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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 97 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 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	F 624	4. DCS and or ADCS will conduct random quality monitoring of resident transfer discharge documentation, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 98 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 behavior or symptoms. 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	F 624		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 624	Continued From page 99 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 624		
F 625 SS=E	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return-	F 625		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4356 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 100 §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) 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; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1) of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to provide written information about the bed hold policy to the resident or the resident's representative prior to and upon transfer to the hospital or therapeutic leave. This information must be provided to all facility residents, regardless of their payment source and include 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	F 625	**F625- Notice of Bed Hold Policy Before/Upon Transfer** 1. Resident #89 transferred to the hospital on 11/02/2018 and returned within 24 hours and has not had any additional transfers. Resident #90 discharge from facility on 12/29/2018. Resident #58 re-admitted to facility on 12/5/2018 and has not had any additional transfers. Resident #22 re-admitted to facility on 11/10/2018 and has not had any additional transfers. Resident #5 re-admitted to facility on 8/27/2018 and has not had any additional transfers. Resident #55 re-admitted to facility on 11/21/2018 and has not had any additional transfers. Lead Admissions re-educated on facility bed hold policy and procedure on 1/21/2019. 2. The UMs will complete quality review of residents transferred and/or discharged in the last 30 days to ensure appropriate documentation is in the resident's medical record that resident or resident representative had been given information pertaining to bed holds on 1/25/2019. Follow up based on findings.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 101 reserve bed payment policy in the state plan, and the nursing facility's policies regarding bed-hold period permitting a resident to return. This failure effected six of 23 residents (Resident #89, Resident #90, Resident #58, Resident #22, Resident #5, and Resident #55). The findings included: 1. The facility staff failed to provide written bed hold notice information when residents were transferred to the hospital-Resident #58. Six residents were identified to have been transferred to local hospitals (Resident #89, Resident #90, Resident #58, Resident #22, Resident #5, and Resident #55). After reviewing the clinical record, none of the six had documentation that the resident or resident representative had been given information pertaining to bed holds. 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	F 625	3. The ADCS and or RDCS will provide re-education to licensed staff and Interdisciplinary team on the federal regulations and guidelines for the notice of bed hold by 1/28/2019. 4. DCS and or ADCS will conduct random quality monitoring of resident transfer discharge documentation to ensure resident or resident representative have been given information pertaining to bed holds, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 102 admissions staff stated if a resident was coming straight back to the same room that room was left undisturbed. The lead admissions staff stated, "We don't even pack the bags. I didn't think it was necessary to offer a bed hold because they are coming back to the same room." The lead admissions staff informed the surveyor that information on the bed hold policy was given and/or provided in the resident's admission packet. The surveyor requested a copy of the bed hold policy. The surveyor reviewed the policy titled "Bed Hold Effective Date 03/01/2015 Revision Date: 11/1/2017 on 12/14/18. The policy read in part "Resident or resident representative will be notified on admission, and at the time of transfer (to the hospital or therapeutic leave) of the bed hold policies, according to Federal and/or State requirements. Procedure: 2. 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 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. 2. The facility staff failed to provide written documentation of bed hold information to Resident #55 when transferred to the hospital.	F 625		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 103 The clinical record of Resident #55 was reviewed 12/12/18 through 12/14/18. Resident #55 was admitted to the facility 8/22/18 and readmitted 10/19/18 and 11/21/18 with diagnoses that included but not limited to type 2 diabetes mellitus with hyperglycemia, cerebral infarction due to embolism of cerebral artery, dysphagia, mild cognitive impairment, lack of coordination, cognitive communication deficit, aphasia, acute cystitis without hematuria, anxiety, bipolar disorder, hyperlipidemia, major depressive disorder, hypertension, and migraines. Resident #55's 14-day minimum data set (MDS) with an assessment reference date (ARD) of 11/2/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #55's current comprehensive care plan identified the resident to be at nutrition/hydration risk r/t (related to) altered nutrient utilization AEB (as evidenced by) diagnoses include DM2 (diabetes mellitus 2) with poorly controlled serum glucose levels, HgbA1c (hemoglobin A1C) at 13.2% 8/18/18. Interventions included to obtain and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow up as indicated. Date initiated 8/27/18 and revision on 12/12/18. Resident #55 was admitted to the hospital 11/12/18. The surveyor was unable to find documentation in the clinical record of required paperwork and notification and informed the unit manager licensed practical nurse #2 on 12/13/18. The surveyor interviewed the admissions staff on 12/14/18 at 11:25 a.m. The lead admissions staff	F 625		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 104 stated the facility does not offer a bed hold due to the facility always having beds available. The lead admissions staff stated if a resident was coming straight back to the same room, that room was left undisturbed. The lead admissions staff stated, "We don't even pack the bags. I didn't think it was necessary to offer a bed hold because they are coming back to the same room." The lead admissions staff informed the surveyor that information on the bed hold policy was given and/or provided in the resident's admission packet. The surveyor requested a copy of the bed hold policy. The surveyor reviewed the policy titled "Bed Hold Effective Date 03/01/2015 Revision Date: 11/1/2017 on 12/14/18. The policy read in part "Resident or resident representative will be notified on admission, and at the time of transfer (to the hospital or therapeutic leave) of the bed hold policies, according to Federal and/or State requirements. Procedure: 2. 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 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. 3. For Resident #89, facility staff failed to provide bed hold policies or written notice of transfer.	F 625		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 105 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 failed 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,	F 625		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 106 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 on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident # 5	F 625		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 107	F 625		

was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively intact.

The surveyor was unable to locate documentation that the staff had provided the bed hold notice to Resident #5 when the resident was transferred to the hospital on 8/12/18.

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 admissions staff stated if a resident was coming straight back to the same room, that room was left undisturbed. The lead admissions staff stated, "We don't even pack the bags. I didn't think it was necessary to offer a bed hold because they are coming back to the same room." The lead admissions staff informed the surveyor that information on the bed hold policy was given and/or provided in the resident's admission packet. The surveyor requested a copy of the bed hold policy.

The surveyor reviewed the policy titled "Bed Hold Effective Date 03/01/2015 Revision Date: 11/1/2017 on 12/14/18. The policy read in part "Resident or resident representative will be notified on admission, and at the time of transfer (to the hospital or therapeutic leave) of the bed hold policies, according to Federal and/or State requirements. Procedure: 2. At the time of transfer to the hospital or therapeutic leave, the

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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 amputation. . 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	F 625		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 109 continues to have large amount of dark brown coffee ground emesis, After speaking to the Resident multiple times throughout the shift Resident has agreed to go to the ED (emergency department)for evaluation ...." The surveyor could not locate documentation in Resident #22's clinical record that indicated that Resident #22 was 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	F 625		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 625	Continued From page 110 DON replied, "A notice will be given to the RP (responsible party), but not to the Resident upon transfer to the hospital". Resident #22 is his own responsible party. The administrative team was made aware of issue during a meeting with survey team on 12/14/18 at 2:00 pm. No further information regarding this issue was provided to the survey team prior to the exit conference on 12/14/18.	F 625		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure an accurate MDS (Minimum Data Set) for 1 of 23 residents in the survey sample (Resident #98). The findings included: The facility staff failed to accurately code the discharge MDS for Resident #98. Resident #98 was admitted to the facility on 10/15/18 and discharged on 10/22/18. The only MDS (Minimum Data Set) available to review were the entry MDS and discharge MDS. Resident #98 had the following diagnoses of, but not limited to diabetes, high blood pressure, neuropathy and acute kidney failure.	F 641	**F641- Accuracy of Assessments** 1. Resident #98 discharge from facility on 10/22/2018. Resident #98's MDS (Minimum Data Set) section A2100 was modified on 12/14/2018 by the MDS Coordinator to reflect accurate discharge reporting. 2. The Regional MDS nurse completed quality review of residents transferred and/or discharged in the last 30 days to ensure accurate coding of section A2100 on the MDS to reflect accurate discharge reporting on 1/13/2019. Follow up based on findings. 3. RDCS provided re-education to MDS team regarding Accuracy of Assessments, 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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 641	Continued From page 111 The surveyor reviewed the closed clinical record of Resident #98 on 12/14/18. During this review, the surveyor noted a physician order dated for 10/19/18, which stated, "Pt. (patient) to d/c (discharge) to _____ (name of receiving facility)". The surveyor reviewed the discharge MDS with an ARD (Assessment Reference Date) of 10/22/18. In Section A2100, the resident was coded as being discharged to an acute hospital. At 10:59 am, the surveyor notified the corporate MDS coordinator #1 of the above documented findings. At 2 pm, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 12/14/18.	F 641	4. DCS and or MDS nurse will conduct random quality monitoring of residents transferred and/or discharged to ensure accurate coding of section A2100 on the MDS to reflect accurate discharge reporting, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders.	F 655	**F655- Baseline Care Plan** 1. Resident #89 assessed by Nurse Practitioner and medication review completed on 1/21/2019, no signs or symptoms of distress at this time. Comprehensive care plan reviewed and revised by Interdisciplinary Team (IDT) on 1/22/2019, care plan reflects current needs of resident. Resident #70 discharge from facility on 1/10/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 113 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 psychiatric evaluation.	F 655		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

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

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 115 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. 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 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. 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.	F 655		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 116 During a summary meeting on 12/3/18, 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. Staff failed to assess the resident after the resident's return to the facility. There is no indication that staff attempted to determine whether there had been a change in the resident's status or needs after the hospitalization. The findings included: The facility staff failed to include a focus area for c-difficile on the baseline care plan for Resident # 70. Resident # 70 was an 87-year-old-female who was originally admitted to the facility on 9/20/18, with a readmission date of 12/10/18. Diagnoses included but were not limited to, c-diff, irritable bowel syndrome with diarrhea, hypertension, and anxiety disorder. The clinical record for Resident # 70 was reviewed on 12/12/18 at 2:41 pm. The most recent MDS (minimum data set) assessment for Resident # 70 was a 14-day scheduled assessment with and ARD (assessment reference date) of 11/15/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 70 had a BIMS (brief interview for mental status) score of 14 out of 15, which indicated that Resident # 70 was cognitively intact.	F 655		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 655	Continued From page 117 Resident # 70 had current orders that included but was not limited to, "Vancomycin HCl 125 mg (milligram) Give 1 capsule by mouth every 6 hours for c-diff for 14 days." On 12/14/18 at 10.30 am, unit manager RN # 1 (registered nurse) presented the surveyor with a copy of the baseline care plan for Resident # 70 that was initiated on 12/10/18. After leaving the facility, the surveyor observed that the baseline care plan for Resident # 70 that was initiated on 12/10/18 at 2:25 pm was incomplete and did not include a focus area regarding care of the resident with c-difficile.	F 655		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(ii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657	**F657- Care Plan Timing and Revision** 1. The Nurse Practitioner assessed Resident #89 and medication review was completed on 1/21/2019. No signs or symptoms of distress were present. Resident #89's comprehensive care plan was reviewed and revised by Interdisciplinary Team (IDT) on 1/22/2019. Resident #89's care plan reflects current needs of resident. A Safe Smoking Evaluation was completed by the UM for Resident #89 on 1/18/2019. 2. The UMs and or MDS nurse will complete a quality review of current residents care plans to ensure care plan reflect resident behaviors and, reflects safe smoking evaluation if applicable by 1/25/2019. Follow up based on findings.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 118 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview and clinical document review, the facility staff failed to review and revise the comprehensive care plan on return from hospital for 1 of 23 residents (89). Resident #89 was admitted to the facility on 3/28/17. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting as her own responsible party. During an interview on 12/13/18, the resident reported being generally content with physical care received, but indicated a desire to transfer to another facility prior to the planned ban on smoking starting in February 2019. The resident reported having asked several times about progress toward the transfer, but having no	F 657	3. The ADCS and or RDCS will provide re-education to licensed nurses and the interdisciplinary team will receive re-education by the DCS on the policy and procedure for timing and revision of Comprehensive Care Plans by 1/28/2019. 4. DCS and or MDS nurse to conduct quality monitoring of 5 resident's care plans to ensure care plans are reviewed and updated when resident's are readmitted to the facility to ensure the care plan reflects resident behaviors, and monitor 5 care plans of residents who smoke to ensure the care plan reflects a safe smoking evaluation, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 119	F 657		

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 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 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).

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 120 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 behavior or symptoms. 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 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	F 657		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4356 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 121 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.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 122 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide nail care to 1 of 23 residents (Resident #58). The findings included: The facility staff failed to provide nail care to Resident #58. Resident #58 was admitted to the facility 12/4/13 and readmitted 12/5/18 with diagnoses that included but not limited to adult failure to thrive, functional intestinal disorders, ileus, rectal tube, sacral ulcer stage 3, hypertension, paroxysmal atrial fibrillation, dementia without behavioral disturbances, pressure ulcers bilateral heels, unstageable, and chronic kidney disease. 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's current comprehensive care plan revised 12/11/18 identified a self-care deficit for	F 677	**F677- ADL Care Provided for Dependent Residents** 1. Resident #58 discharged from facility on 1/17/2019. 2. The UMs completed a quality review of current residents to ensure facility staff provide nail care as needed on 1/20/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed nurses and certified nursing assistants on the policy and procedure for the provision of ADL care by 1/28/2019. 4. DCS and or ADCS will conduct quality monitoring of 5 residents to ensure facility provides nail care as needed, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 123 ADLs (activities of daily living). Interventions: Extensive assistance of 1-2 with bed mobility, dressing, toileting, personal hygiene, bathing, and eating. The surveyor observed Resident #58 on 12/12/18 2:56 p.m. Resident #58 was lying in bed. Both hands were observed on top of the covers. The tops of both hands were bruised. Fingernails on both hands were observed to be long and jagged with brown debris observed under thumbnails and index fingers on both. Nail polish was observed on fingernails but was beginning to chip away. The surveyor observed Resident #58 on 12/13/18 at 7.48 a.m. Resident #58 was in bed and certified nursing assistant #1 was feeding the resident. The fingernails on both hands were long and jagged with brown debris noted under thumbnails and index fingers. C.N.A. #1 stated the resident just returned from the hospital. Resident #58 was readmitted 12/5/18. The surveyor informed the unit manager licensed practical nurse #2 of the above concern on 12/13/18 at 11:03 a.m. and requested the December 2018 ADL records. The surveyor reviewed the December 2018 ADL records for bathing. Resident #58 received a shower on 12/11/18 as documented by the following 4, 4, 2 SH ELW4 12:32. Personal hygiene for December 2018 was reviewed. Each shift was documented that care was provided. The surveyor observed certified nursing assistant #2 providing nail care on 12/13/18 11:07 AM to Resident #58.	F 677		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 124 The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern during the end of the day meeting on 12/13/18 at 4:29 p.m. No further information was provided prior to the exit conference on 12/14/18.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to provide the highest practicable well-being for 3 of 23 residents (Resident #14, Resident #37, and Resident #89). The findings included: 1 The facility staff failed to follow the physician orders for Zaroxolyn for 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 schizophrenia, chronic pain syndrome.	F 684	**F684- Quality of Care** 1. Resident #'s14, 37 and 89 were assessed and a medication review was completed by Nurse Practitioner on 1/21/2019. No signs or symptoms were present. The DCS completed a medication error report for resident #'s14 and 37 on 1/22/2019. 2. The UMs completed quality review of current resident's Medication Administration Record (MAR) and medications, to ensure medication are available for administration on 1/23/2019. The UMs to complete quality review for residents transferred in the last 30 days to ensure proper assessment was completed and reported to Physician timely on 1/25/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed nurses ensuring med availability, Change of condition/assessment and MD/Responsible Party notification by 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 125 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 back of the MAR read "Not available-called pharmacy." The box for 10/13/18 was blank and 10/14/18 was blank. 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 was not administered. The surveyor informed the unit manager licensed practical nurse #2 on 12/13/18 at 10:26 a.m. L.P.N. #2 reviewed the medication administration record and the progress notes and stated the	F 684	4. DCS and or ADCS will conduct quality monitoring of 5 resident's MAR and medications to ensure medication are available for administration, 3 times per week for 4 weeks, then 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 and reported to Physician timely, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 126 medication was not administered. The surveyor informed the administrator, the director of nursing, and the regional registered nurse of the above concern during the end of the day meeting on 12/13/18 at 4:29 p.m. The surveyor requested the pharmacy manifest for Zaroxolyn and a list of the stat box medications. The DON informed the surveyor on 12/14/18 at 8:03 a.m. that there was not a pharmacy manifest for Zaroxolyn and the medication was not in the facility stat box. No further information was provided prior to the exit conference on 12/14/18. 2. The facility staff failed to review the physician's order prior to the administration of a medication, Norvasc, to Resident #37. Resident #37 was admitted to the facility on 4/6/18 with the following diagnoses of, but not limited to heart failure, high blood pressure, diabetes and Cerebral Palsy. On the quarterly MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 10/16/18, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 9 out of a possible score of 15. Resident #37 was also coded as requiring extensive assistance of 1 staff member for dressing and personal hygiene and being totally dependent on 1 staff member for bathing. During the medication administration observation conducted on 12/13/18 at 8:17 am, the surveyor observed LPN (licensed practical nurse) #3 administer Norvasc 5 mg (milligram) po (by mouth) to Resident #37.	F 684		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 127 The surveyor performed a clinical record review on Resident #37 at approximately 1:30 pm. The surveyor could not find a physician order for Norvasc that LPN #3 administered to Resident #37. The surveyor notified LPN #1 of the above documented findings at 2:00 pm and requested copies of the physician's orders, MAR (medication administration record) for the month of December and the facility's policy on medication administration. At 3:10 pm, the surveyor was provided with copies of the above requested materials from LPN #1. The surveyor reviewed these copies and could not find a physician order for Norvasc. The facility's policy titled "6.0 General Dose Preparation and Medication Administration: read in part, " ...4.1 Facility staff should: 4.1.1 Verify each time a medication is administrated that it is the correct medication, at the correct dose, at the correct route, at the correct time, for the right resident ..." At 4:32 pm on 12/13/18, the surveyor notified the administrative team of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 12/14/18. 3. For Resident # 89, facility staff failed to properly assess resident's status and report changes to the resident's physician to facilitate timely treatment. Resident #89 was admitted to the facility on 3/28/17. Diagnoses included, but were not	F 684		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 128	F 684		

limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting as her own responsible party.

During an interview on 12/13/18, the resident reported being generally content with physical care received, but indicated a desire to transfer to another facility prior to the planned ban on smoking starting in February 2019. The resident reported having asked several times about 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 revealed 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

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 129 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.	F 684		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 130 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. 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 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.	F 684		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 131 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. 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 communicate with the resident's physician to report changes in status. The record indicated that staff called the administrator and family and friends of the resident to discuss the situation on that date.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, and clinical record review, the facility staff failed to provide treatment and services to prevent pressure ulcers for 1 of 23 Residents in the survey sample, Resident # 5.	F 686	**F686- Treatment/Services to Prevent/Heal Pressure Ulcers** 1. Resident #5's Physician ordered treatment for the pressure ulcer has been re-evaluated by Nurse Practitioner on 1/21/2019 and treatment is in place at this time. 2. The ADCS completed quality review of residents with pressure ulcers ensure treatments are applied and in place per Physician orders on 1/24/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed nurses and certified nursing assistants on the Clinical Guidelines for skin and wound treatment by 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 132 The findings included The facility failed to ensure that a physician ordered treatment for a sacral pressure ulcer was in place for Resident # 5. Resident # 5 was a 40-year-old-male who was admitted to the facility on 4/20/18, with a readmission date of 8/27/18. Diagnoses included but were not limited to, hypertension, major depressive disorder, anxiety disorder, and benign prostatic hyperplasia The clinical record for Resident # 5 was reviewed on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident # 5 was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively intact. Section M of the MDS assesses skin conditions. In Section M0300, the facility staff documented that Resident # 5 had 1 Stage 2 pressure ulcer during the lookback period for the 9/3/18 ARD. The current plan of care for Resident # 5 was reviewed and revised on 12/10/18. The facility staff documented a focus area for Resident # 5 as "Resident # 5 has the potential for additional impaired skin integrity r/t (related to) overall health condition, co-morbidities, incontinence, decreased mobility." Interventions included but were not limited to, "Administer treatments as ordered and monitor for effectiveness."	F 686	4. DCS and or ADCS will conduct quality monitoring of 5 residents with pressure ulcer treatments to ensure treatments are applied and in place per Physician orders, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 133 Resident # 5 had current orders that included but was not limited to an order to "Cleanse sacrum with NS (normal saline), pat dry. Pack wound with Puracol and cover with dry dressing qd (every day) every day shift for wound." On 12/13/18 at 8:18 am, the surveyor was in Resident # 5's room conducting a Resident interview. The surveyor asked Resident # 5 if he had any sores, open areas, or pressure ulcers. Resident # 5 stated, "I have a wound on my backside, they take pretty good care if it. It's almost healed up; it's something I came here with." On 12/13/18 at 2:14 pm, the surveyor observed wound care for Resident # 5. Resident # 5 stated that he preferred to stand and bend over using his walker for support while his treatment was being done. Upon Resident # 5 bending over and LPN # 1 (licensed practical nurse) pulling down Resident # 5's shorts to initiate treatment, the surveyor observed that there was no dressing covering the wound or packing in the sacral wound. On 12/13/18 at 2:17 pm, the surveyor interviewed LPN # 1. The surveyor asked LPN # 1 if Resident # 5 had a dressing and packing in place prior to initiation of the treatment. LPN # 1 stated, "No there wasn't one on there." The surveyor asked LPN # 1 if Resident # 5 should have had a dressing with packing in place. LPN # 1 stated, "Yes." On 12/13/18 at 2:30 pm, LPN # 1 stated to the surveyor that she went back in and asked Resident # 5 about his dressing. LPN # 1 stated	F 686		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 134 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 686		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to ensure	F 688	**F688- Increase/Prevent Decrease in ROM/Mobility** 1. Resident #11's physician ordered bilateral progressive hand roll orthotics were re-evaluated by occupational therapy on 1/18/2019. Bilateral progressive hand roll orthotics are appropriate and in place per Physician order. 2. The ADCS completed quality review of current residents with physician orders for splints to ensure the splints are applied and in place per Physician orders 1/24/2019. Follow up based on findings.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 135 physician ordered bilateral progressive hand roll orthotics were applied to 1 of 23 residents (Resident #11). The findings included: The facility staff failed to ensure the physician ordered bilateral progressive hand roll orthotics had been applied to Resident #11. The clinical record of Resident #11 was reviewed 12/12/18 through 12/14/18. Resident #11 was admitted to the facility 3/16/18 with diagnoses that included but not limited to cerebral palsy, hand contractures, hypertension, tachycardia, scoliosis, dysphagia, idiopathic epilepsy, severe protein-calorie malnutrition, acute respiratory failure, periodontal disease, intellectual disabilities, constipation, adult failure to thrive, and urinary tract infection. Resident #11's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 9/6/18 assessed the resident with short term-memory loss, long-term memory loss, and severely impaired cognitive skills for daily-decision making. Section O Special Treatments, Procedures, and Programs was reviewed. Resident received (PROM) passive range of motion and splints or braces 4 times in the look back period from 9/6/18 back to 8/31/18. Resident #11's current comprehensive care plan initiated 10/14/18 and revised on 10/14/18 identified a focus area for ADL (activities of daily living) self-care performance deficit r/t (related to) limited ROM (range of motion), limited mobility, ID (intellectual disabilities), CP (cerebral palsy), contractures UE/LE (upper and lower	F 688	3. The ADCS and or RDCS will provide re-education to licensed nurses and certified nursing assistants on the policy and procedure for contracture, prevention by 1/28/2019. 4. DCS and or ADCS will conduct random quality monitoring of residents with splints are applied and in place per Physician orders, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4385 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 136 extremities). Interventions: Contractures: The resident has contractures of the BUE/BLE (bilateral upper and lower extremities). Provide skin care to keep clean and prevent skin breakdown. Splints with restorative nursing. The surveyor reviewed Resident #11's December 2018 physician's orders. Orders included using bilateral progressive hand roll orthotics to promote optimal joint alignment, wrist and digit extension for contracture mgmt. (management) and skin integrity. Check skin integrity under hand splints every shift. The surveyor observed Resident #11 on 12/12/18 at 2:45 p.m. The resident was in bed. A small hand splint was observed in the right hand and a large splint was observed on the left hand. The surveyor observed the resident on 12/13/18 at 8:36 a.m. There was no hand splint in Resident #11's right hand. The left hand did have a hand splint. The surveyor observed Resident #11 again on 12/13/18 at 2:49 p.m. The surveyor did not observe any splints on either the right or the left hand. The surveyor interviewed the restorative certified nursing assistant #3 (RCNA #3) on 12/13/18 at 2:50 p.m. RCNA #3 stated when the restorative aides have to work the floor, they can't apply the splints. During the interview with RCNA #3, the restorative aide found Resident #11's hand/palm splint in the floor. RCNA #3 stated, "We usually put her splints on in the morning and 3-11 shift removes them."	F 688		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 137 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 splints on the resident. No further information was provided prior to the exit conference on 12/14/18.	F 688		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to do a smoking assessment after a change in status for 1 of 23 residents (89). 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	F 689	**F689- Free of Accident Hazards/Supervision/Devices** 1. Resident #89's Safe Smoking Evaluation completed by UM on 1/18/2019. 2. The UMs completed quality review of residents who smoke to ensure smoking assessments are in place and were updated when residents experienced a change in status 1/18/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed nurses on the policy and procedure for completing smoking assessments by 1/28/2019. 4. DCS and or ADCS will conduct random quality monitoring of residents, who smoke, to ensure they have a safe smoking evaluation per policy, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4356 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 138 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 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.	F 689		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 139 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	F 689		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4366 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 140 behavior or symptoms. 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 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. 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. 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	F 689		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 141 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 is no indication that staff attempted to determine whether there had been a change in the resident's status or needs after the hospitalization.	F 689		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to assess the resident's post dialysis needs for 1 of 23 residents (#90). Resident #90 was admitted to the facility on 6/12/18 and readmitted on 12/6/18 with diagnoses including chronic respiratory failure, 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.	F 698	**F698- Dialysis** 1. Resident #90 discharged from facility on 12/29/2018. Facility obtained a copy of dialysis contract for Resident #90 on 12/17/2018. 2. The RDCS completed quality review of dialysis residents to ensure residents are assessed and the communication form is completed upon return from dialysis on 1/23/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed nurses on the policy and procedure for coordination of hemodialysis services by 1/28/19.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 142 Clinical record review on 12/14/18 revealed the resident received hemodialysis therapy 3 times per week. Pre-dialysis assessments were complete for each day of service. The dialysis center usually included vital signs and weights on the forms. There was no post dialysis assessment by facility staff. There were no post dialysis progress notes. The facility policy Coordination of Hemodialysis Services indicated under 'Procedure' that 'the facility will complete the post dialysis information on the Dialysis Communication form and file the completed form in the Resident's Clinical record'. The surveyor asked to review the hemodialysis contract. The facility administrator reported there was no contract with the resident's dialysis provider. The administrator, director of clinical services and the regional director of clinical services were notified of the concern during a summary meeting on 12/15/18.	F 698	4. DCS and or ADCS will conduct random quality monitoring of dialysis residents to ensure residents are assessed and dialysis communication form completed upon return from dialysis, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures	F 755	**F755- Pharmacy Services /Procedures/Pharmacist/Records** 1. Nurse Practitioner assessed Resident #14 and medication review was completed on 1/21/2019. No signs or symptoms of distress were present. DCS completed a medication error report for Resident #14 on 1/22/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 143 that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure physician ordered medications were available for administration for 1 of 23 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	F 755	2. The UMs completed quality review on current resident's MAR and medications to ensure medication are available for administration on 1/22/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed nurses on pharmacy management, general dose preparation and medication administration by 1/28/2019. 4. DCS and or ADCS will conduct random quality monitoring of 5 resident's MAR and medications to ensure medication are available for administration, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 144 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 about medication availability or the reason Zaroxolyn was not administered. 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 was not administered.	F 755		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4358 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 755	Continued From page 145 The surveyor informed the unit manager licensed practical nurse #2 on 12/13/18 at 10:26 a.m. L.P.N. #2 reviewed the medication administration record and the progress notes and stated the medication was not administered. The unit manager L.P.N. #2 was asked about the back-up pharmacy. The unit manager L.P.N. #2 stated CVS was the back-up pharmacy. The surveyor informed the administrator, the director of nursing, and the regional registered nurse of the above concern during the end of the day meeting on 12/13/18 at 4:29 p.m. The surveyor requested the pharmacy manifest for Zaroxolyn and a list of the stat box medications. The DON informed the surveyor on 12/14/18 at 8:03 a.m. that there was not a pharmacy manifest for Zaroxolyn and the medication was not in the facility stat box. No further information was provided prior to the exit conference on 12/14/18.	F 755		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a	F 758	**F758- Free from Unnecessary Psychotropic Meds/PRN use** 1. Resident #73's Physician order for Risperdal has been clarified to reflect monitoring for side effects and effectiveness and identified target behaviors on 12/13/2018. Resident #5's Physician orders for Wellbutrin and Buspirone have been clarified to reflect monitoring for side effects and effectiveness and identified target behaviors on 12/13/2018 Resident #58 discharge from facility on 1/17/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 146 resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure that 3 of 23 Residents in the survey sample were free from	F 758	2. The UMs will complete quality review of current residents receiving psychotropic medications for monitoring for side effects and effectiveness and identified target behaviors on 1/25/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed nurses on the policy and procedure on psychotropic drug medication use and Behavior monitoring by 1/28/19. 4. DCS and or ADCS will conduct random quality monitoring of 5 residents receiving psychotropic medications for monitoring for side effects and effectiveness and identified target behaviors, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	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 C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 73 had a BIMS (brief interview for mental status) score of 14 out of 15, which indicated that Resident # 73 was cognitively intact. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 73 had received antipsychotic medication for 7 days during the look-back period for the 11/27/18 ARD. The current plan of care for Resident # 73 was reviewed and revised on 12/7/18. The facility staff documented a focus area for Resident # 73 as, "The resident is on antipsychotic therapy r/t (related to) psychosis." Interventions included but were not limited to, "Administer antipsychotic medications as ordered by physician. Monitor behavioral symptoms and side effects." Upon	F 758		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 148 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 record for Resident # 73. 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 get back with you." 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 those things from here on out." On 12/13/18 at 5:45 pm, the administrative team was made aware of the findings as stated above.	F 758		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 149	F 758		

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

2. The facility staff failed to monitor Resident # 5 for behaviors, side effects, and effectiveness for physician ordered Wellbutrin and Buspirone.

Resident # 5 was a 40-year-old-male who was admitted to the facility on 4/20/18, with a readmission date of 8/27/18. Diagnoses included but were not limited to, hypertension, major depressive disorder, anxiety disorder, and benign prostatic hyperplasia.

The clinical record for Resident # 5 was reviewed on 12/13/18 at 10:41 am. The most recent MDS (minimum data set) assessment for Resident # 5 was a quarterly assessment with an ARD (assessment reference date) of 9/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 5 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicated that Resident # 15 was cognitively intact. Section N of the MDS assesses medications. In Section N0410, the facility staff documented that Resident # 5 had taken antidepressant and antianxiety medication for 7 days during the look-back period for the 9/3/18 ARD.

The current plan of care for Resident # 5 was reviewed and revised on 12/10/18. The facility staff documented a focus area for Resident # 5 as, "Psychoactive medication use antianxiety medication used for dx (diagnosis) of anxiety. Anti-depressant medication for dx of depression

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	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 HCl 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.

"0-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 notes."

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

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 151 1-movement side effects see progress notes, 2-non movement side effects see progress notes every shift for monitoring." 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. No further information regarding this issue was presented to the survey team prior to the exit conference on 12/14/18. 3. The facility staff to ensure the prn (whenever needed) orders for the psychotropic drug Ativan were limited to 14 days. The physician order dated 12/7/18 read "Give Ativan 0.5 ml (milliliters) by mouth every 8 hours as needed for anxiety, aggitation (sic) for 30 days to Resident #58." Resident #58 was admitted to the facility 12/4/13 and readmitted 12/5/18 with diagnoses that included but not limited to adult failure to thrive, functional intestinal disorders, ileus, rectal tube, sacral ulcer stage 3, hypertension, paroxysmal atrial fibrillation, dementia without behavioral	F 758		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4385 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 152 disturbances, pressure ulcers bilateral heels, unstageable, and chronic kidney disease. 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. Resident #58 was assessed without any signs or symptoms of delirium, behaviors affecting others or psychosis. Section N Medications did not reveal Resident #58 had been administered any psychotropic medications in the 7-day look back period. Resident #58 was in the process of a significant change MDS and comprehensive care plan. Resident #58's current comprehensive care plan revised 5/19/17 identified the resident had impaired cognition and/or impaired thought processes r/t (related to) dementia, hard of hearing and no hearing aids, and chronic respiratory failure. Interventions: Administer meds (medications) as ordered. The surveyor reviewed Resident #58's clinical record. The facility NP (nurse practitioner) ordered Ativan 0.5 ml every 8 hours as needed for anxiety, agitation for 30 days on 12/7/18. The surveyor interviewed the facility NP (other #2) on 12/13/18 at 12:11 p.m. The NP (other #2) stated he forgot and would adjust the Ativan order. The surveyor interviewed the assistant director of nursing on 12/13/18 at 12:15 p.m. and asked for the corrected Ativan order and a summary of all Ativan orders for Resident #58.	F 758		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 153 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 p.m. No further information was provided prior to the exit conference on 12/14/18.	F 758		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review, the facility staff failed to ensure 1 of 23 residents was free of a significant medication error (Resident #55). The findings included: The facility staff to follow the physician orders for sliding scale insulin for Resident #55.	F 760	**F760- Residents Are Free of Significant Med Errors** 1. Nurse Practitioner assessed and completed a medication review for Resident #55 on 1/21/2019. No signs or symptoms of distress were present. DCS completed a medication error report for Resident #55 on 1/22/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 154 The clinical record of Resident #55 was reviewed 12/12/18 through 12/14/18. Resident #55 was admitted to the facility 8/22/18 and readmitted 10/19/18 and 11/21/18 with diagnoses that included but not limited to type 2 diabetes mellitus with hyperglycemia, cerebral infarction due to embolism of cerebral artery, dysphagia, mild cognitive impairment, lack of coordination, cognitive communication deficit, aphasia, acute cystitis without hematuria, anxiety, bipolar disorder, hyperlipidemia, major depressive disorder, hypertension, and migraines. Resident #55's 14-day minimum data set (MDS) with an assessment reference date (ARD) of 11/2/18 assessed the resident with a BIMS (brief interview for mental status) as 15/15. Resident #55's current comprehensive care plan identified the resident to be at nutrition/hydration risk r/t (related to) altered nutrient utilization AEB (as evidenced by) diagnoses include DM2 (diabetes mellitus 2) with poorly controlled serum glucose levels, HgbA1c (hemoglobin A1C) at 13.2% 8/18/18. Interventions included to obtain and monitor lab/diagnostic work as ordered. Report results to MD (medical doctor) and follow up as indicated. Date initiated 8/27/18 and revision on 12/12/18. The December 2018 physician's orders included an order for sliding scale insulin dated 11/29/18 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) 181-240=4u	F 760	2. The ADCS and or RDCS will complete a quality review of current diabetic residents to ensure residents are receiving appropriate sliding scale coverage with documentation in the MAR by 1/25/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed nurses on the policy and procedure for sliding scale insulin administration set up in electronic medical record by 1/28/2019. 4. DCS and or ADCS will conduct random quality monitoring of diabetic residents to ensure residents are receiving appropriate sliding scale coverage with documentation on the MAR, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 155 241-300=6u 301-350=8u 351-400=10u >(greater than) 400 + 12u & (and) call MD. A second physician order read "Accuchecks AC & HS (before meals and at bedtime) four times a day. Start date 11/29/18." The surveyor reviewed the November 2018 and December 2018 electronic medication administration records. The blood sugars were obtained as ordered; however, there was no documentation on the November 2018 or December 2018 electronic medication administration records (eMARs) that the staff administered the sliding scale insulin based on the results of the blood sugars. The blood sugar for 12/1/18 at 0630 was 279. Based on the sliding scale insulin, Resident #55 should have received 6 units of Humalog. The December 2018 eMAR did not have any sliding scale insulin documented. The results of the blood sugars were as follows: 12/1/18 0630-BS=279 12/1/18 1130 BS=308 12/1/18 1630 (4:30 p.m.) BS=305 12/1/18 2030 (8:30 p.m.) BS=309 12/2/18 0630 BS=365 12/2/18 1130 BS=406 12/2/18 1630 BS=267 12/2/18 2030 BS=309 12/3/18 0630 BS=340 12/3/18 1130 BS=389 12/3/18 1630 BS=391 12/3/18 2030 BS=277 12/4/18 0630 BS=400 12/4/18 1130 BS=362 12/4/18 1630 BS=311	F 760		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 760	Continued From page 156 12/4/18 2030 BS=289 12/5/18 0630 BS=391 12/5/18 1130 BS=384 12/5/18 1630 BS=456 12/5/18 2030 BS=365 12/6/18 0630 BS=248 12/6/18 1130 BS=317 12/6/18 1630 BS=302 12/6/18 2030 BS=363 12/7/18 0630 BS=379 12/7/18 1130 BS=288 12/7/18 1630 BS=441 12/7/18 2030 BS=301 12/8/18 0630 BS=289 12/8/18 1130 BS=212 12/8/18 1630 BS=400 12/8/18 2030 BS=236 12/9/18 0630 BS=184 12/9/18 1130 BS=271 12/9/18 1630 BS=309 12/9/18 2030 BS=372 12/10/18 0630 BS=257 12/10/18 1130 BS=257 12/10/18 1630 BS=294 12/10/18 2030 BS=276 12/11/18 0630 BS=358 12/11/18 1630 BS=372 12/11/18 2030 BS=273 12/12/18 0630 BS not obtained. Resident refused 12/12/18 1130 BS=375 The facility staff had not administered sliding scale insulin to Resident #55 when the blood sugar was greater than 131 on any of the above days or times or notified the physician when the blood sugar was 400 or greater. The surveyor informed the unit manager licensed	F 760		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. The unit manager licensed practical nurse #2 informed the surveyor that the nurses had just been administering the 1 unit of Humalog insulin and not administering the sliding scale insulin. The surveyor informed the administrator, the director of nursing, and the regional registered nurse of the above concern on 12/14/18 at 1:49 p.m. and requested the facility policy on diabetes management. The surveyor reviewed the facility policy on diabetes titled "Blood Glucose Monitoring & Disinfecting" on 12/14/18. The policy read in part "Verify physician order. Document result in medical record." The surveyor also reviewed the facility policy titled "6.0 General Dose Preparation and Medication Administration" on 12/14/18. The policy read in part "4.1.2 Confirm that the MAR (medication administration record) reflects the most recent medication order." No further information was provided prior to the exit conference on 12/14/18.	F 760		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761	**F761- Label/Store Drugs and Biologicals** 1. UMs discarded loose medications identified on Hallway 200, rooms 301-305 and 306-310, expired Novolog Flex pen (200 hallway), expired Lantus insulin (on medication cart for rooms 301-305) and Levamir Flex was placed into appropriate package on 12/12/2018.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 158 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, facility document review, and staff interview, the facility staff failed to store and label medications in a secured locked medication box on 1 of 2 nursing units in the facility and failed to discard expired medications on 1 of 2 nursing units in the facility (Hallways 200, 300 and 400). The findings included. The surveyor made the following observations when checking the medication cart on Hallway 200 on 12/12/18 at 12:00 pm: " In the medication cart, 1st drawer, Left hand side there were (1) blue/white capsule, (1) small	F 761	DCS re-educated LPN #2 on preventing medication errors, packages of medications must be placed back into medication cart and cart must be locked prior to leaving medication cart on 1/21/2019. 2. The UMs completed quality review of medication carts and medication rooms for expired medications, appropriate labeling and loose pills on 1/22/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed staff nurses to on the storage and labeling on medications by 1/28/2019. 4. DCS and or ADCS will conduct random quality monitoring of medication carts and medication rooms for expired medications, appropriate labeling and loose pills, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4356 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	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 400 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. The surveyor made the following observation when checking the medication cart for rooms 306-310 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 package.	F 761		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 160 The surveyor made the following observations when checking the medication cart for rooms 301-305 on 12/12/18 at 12:42 pm: " In the 1st drawer, left side of the cart there were (1) tan oblong pill and (2) 1/2 small white pill loose and not in a package. " In the 1st drawer, right side of the cart there was (1) Lantus Insulin multi dose vial 100 u/ml open date 10/30/18 as when opened. The sticker stated to discard after 28 days. The expiration date would had been 11/26/18. This insulin remained in the medication cart. " Also in the1st drawer, right side of the cart there was a Levamir Flex Pen 100 u/ml resident's name on pharmacy label that is affixed to the pen was for Resident #10. The plastic bag that the Lexamir Flexpen was taken out of had a pharmacy label on it, which was for Resident #26. The surveyor asked LPN (licensed practical nurse) #3 whose responsibility it was to discard any medication that is expired on the medication cart. LPN #3 stated, "We are to throw the expired medication away as soon as we see that it is expired." During the medication administration observation on 12/13/18 at 8:29 am, the surveyor made the following observation: " LPN #2 laid the following medications on the end of the tray table that the surveyor was using. The surveyor reviewed the packages for the resident, name of medication, dosage and how often the resident received this medication. The cards were then placed back on the corner of the tray table for LPN #2 to replace back into the	F 761		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 161 medication cart. " LPN #2 turned and went into Resident #9, leaving the medication cart unlocked and packages of medications on the tray table. The medications left on the tray table were Gabapentin, Folic Acid, Cinnamon, Metformin, Vitamin B12, UTI Stat and Lantus Insulin. The surveyor asked LPN #2 where she should had left the medications at when she went into Resident #9's room and she stated, "I should had put them back into the medication cart and locked the cart." The surveyor notified LPN #1 of the above documented findings and observations made. The surveyor requested copies of the facility's policy on medication administration and storage of medications. The facility's policy titled, "5.3 Storage and Expiration of Medications, Biologicals, Syringes and Needles" stated in part, "...Facility should ensure that all medications and biologicals, including treatment items, are securely stored in a locked cabinet/carts or locked medication room that is inaccessible by residents and visitors ...Facility should destroy or return all discontinued, outdated/expired, or deteriorated medications or biologicals in accordance with Pharmacy return/destruction guidelines..." In the facility's policy titled, "6.0 General Dose Preparation and Medication Administration" it read in part, "..Facility staff should not leave medications or chemicals unattended ...Facility should ensure that the medication carts are always locked when out of sight or unattended .." The surveyor notified the administrative team of	F 761		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 162 the above documented findings on 12/13/18 at 4 32 pm. No further information was provided to the surveyor prior to the exit conference on 12/14/18.	F 761		
F 805 SS=D	Food in Form to Meet Individual Needs CFR(s): 483.60(d)(3) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(3) Food prepared in a form designed to meet individual needs. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, the facility staff failed to provide the physician ordered diet to 1 of 23 residents (Resident #58). The findings included: The facility staff failed to follow the physician ordered diet for Resident #58. Resident #58 was admitted to the facility 12/4/13 and readmitted 12/5/18 with diagnoses that included but not limited to adult failure to thrive, functional intestinal disorders, ileus, rectal tube, sacral ulcer stage 3, hypertension, paroxysmal atrial fibrillation, dementia without behavioral disturbances, pressure ulcers bilateral heels, unstageable, and chronic kidney disease. 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	F 805	**F805- Food in Form to Meet Individual Needs** 1. Resident #58 diet order was reviewed to ensure order matches meal ticket. 2. The RDCS completed quality review of current residents' diet orders, meal tickets, and tray for accuracy on 1/23/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed nurses, certified nursing assistants, and Dietary staff on food and drink and that each resident receives and the facility provides— Food prepared in a form designed to meet individual needs by 1/28/2019. 4. DCS and or ADCS will conduct random quality monitoring of 5 current residents' diet orders, meal tickets, and tray for accuracy, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 163 status) as 03/15. Section G Functional Status assessed the resident for eating to require extensive assistance of one person. In Section K Swallowing/Nutritional Approaches, Resident #58 was assessed to have a mechanically altered diet and a therapeutic diet. Resident #58 was in the process of a significant change MDS and comprehensive care plan. Resident #58's current comprehensive care plan revised 12/12/18 identified the resident was a nutrition/hydration risk r/t (related to) self-care deficit, altered nutrient utilization, increased nutrient needs, functional status decline AEB (as evidenced by) dx (diagnoses) include CKD3 (chronic kidney disease), CHF (congestive heart failure), dementia, protein-calorie malnutrition, adult failure to thrive, requires mechanically altered diet for safe and comfortable po (by mouth) intake. Comfort care in place. Interventions: Provide, serve diet as ordered. The surveyor observed Resident #58 at breakfast on 12/13/18 at 7:51 a.m. Resident #58's diet ticket read "NAS (no added salt)-Mechanical Soft Honey Thick/Fortified Foods." Food items on the tray were: scrambled eggs, grits, cranberry orange coffee cake, magic cup, honey thickened milk, and honey thickened coffee. Certified nursing assistant #1 was feeding the resident. Resident #58 took only a few sips by spoon of the honey-thickened milk. The surveyor observed the resident at lunch on 12/13/18 at 12:05 p.m. The diet ticket read "NAS-Mechanical Soft, Honey Thick/Fortified Foods." Resident #58 had the following food items on the tray: carrots, ground Salisbury	F 805		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	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 I (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. The surveyor interviewed the dietary manager on 12/13/18 at 12:25 p.m. The dietary manager checked the diet records and the most recent diet order for Resident #58 had not been entered into the meal tracker. The surveyor informed the administrator, the director of nursing, and the corporate registered nurse of the above concern during the end of the day meeting on 12/13/18 at 4:29 p.m. No further information was provided prior to the	F 805		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 805	Continued From page 165 exit conference on 12/14/18	F 805	**F812- Food Procurement, Store/Prepare/Serve- Sanitary**	
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review the facility staff failed to store, prepare, distribute, and serve food in accordance with professional standards of food service safety. The findings included The facility staff to label, date, and discard expired food items in the kitchen and pantries. On 12/12/18 at 11:47 am, the initial tour of the kitchen was completed. During the initial tour, the	F 812	1. Expired, unlabeled, and undated items identified in the kitchen and pantries were discarded by Dietary Manager and UMs on 12/13/2018. 2. The Dietary Manager completed quality review of kitchen and pantries to ensure food items are labeled, dated, and discarded when expired, on 1/23/2019. Follow up based on findings. 3. The ADCS, RDCS or Food and Beverage Contractor will provide re-education to facility staff on the federal regulations and dietary guidelines for Food Storage: Dry goods by 1/28/19. 4. Dietary Manager and or designee will conduct random quality monitoring of kitchen and pantries to ensure food items are labeled, dated, and discarded when expired, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 812	Continued From page 166 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 apricot 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. No further information regarding this incident was provided to the survey team prior to the exit conference on 12/14/18.	F 812		
F 842	Resident Records - Identifiable Information	F 842		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842 SS=D	Continued From page 167 CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable Information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert	F 842	**F842- Resident Records- Identifiable Information** 1. Nurse Practitioner assessed and completed a medication review for Resident #14 on 1/21/2019. No signs or symptoms of distress were present. DCS completed a medication error report completed on 1/22/2019 for Resident #14. 2. The DCS and or ADCS will complete a quality review of current residents' MAR to ensure narcotics are signed off when administered by 1/25/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to licensed nurses on General Dose Preparation and medication administration by 1/28/19. 4. DCS and or ADCS will conduct random quality monitoring of current residents' MAR to ensure narcotics are signed off when administered, 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 168 a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, the facility staff failed to maintain a complete and accurate clinical record for 1 of 23 residents (Resident #14). The findings included: The facility staff failed to document the administration of Oxycodone 10 mg (milligrams) on the October 2018 medication administration	F 842		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 169 records. 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 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's clinical record revealed a physician order dated 10/22/18 that read "D/C (discontinue) previous oxycodone order. Change Oxycodone 10 mg to q (every) 4 hrs (hours) po (by mouth)." The surveyor reviewed the October 2018 medication administration records (MARs). Oxycodone 10 mg q4hours for pain had been entered onto the October 2018 MAR. The surveyor noted blanks at the following times-10/23/18 at 2:00 a.m., 10/25/18 at 6:00 p.m. and 10/30/18 at 6:00 p.m. The surveyor informed the unit manager licensed practical nurse #2 of the above concern on	F 842		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4356 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 170 12/14/18 at 8:32 a.m. and requested the October 2018 narcotic sheets for Oxycodone. The surveyor and the unit manager licensed practical nurse #2 reviewed the October 2018 narcotic sheets for Oxycodone on 12/14/18 at 8:57 a.m. Oxycodone 10 mg was recorded marked on narcotic sheets for 10/23/18 at 2:00 a.m. and 10/25/18at 6:00 p.m. The 10/30/18 6:00 p.m. dose of Oxycodone was recorded on the electronic medication administration record. When asked if medications should be documented on the MAR as well as on the narcotic sheet, the unit manager L.P.N. #2 stated she would expect staff to document medications administered on the MAR. The surveyor requested the facility policy on medication administration from the unit manager L.P.N. #2 on 12/14/18 09:14 a.m. The surveyor reviewed the facility policy titled "6.0 General Dose Preparation and Medication Administration" on 12/14/18. The policy read in part "Procedure 6. After medication administration, the facility staff should take all measures required by facility policy and applicable law, including, but not limited to the following: 6.1 Document necessary medication administration/treatment information on appropriate forms." The surveyor informed the administrator, the director of nursing and the regional registered nurse on 12/14/18 at 1:49 p.m. prior to the exit conference. No further information was provided prior to the exit conference on 12/14/18.	F 842		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility reported incidents, complaints, and during the course of a quality assurance review, the facility staff failed to identify and develop action plans to address resident rights for safety, dignity, residents who are verbally abused and threatened by visitors, and staff to resident interactions. The findings include: ABUSE Sections §§1819 and 1919 of the Social Security Act provide that each resident has the right to be free from, among other things, physical or mental abuse and corporal punishment. The facility must provide a safe resident environment and protect residents from abuse. As a part of the survey process, the survey team identified harm level deficiencies in the areas of abuse and neglect. The facility staff failed to develop action plans to address resident safety, dignity, verbal abuse, intimidation, and resident to staff relationships. The survey team also identified areas of concern for transfers and discharge requirements, notice given to resident and resident representative prior	F 867	**F867- QAPI/QAA Improvement Activities** 1. The RDCS conducted a QAPI meeting to discuss findings from annual survey and reviewed an action plan to address resident's rights including safety, dignity, residents who are verbally abused and threatened by visitors and or staff on 1/22/2019. 2. The RDCS completed quality review of QAPI meeting minutes for the past 6 months to ensure facility met, at a minimum, monthly to review identified areas of improvement per guidelines on1/22/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to facility staff to on the policy and procedure for QAPI/QAA procedures by 1/28/19. 4. RDCS and or DCS will conduct quality monitoring of QAPI meetings to ensure QAPI Committee will meet a minimum of monthly to review identified areas of improvement per guidelines, weekly x 4 weeks, then monthly x 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 172 to transfer/discharge, preparation for safe and orderly transfer/discharge, bed hold requirements, baseline care plans, care plan timing and revision, quality of care concerns, ADL (activities of daily living), pressure ulcer treatment, accidents, dialysis, range of motion, pharmacy, unnecessary medications, storage and labeling of medications, significant medication errors, kitchen concerns, menus, resident records and infection control. During the meeting with the administrator and the director of nursing on 12/14/18 at 1:12 p.m., the surveyor asked how often the QA committee met and what issues were discussed. The administrator stated the committee met monthly and identified concerns through a number of different avenues. The administrator stated when an area of concern is identified, the director of nursing educates the staff, holds monthly staff meetings, and sends Facility Reported Incidents (FRIs) to Adult Protective Services (APS), DHP (Department of Health Professions), and OLC (office of licensure and certification). The administrator stated the staff are re-educated with each incident whether it means termination of staff to make everything safe. The administrator was referring to an incident involving a licensed practical nurse and Resident #97. The administrator stated concerning Resident #5 and Resident #5's former roommate, APS and the ombudsman had informed the administrator that when the facility had moved the roommate out at some point during his stay, APS and the ombudsman told the facility that they had to move him back. Two concerns were reviewed with the executive director on 12/14/18.	F 867		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 173 A second surveyor spoke to the facility's executive director on 12/14/18 at 8:59 am in the presence of the survey team. The surveyor asked the executive director if he remembered Resident #97 and/or his relationship with LPN#1. The executive director stated that he found out that Resident #97 and LPN #1 were in a relationship. The regional nurse consultant put guidelines in place for LPN #1 and Resident #97 to follow while in the facility. Resident #97 left the facility AMA (against medical advice) with LPN #1 upon her termination due to those guidelines being broken 15 days after the guidelines were set in place on 03/06/18. The executive director voiced that LPN #1 had to be barred from the premises on the evening of 03/06/18. The local police were contacted and spoke to LPN #1 at a location close to the facility. The executive director expressed that Resident #97 wanted to leave AMA with LPN #1. The executive director voiced that facility staff did not report the relationship between Resident #97 and LPN #1 until 02/19/18 and he had no prior knowledge of the relationship. The executive director stated that the facility provider did not have a policy in place at the time of the incident or at the present time regarding facility staff and Resident interactions. The surveyor asked the executive director if he thought that LPN #1 exploited Resident #97 financially. The executive director replied, "Resident #97 was broke. He had no assets, no money, and lived with his parents". The executive director reported to the surveyor that Resident #97 had called the facility after the incident wanting to come back. The guidelines the facility implemented failed and the resident left AMA. The facility failed to	F 867		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 174 develop and implement a policy to address resident to staff relationships. The administrator had been interviewed by a second surveyor on 12/14/18 at 11:05 a.m. with the survey team present. The surveyor asked the executive director what the procedure was for allegations of resident-to-resident abuse. The facility executive director stated, "Separate and investigate." The surveyor asked the facility executive director what the procedure was for allegations of staff to resident abuse. The facility executive director stated that the employee was to be suspended pending investigation. The surveyor asked the facility executive director what was the procedure for allegations of visitor to resident abuse. The facility executive director stated, that a facility reported incident would be submitted, the incident would be investigated, and the visitor would be asked to stay away until the investigation is complete. The surveyor asked the facility executive director why the family was not asked to stay away during the investigation of the allegation of abuse reported by Resident # 5. The facility executive director stated, "Or they meet with me and the director of nursing and we determine if they can come back." "I met with the family on Monday and with Resident # 5's history of 3 or 4 occasions that he has lied, the residents were separated and Resident # 5 was moved to another room." "I decided that the alleged perpetrator could return to the building." The surveyor asked the facility executive director how he could make that determination when the investigation had not been completed. The facility executive director stated, "I don't think it happened." "Resident # 5 tells lies." "In the past he has made accusations and said this happened and he comes back 3 or 4 days later and says he	F 867		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 executive director stated that 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 e exit conference on 12/14/18.	F 867		
F 868 SS=F	QAA Committee CFR(s): 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. (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role;	F 868	**F868- QAA committee** 1. The RDCS conducted a QAPI meeting on 1/22/2019 to discuss findings from annual survey and to discuss staff members who are required to attend the quarterly QA meetings.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 176 §483.75(g)(2) The quality assessment and assurance committee must: (i) Meet at least quarterly and as needed to identifying issues with respect to which quality assessment and assurance activities are necessary. This REQUIREMENT is not met as evidenced by: Based on staff interview and facility document review, the facility staff failed to ensure the required quality assurance committee members attended the quarterly QA meetings. The findings included: The facility staff failed to provide documentation of required committee members' attendance at the quarterly QA (quality assurance) meetings. The surveyor met with the administrator and the director of nursing on 12/14/18 at 1:12 p.m. to discuss quality assurance concerns and to review the previous year's QA meetings. The administrator stated the QA committee met monthly. 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	F 868	2. The RDCS completed quality review of monthly QAPI meetings. in the past 6 months, to ensure attendance and signatures of required committee members were present on 1/22/2019. Follow up based on findings. 3. The ADCS and or RDCS will provide re-education to facility staff on the QAPI policy and procedure by 1/28/19. 4. RDCS and or DCS to conduct quality monitoring of QAPI meeting to ensure attendance and signatures of required committee members, weekly x 4 weeks, then monthly x 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 868	Continued From page 177 administrator, the medical director, and the pharmacist. The director of nursing and an additional staff member were not included on the sign-in sheet. The director of nursing stated she felt sure she had attended but there was no documentation to support the DON's statement. The surveyor informed the administrator, the director of nursing, and the regional registered nurse of the above concern in the end of the day meeting on 12/14/18 at 1:49 p.m. No further information was provided prior to the exit conference on 12/14/18.	F 868		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following	F 880	**F880- Infection Prevention and Control** 1. Resident #70 discharged from the facility on 1/10/2019. CNA #1 is no longer employed at facility as of 1/18/2019. 2. On 1/21/2019, the ADCS completed a quality review on the December 2018 and January 2019 infection control line listings of infections with resolution and identified if admitted with or acquired. The ADCS will complete a quality review of observation of personal protective equipment of gowns and gloves, and appropriate hand hygiene associated with residents in isolation by 1/25/2019. Follow up based on findings.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 178 accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 880	3. The ADCS will receive 1 to 1 re-education on the infection control policy and procedure on 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. 4. DCS and or ADCS will conduct quality monitoring of infection control line listings of infections with resolution and identified if admitted with or acquired, 3 times per week for 4 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, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495326	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4358 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 179 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record review and facility document review, the facility staff failed to follow infection control guidelines/program and failed to follow infection guidelines for 1 of 23 Residents with c-diff (clostridium difficile), Resident # 70. The findings included: 1. The facility staff failed to follow infection control guidelines for c-diff for Resident # 70. Resident # 70 was an 87-year-old-female who was originally admitted to the facility on 9/20/18, with a readmission date of 12/10/18. Diagnoses included but were not limited to, c-diff, irritable bowel syndrome with diarrhea, hypertension, and anxiety disorder. The clinical record for Resident # 70 was reviewed on 12/12/18 at 2:41 pm. The most recent MDS (minimum data set) assessment for Resident # 70 was a 14-day scheduled assessment with and ARD (assessment reference date) of 11/15/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 70 had a BIMS (brief interview for mental status) score of 14 out of 15, which indicated that Resident # 70 was cognitively intact. Resident # 70 had current orders that included but was not limited to, "Vancomycin HCl 125 mg	F 880		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 180 (milligram) Give 1 capsule by mouth every 6 hours for c-diff for 14 days." On 12/12/18 at 12:38 pm, the surveyor observed and isolation cart outside Resident # 70's room along with a sign posted on the resident's door that read. "Stop see nurse for instructions." The surveyor observed CNA # 1 (certified nursing assistant) knock on Resident # 70's door and enter her room without wearing personal protective equipment. The surveyor observed CNA # 1 remove Resident # 70's lunch tray from her room and place the tray on the cart with the other trays that were being picked up from the unit. The surveyor observed CNA # 1 use hand sanitizer on the wall to clean her hands. On 12/12/18 at 2:21 pm, the surveyor interviewed CNA # 1. The surveyor asked CNA # 1 why Resident # 70 was on is on contact precautions. CNA # 1 stated. "She has c-diff." The surveyor asked CNA # 1 what the protocol was when caring for residents with c-diff. CNA # 1 stated that she was expected to wear gown and gloves when delivering care. The surveyor asked CNA # 1 why she entered Resident # 70's room to pick up her tray without personal protective equipment. CNA # 1 stated, didn't think about it like that." "I was under the impression that we had to gown and glove when providing care." The facility policy on "Clostridium Difficile" contained documentation that included but was not limited to: ..."a. Healthcare workers will wear gloves and gowns upon entering the room of a resident with C. difficile infection, and will remove gowns and gloves prior to exiting the room. 11. When caring for residents with diarrhea or	F 880		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 181 fecal incontinence caused by C. difficile, staff will maintain vigilant hand hygiene. Hand washing with soap and water is superior to ABHR (alcohol-based hand rub) for the mechanical removal of C. difficile spores from hands. 12. Glove use when caring for residents with C. difficile infection, washing hands when soap and water upon exiting the room of a resident with C. difficile infection AND strict adherence to hand hygiene in general is considered best practice." ... The facility policy on "Meal Distribution: Infection Control Considerations" contained documentation that included but was not limited to: ..."5. Soiled dishware will be handled using universal precautions, including personal protective equipment such as gloves, goggles, and disposable aprons. On 12/13/18 at 5:45 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 12/14/18. 2. The facility staff failed to resolve infections on the line listing or tracking form for 4 months and failed to have a line listing or tracking form for the month of October 2017. The surveyor reviewed the infection control program with RN (registered nurse) #1 on 12/14/18. In reviewing the line listing or tracking forms, the following months were missing resolution of the resident's infections: March, June and September in 2018 and November in 2017. The surveyor also noted that there was no line listing or tracking form for October 2017. The surveyor notified RN #1 of the above	F 880		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 182 documented findings on 12/14/18. RN #1 stated, "I just started doing these so I don't know where the October one is." The surveyor reviewed the facility's policy titled, "Infection Prevention and Control Program" which read in part, "...Surveillance data and reporting information is used to inform the committee of potential issues and trends ...and used to assess the effectiveness of established infection prevention and control practices ..." The surveyor notified the administrative team on 12/14/18 at 2 pm of the above documented findings. No further information was provided to the surveyor prior to the exit conference on 12/14/18.	F 880		
F 943 SS=D	Abuse, Neglect and Exploitation Training CFR(s): 483.95(c)(1)-(3) §483.95(c) Abuse, neglect, and exploitation. In addition to the freedom from abuse, neglect, and exploitation requirements in § 483.12, facilities must also provide training to their staff that at a minimum educates staff on- §483.95(c)(1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property as set forth at § 483.12. §483.95(c)(2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property §483.95(c)(3) Dementia management and resident abuse prevention. This REQUIREMENT is not met as evidenced	F 943	**F943- Abuse, Neglect, and Exploitation Training** 1. RDCS, with facility DSS present, interviewed Resident #89 on 1/17/2019. Resident #89 feels safe at the facility and feels staff treats him/her with dignity and respect. 2. The RDCS and UMs completed quality review/interviews of all current residents (cognitively impaired residents' representatives were contacted) to ensure residents are free from abuse and neglect on 1/22/19. Follow up based on findings.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 943	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 residents in the survey sample. (89). Resident #89 was admitted to the facility on 3/28/17. Diagnoses included, but were not limited to, hemiplegia and hemiparesis following subarachnoid hemorrhage, dysphagia, encounter for care of tracheostomy, atherosclerotic heart disease, post-traumatic stress disorder, bipolar disorder, atherosclerotic heart disease, diabetes mellitus type I, and chronic obstructive pulmonary heart disease. On the quarterly minimum data set assessment with assessment reference date 10/10/2018, the resident scored 15/15 on the brief interview for mental status and was assessed as lacking signs of delirium, psychosis, or behaviors affecting self or others. The resident's latest safe smoking assessment was dated 9/26/18 and indicated the resident was able to smoke independently. The resident was acting as her own responsible party. During an interview on 12/13/18, the resident reported being generally content with physical care received, but indicated a desire to transfer to another facility prior to the planned ban on smoking starting in February 2019. The resident reported having asked several times about 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.	F 943	3. The ADCS and or RDCS will provide re-education to facility staff on federal regulations and guidelines related to Abuse, Neglect, and Exploitation and Misappropriation by 1/28/2019. 4. DCS and or ADCS will conduct random quality monitoring of 5 facility staff to validate knowledge of Abuse, Neglect, Exploitation & Misappropriation; 3 times per week for 4 weeks, then weekly for 3 months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule modified based on findings. 5. Date of Compliance 1/28/2019.	

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 943	Continued From page 184	F 943		

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 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

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 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. 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 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	F 943		

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 CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496325	A. BUILDING _____ B. WING _____	C 12/14/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHEASANT RIDGE NURSING & REHAB CENTER	4385 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 943	Continued From page 186 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. 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 asked about staff training concerning resident abuse, de-escalation of behaviors, and assessment of residents after hospitalization. No information was provided.	F 943		