PRINTED: 04/23/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G		TE SURVEY MPLETED
NAME OF P	PROVIDER OR SUPPLIER	495325	B. WING_	STREET ADDRESS, CITY, STATE, ZIP CO	Name and Address of the Owner, where the Party of the Owner, where the Party of the Owner, where the Owner, which is the Owner, where the Owner, which is the Owner, which	4/03/2019
PHEASAI	NT RIDGE NURSING &	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	DE	
(X4) ID PREFIX TAG	ÆACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE
{E 000}	Initial Comments		{E 00€	0}		
(F 000)	INITIAL COMMENT	s	{F 000	)		
	through 12/14/18 an 02/12/19 through 02 04/02/19 through 04, required for complian Federal Long Term C Uncorrected deficient report. Corrected dethe CMS 2567-B.  The census in this 10	cies are identified within this efficiencies are identified on				
(F 580) SS=D	consisted of 9 curren (Residents #201 thro Notify of Changes (In CFR(s): 483.10(g)(14 §483.10(g)(14) Notific (i) A facility must Immonsult with the resid	rugh #209).  Nury/Decline/Room, etc.)  N(I)-(Iv)(15)  Cation of Changes.  Tediately Inform the resident;  Tent's physician; and notify.	{F 580}	F 580- Facility Manager, Do to notify MD or significant error for Resident #201 re insulin administrations not administered as ordered by	medication garding t being	
	consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical,			#1. Resident #201 was ass on 04/08/19 by Nurse and found to be stable negative lasting outco	Practitioner with no	
	mental, or psychosoc deterioration in health status in either life-thr clinical complications) (C) A need to alter tre a need to discontinue treatment due to adve	lal status (that is, a o, mental, or psychosocial reatening conditions or o); atment significantly (that is,		an result of the medic omission. MD was notified on 04 Unit Manager regardir Medication omission f #201. New orders rece	ation 4/03/19 by ng the for Resident	

Any deficiency statement ending with an asteriek (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days

other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495325	A. BUILDING _	CONSTRUCTION	(X3) DATE COMPI	LETED
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHA.J CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES		STREET ADDRESS, CITY, STATE, ZIP CODE  4355 PHEASANT RIDGE ROAD, SW  ROANOKE, VA 24014				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
{F 580}	(D) A decision to to resident from the f §483.15(c)(1)(ii).  (ii) When making r (14)(i) of this secticall pertinent inform is available and prophysician.  (iii) The facility must resident and the rewhen there is- (A) A change in rocas specified in §48 (B) A change in rocas specified in §48 (B) A change in resiste law or regulate (e)(10) of this sectific (iv) The facility must update the address phone number of the representative(s).  §483.10(g)(15) Admission to a conthat is a composite §483.5) must discidite physical configuing locations that compart, and must specific for the section of the section	form of treatment); or ransfer or discharge the acility as specified in sotification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the stalso promptly notify the sident representative, if any, or or roommate assignment (3.10(e)(6); or sident rights under Federal or tions as specified in paragraph on, at record and periodically (mailing and email) and the resident most distinct part (as defined in paragraph one in its admission agreement ration, including the various orise the composite distinct cify the policies that apply to ween its different locations (a). Not is not met as evidenced riview and clinical record staff failed to ensure that 1 of 9 of a significant medication (ii). There was no ne physician being notified that	{F 580}	#2. On 04/24/19 an audit we completed by ADON to ensure MD notification of for any current residents identified medication enother residents were identified medication enother residents were identified practice.  #3. On 04/05/19 the DON/D began education with Licustaff regarding the expect Notification of MD for identification of MD for identification Errors. Educate be completed by 04/26/1  #4. Director of Nursing/Design to audit 100% Medication X 3 months or until sustain compliance can be reached ensure compliance with notification of MD. Direct Nursing/Designee to report findings to the Quality As Performance Improvement Committee monthly X 3 mandal The Quality Assurance Performance Improvement Committee includes but it limited to the following mandal Executive Director, Direct Nursing, Medical Director Business Office Manager Managers, MDS, Coordinates	escurred with any rors. No ntified to ne alleged resignee rense tation of rentified re	

PRINTED: 04/23/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495325 B. WING 04/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIF CODE 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETION PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEELCIENCY) (F 580) Continued From page 2 (F 580) Rehab Director, Dietary Manager, The findings included: Director of Social Services, Activity Director, The facility staff failed to ensure Resident #201 Maintenance Director, License was free of a significant medication error in Nurse, and Certified Nursing regards to insulin administration and the physician being notified. Assistants. #5. Compliance Date 5/2/19 Resident #201 was admitted to the facility on 2/10/19 with the following diagnoses of, but not limited to anemia, atrial fibrillation, heart failure, high blood pressure, diabetes, depression and respiratory failure. On the admission MDS (Minimum Data Set) with an ARD (Assessment Reference Date) of 2/17/19, the resident was coded as having a BIMS (Brief Interview for Mental Status) score of 14 out of a possible score

During the clinical record review on 4/2 and 4/3/19 the surveyor noted the following physician order for Resident #201 which stated in part, "....Humalog Kwikpen Solution Pen Injector 100 units/ml Inject per sliding scale: 151-199=0 units, 200-249=2 units, 250-299=4 units, 300-349=6 units, 350-399=8 units>400 call MD subcutaneously before meals and at bedtime every Monday, Wednesday, Friday and Sunday ..."

of 15. Resident #201 was also coded as requiring extensive assistance of 1 staff member for dressing, personal hygiene and bathing.

The surveyor also reviewed the MAR (Medication Administration Record) from 3/20/19 to 4/2/19. On 3/22/19 at 11:00 am, the box for this date and time had a "3" documented and this represents the resident is "LOA" or leave of absence from the facility. Again on 3/25/19, the resident was again documented a "3" for the 11:00 am dose of

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

Quality of Care

§ 483,25 Quality of care

SS=D | CFR(s): 483.25

F 684

No further information was provided to the surveyor prior to the exit conference on 4/3/19.

Quality of care is a fundamental principle that applies to all treatment and care provided to

facility residents. Based on the comprehensive

that residents receive treatment and care in

accordance with professional standards of practice, the comprehensive person-centered

care plan, and the residents' choices.

assessment of a resident, the facility must ensure

Event ID: Y3F113

Fecility ID: VA0208

F 684

If continuation sheet Page 4 of 14

F684- Facility Failed to follow MD

orders for 3 of 9 residents: Resident #207, #206 & #201:

#1. Resident #207 was assessed on

Found to be stable with no

Resident #206 vitals & pain

04/08/19 by Nurse Practitioner.

lasting negative affects as a result

of the alleged deficient practice.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	ULTIPLE CONSTRUCTION DING		SURVEY		
		495325	B. WING		04/	03/2019		
	PHEASANT RIDGE NURSING & REHAB CENTER  (XA) ID SUMMARY STATEMENT OF DESIGNATIONS			STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR {EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY}	SHOULD BE	(X5) COMPLETION DATE		
	by: Based on Resident clinical record reviet and during a medic observation the fact physician's orders if #207, #206 and #2.  The findings included assess lung sounds administering a new the physician's order than the physician's	Interview, staff interview, but, facility document review reation pass and pour reility staff failed to follow for 3 of 9 Residents, Residents 01.  The facility staff failed to sand vital signs prior to pulizer breathing treatment per ers.  admitted to the facility on nitted on 10/17/16. Diagnoses ited to hypertension, diabetes and chronic obstructive  DS (minimum data set) with nit reference date) of 02/25/19 as 15 of 15 in section C, This is a quarterly MDS.  LPN (licensed practical nurse) iten pass and pour on mately 1300. LPN #1 went is room and administered the		assessment were compod/03/19 by licensed in accurately documented resident's medical recording following outcomes and found to be stable negative lasting outcomes license Nurse #1 received one re-education by Union 04/03/19 regarding expectation of following orders.  #2. On 04/26/19 the Director Nursing/Designee compaudit of physician order residents receiving Insurvey he began education to the License physician orders being followed as ordered as ordered as a content of the physician orders being followed as ordered as a content of the Licens regarding the expectation following physicians ord documentation vitals, passessments and respiral assessments in the reside medical record. Education be completed by 04/26/1 Director of Nursing/Designocomplete competency of the complete competency of the competency of th	urse and d in the ord. essed on citioner with no nes as a n omission. red one on nit Manager the g physician or of pleted an s for lin, lication to were ed. or of n providing e staff ons of ers and ain story ent's on to 9. nee			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPI A. BUILDING	2) MULTIPLE CONSTRUCTION BUILDING		E SURVEY PLETED
		495325	B. WING		400	R /03/2019
	ROVIDER OR SUPPLIER	REHAR CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 684	contained a signed which read in part pre-administration lung sounds", "RE-rate, and pulse ox monitoring" and "Ip 0.5-2.5 mg/3 ml. 1 every 6 hours relat pulmonary disease 3 ml".  The surveyor spok 04/02/19 at approx Resident #207 if the lungs or checked his breathing treatment that she had not.  The surveyor spok approximately 1423 she had checked the assessed lung sour breathing treatment Surveyor then infor observed her doing she had done it approximately 1423 she had done it approximately 1425 she had done it approximately 1426 she had done it approximately greathing the treatment of the service of the policy entitled "Policy entitled" approximately consistent of the service of the policy entitled policy entitled "Policy entitled" approximately consistent of the service of the policy entitled policy entitled "Policy entitled" approximately consistent of the policy entitled approximately consistent of the policy entitled approximately entitled approximately entitled "Policy entitled" entitled "Pol	d physician's order summary.  "Check lung sounds every £ hours for monitoring SP: Check pulse rate, resp pre nebulizer, every 6 hours for oratropium-Albuterol solution dose inhale orally via nebulizer led to chronic obstructive a, unspecified (J44.9) 1 dose =  e with Resident #207 on imately 1420. Surveyor asked the nurse had listened to his lis vital signs before giving the st, and Resident #207 stated  be with LPN #1 on 04/02/19 at 5. Surveyor asked LPN #1 if the Resident's vital signs or nds prior to administering the st, and she stated that she had, med LPN #1 that she had not st this and LPN #1 stated that proximately 30 minutes prior to reatment.  If and administrator provided a cles and Procedures Subject: lume nebulizer)", which read  ent and explain the treatment.	F 684	regarding administration Nebulizer treatments to the pre and post assess documentation requiring to audit Medication Administration as followed to a second physician orders and second physician orders and second per day 3 days per week weeks, then 6 per week months or until sustain compliance can be read Director of Nursing/Desobserve License nurse administration of Nebul treatments to include the and post assessment and documentation 2 per with X 3 months or until sustain compliance can be read Director of Nursing/Desobserve License nurse administration of Nebul treatments to include the and post assessment and documentation 2 per with X 4 weeks then 2 per nix 3 months or until sustain compliance can be read Director of Nursing/Destoreport audit findings Quality Assurance Perfolimprovement Committee to the members: Executive Director of Nursing, Members: Executive Director	to include sment and rements. Esignee diministration apliance with apporting ows: 6 sek X 4 k X 3 med ched. Signee to dizer the premoth tained ched. Signee to the ormance see monthly a Assurance se includes following rector,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The second secon	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495325	B. WING		0	R 4/03/2019
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  4355 PHEASANT RIDGE ROAD, SW  ROANOKE, VA 24014				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 684	respiratory rate, pubreathe sounds.  "Assemble neb. "Administer treatedeleted. "Evaluate the Reflectiveness of treasounds, pulse rate, respiratory rate.  The concern of not sounds and vital signoministrative team at approximately 13  No further informative 20 physician orders in Resident for pain evisions before and aft Residents nebulizer  The clinical record resident approximately fractures of sleep apnea, diabeter reflux disease.  Section C (cognitive admission MDS (min with an ARD (assess 03/09/18 included a mental status) summ possible 15 points.  The Residents clinical residents residents clinical residents resi	lse, oxygen saturation and ulizer equipment. atment until medication is desident's response and atment by evaluating breath oxygen saturation and assessing the Resident's lung ans was discussed with the during a meeting on 04/03/19 40.  In provided prior to exit. In the facility failed to follow regards to assessing the very shift and obtaining vital per administering the	F 684	Director, Business Officunit Managers, MDS Conservation of Social Servic Director, Maintenance License Nurse, and Cern Nursing Assistants.  #5. Compliance Date C5/2/	oordinator, y Manager, ces, Activity Director, tified	

PRINTED: 04/23/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 495325 B. WING 04/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATIONS TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 | Continued From page 7 F 684 pain every shift. Check pulse rate, respiration rate and pulse ox (oxygen) pre (before) and post (after) nebulizer (breathing treatment). The nebulizer order was for every 6 hours for shortness of breath. The times documented on the eMAR (electronic medication administration record) for the nebulizer treatments were 12 midnight, 6:00 a.m., 12 noon, and 6:00 p.m. A review of the Residents eMARs revealed that the facility nursing staff had not documented they had completed the following tasks on 03/25/19. Assess Resident for pain every shift. There was no time associated with this on the eMAR. Check pulse rate, respiration rate, and pulse ox pre nebulizer and post nebulizer for 12 noon. The Residents comprehensive care plan included the following focus area, "...has OSA; new onset cough." Interventions included, but were not limited to, observe for SOB (shortness of breath), cough, congestion, and report to the physician as needed."

The facility policy and procedure titled "Nebulizer (small volume nebulizer)" read in part, "...Review physician's order... Evaluate the resident's response and effectiveness of treatment by evaluating breath sounds, pulse rate, oxygen saturation and respiratory rate. Document treatment in the resident's medical record."

There were no nursing progress notes for 03/25/19.

The facility did provide the surveyor with VS (vital signs) obtained on 03/25/19. These were as follows. Blood pressure 8:38 a.m. 123/77.

CENTERS FOR MEDICARE & MEDICAID SERVICES

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A, BUILDN	TPLE CONSTRUCTION		PLETED R	
NAME OF B	BOUIDED OD SUBSTITUTE	483325	B. WING			03/2019
PHEASANT RIDGE NURSING & REHAB CENTER				STREET ADDRESS, CITY, STATE, ZIF COI 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
	1:52 a.m. 96%, 6:21 95%. Pulse summary 8:38 Respiration summar breaths/minute. Temperature 8:38 a. On 04/03/19 at 8:50 assistant) #5 was obroom obtaining the FON 04/03/19 at 8:55 Resident #206 how VS. Resident #206 stake them twice a data on 04/03/19 at 9:00 CNA #5, this CNA vethey obtained the Repulse, respirations, to saturations everyday 7:00 a.m. until 3:00 p. The administrative with the survey team. No further information provided to the survey conference. 3. The facility staff facorders for Resident #administration. Resident #201 was a 2/10/19 with the follow	aturations) 1:40 a.m. 96%, a.m. 96%, and 1:47 p.m.  B a.m. 87 beats per minute. y 8:38 a.m. 19  m. 97.3 oral.  a.m., CNA (certified nursing served in the Residents Residents VS.  a.m., the surveyor asked often the staff obtained their stated that sometimes they by.  a.m., during an interview with stated that sometimes they by.  a.m., during an interview with stated that she worked from b.m.  ere notified of the missing issessment during a meeting on 04/03/19 at 1:40 p.m.  In regarding this issue was by team prior to the exit silled to follow physician 1201 in regards to insulin dmitted to the facility on wing diagnoses of, but not	F6	84		
	2/10/19 with the followallimited to anemia, atr	dmitted to the facility on wing diagnoses of, but not ial fibrillation, heart failure, diabetes, depression and				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495325	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE  4355 PHEASANT RIDGE ROAD, SW  ROANOKE, VA 24014				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION]	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION		
F 684	respiratory failure. (Minimum Data Set Reference Date) of coded as having a Mental Status) soon of 15. Resident #2 requiring extensive for dressing, person During the clinical rr 4/3/19 the surveyor order for Resident # Humalog Kwikper units/ml Inject per s 200-249=2 units, 25 units, 350-399=8 units, 350-399	On the admission MDS t) with an ARD (Assessment (2/17/19, the resident was BIMS (Brief Interview for re of 14 out of a possible score Of was also coded as assistance of 1 staff member hal hygiene and bathing.  ecord review on 4/2 and noted the following physician (201 which stated in part, " a Solution Pen Injector 100 liding scale: 151-199=0 units, (30-299=4 units, 300-349=6 hits>400 call MD ore meals and at bedtime dinesday, Friday and Sunday  eviewed the MAR (Medication ord) from 3/20/19 to 4/2/19, arm, the box for this date and mented and this represents " or leave of absence from in 3/25/19, the resident was a "3" for the 11:00 am dose of ents resident is "LOA". The ind any further documentation at was on leave from the	F 684				

CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A. BUILDING

PRINTED: 04/23/2019 FORM APPROVED

OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X3) DATE SURVEY AND PLAN OF CORRECTION COMPLETED 495325 B, WING 04/03/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, & N PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION 10 (005) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY Continued From page 10 F 684 the insulin was not given on these dates. On 4/3/19 at approximately 11:30 am, the surveyor asked the corporate nurse about the requested documented information that was requested in the end of the day conference on 4/2/19. The corporate nurse stated, "We looked and we don't have anything further to give to you regarding this request." No further information was provided to the surveyor prior to the exit conference on 4/3/19. F 760 Residents are Free of Significant Med Errors F 760 CFR(s): 483.45(f)(2) SS=D F760: Facility failed to ensure RI The facility must ensure that its-#201 did not have a significant §483.45(f)(2) Residents are free of any significant Medication Error: medication errors. This REQUIREMENT is not met as evidenced by: #1. RI #201 was assessed on 04/08/19 Based on staff interview and clinical record by Nurse Practitioner and found to review, the facility staff failed to ensure that 1 of 9 be stable with no negative lasting residents were free of a significant medication outcomes as a result of the error (Resident #201). medication omission. MD was The findings included: notified on 04/03/19 by Unit Manager regarding the The facility staff failed to ensure Resident #201 Medication omission for Resident was free of a significant medication error in #201. New orders received. regards to insulin administration. #2. On 04/24/19 an audit was Resident #201 was admitted to the facility on completed by Unit Managers to 2/10/19 with the following diagnoses of, but not ensure no other residents had limited to anemia, atrial fibrillation, heart failure, high blood pressure, diabetes, depression and significant medication errors. No respiratory failure. On the admission MDS other residents were identified to (Minimum Data Set) with an ARD (Assessment have been affected by the alleged

Reference Date) of 2/17/19, the resident was

deficient practice.

	ENT OF DEFICIENCIES W OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  (X2) MULTIPLE CONSTRUCTION A, BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
	PROVIDER OR SUPPLIER	REHAS CENTER	5	TREET ADDRESS, CITY, STATE, ZIP CODE 355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		04/03/2019
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL IR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(XS) GOMPLETIO DATE
	Mental Status) scor of 15. Resident #20 requiring extensive for dressing, person During the clinical re 4/3/19 the surveyor order for Resident #20 curits/ml Inject per si 200-249=2 units, 25 units, 350-399=8 un subcutaneously before every Monday, Wed	BIMS (Brief Interview for re of 14 out of a possible score of 14 out of a possible score of 1 was also coded as assistance of 1 staff member hal hygiene and bathing.  Becord review on 4/2 and noted the following physician (201 which stated in part, "a Solution Pen Injector 100 iding scale: 151-199=0 units, 00-299=4 units, 300-349=6 its>400 call MD ore meals and at bedtime nesday, Friday and Sunday eviewed the MAR (Medication and) from 3/20/19 to 4/2/19, am, the box for this date and nented and this represents for leave of absence from a 3/25/19, the resident was "3" for the 11:00 am dose of ents resident is "LOA". The find any further documentation the was on leave from the in these dates. The insuling did to the resident as ordered hese 2 days.  The administrative team of a findings on 4/2/19 at min the conference room, and more information for a that the facility staff did not ordered by the physician or physician being notified that	F 760	#3. On 04/05/19 the DON/E began education with Li regarding the expectation following physician order notification of any medit errors. Education to be by 04/26/19.  #4. Director of Nursing/Design audit Medication Administration Administration as followers and suggested to the following physician orders and suggested to the following per week X 4 week per week X 3 months or sustained compliance careached.  Director of Nursing/Designer audit findings to the following per formance Committee X 3 months. The Quality A Performance Committee but is not limited to the following performance Committee but is not limited to the	icense staff on of ers and ication completed gnee to nistration oliance with pporting ws: 6 per day 3 cs, then 6 r until an be gnee to the Quality Assurance includes ollowing ctor, ical Manager, ordinator, Manager, s, Activity rector,	

CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/23/2019 FORM APPROVED

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	E CONSTRUCTION	(X3) DAT	E SURVEY
	A95325 NAME OF PROVIDER OR SUPPLIER PHEASANT RIDGE NURSING & REHAB CENTER		B. WING	04	/03/2019	
	THE OCHORDING B	NCHAB CENTER	1	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	surveyor asked the or requested document requested in the end 4/2/19. The corpora and we don't have as regarding this requestion. No further information surveyor prior to the	imately 11:30 am, the corporate nurse about the ted information that was of the day conference on the nurse stated, "We looked mything further to give to you st."  In was provided to the exit conference on 4/3/19.	F 760			
SS=F	§483.75(g)(2) The quassurance committee (ii) Develop and impleation to correct identifies REQUIREMENT by:  Based on observation interview, facility document facility document facility assurance profacility as evidenced by the areas of Resident Pharmacy Services all monitor the effects of make needed revision needed for the preventified facility included:  As part of the survey godentified deficient prayers and the survey godentified deficient prayers.	sessment and assurance, sality assessment and amust: ament appropriate plans of tiffed quality deficiencies; is not met as evidenced in, Resident interview, staff ament review, and clinical sility staff failed to ensure the gram meet the needs of the py repeated deficiencies in Rights, Quality of Care, and and failed to effectively implemented changes and as to the action plans as action of further deficiencies.	{F 867}	F867: QA regarding Resider Rights, Quality of Care and Pharmacy:  #1. On 04/25/19 the facility Quality Assurance Performance Improvement Committee he ADHOC meeting to review the statement of deficiencies regarding F580, F684, F760 of correction was developed address the identified deficient practice and approved by the committee.  #2. The center acknowledges curesidents had the potential affected by the alleged deficiencies.  #3. Regional Vice President of Operations provided re-educto the Executive Director on 04/04/19 regarding the expectations of	ality eld a he . A plan if to ent e rrent to be tient	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495325	A. BUILDII		VISTRUCTION	CO	R 4/03/2019
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER				4355 F	PHEASANT RIDGE ROAD, SW NOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	COMPLETION DATE
{F 867}	appropriate citation: The administrative sissues regarding the	ctices are detailed under the s in this report.  staff were notified of the eir quality assurance program th the survey team on	{F 84	#4	following the Quality Assurance Improvement and procedure. Executive provided re-education to a Administrative staff regard policy and procedure for CASSURANCE Performance Improvement. Education completed on 04/05/19.  Regional Vice President of Operation/Designee will recompliance with plan of compliance Performance Improvement Committee in X 3 months. The Quality Assurance Performance Improvement Committee in but is not limited to the formembers: Executive Director of Nursing, Medic Director, Business Office Nursing Assistants of Director, Maintenance Director,	t Policy Director the ding the Quality was nonitor orrection & F760 ative t audit monthly ssurance acludes allowing ctor, cal danager, dinator, enager, Activity ector,	