date 11/19/18, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium or psychosis and verbal behaviors on a daily basis. The clinical record indicated the resident was hospitalized 12/3-12/6/18 after complaining of headache and having seizure. On 12/14/18 the surveyor interviewed the unit manager about the transfer paperwork. The unit manager attempted to locate the transfer summary and order summary and said she would find out if anyone gave the resident or his representative a written notice of the reason for transfer. The administrator and director of clinical services were notified of the concern during a summary meeting on 12/14/18. No transfer summary for the receiving facility, written notice of transfer for the resident and representative, or bed hold policy were found for the 12/3/18 hospitalization. 5. The facility staff failed to provide written bed hold notification to the resident and the resident representative when Resident #5 was transferred to the hospital 8/12/18. Resident #5 was readmitted to the facility 8/27/18 with diagnoses that included but not limited to hypertension, major depressive disorder, anxiety disorder, and benign prostatic hyperplasia. The clinical record for Resident # 5 was reviewed

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

on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident # 5

EventID: Y3F111

Facility ID: VA0208

If continuation sheet Page 107 of 187



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F 625	(assessment refere of the MDS assess Section C0500, the Resident # 5 had a mental status) scorr indicated that Resid	ge 107 essment with an ARD nce date) of 9/3/18. Section C es cognitive patterns. In facility staff documented that BIMS (brief interview for e of 15 out of 15, which lent # 15 was cognitively	F 62				
	that the staff had proceed the hospital on 8/12. The surveyor interving 12/14/18 at 11:25 a.	nable to locate documentation ovided the bed hold notice to he resident was transferred to /18. ewed the admissions staff on m. The lead admissions staff es not offer a bed hold due to					
	the facility always he admissions staff sta straight back to the left undisturbed. The "We don't even pack was necessary to of are coming back to the admissions staff info information on the bland/or provided in the packet. The survey	aving beds available. The lead ted if a resident was coming same room, that room was elead admissions staff stated, at the bags. I didn't think it fer a bed hold because they the same room." The lead with the surveyor that ed hold policy was given the resident's admission or requested a copy of the					
290	bed hold policy. The surveyor review Effective Date 03/01 11/1/2017 on 12/14/ "Resident or residen notified on admission (to the hospital or the hold policies, accord requirements. Proce	ed the policy titled "Bed Hold /2015 Revision Date: 18. The policy read in part trepresentative will be not at the time of transfer erapeutic leave) of the bed ing to Federal and/or State edure: 2. At the time of all or therapeutic leave, the					

PRINTED: 01/16/2019

(X5) COMPLETION DATE

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_ 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 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 625

F 625 | Continued From page 108 center will provide a copy of notification of bed

hold. Requirement at the time of transfer is met if the resident's copy of the notice is sent with other papers accompanying the resident to the hospital."

The surveyor informed the administrator, the director of nursing and the regional registered nurse of the issue in the end of the day meeting on 12/14/18 at 2:00 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference on 12/14/18.

6. For Resident #22, the facility staff failed to provide written bed hold notification when Resident #22 was transferred to a local hospital.

Resident #22 is a 58-year-old male who was originally admitted to the facility on 08/04/16, with a readmission date of 11/10/18. Diagnoses included, but were not limited to, hypertension, acute kidney failure, major depressive disorder. diabetes, and complete traumatic amoutation.

The clinical record for Resident #22 was reviewed 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 Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident #24 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. It contained a progress note in the clinical record documented on 11/07/18 at 7:30 pm which read in part, "Resident

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 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) IO PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 625 | Continued From page 109 F 625 confinues 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 offered a bed hold upon admission to the local hospital on 11/07/18. On 12/14/18 at 10:56 am the surveyor spoke to admissions care liaison. The admission care liaison voiced that they do not offer a bed hold due to the facility always having beds available. The admissions care liaison stated, "So if resident is coming straight back to the bed we leave the room undisturbed. I did not think it was necessary to offer a bed hold because they are coming back to the same room". The admissions care liaison reported to the surveyor that bed hold policy is given and/or provided in the Resident's admission packet. On 12/14/18 the surveyor was provided with a copy of a policy/procedure with the subject entitled "Bed Hold". Under the section entitled "Procedure" #2 read in part, "At the time of transfer to the hospital or therapeutic leave, the center will provide a copy of notification of bed hold Requirement at the time of transfer is met if the Resident's copy of the notice is sent with other papers accompanying the Resident to the hospital". The surveyor spoke to the DON on 12/14/18 at 11:26 am. The surveyor asked if a bed hold notice was sent with the Resident upon transfer to another facility such as the local hospital. The

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10/15/18 and discharged on 10/22/18. The only

Resident #98 had the following diagnoses of, but

MDS (Minimum Data Set) available to review

not limited to diabetes, high blood pressure, neuropathy and acute kidney failure.

were the entry MDS and discharge MDS.

including the assessment must

accurately reflect the resident's

status and section A2100 must

reflect accurate discharge

reporting, by 1/21/2019.

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:	(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		E SURVEY PLETED
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NAME OF PROVIDER OR SUPPLIER PHEASANT RIDGE NURSING & REM	HAB CENTER	4	STREET ADDRESS, CITY, STATE, ZIP CODE 4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		/14/2018
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of Resident #98 on 12/ the surveyor noted a ph 10/19/18, which stated, (discharge) to	the closed clinical record 14/18. During this review. hysician order dated for "Pt. (patient) to d/c hame of receiving reviewed the discharge essment Reference Date) A2100, the resident was ged to an acute hospital. For notified the corporate the above documented otified the administrative mented findings. vas provided to the it conference on 12/14/18. It is a Person-Centered Care are Plans ty must develop and are plan for each resident tions needed to provide intered care of the resident standards of quality care, must- 48 hours of a resident I to-	F 641	4. DCS and or MDS conduct random quamonitoring of reside transferred and/or densure accurate code section A2100 on the reflect accurate discreporting, 3 times perweeks, then weekly months. Findings to to QAPI committee rupdated as indicated monitoring schedule based on findings. 5. Date of Compliant 1/28/2019. F655- Baseline 1. Resident #89 Nurse Practitions medication reviee 1/21/2019, no sign symptoms of distime. Compreher reviewed and refunterdisciplinary 1/22/2019, care current needs of Resident #70 distanting facility on 1/10/2	anurse will ality ality ality ality ality and sischarged to be a MDS to tharge ar week for 4 for 3 a be reported monthly and al. Quality modified ace Care Plan assessed by a completed on a complete and a complete a	

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 4385 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 655 Continued From page 112 F 655 2. The Director of Clinical (C) Dietary orders. Services and or UMs to (D) Therapy services. complete a quality review of (E) Social services. current residents admitted in the (F) PASARR recommendation, if applicable. last 30 days to ensure the baseline care plan is current and reflects the needs of the resident §483.21(a)(2) The facility may develop a on 1/25/2019. Follow up based comprehensive care plan in place of the baseline on findings. care plan if the comprehensive care plan-(i) is developed within 48 hours of the resident's The ADCS and or RDCS will provide re-education to licensed (ii) Meets the requirements set forth in paragraph nurses and the Interdisciplinary (b) of this section (excepting paragraph (b)(2)(i) of team will receive re-education this section). from the DCS on Comprehensive Person-§483.21(a)(3) The facility must provide the Centered Care Planning and resident and their representative with a summary Baseline Care Plans by of the baseline care plan that includes but is not 1/28/2019. limited to: (i) The initial goals of the resident. 4. DCS and or ADCS will (ii) A summary of the resident's medications and conduct random quality dietary instructions. monitoring of admissions/re-(iii) Any services and treatments to be admissions to ensure the administered by the facility and personnel acting baseline care plan is current and on behalf of the facility. reflects the needs of the (iv) Any updated information based on the details resident, 3 times per week for 4 of the comprehensive care plan, as necessary. weeks, then weekly for 3 This REQUIREMENT is not met as evidenced months. Findings to be reported by: Based on resident interview, staff interview and to QAPI committee monthly and clinical record review, the facility staff failed to updated as indicated. Quality implement baseline care plan on return from monitoring schedule modified hospital for 1 of 23 residents (89). based on findings. Resident #89 was admitted to the facility on 5. Date of Compliance 3/28/17. Diagnoses included, but were not 1/28/2019. limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter

for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar

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. WING 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 PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) COMPLETION CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 655 | Continued From page 113 F 655 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 smoke 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 guardianship situation) and he said not to let her

leave and to get her a psychlatric evaluation.

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 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 (X6) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 655 Continued From page 114 F 655 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. In the hospital discharge summary, the hospital psychiatrist assessment dated 11/2/18 said the resident was exhibiting no symptoms, but wanted her to stay at the hospital until Adult Protective Services (APS) could talk to her-concern was the resident's safety from facility staff. The hospital note included in history that nursing home staff called the police and reported Resident #89 was trying to blow up the building and kill residents. Police declined to remove her from the building after interviewing the resident and her room mate (who said the resident had not said that, but the nurse had). A nurse's note dated 11/2/18 indicated that the resident reported to staff that she felt staff was stealing from her and that the resident signed paperwork indicating intention to leave before staff called police to deal with the situation (it was unclear whether the police were supposed to remove the resident or prevent her from leaving, but that she would not be allowed to leave with the person of her choice). A nurse's note dated 11/3/18 indicated that the resident asked to smoke and the nurse refused to give her cigarettes, saying that the resident was told she couldn't take off her oxygen because saturation levels might drop and the resident was given a sedative medication instead.

During an interview on 12/14/18 at 10:10 AM, the DCS said that there was a lot of concern about

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F 655	the resident's safet unable to locate do notifying the physic retraining staff cond behaviors before caunable to locate do behavior or sympto. The surveyor discussiness office directors. She stated so and came in after discussiness office Masmoke. She had resaying she was cleased business office Masmoking outside how they told her she conformate was upsuin case the resident office Manager new to the room mate. Called the administr dealing with the situation of the resident of the medical record for a signification of the reresident, a family more than the clinical record of the clinical record of the clinical record of the resident, a family more than the clinical record of the clinical record of the clinical record of the reresident, a family more than the clinical record of the clinical reco	y. However, the surveyor was cumentation of behavior, ian of behavior changes, or cerning de-escalation of alling police. Facility staff were cumentation of any record of ms. ssed the 11/2 incident with the actor, who obtained the ECO he was working on 11/2/18 inner and the police were in that the resident wanted to atturned from the doctor's office ared to smoke. Staff told the mager the resident was turn and getting upset when audin't. Staff said the et and wouldn't go in the room as smoked. The Business er saw the resident or talked. The Business Office Manager ator who told her he had been lation for hours. He told her to a TDO (called ECO above). Manager took some supervisor and a CNA to the	F 655				

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F 655	Continued From page	ge 116	F 65	5		
	surveyor reported to clinical (DCS) and to for clinical services to on 11/2 described in record any assessment or contagrior to the transfer, resident after the resident after the resident after the resident's status hospitalization. The findings include The facility staff failed c-difficile on the base 70. Resident # 70 was a	d: d to include a focus area for eline care plan for Resident # n 87-year-old-female who				
	was originally admitt with a readmission d included but were no	ed to the facility on 9/20/18, late of 12/10/18. Diagnoses of limited to, c-diff, irritable a diarrhea, hypertension, and				
	recent MDS (minimu Resident # 70 was a assessment with and	8 at 2:41 pm. The most m data set) assessment for 14-day scheduled I ARD (assessment				
	MDS assesses cogn C0500, the facility sta # 70 had a BIMS (bri	/15/18. Section C of the itive patterns. In Section aff documented that Resident ef interview for mental ut of 15, which indicated that ognitively intact.	a		29	

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

PRINTED: 01/16/2019 FORM APPROVED

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F 655	Resident # 70 had but was not limited (milligram) Give 1 of hours for c-diff for On 12/14/18 at 10.	current orders that included to, "Vancomycin HCI 125 mg capsule by mouth every 6	F 655			
	copy of the baselin that was initiated o facility, the surveyor care plan for Resid 12/10/18 at 2:25 pr	e care plan for Resident # 70 n 12/10/18. After leaving the or observed that the baseline ent # 70 that was initiated on my was incomplete and did not a regarding care of the		<u>F857- Care Pian Timin</u> Revision		
SS≃D	§483.21(b)(2) A conbe- (i) Developed within the comprehensive (ii) Prepared by an includes but is not I. (A) The attending p (B) A registered nur resident. (C) A nurse aide wit resident. (D) A member of for (E) To the extent pre	2)(i)-(ii) whensive Care Plans imprehensive care plan must in 7 days after completion of assessment. interdisciplinary team, that imited to	F 657	1. The Nurse Practition assessed Resident #89 medication review was completed on 1/21/2019 signs or symptoms of diswere present. Resident comprehensive care plan reviewed and revised by Interdisciplinary Team (II 1/22/2019. Resident #85 plan reflects current need resident. A Safe Smokin Evaluation was complete UM for Resident #89 on 1/18/2019. 2. The UMs and or MDS	and No stress \$89's n was OT) on or o's care dis of or	
	medical record if the and their resident re not practicable for the resident's care plan	t be included in a resident's participation of the resident appresentative is determined no development of the staff or professionals in		will complete a quality re- current residents care platensure care plan reflect not behaviors and, reflects satisfied by 1/25/2019. Follow up on findings.	view of ins to esident ife licable	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	NSTRUCTION	СОМ	SURVEY PLETED
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F 657	disciplines as determ or as requested by the (iii) Reviewed and reviewed and reviewed and reviewed and reviewed and reviewed assessments. This REQUIREMENT by: Based on resident in clinical document reviewed and revise the on return from hospital review of tracheosto disease, post-traumal disorder, atherosclero mellitus type 1, and cheart 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 stated 9/26/18 and indices to smoke independent as her own responsible. During an interview or reported being general care received, but indicanother facility prior to	nined by the resident's needs are resident. rised by the interdisciplinary assment, including both the quarterly review It is not met as evidenced atterview, staff interview and iew, the facility staff failed to a comprehensive care plan at for 1 of 23 residents (89). mitted to the facility on included, but were not and hemiparesis following thage, dysphagia, encounter my, atherosclerotic heart tic stress disorder, bipolar out the eart disease, diabetes aronic obstructive pulmonary a quarterly 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 licated the resident was able thy. The resident was able thy. The resident was acting the party. In 12/13/18, the resident alty content with physical icated a desire to transfer to other planned ban on abruary 2019. The resident if several times about	F 657	3. The ADCS and or RDC provide re-education to lic nurses and the interdiscip team will receive re-educathe DCS on the policy and procedure for timing and rof Comprehensive Care Pby 1/28/2019. 4. DCS and or MDS nurs conduct quality monitoring resident's care plans to ercare plans are reviewed a updated when resident's a readmitted to the facility to ensure the care plan refle resident behaviors, and m5 care plans of residents smoke to ensure the care reflects a safe smoking evaluation, 3 times per will weeks, then weekly for months. Findings to be reto QAPI committee month updated as indicated. Qui monitoring schedule mod based on findings. 5. Date of Compliance 1/28/2019.	ensed linary tion by evision lans e to o of 5 asure and are o cts conitor who plan eek for 3 eported ly and ality	

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F 657	timeline for the tran reported being sent tracheostomy revision resident said she hanotice of the reason. Clinical record revies staff member took to CNA and nurse on could not smoke as resident's smoking indicated the reside independent smoke leave AMA (against paperwork indicatin started calling familicalled the resident's guardianship situatileave and to get he Staff requested a Eorder) and called arresident to the hospital discipsychiatrist assessing resident was exhibited to stay at the hospitalization or that the requiring hospitalization or that the requiring hospitalization to stay at the hospitalization or stay at the hospitalization or that the requiring hospitalization or that the region of the hospital discipsion of the hospita	insfer. The resident also it to the hospital for ion the month before. The ad been given no written as for transfer to the hospital. Hew reveled that on 11/2/18, a sthe resident's cigarettes. The duty told the resident she is a safety concern. The assessment from 9/23/28 and was safe as an er. The resident requested to a medical advice), signed and the transfer of a ride. Staff is father (this was not a ion) and he said not to let her or a psychiatric evaluation. In CO (emergency commitment in ambulance to take the obtal. There was no indication ician was notified of the re was a change of condition	F 65				

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F 657	Continued From pa	ge 120	F 69	57		
	resident reported to stealing from her ar paperwork indicating staff called police to unclear whether the remove the resident but that she would not the person of her challed the smoke and the nurse cigarettes, saying the couldn't take off her levels might drop an sedative medication. During an interview DCS said that there the resident's safety unable to locate doc notifying the physiciar etraining staff concerts.	d 11/2/18 indicated that the staff that she felt staff was id that the resident signed g intention to leave before deal with the situation (it was police were supposed to or prevent her from leaving, not be allowed to leave with oice). A nurse's note dated at the resident asked to e refused to give her at the resident was told she oxygen because saturation d the resident was given a instead. on 12/14/18 at 10:10 AM, the was a lot of concern about. However, the surveyor was umentation of behavior, an of behavior changes, or eming de-escalation of ling police. Facility staff were			3	
	unable to locate doc behavior or symptom	umentation of any record of as.				
1	Business office directorder. She stated she and came in after directorder. Staff told her to smoke. She had retus saying she was clear Business Office Manamoking outside hour hey told her she couronmate was upset	sed the 11/2 incident with the tor, who obtained the ECO awas working on 11/2/18 iner and the police were that the resident wanted to arned from the doctor's office ed to smoke. Staff told the ager the resident was and getting upset when Idn't. Staff said the and wouldn't go in the room smoked. The Business				

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 (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING _ 495325 B. WING 12/14/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4366 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 657 Continued From page 121 F 657 Office Manager never saw the resident or talked to the room mate. The Business Office Manager called the administrator who told her he had been dealing with the situation for hours. He told her to go downtown to get a TDO (called ECO above). The Business Office Manager took some statements from a supervisor and a CNA to the magistrate for a TDO (ECO). There was no transfer summary or assessment in the medical record for that date. The director of nursing was unable to locate any transfer documentation, assessments, or written notification of the reason for transfer given to the resident, a family member, or hospital staff. The clinical record did not include an assessment of the resident's status or a care plan revision upon the resident's return from the hospital There was no behavior assessment or reassessment of the resident's Safe Smoking Evaluation after hospitalization. During a summary meeting on 12/13/18, the surveyor reported to the administrator, director of clinical (DCS) and the corporate regional director for clinical services the concern with the situation on 11/3 described in the record. Staff did not record any assessment or complete a transfer assessment or contact the resident's physician prior to the transfer. Staff failed to assess the resident after the resident's return to the facility. There was no indication that staff attempted to determine whether there had been a change in the resident's status or needs after the hospitalization. ADL Care Provided for Dependent Residents F 677 F 677 CFR(s): 483.24(a)(2) SS=D

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_ 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 (X5) COMPLETION DATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 677 Continued From page 122 F 677 F677- ADL Care Provided for §483.24(a)(2) A resident who is unable to carry Dependent Residents out activities of daily living receives the necessary services to maintain good nutrition, grooming, and Resident #58 discharged from personal and oral hygiene; facility on 1/17/2019. This REQUIREMENT is not met as evidenced bv: Based on observation, staff interview and clinical 2. The UMs completed a quality review of current residents to record review, the facility staff failed to provide ensure facility staff provide nail nail care to 1 of 23 residents (Resident #58). care as needed on 1/20/2019. Follow up based on findings. The findings included: 3. The ADCS and or RDCS will The facility staff failed to provide nail care to provide re-education to licensed Resident #58. nurses and certified nursing assistants on the policy and Resident #58 was admitted to the facility 12/4/13 procedure for the provision of and readmitted 12/5/18 with diagnoses that ADL care by 1/28/2019. included but not limited to adult failure to thrive. functional intestinal disorders, ileus, rectal tube. 4. DC\$ and or ADC\$ will sacral ulcer stage 3, hypertension, paroxysmal conduct quality monitoring of 5 atrial fibrillation, dementia without behavioral residents to ensure facility disturbances, pressure ulcers bilateral heels, provides nail care as needed, 3 unstageable, and chronic kidney disease. times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee Resident #58's quarterly minimum data set monthly and updated as (MDS) assessment with an assessment indicated. Quality monitoring reference date (ARD) of 11/7/18 assessed the schedule modified based on resident with a BIMS (brief interview for mental findings. status) as 03/15. Section G Functional Status assessed the resident to need extensive assistance of one person for personal hygiene 5. Date of Compliance and was totally dependent on one person for 1/28/2019. bathing. Resident #58 was in the process of a significant change MDS and comprehensive care plan. Resident #58's current comprehensive care plan

revised 12/11/18 identified a self-care deficit for

		MEDICAID SERVICES		APPROVED TO SERVE	OMB	RM APPROVE NO. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION IG	(X3) DA	TE SURVEY MPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		2 * 52 (1)	STREET ADDRESS, CITY, STATE, ZIP	CODE	2/14/2018	
PHEASA	IT RIDGE NURSING & R	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 677	Extensive assistance dressing, toileting, pe eating.	e 123 aity living). Interventions; of 1-2 with bed mobility, ersonal hygiene, bathing, and ed Resident #58 on 12/12/18	F 67	777			
	2:56 p.m. Resident # hands were observed tops of both hands we both hands were observed with brown debris obsindex fingers on both.	f58 was lying in bed. Both if on top of the covers. The ere bruised. Fingernails on erved to be long and jagged served under thumbnails and . Nail polish was observed a beginning to chip away.					
	at 7:48 a.m. Residen certified nursing assis resident. The fingernal long and Jagged with I	stant #1 was feeding the ails on both hands were brown debris noted under fingers C.N.A. #1 stated ned from the hospital.		=			
	The surveyor informed practical nurse #2 of the 12/13/18 at 11:03 a.m. December 2018 ADL	. and requested the					
	records for bathing. R shower on 12/11/18 as following 4, 4, 2 SH El hygiene for December	d the December 2018 ADL desident #58 received a s documented by the LVV4 12:32. Personal 2018 was reviewed. Each that care was provided.					
	The surveyor observed #2 providing nail care Resident #58.	d certified nursing assistant on 12/13/18 11:07 AM to		Tillwa E A			
			1	Į.			

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

PRINTED: 01/16/2019 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495325	B. WING		С	
	PROVIDER OR SUPPLIER NT RIDGE NURSING 8	REHAB CENTER	435	EET ADDRESS, CITY, STATE, ZIP CODE 5 PHEASANT RIDGE ROAD, SW ANOKE, VA 24014	11	2/14/2018
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LOBE	(X5) COMPLETION DATE
F 677	The surveyor informative of the above day meeting on 12 No further informative exit conference on	med the administrator, the and the corporate registered concern during the end of the /13/18 at 4:29 p.m.	F 677			
	S 483.25 Quality of Quality of care is a applies to all treatm facility residents. Be assessment of a rethat residents received accordance with propractice, the comprocare plan, and the rotal This REQUIREMENT by: Based on staff intereview, and clinical failed to provide the for 3 of 23 residents and Resident #89). The findings included the form of the facility staff orders for Zaroxolyr. The clinical record of 12/12/18 through 12 admitted to the facility of the facility o	fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered residents' choices. It is not met as evidenced review, facility document record review, the facility staff in highest practicable well-being is (Resident #14, Resident #37, and: If Resident #14 was reviewed 2/14/18. Resident #14 was the 6/11/18 with diagnoses that ted to acute pulmonary y faiture, paranoid	F 684	1. Resident #'s14, 37 and 8 were assessed and a medic review was completed by N Practitioner on 1/21/2019. Note that is signs or symptoms were present. The DCS complet medication error report for resident #'s14 and 37 on 1/22/2019. 2. The UMs completed qual review of current resident's Medication Administration Record (MAR) and medicate to ensure medication are available for administration 1/23/2019. The UMs to complete quality review for residents transferred in the 30 days to ensure proper assessment was completed reported to Physician timely 1/25/2019. Follow up based findings. 3. The ADCS and or RDCS provide re-education to lice nurses ensuring med availa Change of condition/assess and MD/Responsible Party	eation urse lo ed a ity ons, on last and on on on	

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES		- Alexander (Carlotte Carlotte	PRINTED: 01/16/2 FORM APPROV OMB NO. 0938-0:	VΕ
	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
11444		495325	B. WING		C	
3115	PROVIDER OR SUPPLIER	REHAB CENTER		STREET ADDRESS, CITY STATE ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	12/14/2018	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RE COMPLETIO	NK
	chronic systolic heat Hepatitis C, chronic disease, major depidisorder, schizoaffe dependence, anxiel difficile, tobacco abskin, and adjustmer Resident #14's qual (MDS) assessment reference date (ARI resident with a BIMS status) as 15/15. Resident #14 had a 10/12/18 that read "X x 3 days po (by mou failure)." The surveyor review medication administration administration administration of the MAR read "No The box for 10/13/18 was blank. The surveyor review or green and for 10/12/18. Inote for 10/12/1	art failure, chronic viral cobstructive pulmonary ressive disorder, bipolar rective disorder, opioid by disorder. Ciostridium use, malignant neoplasm of at disorder. Arterly minimum data set with an assessment D) of 9/13/18 assessed the S (brief interview for mental physician order dated Zaroxolyn 2.5 mg (milligrams) with CHF (congestive heart led the October 2018 ration records (MARs), and been entered onto the 118. The 10/12/18 box had led and written on the back of available-called pharmacy." It was blank and 10/14/18 ed the interdisciplinary ctober 2018. There was not The notes for 10/13/18 and urment the reason Zaroxolyn	F 68	4. DCS and or ADCS will conduct quality monitoring of resident's MAR and medication to ensure medication are available for administration, 3 times per week for 4 weeks, the weekly for 3 months. DCS and or ADCS will conduct random quality monitoring of the medical record residents with a change of condition to ensure proper assessment was completed as reported to Physician timely, 3 times per week for 4 weeks, findings be reported to QAPI committed monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	nen d cal e	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES				PRINTED. 01/16/201 FORM APPROVE
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		A BUILDIA	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED C	
The second secon	45	B. WING _		12/14/2018
			STREET ADDRESS, CITY, STATE. ZI 4365 PHEASANT RIDGE ROAD, S ROANOKE, VA 24014	
EFICIENCY MUST BE PRECEDED!	BY FUEL	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COMPLETION OF THE APPROPRIATE DATE
informed the administrator, sing, and the regional regispove concern during the er in 12/13/18 at 4:29 p.m. The sted the pharmacy manifer a list of the stat box medical med the surveyor on 12/14 there was not a pharmacy and the medication was not a madical medical medic	stered and of the ane est for cations. 4/18 at manifest t in the to the aysician's cation, on t not e, rterly 3, the also f 1 staff e and r for	F 68		
	A953 PLIER ING & REHAB CENTER IMARY STATEMENT OF DEFICIENCE FICIENCY MUST BE PRECEDED FORY OR LSC IDENTIFYING INFORMATION OF A STATEMENT OF DEFICIENCE OF A STATEMENT OF A STATEM	CARE & MEDICAID SERVICES (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER: 495325 PLIER IMARY STATEMENT OF DEFICIENCIES EFICIENCY MUST BE PRECEDED BY PULL FORY OR LSC IDENTIFYING INFORMATION) om page 126 as not administered. Informed the administrator, the sing, and the regional registered bove concern during the end of the in 12/13/18 at 4:29 p.m. The seted the pharmacy manifest for a list of the stat box medications. The medication was not in the contact the medication was not in the interval of the state of the physician is and the medication of a medication, sident #37. In Data Set) with an ARD deference Date) of 10/16/18, the coded as having a BIMS (Brief cental Status) score of 9 out of a of 15. Resident #37 was also ring extensive assistance of 1 staff send and personal hygiene and pendent on 1 staff member for licensed practical nurse) #3	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 498325 B. WING	ARE & MEDICAID SERVICES X1) PROVIDERSUPPLIERCILA (X2) MULTIPLE CONSTRUCTION A BUILDING BUILDING A BUILDING B

CENTE	RS FOR MEDICARI	AND HUMAN SERVICES 8 MEDICAID SERVICES	2 /3 /3		FO	TED: 01/16/20 DRM APPROVE NO: 0938-039	
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DA	(X3) DATE SURVEY COMPLETED	
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	AME OF PROVIDER OR SUPPLIER HEASANT RIDGE NURSING & REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		2/14/2018	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE CORRECTIVE CORRECTION CORRECTI	ON SHOULD BE IE APPROPRIATE	COMPLETION DATE	
F 684	Continued From p		F 68	4			
	on Resident #37 a surveyor could not	ormed a clinical record review t approximately 1:30 pm. The find a physician order for #3 administered to Resident					
	documented finding copies of the physic (medication admini	stration record) for the month					
	copies of the above LPN #1. The surve could not find a phy facility's policy titled Preparation and Me in part, "4.1 Faci each time a medica the correct medicati	veyor was provided with requested materials from yor reviewed these copies and sician order for Norvasc. The 16.0 General Dose idication Administration: read lity staff should: 4.1.1 Verify tion is administrated that it is on, at the correct dose, at the correct time, for the right					
1	At 4:32 pm on 12/13 administrative team indings.	i/18, the surveyor notified the of the above documented	A.				
S S F	surveyor prior to the B. For Resident # 89 properly assess resident	en was provided to the exit conference on 12/14/18. If a cility staff failed to dent's status and report ent's physician to facilitate			W I	1 N	
3	Resident #89 was a	dmitted to the facility on included, but were not					

TATEPACALL	OF DEFICIENCIES	MEDICAID SERVICES			OWB	NO. 0938-03
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
	110, a. l. 11	495325	B. WING_			C 2/14/2018
VAME OF P	ROVIDER OR SUPPLIER	n we la United to		STREET ADDRESS, CITY, STATE, ZIP C		2/1-7/2010
PHEASAI	IT RIDGE NURSING &	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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	subarachnoid hemore for care of tracheost disease, post-traumatisorder, atheroscler mellitus type I, and of heart disease. On the set assessment with 10/10/2018, the resident interview for meassessed as lacking or behaviors affecting resident's latest safe dated 9/26/18 and in to smoke independe as her own responsitional puring an interview of reported being genericare received, but incanother facility prior is smoking starting in Freported having asked progress toward the timeline for the transfreported being sent to tracheostomy revision.	a and hemiparesis following rrhage, dysphagia, encounter omy, atherosclerotic heart atic stress disorder, bipolar rotic heart disease, diabetes shronic obstructive pulmonary ne quarterly minimum data assessment reference date dent scored 15/15 on the ental status and was signs of delirium, psychosis, g self or others. The smoking assessment was dicated the resident was acting one party. In 12/13/18, the resident raily content with physical dicated a desire to transfer to to the planned ban on ebruary 2019. The resident ransfer, but having no fer. The resident also	F 68			
	Clinical record review staff member took the CNA and nurse on du could not smoke as a resident's smoking as indicated the resident	sessment from 9/23/28				

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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (K5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PRFFX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY F 684 Continued From page 129 F 684 started calling family and friends for a ride. Staff called the resident's father (this was not a guardianship situation) and he said not to let her leave and to get her a psychiatric evaluation. 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. In the hospital discharge summary, the hospital psychiatrist assessment dated 11/2/18 said the resident was exhibiting no symptoms, but wanted her to stay at the hospital until APS could talk to her- concern was the resident's safety from facility staff. The hospital note included in history that nursing home staff called the police and reported Resident #89 was trying to blow up the building and kill residents. Police declined to remove her from the building after interviewing the resident and her room mate (who said the resident had not said that, but the nurse had). A nurse's note dated 11/2/18 indicated that the resident reported to staff that she felt staff was stealing from her and that the resident signed paperwork indicating intention to leave before staff called police to deal with the situation (it was unclear whether the police were supposed to remove the resident or prevent her from leaving, but that she would not be allowed to leave with the person of her choice). A nurse's note dated 11/3/18 indicated that the resident asked to smoke and the nurse refused to give her cigarettes, saying that the resident was told she couldn't take off her oxygen because saturation levels might drop and the resident was given a sedative medication instead.

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				ORM APPROVE 3 NO. 0938-039	
TATEMENT ND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION	(X3)	DATE SURVEY COMPLETED	
		495325	B. WING			12/14/2018	
NAME OF P	AME OF PROVIDER OR SUPPLIER		1 8	STREET ADDRESS, CITY, STA	TE. ZIP CODE	12/14/2010	
PHEASAN	NT RIDGE NURSING & R	EHAB CENTER		4355 PHEASANT RIDGE ROANOKE, VA 24014	AD, SW		
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F 684	Continued From page	e 130	. F6	34			
	DCS said that there we the resident's safety.	on 12/14/18 at 10:10 AM, the vas a lot of concern about However, the surveyor was imentation of behavior,					
	notifying the physicial retraining staff concer behaviors before calli	n of behavior changes, or rning de-escalation of ng police. Facility staff were mentation of any record of					
	Business office direct order. She stated she and came in after direct there. Staff told her th	ed the 11/2 incident with the or, who obtained the ECO was working on 11/2/18 ner and the police were nat the resident wanted to					
	saying she was cleare Business Office Mana smoking outside hour they told her she could	s and getting upset when do't. Staff said the					
	in case the resident so Office Manager never to the room mate. Th	saw the resident or talked e Business Office Manager					
	dealing with the situat go downtown to get a The Business Office N statements from a sup	ervisor and a CNA to the					
	the medical record for nursing was unable to	summary or assessment in that date. The director of locate any transfer					
	documentation, asses: notification of the reas resident, a family men	on for transfer given to the					

CENTER	S FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 01/ FORM APP OMB NO. 093	ROVE
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. SUILDING		(X3) DATE SURVEY COMPLETED	
	495325		B. WING		C	
NAME OF P	ROVIDER OR SUPPLIER	Attacks in South Carety		STREET ADDRESS, CITY, STATE, ZIP CODE	12/14/20	18
PHEASAN	IT 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RE COM	(XS) PLETION DATE
F 684	of the resident's sta	ige 131 did not include an assessment itus or a care plan revision return from the hospital.	F 68	4		
F 686 SS=D	clinical (DCS) and for clinical services on 11/2 described in communicate with the report changes in sithat staff called the friends of the reside that date.	the administrator, director of the corporate regional director the concern with the situation in the record. Staff did not the resident's physician to tatus. The record indicated administrator and family and and to discuss the situation on Prevent/Heal Pressure Ulcer ((()(ii))	F 686	F686- Treatment/Services Prevent/Heal Pressure Uto	to	
	resident, the facility (i) A resident receive professional standar pressure ulcers and ulcers unless the inc demonstrates that th (ii) A resident with pr necessary treatment with professional sta promote healing, pre new ulcers from dev. This REQUIREMEN by: Based on observatio clinical record review provide treatment an	rehensive assessment of a must ensure that- as care, consistent with rids of practice, to prevent does not develop pressure dividual's clinical condition and were unavoidable; and ressure ulcers receives and services, consistent and services, consistent infection and prevent eloping. T is not met as evidenced on, resident interview, and the facility staff failed to discrete services to prevent of 23 Residents in the		1. Resident #5's Physician ordered treatment for the pressure ulcer has been reevaluated by Nurse Practitio on 1/21/2019 and treatment place at this time. 2. The ADCS completed quareview of residents with pressulcers ensure treatments are applied and in place per Physician orders on 1/24/201 Follow up based on findings. 3. The ADCS and or RDCS v provide re-education to licens nurses and certified nursing assistants on the Clinical Guidelines for skin and wound treatment by 1/28/2019.	ner is in llity sure 9.	

		AND HUMAN SERVICES				TED: 01/16/2019 DRM APPROVED	
STATEMENT	OF DEFICIENCIES F CORRECTION			TIPLE CONSTRUCTION	(X3) D	(X3) DATE SURVEY COMPLETED	
	495325		B. WING_			C 12/14/2018	
	PROVIDER OR SUPPLIER	REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		12/14/2010	
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	The findings include The facility failed to ordered treatment for in place for Resident Resident # 5 was a admitted to the facility readmission date of but were not limited depressive disorder, prostatic hyperplasia. The clinical record for on 12/13/18 at 10.41 (minimum data set) as was a quarterly asses (assessment referent of the MDS assesses Section C0500, the findicated that Resident # 5 had a Emental status) score indicated that Reside intact. Section M of the conditions. In Section documented that Respressure ulcer during 9/3/18 ARD. The current plan of conversed and revised staff documented a for as "Resident # 5 has impaired skin integrity health condition, condecreased mobility."	ensure that a physician or a sacral pressure ulcer was at # 5. 40-year-old-male who was by on 4/20/18, with a 8/27/18. Diagnoses included to, hypertension, major anxiety disorder, and benign or Resident # 5 was reviewed am. The most recent MDS assessment for Resident # 5 issment with an ARD ce date) of 9/3/18. Section C is cognitive patterns. In facility staff documented that MMS (brief interview for of 15 out of 15, which ent # 15 was cognitively the MDS assesses skin in M0300, the facility staff sident # 5 had 1 Stage 2 in the lookback period for additional by r/t (related to) overall morbidities, incontinence, Interventions included but Administer treatments as	F	4. DCS and or ADCS conduct quality monitoresidents with pressunt treatments to ensure to are applied and in place. Physician orders, 3 time week for 4 weeks, there for 3 months. Findings reported to QAPI commonthly and updated a indicated. Quality monischedule modified basefindings. 5. Date of Compliance 1/28/2019.	ring of 5 e ulcer realments re per es per i weekly to be nittee s toring ed on		

		& MEDICAID SERVICES					RM APPROVE 10. 0938-039	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	St. 68-14	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER		// >	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 1	2/14/2018	
PHEASAI	IT RIDGE NURSING &	REHAB CENTER			PHEASANT RIDGE ROAD, SW NOKE, VA 24014			
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F 686	Continued From pa	age 133	F	686				
	Resident # 5 had c	urrent orders that included but		İ			-71	
	was not limited to a	on order to "Cleanse sacrum						
	with NS (normal sa	line), pat dry. Pack wound with						
	day) every day shift	with dry dressing qd (every it for wound."					1150	
	On 12/13/18 at 8:18	8 am, the surveyor was in						
	interview. The surve	n conducting a Resident eyor asked Resident # 5 if he						
	had any sores, ope	n areas, or pressure ulcers.	İ					
	Resident # 5 stated	i, "I have a wound on my pretty good care if it. It's			•			
	almost healed up; it with."	s something I came here						
	wound care for Res that he preferred to his walker for suppo	pm, the surveyor observed ident # 5. Resident # 5 stated stand and bend over using ort while his treatment was						
	being done. Upon R	Resident # 5 bending over and						
	Resident # 5's short	ractical nurse) pulling down is to initiate treatment, the				12		
	surveyor observed t	hat there was no dressing						
	covering the wound wound.	or packing in the sacral		-				
	On 12/13/18 at 2:17 LPN # 1. The survey	pm, the surveyor interviewed yor asked LPN # 1 if Resident						
	# 5 had a dressing a	and packing in place prior to						
	initiation of the treat	ment. LPN# 1 stated, "No there." The surveyor asked	16			a 0		
	LPN # 1 if Resident	# 5 should have had a				ш		
	dressing with packin "Yes."	in place. LPN # 1 stated,		T.				
	On 12/13/18 at 2:30	pm, LPN # 1 stated to the ent back in and asked						
	Resident # 5 about h	nis dressing. LPN # 1 stated						

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 .. 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 10 PROMDER'S PLAN OF CORRECTION (X5) 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 686 Continued From page 134 F 686 that Resident # 5 told her that the dressing came off during ADL (activities of daily living) care last night. The surveyor asked LPN # 1 if the CNA (certified nursing assistant) staff was expected to make the charge nurse aware so that the dressing can be replaced. LPN # 1 stated, "Yes." On 12/13/18 at 5:45 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 12/14/18. F 688 Increase/Prevent Decrease in ROM/Mobility F 688 SS=D | CFR(s): 483.25(c)(1)-(3) F688-Increase/Prevent Decrease in ROM/Mobility §483.25(c) Mobility §483.25(c)(1) The facility must ensure that a 1. Resident #11's physician resident who enters the facility without limited ordered bilateral progressive range of motion does not experience reduction in hand roll orthotics were rerange of motion unless the resident's clinical evaluated by occupational condition demonstrates that a reduction in range of motion is unavoidable; and therapy on 1/18/2019. Bilateral progressive hand roll orthotics §483.25(c)(2) A resident with limited range of are appropriate and in place per motion receives appropriate treatment and Physician order. services to increase range of motion and/or to prevent further decrease in range of motion. 2. The ADCS completed quality review of current residents with §483.25(c)(3) A resident with limited mobility physician orders for splints to receives appropriate services, equipment, and ensure the splints are applied assistance to maintain or improve mobility with and in place per Physician orders 1/24/2019. Follow up the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. based on findings. This REQUIREMENT is not met as evidenced Based on observation, staff interview and clinical record review, the facility staff falled to ensure

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES MEDICAID SERVICES		and the best of the second		RM APPROVE NO. 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
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F 688	orthotics were applied (Resident #11). The findings include The facility staff faile ordered bilateral prohad been applied to The clinical record of 12/12/18 through 12 admitted to the facility included but not limit contractures, hypertedysphagia, idiopathic protein-calorie maint failure, periodontal differences (Residue).	d: d to ensure the physician gressive hand roll ad to ensure the physician gressive hand roll orthotics Resident #11. f Resident #11 was reviewed /14/18. Resident #11 was ty 3/16/18 with diagnoses that led to cerebral palsy, hand ension, tachycardia, scoliosis, c epilepsy, severe utrition, acute respiratory isease, intellectual ition, adult failure to thrive,	F 688	3. The ADCS and or RDC provide re-education to lic nurses and certified nursir assistants on the policy ar procedure for contracture, prevention by 1/28/2019. 4. DCS and or ADCS will conduct random quality monitoring of residents will splints are applied and in per Physician orders, 3 tim week for 4 weeks, then we for 3 months. Findings to reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based of findings. 5. Date of Compliance 1/28/2019.	enseding and the blace ness per lekly be		
	assessment with an a (ARD) of 9/6/18 asseterm-memory loss, lo severely impaired codaily-decision making Treatments, Procedureviewed. Resident arange of motion and the look back period. Resident #11's currentitiated 10/14/18 and identified a focus area living) self-care period limited ROM (range of the code in the look back).	g. Section O Special tres, and Programs was received (PROM) passive splints or braces 4 times in from 9/6/18 back to 8/31/18. nt comprehensive care plan					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES		J HUMAN SERVICES MEDICAID SERVICES			FC	TED: 01/16/201 DRM APPROVE
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		495325	B. WING	369		12/14/2018
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resident has (bilateral upp skin care to be breakdown). The surveyor 2018 physicibilateral progromote optimextension for and skin interpolate states and splints. The surveyor at 2:45 p.m. hand splint we large splint we large splint we large splint with the surveyor at 8:36 a.m. Resident #11 a hand splint. The surveyor 12/13/18 at 2 observe any shand. The surveyor nursing assist 2:50 p.m. Roaides have to splints. During restorative aid splint in the file.	interventic contracture per and low keep clean Splints with reviewed itan's orders gressive hat imal joint all recontracture grity. Cheevery shift robserved The residence as observed There was observed There was l's right hat the splints on each of the found Roor, RCNA son in the	ions: Contractures: The res of the BUE/BLE ver extremities). Provide and prevent skin the restorative nursing. Resident #11's December so Orders included using and roll orthotics to lignment, wrist and digit re rigint. (management) ck skin integrity under	F 68			

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 O(3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A BUILDING 495325 8. WING 12/14/2018 NAME OF PROVIDER OR SUPPLIER STREET AUDRESS, 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 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **EACH CORRECTIVE ACTION SHOULD BE** DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 688 Continued From page 137 F 688 The surveyor informed the director of nursing of the above concern on 12/14/18 at 10:04 a.m. The DON stated when the CNAs are pulled to the floor, the nurses are responsible for placing the F689- Free of Accident splints on the resident. Hazards/Supervision/Devices No further information was provided prior to the 1. Resident #89's Safe Smoking exit conference on 12/14/18. Evaluation completed by UM on F 689 : Free of Accident Hazards/Supervision/Devices F 689 1/18/2019. CFR(s): 483.25(d)(1)(2) SS=D 2. The UMs completed quality §483.25(d) Accidents. review of residents who smoke The facility must ensure that to ensure smoking assessments §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and are in place and were updated when residents experienced a §483.25(d)(2)Each resident receives adequate change in status 1/18/2019. supervision and assistance devices to prevent Follow up based on findings. accidents This REQUIREMENT is not met as evidenced 3. The ADCS and or RDCS will provide re-education to licensed Based on staff interview and clinical record nurses on the policy and review, the facility staff failed to do a smoking procedure for completing assessment after a change in status for 1 of 23 smoking assessments by 1/28/2019. residents (89). 4. DCS and or ADCS will Resident #89 was admitted to the facility on conduct random quality 3/28/17. Diagnoses included, but were not monitoring of residents, who limited to, hemiplegia and hemiparesis following smoke, to ensure they have a subarachnoid hemorrhage, dysphagla, encounter safe smoking evaluation per for care of tracheostomy, atherosclerotic heart policy, 3 times per week for 4 disease, post-traumatic stress disorder, bipolar weeks, then weekly for 3 disorder, atherosclerotic heart disease, diabetes months. Findings to be reported mellitus type I, and chronic obstructive pulmonary to QAPI committee monthly and heart disease. On the quarterly minimum data updated as indicated. Quality set assessment with assessment reference date monitoring schedule modified 10/10/2018, the resident scored 15/15 on the based on findings. brief interview for mental status and was

5. Date of Compliance

1/28/2019.

DEPART CENTER	TMENT OF HEALTH A RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			, F	NTED: 01/16/201	
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	12/14/2018	
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F 689	or behaviors affecting resident's latest safe dated 9/26/18 and in	signs of delirium, psychosis, ig self or others. The smoking assessment was able intly. The resident was acting	F 689		0.		
	During an interview of reported being gene care received, but in another facility prior smoking starting in Freported having asked progress toward the timeline for the transit reported being sent to tracheostomy revision resident said she had	on 12/13/18, the resident rally content with physical dicated a desire to transfer to to the planned ban on ebruary 2019. The resident ed several times about transfer, but having no fer. The resident also the hospital for the month before. The					
	Clinical record review staff member took the CNA and nurse on decould not smoke as a resident's smoking as indicated the resident independent smoker. Iteave AMA (against material paperwork indicating started calling family a called the resident's fire	The resident requested to nedical advice), signed that was her intent, and and friends for a ride. Staff ather (this was not a			55 17 17		
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	eave and to get her a Staff requested a ECC order) and called an a resident to the hospita the resident's physicia	was a change of condition					

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 (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED 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 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 689 Continued From page 139 F 689 In the hospital discharge summary, the hospital psychiatrist assessment dated 11/2/18 said the resident was exhibiting no symptoms, but wanted her to stay at the hospital until Adult Protective Services (APS) could talk to her- concern was the resident's safety from facility staff. The hospital note included in history that nursing home staff called the police and reported Resident #89 was trying to blow up the building and kill residents. Police declined to remove her from the building after interviewing the resident and her room mate (who said the resident had not said that, but the nurse had). A nurse's note dated 11/2/18 indicated that the resident reported to staff that she felt staff was stealing from her and that the resident signed paperwork indicating intention to leave before staff called police to deal with the situation (it was unclear whether the police were supposed to remove the resident or prevent her from leaving. but that she would not be allowed to leave with the person of her choice). A nurse's note dated 11/3/18 indicated that the resident asked to smoke and the nurse refused to give her cigarettes, saying that the resident was told she couldn't take off her oxygen because saturation levels might drop and the resident was given a sedative medication instead. During an interview on 12/14/18 at 10:10 AM, the DCS said that there was a lot of concern about the resident's safety. However, the surveyor was unable to locate documentation of behavior, notifying the physician of behavior changes, or retraining staff concerning de-escalation of behaviors before calling police. Facility staff were

unable to locate documentation of any record of

		AND HUMAN SERVICES & MEDICAID SERVICES				RM APPROVEI NO. 0938-039	
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F 689	Continued From probability of the continued From probability or symptoms.	" I I I I I I I I I I I I I I I I I I I	F 68	39			
Business office director, who order. She stated she was wand came in after dinner and there. Staff told her that the smoke. She had returned from saying she was cleared to smoking outside hours and go they told her she couldn't. So roommate was upset and wo in case the resident smoked. Office Manager never saw the to the room mate. The Business office administrator who		dinner and the police were er that the resident wanted to elumed from the doctor's office lared to smoke. Staff told the laranger the resident was purs and getting upset when buildn't. Staff said the later and wouldn't go in the room at smoked. The Business ever saw the resident or talked. The Business Office Manager rator who told her he had been lustion for hours. He told her to talked a TDO (called ECO above) be Manager took some supervisor and a CNA to the					
	the medical record nursing was unable documentation, ass notification of the re	afer summary or assessment in for that date. The director of the to locate any transfer sessments, or written teason for transfer given to the member, or hospital staff.					
	of the resident's sta	did not include an assessment stus or a care plan revision return from the hospital.					
	surveyor reported to clinical (DCS) and for clinical services	meeting on 12/13/18, the othe administrator, director of the corporate regional director the concern with the situation of the record. Staff did not					

	OF DEFICIENCIES	MEDICAID SERVICES	200 200 18004	THE RESERVE OF SECTION SERVED AND SECTION SECT	OMB N	RM APPROV IO. 0938-03
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLEYED C	
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F 689	assessment or conta prior to the transfer. resident after the res There is no indication	ent or complete a transfer ct the resident's physician Staff failed to assess the ident's return to the facility in that staff attempted to lere had been a change in	F 689		7 7	
SS=D	require dialysis receive with professional star comprehensive personal star comprehens	is not met as evidenced iew, facility document cord review, the facility staff esident's post dialysis needs #90). mitted to the facility on ed on 12/6/18 with hronic respiratory failure, dysphagia, end stage renal lysis, hypertension, type 2	F 698	1. Resident #90 discharged facility on 12/29/2018. Facility on 12/29/2018. Facility obtained a copy of dialysis contract for Resident #90 or 12/17/2018. 2. The RDCS completed quareview of dialysis residents ensure residents are assess and the communication form completed upon return from dialysis on 1/23/2019. Folic based on findings. 3. The ADCS and or RDCS provide re-education to lice nurses on the policy and procedure for coordination hemodialysis services by 1/28/19.	rality to sed n is bw up	

STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CL/A IDENTIFICATION NUMBER:		LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
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PREFIX TAG	(EACH DEFICIEN	NAY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ie «	(X5) DATE
F 755 SS=D	Clinical record revieresident received he per week. Pre-dialy complete for each discenser usually include the forms. There was assessment by facility dialysis progress no The facility policy Conservices indicated unfacility will complete on the Dialysis Compounded form in the The surveyor asked contract. The facility was no contract with provider. The administrator, diether ending of the concern of 12/15/18. Pharmacy Srvcs/Proc CFR(s): 483.45(a)(b) §483.45 Pharmacy Structures and biologicals them under an agree §483.70(g). The facility personnel to administration of the concern of th	w on 12/14/18 revealed the emodialysis therapy 3 times risis assessments were ay of service. The dialysis ded vital signs and weights on as no post dialysis ity staff. There were no post tes. Cordination of Hemodialysis inder 'Procedure' that 'the the post dialysis information munication form and file the Resident's Clinical record'. Ito review the hemodialysis administrator reported there the resident's dialysis rector of clinical services were in during a summary meeting cedures/Pharmacist/Records (1)-(3) Rervices ride routine and emergency to its residents, or obtain ment described in lity may permit unlicensed ter drugs if State law	F 698	4. DCS and or ADCS will conduct random quality monitoring of dialysis residents are assessed and dialysis communication form comple upon return from dialysis, 3 times per week for 4 weeks, weekly for 3 months. Finding be reported to QAPI committed monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019. F755- Pharmacy Services / Procedures / Pharmacist / Records 1. Nurse Practitioner assessed Resident #14 and medication review was completed on 1/21/2019. No signs or	ted then gs to ee	
	permits, but only under the general supervision of licensed nurse. 483.45(a) Procedures. A facility must provide charmaceutical services (including procedures			symptoms of distress were present. DCS completed a medication error report for Resident #14 on 1/22/2019.		

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 (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION 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) (D PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX IEACH CORRECTIVE ACTION SHOULD BE PREFIX COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE CATE DEFICIENCY) F 755 Continued From page 143 F 755 2. The UMs completed quality that assure the accurate acquiring, receiving, review on current resident's dispensing, and administering of all drugs and MAR and medications to ensure biologicals) to meet the needs of each resident. medication are available for administration on 1/22/2019. §483.45(b) Service Consultation. The facility Follow up based on findings. must employ or obtain the services of a licensed pharmacist who-3. The ADCS and or RDCS will provide re-education to licensed §483.45(b)(1) Provides consultation on all nurses on pharmacy aspects of the provision of pharmacy services in management, general dose the facility. preparation and medication administration by 1/28/2019. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in 4. DCS and or ADCS will conduct random quality sufficient detail to enable an accurate reconciliation; and monitoring of 5 resident's MAR and medications to ensure medication are available for §483.45(b)(3) Determines that drug records are in administration, 3 times per week order and that an account of all controlled drugs for 4 weeks, then weekly for 3 is maintained and periodically reconciled. months. Findings to be reported This REQUIREMENT is not met as evidenced to QAPI committee monthly and by: updated as indicated. Quality Based on staff interview, facility document monitoring schedule modified review, and clinical record review, the facility staff based on findings. failed to ensure physician ordered medications 5. Date of Compliance were available for administration for 1 of 23 1/28/2019. residents (Resident #14). The findings included: The facility staff failed to ensure the physician ordered medication Zaroxolyn was available for administration to Resident #14 The clinical record of Resident #14 was reviewed 12/12/18 through 12/14/18. Resident #14 was admitted to the facility 6/11/18 with diagnoses that included but not limited to acute pulmonary

edema, acute kidney failure, paranoid

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 IDENTIFICATION NUMBER A. BUILDING_ COMPLETED 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 SUMMARY STATEMENT OF DEFICIENCIES 1D PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) Continued From page 144 F 755 schizophrenia, chronic pain syndrome, dysphagia, obsessive-compulsive disorder, chronic systolic heart failure, chronic viral Hepatitis C, chronic obstructive pulmonary disease, major depressive disorder, bipolar disorder, schizoaffective disorder, opioid dependence, anxiety disorder, Clostridium difficile, tobacco abuse, malignant neoplasm of skin, and adjustment disorder. Resident #14's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/13/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #14 had a physician order dated 10/12/18 that read "Zaroxolyn 2.5 mg (milligrams) x 3 days po (by mouth) CHF (congestive heart failure)." The surveyor reviewed the October 2018 medication administration records (MARs). Zaroxolyn 2.5 mg had been entered onto the MAR to begin 10/12/18. The 10/12/18 box had initials that were circled and written on the reverse side of the MAR read "Not available-called pharmacy." The box for 10/13/18 was blank and 10/14/18 was blank. The reverse side of the MAR did not have documentation

was not administered.

about medication availability or the reason

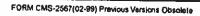
The surveyor reviewed the interdisciplinary progress notes for October 2018. There was not a note for 10/12/18. The notes for 10/13/18 and 10/14/18 did not document the reason Zaroxolyn

Zaroxolyn was not administered.

STATEMENT	F OF DEFICIENCIES	MEDICAID SERVICES	IS WAY IS		OMP.	NO. 0938-039
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	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	2/14/2018
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	The surveyor informe practical nurse #2 on L.P.N. #2 reviewed the record and the progree medication was not at manager L.P.N. #2 was pharmacy. The unit m CVS was the back-up. The surveyor informed director of nursing, and nurse of the above corday meeting on 12/13/surveyor requested the Zaroxolyn and a list of The DON informed the 8:03 a.m. that there was	d the unit manager licensed 12/13/18 at 10:26 a.m. e medication administration ss notes and stated the dministered. The unit as asked about the back-up nanager L.P.N. #2 stated pharmacy. If the administrator, the did the regional registered according the end of the	F 75	55		
F 758 F SS=D S S S S S S S S S S S S S S S S S	No further information vexit conference on 12/1 Free from Unnec Psychotropic (483.45(e) Psychotropic)	was provided prior to the 4/18. notropic Meds/PRN Use (1)-(5) c Drugs. tropic drug is any drug that esociated with mental . These drugs include, ugs in the following	F 758	F758- Free from Unnec- Psychotropic Meds/PR 1. Resident #73's Physic order for Risperdal has be clarified to reflect monitor side effects and effectives and identified target behad on 12/13/2018. Resident Physician orders for Wellth and Buspirone have been clarified to reflect monitoriside effects and effectives and identified target behad on 12/13/2018. Resident # discharge from facility on 1/17/2019.	N use cian een ing for ness viors #5's butrin ng for ness viors	

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F 758	Continued From page	e 146	F 758			7
	resident, the facility n	nust ensure that	72			
				2. The UMs will complete q	uality	
		ents who have not used		review of current residents receiving psychotropic		
		re not given these drugs		medications for monitoring f	or	
		n is necessary to treat a		side effects and effectivenes	s	
	in the clinical record:	diagnosed and documented		and identified target behavio	rs	
	in the chilical record,			on 1/25/2019. Follow up bas on findings.	ed	
	§483.45(e)(2) Reside	ents who use psychotropic		on indings.		
		dose reductions, and		3. The ADCS and or RDCS	will 5	
	behavioral intervention			provide re-education to licen		
	1000	effort to discontinue these		nurses on the policy and		
	drugs;			procedure on psychotropic d	rug	
	§483.45(e)(3) Reside	ints do not receive	1	medication use and Behavio	r	
		ursuant to a PRN order	1	monitoring by 1/28/19.		
		n is necessary to treat a		4 000 4 4000 15		
	diagnosed specific co	ondition that is documented		DCS and or ADCS will conduct random quality		
	in the clinical record;	and		monitoring of 5 residents		
	0.400.45(.)(4).550			receiving psychotropic		
		rders for psychotropic drugs Except as provided in		medications for monitoring fo	r	
	§483.45(e)(5), if the a			Side effects and effectivenes	3	
	prescribing practition			and identified target behavior times per week for 4 weeks,	s, 3	
		RN order to be extended		weekly for 3 months. Finding	is to	
	beyond 14 days, he d	or she should document their		be reported to QAPI committee	e	
		ent's medical record and		monthly and updated as		
	indicate the duration t	for the PRN order.		indicated. Quality monitoring schedule modified based on		
	CARRAGE ARIONEL BENIO	rders for anti-psychotic	j	findings.		
	drugs are limited to 1					
	renewed unless the a					
		er evaluates the resident for		5. Date of Compliance]	
	the appropriateness of	of that medication.		1/28/2019.		
		is not met as evidenced				
	by:					
		iew and clinical record If failed to ensure that 3 of				
		in falled to ensure that 3 of		2		

CENTE	CENTERS FOR MEDICARE & MEDICAID SERVICES				PRI	NTED: 01/16/201 FORM APPROVE	
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	Continued From page 147 unnecessary psychotropic medications. Resident #73, Resident #5, and Resident #58. The findings included: 1. The facility staff failed to identify target behaviors and monitor for side effects and effectiveness associated with physician ordered Risperdal for Resident #73. Resident #73 was a 59-year-old-female who was admitted to the facility on 11/13/18. Diagnoses included but were not limited to: Charcot's joint, schizophrenia, bipolar disorder, and hypertension. The clinical record for Resident #73 was reviewed on 12/12/18 at 3:13 pm. The most recent MDS (minimum data set) assessment was a 14-day scheduled assessment with an ARD (assessment reference date) of 11/27/18. Section		F 75	DEFICIENC	· Y)		
	Section C0500, the fact Resident # 73 had a B mental status) score or indicated that Resident intact. Section N of the medications. In Section documented that Residentipsychotic medication for the Current plan of can reviewed and revised of documented a focus ar The resident is on anti-	t # 73 was cognitively MDS assesses N0410, the facility staff dent # 73 had received on for 7 days during the e 11/27/18 ARD. e for Resident # 73 was on 12/7/18. The facility staff ea for Resident # 73 as, psychotic therapy r/t Interventions included but minister antipsychotic by physician. Monitor					





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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 (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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION DATE PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 758 Continued From page 148 F 758 review of the plan of care for Resident #73, the surveyor did not locate any target behaviors associated with the use of antipsychotic therapy. Resident # 73 had orders that included but was not limited to, "Risperidone tablet 3 mg (milligram) Give one tablet by mouth at bedtime for bipolar disorder." The physician initiated order on 11/29/18. Resident # 73 also had orders that were initiated by the physician on 12/6/18 for "Risperdal Consta Suspension Reconstituted 50 mg Inject 50 ml (milliliters) intramuscularly in the afternoon every 2 weeks on Wed related to unspecified psychosis." On 12/13/18 at 9:23 am, the surveyor reviewed the medication administration record for Resident # 73 and did not locate any behavior monitoring or monitoring for side effects or effectiveness. On 12/13/18 at 9:30 am, the surveyor spoke with unit manager RN # 1 (registered nurse) and made her aware that the surveyor did not locate target behavior and monitoring for side effects

and effectiveness for the Risperdal in the clinical

On 12/13/18 at 9:38 am, unit manager RN # 1 reviewed the clinical record for Resident # 73 and stated, "I'm not seeing it, I will check further and

On 12/13/18 at 9:46 am, unit manager RN # 1 approached the surveyor and stated "it's an order that had not been added but we will be monitoring

On 12/13/18 at 5:45 pm, the administrative team was made aware of the findings as stated above.

record for Resident # 73

those things from here on out."

get back with you."

		& MEDICAID SERVICES		io. Beer W. Medicalis		NO. 0938-039
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F 758	Continued From page	ge 149	F 7	58		
	No further information presented to the sur conference on 12/14	on regarding this Issue was rvey team prior to the exit 4/18.				
	for behaviors, side e	failed to monitor Resident # 5 effects, and effectiveness for Vellbutrin and Buspirone.	Zw La			
	admitted to the facili readmission date of but were not limited	8/27/18. Diagnoses included to, hypertension, major anxiety disorder, and benign				
	The clinical record for on 12/13/18 at 10:41 (minimum data set) a was a quarterly asse (assessment referent of the MDS assesses Section C0500, the fragident # 5 had a Emental status) score indicated that Reside intact. Section N of the medications. In Section documented that Resantidepressant and a	or Resident # 5 was reviewed am. The most recent MDS assessment for Resident # 5 assessment with an ARD ce date) of 9/3/18. Section C is cognitive patterns. In facility staff documented that BIMS (brief interview for of 15 out of 15, which ent # 15 was cognitively the MDS assesses on NO410, the facility staff				
	reviewed and revised staff documented a fo as, "Psychoactive me	are for Resident # 5 was I on 12/10/18. The facility ocus area for Resident # 5 idication use antianxiety (ix (diagnosis) of anxiety.				

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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 150 F 758 added after ARD," Interventions included but were not limited to, "Report residual signs and symptoms of depression or problematic side effects to practitioner," and "Monitor behavioral symptoms and side effects such as: appetite changes, memory impairment, muscle weakness, sedation." Resident # 5 had current orders that included but were not limited to an order that was initiated by the physician on 11/29/18 for "Buspirone HCI Tablet 15 mg (milligram) give 1 tablet by mouth three times a day related to anxiety," and "Wellbutrin SR tablet extended release 12 hour 200 mg give 1 tablet by mouth one time a day for depression that was initiated by the physician on 11/30/18." On 12/13/18 at 12:36 pm, the surveyor reviewed the December 2018 medication administration record for Resident # 5 and did not locate monitoring for behaviors, side effects, or effectiveness associated with the use of the physician ordered Wellbutrin and Buspirone On 12/14/18 at 12:20 pm, the surveyor reviewed the December 2018 medication administration record for Resident # 5 and observed the following orders had been initiated on 12/13/18 at 3:00pm. "O-no behavior, 1-agitation, 2-combative, 3-verbally inappropriate, 4-sexually inappropriate, 5-crying, 6-calling out, 7-screaming, 8-hallucinations, 9-delusions, 10-resists care, 11-socially inappropriate, 12-other see progress

""Side effects (Psychoactive med use): 0-none,

notes."

CENTERS FOR MEDICARE & MEDICAID SERVICES				PRINTED: 01/16/201 FORM APPROVE		
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F 758	Continued From pa 1-movement side e 2-non movement s every shift for moni	iffects see progress notes, ide effects see progress notes	F 75	8	^ #E!	
	On 12/13/18 at 12:45 pm, the surveyor interviewed unit manager RN # 1 (registered nurse). The surveyor made unit manager RN # 1 aware that upon Initial review of the December 2018 medication administration record for Resident # 5 the surveyor did not locate any monitoring for behaviors, side effects or effectiveness associated with the physician ordered Wellbutrin and Buspirone, and now as of 12/13/18 at 3:00 pm Resident # 5 now has orders to monitor for behaviors and side effects. Unit Manager RN # 1 stated that after the surveyor had a conversation with her about behaviors and monitoring for Resident # 73, Resident # 5's orders were updated to include monitoring. On 12/14/18 at 2:02 pm, the administrative team was made aware of the findings as stated above.					
F a ir from S	presented to the sur- conference on 12/14 3. The facility staff to needed) orders for the vere limited to 14 da fated 12/7/18 read " by mouth every 8 ho aggitation (sic) for 30 Resident #58 was ad- and readmitted 12/5/ included but not limite functional intestinal di- acral ulcer stage 3,	on regarding this issue was every team prior to the exit /18. It is ensure the prin (whenever the psychotropic drug Ativan exit) is as needed for anxiety, it days to Resident #58." Imitted to the facility 12/4/13 and to adult failure to thrive, isorders, ileus, rectal tube, hypertension, paroxysmal entia without behavioral				

		ND HUMAN SERVICES MEDICAID SERVICES		a C	FORM	D: 01/16/201
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F 758	Continued From page	e 152	F 758			
	_	re ulcers bilateral heels,	1 750			
	Resident #58's quarte (MDS) assessment w	erly minimum data set				
	reference date (ARD)	of 11/7/18 assessed the				
	resident with a BIMS	(brief interview for mental			-	
	status) as 03/15. Resi without any signs or s	ident #58 was assessed				
		hers or psychosis. Section		· 100	i	
	N Medications did not	reveal Resident #58 had	i		1	
	been administered an	y psychotropic medications			j	
	in the 7-day look back	period.		0	1	
	Resident #58 was in to change MDS and com-	he process of a significant prehensive care plan.				
	Resident #58's curren	t comprehensive care plan				
	revised 5/19/17 identif	led the resident had			- 1	
	impaired cognition and	/or impaired thought				
	processes r/t (related thearing and no hearing	(O) dementia, hard of				
7.0	respiratory failure. Inte	erventions: Administer				
	meds (medications) as	ordered.				
	The surveyor reviewed	Resident #58's clinical				
[record. The facility NF					,
	ordered Ativan 0.5 ml	every 8 hours as needed			Į.	
	for anxiety, agitation for	or 30 days on 12/7/18.				
	The surveyor interview	red the facility NP (other				
	#2) on 12/13/18 at 12:	11 p.m. The NP (other #2)				
	stated he forgot and wo order.	ould adjust the Ativan				
	The surveyor interview	ed the assistant director of				
	nursing on 12/13/18 at	12:15 p.m. and asked for				
		der and a summary of all				
i	Ativan orders for Resid	lent #58.				

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

Event (D; Y3F111

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 8, 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 (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 758 Continued From page 153 F 758 The director of nursing provided the surveyor with a summary of Resident #58's physician's orders for Ativan on 12/14/18 at 7:50 a.m. The DON stated the order written on 12/7/18 was the only order for Ativan until the order was changed on 12/13/18. The surveyor reviewed the December 2018 electronic medication administration records (eMARS). Resident #58 had not received any Ativan since the physician ordered the medication on 12/7/18. The surveyor informed the administrator, the director of nursing, and the regional registered nurse of the above concern on 12/13/18 at 4:29 No further information was provided prior to the exit conference on 12/14/18. F 760 Residents are Free of Significant Med Errors F 760 CFR(s): 483.45(f)(2) SS≖E F760- Residents Are Free of Significant Med Errors The facility must ensure that its-§483.45(f)(2) Residents are free of any significant medication errors. 1. Nurse Practitioner assessed This REQUIREMENT is not met as evidenced and completed a medication by: review for Resident #55 on Based on staff interview, facility document 1/21/2019. No signs or review, and clinical record review, the facility staff symptoms of distress were failed to ensure 1 of 23 residents was free of a present. DCS completed a significant medication error (Resident #55). medication error report for Resident #55 on 1/22/2019. The findings included: The facility staff to follow the physician orders for sliding scale insulin for Resident #55.

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 IDENTIFICATION NUMBER: A. BUILDING_ COMPLETED C 495325 B. WING NAME OF PROVIDER OR SUPPLIER 12/14/2018 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 PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (2(5) PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 760 Continued From page 154 F 760 2. The ADCS and or RDCS will complete a quality review of The clinical record of Resident #55 was reviewed current diabetic residents to 12/12/18 through 12/14/18. Resident #55 was ensure residents are receiving admitted to the facility 8/22/18 and readmitted appropriate sliding scale coverage with documentation in 10/19/18 and 11/21/18 with diagnoses that the MAR by 1/25/2019. Follow included but not limited to type 2 diabetes mellitus up based on findings. with hyperglycemia, cerebral infarction due to embolism of cerebral artery, dysphagia, mild 3. The ADCS and or RDCS will cognitive impairment, lack of coordination, provide re-education to licensed cognitive communication deficit, aphasia, acute nurses on the policy and cystitis without hematuria, anxiety, bipolar disorder, hyperlipidemia, major depressive procedure for sliding scale disorder, hypertension, and migraines. insulin administration set up in electronic medical record by Resident #55's 14-day minimum data set (MDS) 1/28/2019. with an assessment reference date (ARD) of 11/2/18 assessed the resident with a BIMS (brief 4. DCS and or ADCS will interview for mental status) as 15/15. conduct random quality monitoring of diabetic residents Resident #55's current comprehensive care plan to ensure residents are receiving identified the resident to be at nutrition/hydration appropriate sliding scale risk r/t (related to) altered nutrient utilization AEB coverage with documentation on (as evidenced by) diagnoses include DM2 the MAR, 3 times per week for 4 (diabetes mellitus 2) with poorly controlled serum weeks, then weekly for 3 glucose levels, HgbA1c (hemoglobin A1C) at months. Findings to be reported 13.2% 8/18/18. Interventions included to obtain to QAPI committee monthly and and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow updated as indicated. Quality up as indicated. Date initiated 8/27/18 and monitoring schedule modified revision on 12/12/18. based on findings. The December 2018 physician's orders included Date of Compliance an order for sliding scale insulin dated 11/29/18 1/28/2019. that read "Humalog Kwik/Pen Solution Pen-Injector 100 unit/ml (milliliter) (insulin Lispro) Inject 1 unit subcutaneously four times a day for DM (diabetes mellitus) per s/s (sliding scale) 131-180=2 u (units)

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER 495325		A. BUILDING			PLETED		
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	A second physician HS (before meals a day. Start date 11/2) The surveyor review December 2018 ele administration record obtained as ordered documentation on the December 2018 ele administration record administered the slittle results of the blofor 12/1/18 at 0630 sliding scale insulin, received 6 units of H2018 eMAR did not documented. The results of the blocoumented. The results of the blocoumented. The results of the blocoumented. The 12/1/18 1130 BS=30 12/1/18 1630 (8:30 pt/1/18 130 BS=30 12/2/18 1630 BS=36 12/2/18 12/2/18 1630 BS=36 12/2/18 12/2/18 1630 BS=36 12/2/18 12/2/2/18 12/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/2/	order read "Accuchecks AC & and at bedtime) four times a 29/18." Wed the November 2018 and actronic medication rds. The blood sugars were do however, there was no he November 2018 or actronic medication rds (eMARs) that the staff ding scale insulin based on bood sugars. The blood sugar was 279. Based on the Resident #55 should have drumalog. The December have any sliding scale insulin bood sugars were as follows: 79 08 p.m.) BS=305 p.m.) BS=309 35 p.m.) BS=309 35	F 76	DEFICIENCY)			
	12/2/18 2030 BS=30 12/3/18 0630 BS=34 12/3/18 1130 BS=38 12/3/18 1630 BS=39 12/3/18 2030 BS=27 12/4/18 0630 BS=40 12/4/18 1130 BS=36	60 99 91 77 90 92					

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: 495325 NAME OF PROVIDER OR SUPPLIER PHEASANT RIDGE NURSING & REHAB CENTER			100	IX2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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			STREET ADDRESS, CITY, STATE, ZIP 6 4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	CODE	12/14/2018		
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F 760		9 1 4 6 5 8 7 7 2 3 9 8 1 1 1 9 2 0 6 4 1 9 2 7 7 7 7 7 7 7 7 7 8 7 8 7 7 8 7 8 7 8	F	760			
	days or times or notifi blood sugar was 400	an 131 on any of the above ied the physician when the or greater. d the unit manager licensed					

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STATEMENT	ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDH	IPLE CONSTRUCTION NG	OMB NO. 0938-0 (X3) DATE SURVEY COMPLETED	
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F 760	F 760 Continued From page 157 practical nurse #2, the director of nursing (DON) and the regional registered nurse of the above concern on 12/14/18 at 12:47 p.m. and asked where the sliding scale insulin was documented.		F 76	50	Kiv M = S	
	informed the survey been administering and not administering	censed practical nurse #2 or that the nurses had just the 1 unit of Humalog insulin ng the sliding scale insulin.				
- 1	nurse of the above	ned the administrator, the and the regional registered concern on 12/14/18 at 1:49 the facility policy on diabetes				
	diabetes titled "Bloo Disinfecting" on 12/1	red the facility policy on d Glucose Monitoring & 4/18. The policy read in part der. Document result in				
1	"6.0 General Dose P Administration" on 12 part "4.1.2 Confirm ti	viewed the facility policy titled reparation and Medication 2/14/18. The policy read in nat the MAR (medication I) reflects the most recent		F761- Label/Store Drugs a Biologicals	<u>nd</u>	
F 761 L	lo further information was provided prior to the xit conference on 12/14/18. abel/Store Drugs and Biologicals FR(s): 483.45(g)(h)(1)(2)		F 761	UMs discarded loose medications identified on Hallway 200, rooms 301-30 and 306-310, expired Novol Flex pen (200 hallway), exp	log	
i L	Drugs and biologicals	of Orugs and Biologicals sused in the facility must be with currently accepted s, and include the		Lantus insulin (on medication cart for rooms 301-305) and Levamir Flex was placed into appropriate package on 12/12/2018	n	

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 (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495325 8 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 (X5) 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 761 DCS re-educated LPN #2 on Continued From page 158 F 761 preventing medication errors. appropriate accessory and cautionary packages of medications must instructions, and the expiration date when be placed back into medication applicable. cart and cart must be locked §483.45(h) Storage of Drugs and Biologicals prior to leaving medication cart on 1/21/2019. §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and 2. The UMs completed quality biologicals in locked compartments under proper review of medication carts and temperature controls, and permit only authorized medication rooms for expired personnel to have access to the keys. medications, appropriate labeling and loose pills on §483.45(h)(2) The facility must provide separately 1/22/2019. Follow up based on locked, permanently affixed compartments for findings. storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to 3. The ADCS and or RDCS will abuse, except when the facility uses single unit provide re-education to licensed package drug distribution systems in which the staff nurses to on the storage quantity stored is minimal and a missing dose can and tabeling on medications by be readily detected. This REQUIREMENT is not met as evidenced 1/28/2019. by: Based on observation, facility document review, 4. DCS and or ADCS will and staff interview, the facility staff failed to store conduct random quality and label medications in a secured locked monitoring of medication carts medication box on 1 of 2 nursing units in the and medication rooms for facility and failed to discard expired medications expired medications, appropriate on 1 of 2 nursing units in the facility (Hallways labeling and loose pills, 3 times 200, 300 and 400). per week for 4 weeks, then weekly for 3 months. Findings to The findings included: be reported to QAPI committee monthly and updated as The surveyor made the following observations indicated. Quality monitoring when checking the medication cart on Hallway schedule modified based on 200 on 12/12/18 at 12:00 pm: findings. In the medication cart, 1st drawer, Left hand 5. Date of Compliance

side there were (1) blue/white capsule, (1) small

1/28/2019.

OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	The State of the S	CIMID	VO. 0938-039
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Continued From page 159 white pill and (1) 1/2 tablet small white pill were found loose and not in a package. "In the medication cart, 2nd drawer, Left hand side there were (1) small white pill, 1/2 small white pill, 1/2 medium white pill and (1) white capsule were found loose and not in a package. "In the 1st drawer, right side of the cart there was a Novolog Flexpen with an opened date of 11/10/18 documented on it. The label said it was good for 28 days after the pen was opened. This insulin expired on 12/6/18 but remained in the medication cart. In the 2nd drawer, right side of the cart, there were (1) medium white pill, (1) small yellow pill and (1) small orange pill loose in the drawer and not in a package. The surveyor made the following observations when checking the medication cart on Hallway		F 76			
was (1) 1/2 small white backage. In the 2nd drawer was (1) medium greer backage. In the 1st drawer, was (1) medium white backage. The surveyor made the when checking the medium the second drawer, was the second drawer.	e pill loose and not in a right side of the cart there in pill loose and not in a right side of the cart there pill loose and not in a e following observation idication cart for rooms at 12:42 pm:				
	SUMMARY SI (EACH DEFICIENC REGULATORY OR Continued From page white pill and (1) 1/2 found loose and not i in the medication side there were (1) si white pill, 1/2 medium capsule were found it in the 1st drawer was a Novolog Flexp 11/10/18 documented good for 28 days afte insulin expired on 12/ medication cart. In the 2nd drawer were (1) medium white and (1) small orange and not in a package. In the 3rd drawer was (1) 1/2 small white backage. In the 2nd drawer was (1) medium greer vas (1) medium greer vas (1) medium white backage. In the 1st drawer, was (1) medium white backage. In the 1st drawer, was (1) medium white backage. In the second drawer white second drawer when checking the me 06-310 on 12/12/18 a In the second drawer was (1) 1/2 peace	white pill and (1) 1/2 tablet small white pill were found loose and not in a package. In the medication cart, 2nd drawer, Left hand side there were (1) small white pill, 1/2 small white pill, 1/2 medium white pill and (1) white capsule were found loose and not in a package. In the 1st drawer, right side of the cart there was a Novolog Flexpen with an opened date of 11/10/18 documented on it. The label said it was good for 28 days after the pen was opened. This insulin expired on 12/6/18 but remained in the medication cart. In the 2nd drawer, right side of the cart, there were (1) medium white pill, (1) small yellow pill and (1) small orange pill loose in the drawer and not in a package. The surveyor made the following observations when checking the medication cart on Hallway 100 on 12/21/18 at 12:23 pm. In the 3rd drawer, left side of the cart there was (1) 1/2 small white pill loose and not in a backage. In the 2nd drawer, right side of the cart there was (1) medium green pill loose and not in a backage. In the 1st drawer, right side of the cart there was (1) medium white pill loose and not in a backage. In the 1st drawer, right side of the cart there was (1) medium white pill loose and not in a backage. In the second drawer, left side of the cart there was (1) medium white pill loose and not in a backage. In the second drawer, left side of the cart there was (1) medium white pill loose and not in a backage. In the second drawer, left side of the cart there was (1) peach small pill loose and not in	SUMMARY STATEMENT OF DEFICIENCIES (EACH DERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F76 Continued From page 159 white pill and (1) 1/2 tablet small white pill were found loose and not in a package. In the medication cart, 2nd drawer, Left hand side there were (1) small white pill, 1/2 small white pill, 1/2 medium white pill and (1) white capsule were found loose and not in a package. In the 1st drawer, right side of the cart there was a Novolog Flexpen with an opened date of 11/10/18 documented on it. The label said it was good for 28 days after the pen was opened. This insulin expired on 12/6/18 but remained in the medication cart. In the 2nd drawer, right side of the cart, there were (1) medium white pill, (1) small yellow pill and (1) small orange pill loose in the drawer and not in a package. The surveyor made the following observations when checking the medication cart on Hallway 100 on 12/21/18 at 12:23 pm. In the 3rd drawer, left side of the cart there was (1) 1/2 small white pill loose and not in a package. In the 2nd drawer, right side of the cart there was (1) medium green pill loose and not in a package. In the 1st drawer, right side of the cart there was (1) medium white pill loose and not in a package. In the surveyor made the following observation when checking the medication cart for rooms 106-310 on 12/12/18 at 12:42 pm: In the second drawer, left side of the cart there was (1) 1/2 peach small pill loose and not in	A 355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES (EACH DERICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) Continued From page 159 white pill and (1) 1/2 tablet small white pill were found loose and not in a package. In the medication cart, 2nd drawer, Left hand slde there were (1) small white pill and (1) white capsule were found loose and not in a package. In the 1st drawer, right side of the cart there was a Novolog Flexpen with an opened date of 11/10/18 documented on it. The label said it was good for 28 days after the pen was opened. This insulin expired on 12/6/18 but remained in the medication cart. In the 2nd drawer, right side of the cart, there were (1) medium white pill, (1) small yellow pill and (1) small orange pill loose in the drawer and not in a package. The surveyor made the following observations when checking the medication cart on Hallway 100 on 12/21/18 at 12:23 pm. In the 3rd drawer, right side of the cart there was (1) 1/2 small white pill loose and not in a package. In the 1st drawer, right side of the cart there was (1) medium green pill loose and not in a package. The surveyor made the following observation when checking the medication cart for rooms 06-310 on 12/12/18 at 12:242 pm: In the second drawer, left side of the cart there was (1) 1/2 peach small pill loose and not in a package.	TRIDGE NURSING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 159 white pill and (1) 1/2 tablet small white pill were found loose and not in a package. In the medication cart, 2nd drawer, Left hand side there were (1) small white pill and (1) white capsule were found loose and not in a package. In the 1st drawer, right side of the cart there was a Novolog Fisxpen with an opened date of 11/10/18 documented on it. The label said it was good for 28 days after the pen was opened. This insulin expired on 12/8/18 but remained in the medication cart. In the 2nd drawer, left side of the cart, there were (1) medium white pill (1) small yellow pill and (1) mail orange pill loose in the drawer and not in a package. The surveyor made the following observations when checking the medication cart on Hallway 100 on 12/21/18 at 12/23 pm. In the 2nd drawer, right side of the cart there was (1) medium green pill loose and not in a package. In the 1st drawer, right side of the cart there was (1) medium white pill loose and not in a package. In the 1st drawer, right side of the cart there was (1) medium white pill loose and not in a package. In the 2nd drawer, right side of the cart there was (1) medium white pill loose and not in a package. In the second drawer, right side of the cart there was (1) medium white pill loose and not in a package. In the second drawer, left side of the cart there was (1) package mail pill loose and not in a package. The surveyor made the following observation hen checking the medication cart for rooms 06-310 on 12/12/18 at 12:42 pm: In the second drawer, left side of the cart there was (1) package mail pill loose and not in a package.

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	ALTH AND HUMAN SERVICES			FOR	D: 01/16/2019
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PREFIX (EACH D			PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION GROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE APPROPRIATE	(X5) COMPLETION DATE
leaving the mapackages of no The medication Gabapentin, F. Vitamin B12, The surveyor had left the me Resident #9's put them back the cart." The surveyor documented find The surveyor of policy on medications. The facility's preparation of M and Needles" ensure that all including treat locked cabinet that is inaccesFacility should discontinued, a medications or Pharmacy return the facility's Preparation and read in part, "medications or should ensure	art. Jurned and went into Resident #9, adication cart unlocked and hedications on the tray table, and left on the tray table were folic Acid, Cinnamon, Metformin, UTI Stat and Lantus Insulin. Just a	F 76			

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 495325 9. 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 (X5) COMPLETION DATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 761 Continued From page 162 F 761 the above documented findings on 12/13/18 at 4:32 pm. F805- Food in Form to Meet No further information was provided to the surveyor prior to the exit conference on 12/14/18. **Individual Needs** F 805 Food in Form to Meet Individual Needs F 805 1. Resident #58 diet order was SS=D CFR(s): 483.60(d)(3) reviewed to ensure order §483.60(d) Food and drink matches meal ticket. Each resident receives and the facility provides-2. The RDCS completed quality §483.60(d)(3) Food prepared in a form designed review of current residents' diet to meet individual needs. orders, meal tickets, and tray for accuracy on 1/23/2019. Follow This REQUIREMENT is not met as evidenced up based on findings, by: Based on observation, staff interview and clinical 3. The ADCS and or RDCS will record review, the facility staff failed to provide provide re-education to licensed the physician ordered diet to 1 of 23 residents nurses, certified nursing (Resident #58). assistants, and Dietary staff on food and drink and that each The findings included: resident receives and the facility provides--- Food prepared in a The facility staff failed to follow the physician form designed to meet individual ordered diet for Resident #58. needs by 1/28/2019. Resident #58 was admitted to the facility 12/4/13 4. DCS and or ADCS will and readmitted 12/5/18 with diagnoses that conduct random quality included but not limited to adult failure to thrive. monitoring of 5 current residents' functional intestinal disorders, ileus, rectal tube. diet orders, meal tickets, and sacral ulcer stage 3, hypertension, paroxysmal tray for accuracy, 3 times per atrial fibrillation, dementia without behavioral week for 4 weeks, then weekly disturbances, pressure ulcers bilateral heels, for 3 months. Findings to be reported to QAPI committee unstageable, and chronic kidney disease. monthly and updated as indicated. Quality monitoring Resident #58's quarterly minimum data set schedule modified based on (MDS) assessment with an assessment findings. reference date (ARD) of 11/7/18 assessed the Date of Compliance resident with a BIMS (brief interview for mental

1/28/2019.

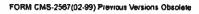
	VORUMENT OF STREET	MEDICAID SERVICES				RM APPROVED 10. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA NO PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X1) PROVIDER/SUPPLIER/SU		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER PHEASANT RIDGE NURSING & REHAB CENTER				STREET ADDRESS, CITY STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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F 805	assessed the reside extensive assistance Swallowing/Nutrition was assessed to har and a therapeutic did Resident #58 was in change MDS and co Resident #58's currerevised 12/12/18 identification/hydration risdeficit, altered nutrien nutrient needs, funct evidenced by) dx (did (chronic kidney disea failure), dementia, pradult failure to thrive, altered diet for safe a mouth) intake. Comfinterventions: Providenterventions: Providence The surveyor observed on 12/13/18 at 7:51 at ticket read "NAS (no Honey Thick/Fortified tray were: scrambled orange coffee cake, milk, and honey thick nursing assistant #1 Resident #58 took on honey-thickened milk The surveyor observed 12/13/18 at 12:05 p.m. "NAS-Mechanical So Foods." Resident #58	ection G Functional Status and for eating to require a of one person. In Section K al Approaches, Resident #58 //e a mechanically altered diet et. the process of a significant imprehensive care plan intified the resident was a sk r/t (related to) self-care intuitilization, increased ional status decline AEB (as agnoses) include CKD3 ase), CHF (congestive heart otein-calorie malnutrition, requires mechanically and comfortable po (by fort care in place. Ide, serve diet as ordered. ded Resident #58 at breakfast in.m. Resident #58's diet added salt)-Mechanical Soft if Foods." Food items on the dieggs, grits, cranberry magic cup, honey thickened ened coffee. Certified was feeding the resident. Ity a few sips by spoon of the	F 80			

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES	-ca			RM APPROVED NO. 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLU IDENTIFICATION NUMBER.		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULT A. BUILDIN	PLE CONSTRUCTION IG	(X3) DA	TE SURVEY
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODF 1	2/14/2018
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	Continued From page 164 steak, mashed potatoes, roll, fruit cocktail, honey thickened coffee, water and milk, and magic cup. The surveyor reviewed Resident #58's clinical record. Resident #58's diet order dated 12/7/18 was pureed texture, honey thickened liquids, fortified foods with a magic cup ordered three times a day. Resident #58 was served a dysphagia diet! (NAS, mechanical soft, honey thickened liquids and fortified foods) at breakfast and lunch 12/13/18. The surveyor interviewed the unit manager licensed practical nurse #1 and the dietary manager on 12/13/18 at 12:13 p.m. The diet order dated 12/5/18 was the most current diet order that had been entered into the meal tracker the dietary staff use for diets. The surveyor informed the director of nursing (DON) of the above concern with the physician's orders not followed for Resident #58's diet on 12/13/18 at 12:21 p.m. The DON stated that the nurses complete a diet slip and send to dietary. Dietary staff are responsible for changing the diet order in the meal tracker.		F 80	05		
	order for Resident #. the meal tracker. The surveyor information of nursing, a nurse of the above contracts.	ords and the most recent diet 58 had not been entered into ed the administrator, the nd the corporate registered oncern during the end of the				*
	day meeting on 12/1 No further informatio	3/18 at 4;29 p.m. n was provided prior to the				

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 4365 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (XS) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION! TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 805 Continued From page 165 F 805 F812- Food Procurement, exit conference on 12/14/18. Store/Prepare/Serve-Sanitary F 812 Food Procurement, Store/Prepare/Serve-Sanitary F 812 SS=F CFR(s): 483.60(i)(1)(2) 1. Expired, unlabeled, and undated items identified in the §483.60(i) Food safety requirements. kitchen and pantries were The facility must discarded by Dietary Manager and UMs on 12/13/2018. §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. 2. The Dietary Manager (i) This may include food items obtained directly completed quality review of from local producers, subject to applicable State kitchen and pantries to ensure and local laws or regulations. food items are labeled, dated, (ii) This provision does not prohibit or prevent and discarded when expired, on facilities from using produce grown in facility 1/23/2019. Follow up based on gardens, subject to compliance with applicable findings. safe growing and food-handling practices. (iii) This provision does not preclude residents 3. The ADCS, RDCS or Food from consuming foods not procured by the facility. and Beverage Contractor will provide re-education to facility §483.60(i)(2) - Store, prepare, distribute and staff on the federal regulations serve food in accordance with professional and dietary guidelines for Food standards for food service safety. Storage: Dry goods by 1/28/19. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility 4. Dietary Manager and or document review the facility staff failed to store. designee will conduct random prepare, distribute, and serve food in accordance quality monitoring of kitchen and with professional standards of food service pantries to ensure food items are safety. labeled, dated, and discarded when expired, 3 times per week The findings included for 4 weeks, then weekly for 3 months. Findings to be reported The facility staff to label, date, and discard to QAPI committee monthly and updated as indicated. Quality expired food items in the kitchen and pantries. monitoring schedule modified On 12/12/18 at 11:47 am, the initial tour of the based on findings. Date of Compliance kitchen was completed. During the initial tour, the





Facility ID: VA0208

1/28/2019.

If continuation sheet Page 168 of 187



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 4356 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 166 F 812 surveyor observed Clabber girl double action baking powder with a best by date of 9/13/2018 printed on the container, and a 1-gallon bottle of Marsala cooking wine with a best by date of 10/1/18 printed on the container. The surveyor asked the dietary services manager if the items should be removed from the kitchen. The dietary services manager stated, "Absolutely." On 12/12/18 at 1:13 pm, the surveyor reviewed the unit pantry for the 600-700 hall. In the refrigerator, the surveyor observed an Applebee's container with a Resident name listed on It but no date was documented. The surveyor also observed a container with 4 cupcakes labeled with a resident's name and no date, and a jar of apricol preserves with a resident's name labeled on the jar with no date. In the freezer the surveyor observed 1.12 gal Neapolitan ice cream with no name or date and 3 lean cuisine meals labeled with a resident's room number with no date. On 12/13/18 at 9:56 am, the surveyor spoke with unit manager RN # 1 about the items observed in the pantry that were not labeled properly. Unit manager RN # 1 stated that she thought that the ice cream was from a party that was held on the unit some time ago she would take care of the items. On 12/14/18 at 2:02 pm, the administrative team was made aware of the findings as stated above.

conference on 12/14/18.

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

Resident Records - Identifiable Information

F 842

		MEDICAID SERVICES			FO	RM APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		(X2) MULTIF	PLE CONSTRUCTION	The second second second second	OMB NO. 0938-039 (X3) DATE SURVEY	
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NAME OF P	ROVIDER OR SUPPLIER		THE STATE OF THE S	STREET ADDRESS, CITY, STATE ZIP CODE	or	
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F 842 SS=D	Tomas and Thompag		F 84	2 F842- Resident Records Identifiable Information		
	(i) A facility may not resident-identifiable to resident-identifiable to accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accordance with a coagrees not to use or except to the extent to do so. §483.70(i) Medical re §483.70(i)(1) In accordance must maintain medical that are- (ii) Complete; (iii) Accurately documically accessible (iv) Systematically org. §483.70(i)(2) The facial information contain regardless of the form records, except when (i) To the individual, or representative where (ii) Required by Law; (iii) For treatment, pay operations, as permitt with 45 CFR 164.506; (iv) For public health an eglect, or domestic vactivities, judicial and law enforcement purp purposes, research purpour service in the side of the context of the contex	elease information that is to an agent only in contract under which the agent disclose the information the facility itself is permitted disclose the information the facility itself is permitted disclose the information the facility itself is permitted disclose with accepted distance ach resident distance dista		1. Nurse Practitioner assistand completed a medicate review for Resident #14 of 1/21/2019. No signs or symptoms of distress were present. DCS completed medication error report completed on 1/22/2019 for Resident #14. 2. The DCS and or ADC complete a quality review current residents' MAR to narcotics are signed off wadministered by 1/25/2019 Follow up based on finding. 3. The ADCS and or RD provide re-education to lice nurses on General Dose Preparation and medication administration by 1/28/19. 4. DCS and or ADCS will conduct random quality monitoring of current reside MAR to ensure narcotics a signed off when administed times per week for 4 week weekly for 3 months. Find be reported to QAPI commonthly and updated as indicated. Quality monitoring schedule modified based of findings. 5. Date of Compliance 1/28/2019.	tion on re a for S will of ensure then 9. lgs. CS will censed on lents' are lered, 3 ls, then fings to nittee on	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495325		(X2) MULTIS A. BUILDING B. WING	rle construction	(X3) DATE SURVE COMPLETED C		
NAME OF P	ROVIDER OR SUPPLIER	0.000		STREET ADDRESS, CITY, STATE, ZIP CODE		2/14/2018
	IT RIDGE NURSING &	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
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F 842	a serious threat to he by and in compliance §483,70(i)(3) The farecord information a unauthorized use. §483,70(i)(4) Medic for- (i) The period of time (ii) Five years from there is no requirem (iii) For a minor, 3 yillegal age under State §483,70(i)(5) The minor, 3 yillegal age under State §483,70(i)(5) The minor (ii) A record of the minor (iii) The comprehensional for the minor condition of the minor conditio	nealth or safety as permitted be with 45 CFR 164,512. actility must safeguard medical against loss, destruction, or all records must be retained be required by State law; or the date of discharge when the state law; or ears after a resident reaches the law. The dical record must containation to identify the resident; assessments; sive plan of care and services by preadmission screening evaluations and ducted by the State; se's, and other licensed ess notes; and ology and other diagnostic required under §483.50. It is not met as evidenced by the facility staff failed ete and accurate clinical estidents (Resident #14).	F 84			

		AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 01/16/201 RMAPPROVE IO: 0938-039
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) DA	re Survey MPLETED
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(X4) ID PREFIX TAG	Tommoda i form page 100		ID PREFIX TAG	PROVIDER'S PLAN OF COR- (EACH CORRECTIVE ACTION & CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(25) COMPLETION DATE
F 842	records. The clinical record 12/12/18 through 1 admitted to the fact included but not line edema, acute kidn schizophrenia, chrodysphagia, obsess chronic systolic het Hepatitis C, chronic disease, major dependence, anxied difficile, tobacco at skin, and adjustme Resident #14's qua (MDS) assessment reference date (AR resident with a BIM status) as 15/15.	of Resident #14 was reviewed 12/14/18. Resident #14 was illity 6/11/18 with diagnoses that nited to acute pulmonary ey failure, paranoid onic pain syndrome, ive-compulsive disorder, art failure, chronic viral costructive pulmonary pressive disorder, bipolar ective disorder, opioid and disorder, Clostridium puse, malignant neoplasm of ant disorder. Interly minimum data set the with an assessment into 19/13/18 assessed the IS (brief interview for mental	F 84	2		
	physician order dat (discontinue) previo	ical record revealed a ed 10/22/18 that read "D/C ous oxycodone order. Change to q (every) 4 hrs (hours) po				B 5. 50.4.
	medication adminis Oxycodone 10 mg o entered onto the Od surveyor noted blan	:00 a.m., 10/25/18 at 6:00				
		ned the unit manager licensed		a u = a u		

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

PRINTED: 01/16/2019 FORM APPROVED

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	PROVIDER OR SUPPLIER		4:	TREET ADDRESS, CITY, STATE, ZIP CO 356 PHEASANT RIDGE ROAD, SW OANOKE, VA 24014	DE	12/14/2018	
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	12/14/18 at 8:32 at 2018 narcotic sheets for 8:57 a.m. Oxycod marked on narcotic a.m. and 10/25/18 p.m. dose of Oxycelectronic medication when asked if medication documented on the narcotic sheet, the she would expect administered on the The surveyor requested and the surveyor review General Dose Prep Administration" on part "Procedure 6. administration, the measures required applicable law, included in the surveyor informs."	the unit manager licensed reviewed the October ets for Oxycodone. the unit manager licensed reviewed the October 2018 of Oxycodone on 12/14/18 at lone 10 mg was recorded of sheets for 10/23/18 at 2.00 at 6:00 p.m. The 10/30/18 6:00 odone was recorded on the fon administration record, dications should be at MAR as well as on the unit manager L.P.N. #2 stated staff to document medications at MAR. The steed the facility policy on stration from the unit manager /18 09:14 a.m. The policy read in After medication facility staff should take all by facility policy and uding, but not limited to the ment necessary medication ment information on the did the administrator, the end the regional registered	F 842				

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 (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 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY F867- QAPI/QAA Improvement **Activities** F 867 **QAPI/QAA** Improvement Activities F 867 CFR(s): 483.75(g)(2)(ii) SS=F 1. The RDCS conducted a QAPI meeting to discuss findings from §483.75(g) Quality assessment and assurance. annual survey and reviewed an action plan to address resident's §483.75(g)(2) The quality assessment and assurance committee must: rights including safety, dignity, (ii) Develop and implement appropriate plans of residents who are verbally action to correct identified quality deficiencies; abused and threatened by This REQUIREMENT is not met as evidenced visitors and or staff on 1/22/2019. Based on staff interview, clinical record review, facility reported incidents, complaints, and during 2. The RDCS completed quality the course of a quality assurance review, the review of QAPI meeting minutes facility staff failed to identify and develop action for the past 6 months to ensure plans to address resident rights for safety, dignity, facility met, at a minimum, residents who are verbally abused and monthly to review identified threatened by visitors, and staff to resident areas of improvement per interactions. guidelines on 1/22/2019. Follow up based on findings. The findings include: 3. The ADCS and or RDCS will provide re-education to facility **ABUSE** staff to on the policy and Sections §§1819 and 1919 of the Social Security procedure for QAPI/QAA Act provide that each resident has the right to be procedures by 1/28/19. free from, among other things, physical or mental abuse and corporal punishment. The facility 4. RDCS and or DCS will must provide a safe resident environment and conduct quality monitoring of protect residents from abuse. QAPI meetings to ensure QAPI Committee will meet a minimum As a part of the survey process, the survey team of monthly to review identified identified harm level deficiencies in the areas of areas of improvement per abuse and neglect. The facility staff failed to guidelines, weekly x 4 weeks, develop action plans to address resident safety. then monthly x 3 months. dignity, verbal abuse, intimidation, and resident to Findings to be reported to QAPI staff relationships. committee monthly and updated as indicated. Quality monitoring schedule modified based on The survey team also identified areas of concern for transfers and discharge requirements, notice findings. 5. Date of Compliance given to resident and resident representative prior

1/28/2019.

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	VIII SANDERS OF THE S	MEDICAID SERVICES				NO. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DA	TE SURVEY MPLETED C
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F 867	to transfer/discharge orderly transfer/disc requirements, basel timing and revision. (activities of daily liv treatment, accidents pharmacy, unneces: labeling of medicatic errors, kitchen concand infection contro. During the meeting director of nursing of surveyor asked how and what issues we administrator stated and identified conce different avenues, an area of concern nursing educates the meetings, and send (FRIs) to Adult Prote (office of licensure administrator stated each incident wheth staff to make everyt was referring to an practical nurse and administrator stated Resident #5's forme ombudsman had into when the facility has some point during hombudsman told the him back.	e, preparation for safe and harge, bed hold ine care plans, care plan quality of care concerns, ADL ing), pressure ulcer of dialysis, range of motion, sary medications, storage and ons, significant medication erns, menus, resident records with the administrator and the in 12/14/18 at 1:12 p.m., the often the QA committee met re discussed. The the committee met monthly erns through a number of the administrator stated when is identified, the director of e staff, holds monthly staff is Facility Reported Incidents ective Services (APS), DHP with Professions), and OLC and certification). The the staff are re-educated with the it means termination of thing safe. The administrator incident involving a licensed Resident #97. The concerning Resident #5 and the formed the administrator that dimoved the roommate out at his stay, APS and the efacility that they had to move	F 867			

		AND HUMAN SERVICES & MEDICAID SERVICES			FOI	ED: 01/16/201 RM APPROVE IO. 0938-039
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NAME OF P	ROVIDER OR SUPPLIER		10-14-	STREET ADDRESS, CITY, STATE, ZIP C		2/14/2018
PHEASA	NT RIDGE NURSING 8	L REHAB CENTER		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) Continued From page 173 A second surveyor spoke to the facility's		PREFO TAG	(EACH CORRECTIVE ACT) CROSS-REFERENCED TO T	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
F 867	Continued From p	age 173	F8	967		
				The Health		
		r spoke to the facility's on 12/14/18 at 8:59 am in the	II A	r man i ma ma ma ma ma ma ma ma ma ma ma ma ma		
		rvey team. The surveyor	■ :			
		ve director if he remembered				11.08
		or his relationship with LPN#1.				
		ctor stated that he found out				(4.1
		and LPN #1 were in a		and the second of the second of		2000
		egional nurse consultant put for LPN #1 and Resident #97	10			
		ne facility. Resident #97 left the				
		st medical advice) with LPN #1		ENTREES OF		
	upon her termination	on due to those guidelines		2761		
		ays after the guidelines were				
		06/18. The executive director				j
200		had to be barred from the				
		rening of 03/06/18. The local sted and spoke to LPN #1 at a		IF III III.2 IB		
		e facility. The executive				
		that Resident #97 wanted to				
		N #1. The executive director				
	A PURE UNITED TO THE PERSON OF	staff did not report the		- Saw		
		an Resident #97 and LPN #1				
		he had no prior knowledge of	-	08 28 20		
		ne executive director stated vider did not have a policy in				
		f the incident or at the present		N N N N N		
		lity staff and Resident				
		surveyor asked the executive				9.
	director if he though	ht that LPN #1 exploited				
		cially. The executive director				X
		#97 was broke. He had no	Í			60
		and lived with his parents". ctor reported to the surveyor	3	miles of the later		
		nad called the facility after the	į.			
	incident wanting to	NATIONAL PROPERTY OF THE PROPE				
	The guidelines the	facility implemented failed and				
		IA. The facility failed to		THE STATE OF THE PARTY OF THE P		

TATEMENT	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	/You has per	PLE CONSTRUCTION		NO. 0938-03
ND PLAN O	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN			ATE SURVEY DMPLETED
		495325	B. WING		С	
NAME OF F	PROVIDER OR SUPPLIER			CTGCT ADOPCED OF A	1	2/14/2018
	NT RIDGE NURSING & R	EHAB CENTER		STREET ADDRESS, CITY, STATE ZIP CO 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	develop and implement resident to staff relation to staff relation to staff relation the surveyor on the survey team presexecutive director who allegations of resident facility executive director who allegations of staff to executive director staff to be suspended pendicular to be suspended	ent a policy to address onships. If been interviewed by a second procedure was for the procedure was for the procedure was for the procedure was for the procedure was for resident abuse. The corresident abuse. The facility at the procedure was for resident abuse. The facility at the procedure was for resident abuse. The facility that the employee was ding investigation. The cility executive director what rallegations of visitor to acility executive director exported incident would be at would be investigated, and sked to stay away until the external the investigation of the corred by Resident # 5. The tor stated, "Or they meet or of nursing and we come back." "I met with the with Resident # 5's history at he has lied, the residents esident # 5 was moved to	F 86			
	another room." "I decide perpetrator could return surveyor asked the faction had not be could make that definition had not be executive director state happened." "Resident had not made accusation had not made accusation had not made accusation."	ded that the alleged in to the building." The colling when the definition of the colling when the deen completed. The facility	2			

DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 01/16/2019

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES				NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DA	ATE SURVEY MPLETED C
WWE OF S	PHEASANT RIDGE NURSING & REHAB CENTER [X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 867 Continued From page 175 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 social services manager interviewed CNA # 2. The facility staff failed to ensure an investigation was started within the time-frame (start investigation 2 hours after concern of abuse) and failed to develop and implement a facility policy for resident to visitor abuse. The administrator was asked about policies for resident to visitor abuse and staff to resident interactions. The administrator stated none as of today but "it won't happen again." No further information was provided prior to the exit conference on 12/14/18. QAA Committee CFR(s): 483.75(g) Quality assessment and assurance. §483.75(g) (1) (i) (iii)(2)(i) \$483.75(g) Quality assessment and assurance. §483.75(g)(1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services.		1	2/14/2018		
		REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
PREFIX	(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	PREFIX	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	COMPLETION DATE
F 868 SS=F	is sorry." "I am mo LPN # 1; I think sh the police." It's a lo CNA # 2 and LPN the family." "My iss will deal with her a asked the facility e interviewed CNA # director stated that executive director services manager in the facility staff fair was started within a investigation 2 hou failed to develop are for resident to visitor. The administrator was resident to visitor at interactions. The atoday but "it won't have long to the complete on QAA Committee CFR(s): 483.75(g)(1) A fact assessment and as at a minimum of: (i) The director of noting the content of the content	re concerned with this nurse e put Resident # 5 up to calling of of drama involved in this with # 1." "They have issues with sue is more with LPN # 1 and I fiter this is over." The surveyor executive director if he 12. The facility executive 13. The facility executive 14. The facility executive 15. The facility executive 16. The facility executive 17. The facility executive 18. The facility policy 18. The facility policy 18. The facility policy 18. The facility executive 18.			scuss y and	

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_ 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 1D PROVIDER'S PLAN OF CORRECTION (XS) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE TAG REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) F 868 Continued From page 176 F 868 2. The RDCS completed quality review of monthly QAPI §483.75(g)(2) The quality assessment and meetings, in the past 6 months, assurance committee must: to ensure attendance and (i) Meet at least quarterly and as needed to signatures of required committee identifying issues with respect to which quality members were present on assessment and assurance activities are 1/22/2019. Follow up based on necessary findings. This REQUIREMENT is not met as evidenced 3. The ADCS and or RDCS will Based on staff interview and facility document provide re-education to facility review, the facility staff failed to ensure the staff on the QAPI policy and required quality assurance committee members procedure by 1/28/19. attended the quarterly QA meetings. 4. RDCS and or DCS to conduct The findings included: quality monitoring of QAPI meeting to ensure attendance The facility staff failed to provide documentation and signatures of required of required committee members' attendance at committee members, weekly x 4 weeks, then monthly x 3 months. the quarterly QA (quality assurance) meetings. Findings to be reported to QAPI committee monthly and updated The surveyor met with the administrator and the as indicated. Quality monitoring director of nursing on 12/14/18 at 1:12 p.m. to schedule modified based on discuss quality assurance concerns and to review findings. the previous year's QA meetings. The administrator stated the QA committee met 5. Date of Compliance monthly. 1/28/2019. The administrator provided the sign in sheets for the quarterly meetings. The 8/29/18 quarterly QA meeting did not have the required committee members' signatures on the sign in sheet. The sign-in sheet included the administrator, the director of nursing, the medical director, and the social worker. The committee meeting failed to include an additional staff member. The 4/25/18 quarterly QA meeting did not have the required committee members' signatures on

the sign-in sheet. The sign-in sheet included the

DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				FO	PRINTED: 01/16/2016 FORM APPROVE OMB NO. 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
	495325	8. WNG			C	
NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		2/14/2018	
PHEASANT RIDGE NURSING & RE	HAB CENTER	1	355 PHEASANT RIDGE ROAD, SW COANOKE, VA 24014			
PREFIX (EACH DEFICIENCY	NEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	VLD BE	COMPLETION DATE	
sign-in sheet. The dire felt sure she had atten documentation to supp. The surveyor informed director of nursing, and nurse of the above commeeting on 12/14/18 at No further information exit conference on 12/1 Infection Prevention & CFR(s): 483.80(a)(1)(2) §483.80 infection Cont The facility must estable infection prevention and designed to provide a signed to provide and transing diseases and infections. §483.80(a) Infection proprogram. The facility must estable and control program (IF a minimum, the following investigating, and communicable diseases staff, volunteers, visitors providing services under the surveyor of	dical director, and the stor of nursing and an er were not included on the sector of nursing stated she ded but there was no port the DON's statement. If the administrator, the difference in the end of the day to 1:49 p.m. It the administrator to the day to 1:49 p.m. It the administrator to the day to 1:49 p.m. It is provided prior to the 14/18. Control (2)(4)(e)(f) It is and maintain and difference of communicable states and to help prevent the emission of communicable states and infection prevention of the prevention of	F 868	F880- Infection Prevention Control 1. Resident #70 discharged the facility on 1/10/2019. Of #1 is no longer employed a facility as of 1/18/2019. 2. On 1/21/2019, the ADCS completed a quality review the December 2018 and Ja 2019 infection control line listings of infections with resolution and identified if admitted with or acquired. ADCS will complete a quality review of observation of personal protective equipments and gloves, and appropriate hand hygiene associated with residents in	f from ENA t on anuary The ity		

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

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING	ONSTRUCTION	(X3) DATE SURVEY COMPLETED C
80 1 3	A. 1914	495325	B. WING		12/14/2018
	ROVIDER OR SUPPLIER	REHAB CENTER	435	REET ADDRESS, CITY, STATE, ZIP CODE 5 PHEASANT RIDGE ROAD, SW ANOKE, VA 24014	1 121472010
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 880	accepted national standard and training to the possible communication of the persons in the facilit (ii) When and to who communicable disease reported; (iii) Standard and trait to be followed to pre (iv) When and how is resident; including b (A) The type and duit depending upon the involved, and (B) A requirement the least restrictive possicircumstances. (v) The circumstance must prohibit employ disease or infected scontact with resident (vi) The hand hygiene by staff involved in disease actions tall \$483.80(a)(4) A systidentified under the forrective actions tall \$483.80(e) Linens. Personnel must hand	tendards; en standards, policies, and program, which must include, or eliliance designed to identify able diseases or ey can spread to other ey; om possible incidents of ase or infections should be ensmission-based precautions event spread of infections; colation should be used for a cut not limited to: ration of the isolation, infectious agent or organism at the isolation should be the elible for the resident under the essential estate of the food, if direct the disease; and a procedures to be followed direct resident contact. The employment is the end of the elible for recording incidents facility's IPCP and the	F 880	 The ADCS will receive 1 to 1 re-education on the infection control policy and procedure of 1/23/2019. The ADCS and or RDCS will provide re-education to facility staff on the policy and procedure for Infection Control by 1/28/2019. DCS and or ADCS will conduct quality monitoring of infections with resolution and identified if admitted with or acquired, 3 times per week for weeks, then weekly for 3 months. DCS and or ADCS will conduct quality monitoring of observation of personal protective equipment of gowns and gloves, and appropriate hand hygiene associated with resident in insolation (c-diff), 3 times per week for 4 weeks, the weekly for 3 months. Findings be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. Date of Compliance 1/28/2019. 	n d d ill

		AND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 01/16/201 MAPPROVE
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATI COM	O. 0938-039 E SURVEY PLETED C
NAME OF C		495326	B. WING	AND DESCRIPTION OF THE PARTY OF	12/14/2018	
NAME OF F	ROVIDER OR SUPPLIER		Street Les	STREET ADDRESS, CITY, STATE, ZIP CODE		714/2010
PHEASA	NT RIDGE NURSING &	1. 16 2. A. C.		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION OATE
F 880	Continued From pag	ge 179	F 88	0		
t fi g g g () T 1 c R w w in	IPCP and update the This REQUIREMEN by: Based on observation record review and fa facility staff failed to guidelines/program a guidelines for 1 of 23 (clostridium difficile), The findings included 1. The facility staff control guidelines for Resident # 70 was an was originally admitted with a readmission desincluded but were not bowel syndrome with	uct an annual review of its eir program, as necessary. T is not met as evidenced on, staff Interview, clinical cility document review, the follow infection control and failed to follow infection is Residents with c-diff Resident # 70.				
	recent MDS (minimun Resident # 70 was a assessment with and reference date) of 11/ MDS assesses cognit C0500, the facility sta # 70 had a BIMS (brie	at 2:41 pm. The most of data set) assessment for of data set) assessment for of data set) assessment of data set) assessment of data set of the of documented that Resident of of 15, which indicated that				
		rent orders that included			147	

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

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495325	B. WING			C 12/14/2018
	ROVIDER OR SUPPLIER NT RIDGE NURSING & R	EHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	E	1,2/14/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES IY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COP X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	
F 880	(milligram) Give 1 ca hours for c-diff for 14 On 12/12/18 at 12:38 and isolation cart out along with a sign post that read. "Stop see is surveyor observed C assistant) knock on Fenter her room withour ordective equipment CNA#1 remove Resher room and place the other trays that were unit. The surveyor of sanitizer on the wall the CNA#1. The surveyor CNA#1 stated. "She asked CNA#1 what caring for residents with that she was expected when delivering care. 1 why she entered Resup her tray without perequipment. CNA#1 is like that." "I was under had to gown and glove the facility policy on contained documentation timited to:"a. Healthcare work gowns upon entering C. difficile infection, a gloves prior to exiting	psule by mouth every 6 days." pm, the surveyor observed side Resident # 70's room ted on the resident's door nurse for instructions." The that 1 (certified nursing tesident # 70's door and ut wearing personal. The surveyor observed ident # 70's lunch tray from the tray on the cart with the being picked up from the being picked up from the oclean her hands. The surveyor interviewed or asked CNA # 1 use hand to clean her hands. The surveyor interviewed or asked CNA # 1 why is on contact precautions. The surveyor the protocol was when with c-diff. CNA # 1 stated do to wear gown and gloves. The surveyor asked CNA # sesident # 70's room to pick insonal protective stated, didn't think about it in the impression that we when providing care." Clostridium Difficile to the room of a resident with and will remove gowns and	F	880		

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

Event ID: Y3F111

Facility ID: VA0208



	The second secon	AND 1414	T COLOR IN THE STATE OF THE STA	COLUMN - WINDOW	IO. 0938-039
	IDENTIFICATION NUMBER:	Service Committee			TE SURVEY MPLETED
0.01/20/ #=	495325	B. WING		1:	C 2/14/2018
K SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
NURSING &	REHAB CENTER	W HO	4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
ACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	OULD BE	COMPLETION DATE
ontinence on vigilant har pland water based hand of C. difficille use when infection, was on exiting the policy on Consideration ded but was led dishward precaution e equipmen	aused by C. difficile, staff will and hygiene. Hand washing is superior to ABHR drub) for the mechanical espores from hands. caring for residents with C. ashing hands when soap and he room of a resident with C. D strict adherence to hand a considered best practice."	F 88			
e aware of a rinformation or to the exit actility staff facting or trace a line I October 20 ayor review with RN (region reviewing for the residual september	the findings as stated above. In was provided to the survey a conference on 12/14/18, sailed to resolve infections on the string form for 4 months and isting or tracking form for the 17. Bed the infection control gistered nurse) #1 on the string or tracking months were missing dent's infections: March. In 2018 and November in				
THE REPORT OF THE PROPERTY OF THE PARTY OF T	R SUPPLIER NURSING & SUMMARY SEACH DEFICIENT EGULATORY OF THE PROPERTY OF THE	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495325 B. WING	INCIDES (XI) PROVIDERISUPPLICATION NUMBER: 495326 RESUPPLIER WESUPPLIER SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST STEP ENCORPORATION THAT THE PROVIDENCY OF THE PREFIX PROMORE, VA. 24014 SUMMARY STATEMENT OF DEFICIENCIES ACH DEFICIENCY MUST SEPRECEDED BY FULL FROM TAG CORRECTIVE AND OF CORRECTIVE AND	A SUPPLIER (X1) PROMOBERSUPPLIERACION (ASSUPPLIER) A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE 496325 SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY OF LISC (DEMTFYING INFORMATION) ed From page 181 continence caused by C. difficile, staff will n vigilant hand hygiene. Hand washing ap and water is superior to ABHR -based hand rub) for the mechanical of C. difficile spores from hands. re use when caring for residents with C. infection, washing hands when soap and son exiting the room of a resident with C. infection, washing hands when soap and son exiting the room of a resident with C. infection AND strict adherence to hand in general is considered best practice: iity policy on "Meal Distribution: Infection Considerations" contained documentation used but was not imited to: lied distware will be handled using in precautions, including personal in equipment such as gloves, goggles, osable aprons. 3/18 at 5:45 pm, the administrative team se aware of the findings as stated above. er information was provided to the survey or to the exit conference on 12/14/18. actility staff failed to resolve infections on isting or tracking form for 4 months and have a line listing or tracking form for the I october 2017. reyor reviewed the infection control with RN (registered nurse) #1 on in reviewing the fine listing to tracking te following months were missing n of the resident's infections: March. September in 2018 and November in

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	/Y21 1414 7151 -	CONSTRUCTION	OMB NO. 093	
	FCORRECTION	ICENTIFICATION NUMBER:	A. BUILDING	CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		495325	B. WING		C	
NAME OF P	PROVIDER OR SUPPLIER	- Fallowers State Billion	S	TREET ADDRESS, CITY, STATE, ZIP CODE	12/14/20	18
PHEASAI	NT RIDGE NURSING &	REHAB CENTER		355 PHEASANT RIDGE ROAD, SW OANOKE, VA 24014		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	REGULATORY OF	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMP	PLETIO DATE
F 880	Continued From pag	ge 182	F 880			
		s on 12/14/18. RN #1 stated,	, 660			
	"I just started doing	these so I don't know where				
	the October one is."					
	The european review	and the feelith de entire title d				
	"Infection Prevention	red the facility's policy titled, n and Control Program" which				
	read in part, " Sun	veillance data and reporting				
	information is used t	to inform the committee of				
		trendsand used to assess				
	prevention and conti	established infection				
	The surveyor notified	d the administrative team on			4	
	12/14/18 at 2 pm of the findings.	the above documented				
	ilitaniga.					4
		n was provided to the				
		exit conference on 12/14/18.				
	and the same of the same		F 943	F943- Abuse, Neglect, and		
22=D	CFR(s): 483.95(c)(1))-(3)		Exploitation Training		
	§483.95(c) Abuse, no	eglect, and exploitation		4 5500 111 4 111		
	In addition to the free	edom from abuse, neglect,		1. RDCS, with facility DSS	els	
	and exploitation requ	irements in § 483.12,		present, interviewed Resident #89 on 1/17/2019. Resident #		
	that at a minimum ed	rovide training to their staff	1	feels safe at the facility and fee		
	cier et a minimoni en	rucales stait on-		staff treats him/her with dignity		
	§483.95(c)(1) Activiti	es that constitute abuse,	12.5	and respect.		
		and misappropriation of	8i		1	
	resident property as	set forth at § 483.12.	2	The RDCS and UMs completed quality		
- 1	§483.95(c)(2) Proced	dures for reporting incidents		review/interviews of all current		
	of abuse, neglect, ex			residents (cognitively impaired		
	misappropriation of re			residents' representatives were		
	£402 0E/aV2\ Da	-C		contacted) to ensure residents are free from abuse and neglect		
	resident abuse preve	ntia management and		on 1/22/19. Follow up based o	n	
		is not met as evidenced		findings.		

		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	ED: 01/16/2019 RM APPROVED IO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The Secretary and Ultra-	(X2) MULTIPLE CONSTRUCTION A BUILDING				
		495325	B. WING			С		
NAME OF P	ROVIDER OR SUPPLIER	SP SERVICE SHEET AND THE		STREET ADDRESS, CITY, STATE, ZIP CODE	17	2/14/2018		
PHEASA	PHEASANT RIDGE NURSING & REHAB CENTER			4355 PHEASANT RIDGE ROAD, SW ROANDKE, VA 24014				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 183 by: Based on staff interview and clinical record review, the facility staff failed to provide staff training on abuse and de-escalation techniques/training for staff caring for 1 of 23 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.		PROVIDER'S PLAN OF CORRECT! (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROVIDENCY)	ON SHOULD BE COMPLETE HE APPROPRIATE DATE				
F 943			F 94	3. The ADCS and or RDG provide re-education to fa staff on federal regulation guidelines related to Abus Neglect, and Exploitation Misappropriation by 1/28/ 4. DCS and or ADCS will conduct random quality monitoring of 5 facility state validate knowledge of Abus Neglect, Exploitation & Misappropriation; 3 times week for 4 weeks, then we for 3 months. Findings to reported to QAPI committed monthly and updated as indicated. Quality monitoring schedule modified based of findings. 5. Date of Compliance	clity s and se, and 2019. If to use, per eekly be ee			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						PRINTED: 01/16/2019 FORM APPROVED		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
01 548		495325	B. WING		C 4214412042			
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE ZIP CODE	12/14/2018 P CODE			
PHEASANT RIDGE NURSING & REHAB CENTER			4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014					
(X4) ID PREFIX TAG			ID PROVIDER'S PLAN PREFIX (EACH CORRECTIVE A TAG CROSS-REFERENCED T DEFICIE		CTION SHOULD BE COMPLE O THE APPROPRIATE DAT			
F 943	SANT RIDGE NURSING & REHAB CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 943					

CENTER	RS FOR MEDICARE &	MEDICAID SERVICES				ORM APPROVED 3 NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495325	B. WING_	COLUMBATA MARKETINE		12/14/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
PHEASAN	NT RIDGE NURSING & R	EHAB CENTER		4355 PHEASANT RIDGE ROAD, SY ROANOKE, VA 24014	y division di la succession di la succes	
(X4) ID PREFIX TAG	(EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 943	Continued From page 185 unclear whether the police were supposed to remove the resident or prevent her from leaving, but that she would not be allowed to leave with the person of her choice). A nurse's note dated 11/3/18 indicated that the resident asked to smoke and the nurse refused to give her cigarettes, saying that the resident was told she couldn't take off her oxygen because saturation levels might drop and the resident was given a sedative medication instead. During an interview on 12/14/18 at 10:10 AM, the DCS said that there was a lot of concern about the resident's safety. However, the surveyor was unable to locate documentation of behavior, notifying the physician of behavior changes, or retraining staff concerning de-escalation of behaviors before calling police. Facility staff were unable to locate documentation of any record of behavior or symptoms.		F9	143		
	Business office directed order. She stated she and came in after dinrithere. Staff told her the smoke. She had return saying she was cleare Business Office Mana smoking outside hours they told her she could roommate was upset a in case the resident smoothing office Manager never to the room mate. The called the administrated dealing with the situation.	s and getting upset when dn't. Staff said the and wouldn't go in the room moked. The Business saw the resident or talked Business Office Manager or who told her he had been on for hours. He told her to TDO (called ECO above).				

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

		ND HUMAN SERVICES					D: 01/16/2019
		MEDICAID SERVICES					O. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		· · · · · · · · · · · · · · · · · · ·	(X3) DATE SURVEY COMPLETED	
496326		496326	8. WING		C 12/14/2018		
NAME OF P	ROVIDER OR SUPPLIER			7	STREET ADDRESS, CITY, STATE, ZIP CODE		
PHEASAN	IT RIDGE NURSING & RI	EHAB CENTER		Ι.	4385 PHEASANT RIDGE ROAD, SW		4
					ROANOKE, VA 24014		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION) TAG CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)			(K5) COMPLETION DATE			
F 943	Continued From page	186		943			
	statements from a supervisor and a CNA to the magistrate for a TDO (ECO). There was no transfer summary or assessment in the medical record for that date. The director of			343			
			ļ				
	nursing was unable to documentation, asses	sments, or written					
	notification of the reas resident, a family men	son for transfer given to the nber, or hospital staff.	54				
	The clinical record did not include an assessment of the resident's status or a care plan revision						
	upon the resident's rel						
	During a summary meeting on 12/13/18, the surveyor reported to the administrator, director of clinical (DCS) and the corporate regional director for clinical services the concern with the situation on 11/2 described in the record. The surveyor					37	
	abuse, de-escalation of	nts after hospitalization. No					
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			1				

Event ID: Y3F111



Fecility ID: VA0208