PRINTED: 03/06/2019

STATEMENT OF DEPICIENCES AND PLAN OF CORRECTION  A BUILDING  NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER  PHEASANT RIDGE NURSING & REHAB CENTER  STREET ADDRESS. CITY. STATE. JP CODE 455 PHEASANT RIDGE ROUND STATEMENT OF DEPICEMENTS  ROANOKE, VA 22014  JULII SEARCH SERVICE OF THE STATEMENT OF DEPICEMENTS  REGULATORY OR LSC IDENTIFYING INFORMATION)  (E 000) Initial Comments  (E 000) Initial Comments  (F 000) INITIAL COMMENTS  An unannounced Medicare / Medicaid revisit to the standard survey conducted 12/12/18 through 12/14/18 was conducted 2/12/19 through 2/13/19. Significant corrections are required for compliance with the following Federal Long Term Care Requirements. Uncorrected deficiencies are identified on the CMS 2567-B. Compliants were investigated during this survey.  The census in this 101 certified bed facility was 90 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents 101 through 116)  F 580  SSS-D  F 580 Notification of Changes  (I) A facility must immediately inform the resident; consult with the resident shyrical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-interactions or clinical complications);  (C) A need to alter treatment significantly (that is, a deterioration in health, mental, or psychosocial status in either life-interactions and the processor of the control of the change of the control of the change in condition or clinical complications);  (C) A need to alter treatment significantly (that is, a deterioration in health, mental), or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status			MEDICAID SERVICES			FORM APPRO OMB NO. 0938-0	
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PHEASANT RIDGE NURSING & REHAB CENTER  SISS PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014  INATIO  INATIO  INATIO  INITIAL COMMENTS  An unannounced Medicare/Medicaid revisit to the standard survey conducted 121/218 through 121/214/18 was conducted 211/218 through 121/218 through 121/21			495325	B. WING			
PREFIX   REGULATORY OF USCIDENTIFING INFORMATION    PREFIX TAG   REGULATORY OF USCIDENTIFING INFORMATION    PREFIX TAG   REGULATORY OF USCIDENTIFING INFORMATION    REGULATORY OF USCIDENTIFICATION    REGULATORY OF USC			REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW	02.10/2015	
(F 000)  An unannounced Medicare/Medicaid revisit to the standard survey conducted 12/12/18 through 12/14/18 was conducted 2/12/19 through 2/13/19. Significant corrections are required for compliance with the following Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B Complaints were investigated during this survey.  The census in this 101 certified bed facility was 90 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents 101 through 116).  F 580  Notify of Changes (Injury/Decline/Room, etc.)  CPR(s): 483.10(g)(141)(-iv)(15)  \$483.10(g)(141) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, 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, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE COMPLET	
An unannounced Medicare/Medicaid revisit to the standard survey conducted 12/12/18 through 12/14/18 was conducted 12/12/19 through 2/13/19. Significant corrections are required for compliance with the following Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. Complaints were investigated during this survey.  The census in this 101 certified bed facility was 90 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents 101 through 116).  F 580  CFR(s): 483 10(g)(14)(i)-(iv)(15)  F 580  CFR(s): 483 10(g)(14)(i)-(iv)(15)  F 580  F 580 Notification of Change  1. On 02/13/19 the Unit Manager notified the Nurse Practitioner of the change in condition that 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, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);  (C) A need to alter treatment significantly (that is,	{E 000}	Initial Comments		{E 000]			
standard survey conducted 12/12/18 through 12/14/18 was conducted 27/12/19 through 2/13/19. Significant corrections are required for compliance with the following Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B. Complaints were investigated during this survey.  The census in this 101 certified bed facility was 90 at the time of the survey. The survey sample consisted of 16 current Resident reviews (Residents 101 through 116).  F 580  Notify of Changes (Injury/Decline/Room, etc.)  CFR(s): 483.10(g)(14) Notification of Changes.  (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, 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, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);  (C) A need to alter treatment significantly (that is,	(F 000)	INITIAL COMMENT	S	{F 000}			
a need to discontinue an existing form of from the facility on 03/04/19.  treatment due to adverse consequences, or to commence a new form of treatment); or	F 580 SS=D	standard survey con 12/14/18 was condu Significant correction compliance with the Care Requirements. are identified within the Complaints were involved in the complaints were involved in the time of the consisted of 16 curre (Residents 101 through the consult with the resident of the consult with the resident with his or consult with the resident with his or representative (s) when the consults in injury and the con	ducted 12/12/18 through cted 2/12/19 through 2/13/19. In a are required for following Federal Long Term Uncorrected deficiencies this report. Corrected stified on the CMS 2567-B. estigated during this survey.  Of certified bed facility was survey. The survey sample ent Resident reviews uph 116). Injury/Decline/Room, etc.) 4)(i)-(iv)(15). Ideation of Changes. Inediately inform the resident; there is there is the potential for requiring in; inge in the resident which has the potential for requiring in; inge in the resident or sold in the resident of that is, a in mental, or psychosocial incatening conditions or sol; eatment significantly (that is, a e an existing form of rerse consequences, or to	F 580	1. On 02/13/19 the Un Manager notified the Nurse Practitioner of change in condition resident # 102 exper Based on the most of assessment by the Practitioner on 02/2 adverse effects were	of the that rienced. The recent Nurse 28/19 no e noted. This rock of the content	

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 80 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.

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES				O. 0938-03
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENT:FICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DAT	E SURVEY
		495325	B. WING		02/13/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02	/13/2019
HEASA	NT RIDGE NURSING 8	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION:	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	O BE	(XS) COMPLETIC DATE
	(D) A decision to tr resident from the fa \$483.15(c)(1)(ii).  (ii) When making n (14)(i) of this sectic all pertinent information is available and prophysician.  (iii) The facility must resident and the residen	ansfer or discharge the acility as specified in otification under paragraph (g) on, the facility must ensure that ation specified in §483.15(c)(2) ovided upon request to the st also promptly notify the sident representative, if any, arm or roommate assignment 3.10(e)(6): or ident rights under Federal or tions as specified in paragraph on, at record and periodically (mailing and email) and he resident apposite distinct part (as defined in see in its admission agreement ration, including the various rise the composite distinct totify the policies that apply to een its different locations of the cord review and staff or staff failed to notify the ge in Resident condition for 1 are survey sample, Resident #	F 58	<ol> <li>Quality Review of residence a charcondition in the last 30 was completed on 2/2 DON or Unit Manager. Follow up based on fine 3. DON/ADON / Unit Manager educated licensed in the regulation, policy a procedure for notification of changes on 03/11/19.</li> <li>DON/ADON/ Unit Manager procedure Quality Monitor of nursing documentation of nursing documentation of notification of residenchanges to the MD/NP are procedure for notification of residenchanges to the MD/NP are procedure for the monthly of the findings to be reported committee by the DON aupdated as indicated. Of monitoring schedule will modified based on findings. Date of Compliance: 03/3</li> </ol>	dings. dings. dings. agers urses on nd on on ers ering on nt and week y x c 2 month to QAPI and duality be ngs.	s.

		ND HUMAN SERVICES MEDICAID SERVICES			FC	TED: 03/06/201 DRM APPROVE NO: 0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
NAME 05 5		495325	B. WING_			R 0 <b>2/13/201</b> 9
	ROVIDER OR SUPPLIER	REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF IEACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	(KS) COMPLETION DATE
F 580	Continued From pag	e 2	F 58	o		
	The facility staff failed change of condition i	d to notify the physician of a n Resident # 102 on 1/2/19.				
	admitted to the facility readmission date of 8 but were not limited to	3/27/18. Diagnoses included o, hypertension, major anxiety disorder, and benign				
	recent MDS (minimur a quarterly assessme (assessment reference C of the MDS assessi Section C0500, the fa Resident # 102 had a mental status) score of	at 12:42 pm. The most in data set) assessment was ent with an ARD be date) of 12/4/18. Section les cognitive patterns. In actifity staff documented that BIMS (brief interview for				
	and revised on 2/17/1 documented a focus a "Resident # 102 has a (related to) quadripleg GERD (gastroesophawounds, PVD (periphetransverse myelitis, check pain, muscle spaincluded but were not	area for Resident # 102 as, alterations in pain R/T gia C5-C7, neuropathy, geal reflux disease), areal vascular disease), aronic pain syndrome, low asms." Interventions limited to, "Medications per fy physician if interventions current complaint is a				

Resident # 102 had current orders for

Event ID: Y3F112

Facility ID: VA0208

If continuation sheet Page 3 of 45



03/12/2019 14:35

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/06/2019 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 02/13/2019 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 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY F 580 | Continued From page 3 F 580 "Methadone HCI Tablet 10 mg (milligram) Give 12 tablet by mouth one time a day for pain," which was initiated by the physician on 11/29/18. Resident # 102 also had orders for Oxycodone HCl tablet 5 mg Give 2 tablet by mouth every 6 hours as needed for pain related to low back pain," which was initiated by the physician on 12/6/18. A progress note documented on 1/2/19 at 12:34 pm was documented as. "This nurse spoke with (Pharmacy employee's name withheld) from (pharmacy name withheld), manager, about methadone not arriving in a timely manner. (Pharmacy employee's name withheld) verified medication was ordered on 12/31 online however due to the holiday it could not be filled. Then the next day nurse again called pharmacy again and requested the medication. Pt. received 40 mg, which is what we had on hand. The pharmacy explained that they needed new script due to it being a holiday and needing to get med from a different pharmacy because it is controlled. Script was obtained and faxed med was not here 1/2/19 in the morning nurse again called pharmacy requested it stat in which (Pharmacy employee's name withheld) at (pharmacy's name withheld) stated it would be sent. 12 pm and medication was still not here. Nurse called back again spoke to (pharmacy employee's name withheld) in which she stated (pharmacy employee's name withheld) never put in as stat order. Order was not in as stat per (Pharmacy employee's name withheld), manager. This nurse assessed pt around 10 am. Pt appears pale, diaphoretic, states he is nauseated in which nurse gave 4 mg Zofran. States he had been having diarrhea and urinating

on himself all night. Vitals stable. Pt stable. This nurse informed him of plan to contact pharmacy

		ND HUMAN SERVICES MEDICAID SERVICES			FC	DRM APPROVE
STATEMEN?	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION  G	(X3) D	NO. 0938-039 ATE SURVEY OMPLETED
NAME OF	POMPE OF THE P	495325	B. WING			R 02/13/2019
	PROVIDER OR SUPPLIER	REHAB CENTER		STREET ADDRESS, CITY, STATE, 4355 PHEASANT RIDGE ROAD, ROANOKE, VA 24014	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN [EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	COMPLETION DATE
	and discuss how we medication in stat. Exthat meds will need to card of meds is started days in advance of a employee's name with track of med by reord (Wednesday), then the (Friday) and then money week to make sure it Next script due jan (Jamedication is on it's well-employee's name with monitor. Pt updated of surveyor observed the documentation of phylof condition for Reside the unit manager RN if she was aware of Resident # 102 did no ordered Methadone in administration. RN # 1 of the incident but courted Resident # 102 did no available in the facility stated, "Yes." RN # 1 is come into the facility stated, "Yes." RN # 1 is was shaking, diaphore diarrhea. The surveyor progress note for Resideoumented on 1/2/19 The surveyor asked Resident # 102 and he withdrawals." RN # 1 is was shaking, diaphore diarrhea. The surveyor asked Resident # 102 and he withdrawals." RN # 1 is was shaking, diaphore diarrhea. The surveyor asked Resident # 102 and he withdrawals." RN # 1 is was shaking, diaphore diarrhea. The surveyor asked RI incident that surv	will avoid this again and get ducation provided to staff to be reordered when the 4th ad and to order meds several holiday. Per (Pharmacy hheld) this nurse could keep dering every week on wed the following week on frinn (Monday) on the third falls in line with insurance, anuary) 21st. Stativay per (Pharmacy hheld). Will continue to an plan of care." The at there was no sician notification of change ent # 102.  In, the surveyor interviewed # 1. The surveyor asked RN of any incidents where at have his physician in the facility for a stated that she was aware all on the call the exact date. In # 1 if there was an on New Year's Day when the thave his Methadone for administration. RN # 1 stated that when she did the went in to assess the was in "full blown stated that Resident # 102 state, and was having in then reviewed the	F 58	30		

CENTE	RS FOR MEDICAR	AND HUMAN SERVICES  & MEDICAID SERVICES			FOI	ED: 03/06/2	
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING	CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY MPLETED	
		495325	B. WING			R	
NAME OF F	PROVIDER OR SUPPLIER	40.00	ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 0	2/13/2019	
PHEASA	NT RIDGE NURSING	REHAB CENTER	43	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
(X4) ID PREFIX	SUMMARY (EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECT		(X5)	
TAG	REGULATORY	OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)		DATE	
F 580	Continued From p	age 5	F 500				
		Resident # 102. RN # 1 stated	F 580				
	that she had writte	n the progress note on 1/2/19					
	at 12:34 om The	surveyor asked RN # 1 if she					
	had informed the	physician of the change of					
	condition in Reside	ent # 102 that had been					
	documented in the	progress note on 1/2/19 at					
	12:34 pm. RN # 1	stated that she did notify the					
	nurse practitioner.	RN # 1 reviewed the progress				1	
	note along with the	surveyor and RN # 1 agreed					
	that she did not do	cument physician notification					
	of change in Resid	ent # 102's status on 1/2/19 at					
	12:34 pm. The sun	veyor asked RN # 1 who she					
	made aware of the	change in Resident # 102's					
1	condition on 1/2/19	. RN # 1 stated that she made					
1	(Nurse practitioner	s name withheld) aware.					
	On 2/13/19 at 3:30	pm, the surveyor spoke with					
	(Nurse Practitioner	's name withheld) via					
	telephone in the pri	esence of RN #1 and 2 other					
	surveyors. The sun	veyor asked the nurse					
1	change in Resident	d been made aware of a					
1	The purse procition	# 102's condition on 1/2/19.					
	interiected and state	ner stated, "No." RN # 1 then ed, "(Nurse practitioner's					
	name withheld) I co	alled you on that day to make					
- 1	you aware of the ch	nange with Resident # 102."					
	The purse practition	ner stated, "You probably did."	3				
	"I must have forgott	ten." The surveyor asked the					
	nurse practitioner if	he would expect the nurses to					
	make him aware wh	nen Residents experience a	1				
- 1	change in condition	. The nurse practitioner				2	
1	stated, "Yes." The s	surveyor asked the nurse					
- 1	practitioner what he	would have done for					
1	Resident # 102 if he	had been made aware of his					
	change of condition	on 1/2/19. The nurse					
	practitioner stated, '	Probably give him some					
	Ativan." The survey	or asked the nurse					
		as all that he would have					
	ordered for Residen	t # 102 The guree					

		ND HUMAN SERVICES MEDICAID SERVICES				FOR	D: 03/06/2019 M APPROVED D: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING			(X3) DATE COMP	SURVEY
		495325	B. WING			1	R 13/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	02/	13/2019
PHEASAN	NT RIDGE NURSING & R	EHAB CENTER			IEASANT RIDGE ROAD, SW DKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(XS) COMPLETION DATE
F 580	practitioner stated, "" The facility policy on Condition" contained but was not limited to" Procedure The nurse to notify th Resident Represents Significant change in physical, mental, or polytical of the control	Yes." "Notification of Change in documentation that included	F 58		F 686 Treatment-Heal Press		
(F 686) SS=D	CFR(s): 483.25(b)(1) §483.25(b) Skin Integ §483.25(b)(1) Pressu Based on the compre resident, the facility in (i) A resident receive professional standard pressure ulcers and of ulcers unless the indi demonstrates that the (ii) A resident with pro- necessary treatment with professional stan promote healing, pre- new ulcers from deve	revent/Heal Pressure Ulcer (i)(ii)  grity  g	{F 686	1.	The ADON reassessed the waresident # 102 and obtained treatment order on 2/13/19 adverse effects were noted Resident #102 has been discharged from the facility on 03/04/19.	ound or d a D. No eleted esidents eatment sweep Manage	ers

DEPART CENTER	MENT OF HEALTH	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 03/06/2011 FORM APPROVEI
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495325	B. WING		R
NAME OF F	ROMDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/13/2019
PHEASAI	NT RIDGE NURSING &	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
(F 686)	interview, the facilit treatment and servi pressure ulcers for survey sample. Res The findings include The facility staff fail 102 had current treatler.  Resident # 102 was admitted to the facility admitted to the facility readmission date of but were not limited depressive disorder prostatic hyperplasion. The clinical record for reviewed on 2/12/15 recent MDS (minimus a quarterly assessment reference of the MDS assessment reference of the MDS assessment assessment assessment assessment assessment assessment assessment assessment for the Resident # 102 had mental status) score indicated that Resident assessment assessme	y staff failed to provide toes necessary to prevent 1 of 12 Residents in the sident # 102.  ed:  ed to ensure that Resident # atment for a sacral pressure  is a 40-year-old-male who was lity on 4/20/18 with a 8/27/18. Diagnoses included to, hypertension, major r, anxiety disorder, and benign a.  or Resident # 102 was at 12:42 pm. The most um data set) assessment was lited with an ARD necedate) of 12/4/18. Section isses cognitive patterns. In facility staff documented that a BIMS (brief interview for e of 15 out of 15, which ent # 102 was cognitively the MDS assesses skin on M0210, the facility staff esident # 102 had one or	{F 686	3. Education was provided to staff by the DON/ADON/ Managers on the regulation policy and procedure for treatment of pressure ulce 03/11/19. Competency of for Clean dressings were completed for licensed state.  4. DON/ADON/Unit Manager conduct Quality Monitoring residents with pressure ulce 15 times weekly for 4 weeks monthly for 3 month and indicated. Results to be rest to QAPI committee month the DON, and updated as Quality monitoring sched be modified based on find 5. Date of Compliance: 03/20	Unit on and ers on eservations off 03/15/19 es to og of cers s, then PRN as eported only by indicated. ule will ings.

## DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 03/06/2019 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY DENTIFICATION NUMBER COMPLETED A. BUILDING\_ 495325 B. WING 02/13/2019 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 (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 686) Continued From page 8 {F 686} "Administer treatments as ordered and monitor for effectiveness." The February 2019 treatment administration record had orders that included but were not limited to. "Cleanse sacral wound with NS (normal saline), pat dry. Apply anasept gel to packing strip and sprinkle collagen powder, pack wound with cotton tipped applicator. Cover with hydrogel sheet (cut to size) and secure with tegaderm qd (every day) and prn (as needed) every day and evening shift for wound for 30 days." This order was initiated by the physician on 1/7/19. The surveyor observed that the physician ordered treatment had been completed as of 2/6/19. The surveyor did not observe any current treatment orders after 2/6/19 for the stage 2 pressure ulcer to the sacrum for Resident # 102. On 2/13/19 at 10:36 am, the surveyor observed a progress note for Resident # 102 that had been documented on 2/12/19 at 2:49 pm. The progress note was documented as, "Resident discussed in weekly IDT (interdisciplinary team) meeting. Resident has Stage II to sacrum. Chronic wound measuring 0.3 x 0.3 x 0.3 cm (centimeters). Resident non compliant with dressing changes, often refusing for the treatment to be changed or replacement of a dislodged dressing. Resident inserviced on proper treatment changes and reproach if refusing. Resident verbalized understanding. MD (medical doctor) to eval on next rounding day."

On 2/13/19 at 10:38 am, the surveyor reviewed the February 2019 treatment administration record for Resident # 102. The surveyor observed that Resident # 102 had not had treatment to the Stage II pressure ulcer to the sacrum since

PRINTED: 03/06/2019 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 COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING 495325 02/13/2019 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 PROVIDER'S PLAN OF CORRECTION COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 686) Continued From page 9 {F 686} 2/8/19 On 2/13/19 at 3:30 pm, the surveyor spoke with the unit manager RN # 1 (registered nurse), RN # 1 reviewed the February 2019 treatment administration record along with the surveyor and agreed that Resident # 102 did not have current physician's orders for treatment to the Stage II pressure ulcer to his sacrum. On 2/13/19 at 7:00 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 2/13/19. F 697 Pain Management F 697 F 697 Pain Management SS=G CFR(s): 483.25(k) 1. On 02/12/19 the unit manger §483.25(k) Pain Management. completed a medication The facility must ensure that pain management is provided to residents who require such services, administration record to consistent with professional standards of practice, medications audit to ensure the comprehensive person-centered care plan, and the residents' goals and preferences. medications were available This REQUIREMENT is not met as evidenced for resident # 102. by: Resident #102 was discharged Based on clinical record review, Resident interview, staff interview, and facility document from the facility on 03/04/19. review, the facility staff failed to provide effective 2. DON/ADON/Unit Managers pain management for 1 of 12 Residents in the survey sample, Resident # 102. conducted a Quality Review of pain medication on current

The findings included

The facility staff failed to ensure that the physician

ordered Methadone was in the facility and

available for administration, which resulted in

residents to ensure

medications are available

as ordered on 02/12/19.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIS	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/13/2013
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	incomplete and late caused Resident # 1 9/10 and 10/10, and symptoms because of in the facility.  Resident # 102 was a admitted to the facility readmission date of 8 but were not limited to depressive disorder, prostatic hyperplasia.  The clinical record for reviewed on 2/12/19 arecent MDS (minimum a quarterly assessme (assessment reference C of the MDS assessive C of the MDS assessive C of the MDS assessive disorder # 102 had a mental status) score of indicated that Resident intact.  The plan of care for R and revised on 2/17/11 documented a focus a "Resident # 102 has a (related to) quadripleg GERD (gastroesophagwounds. PVD (periphetransverse myelitis, cheack pain, muscle spaincluded but were not	dose administrations. This 02 to report a pain scale of experience withdrawal of not having the Methadone a 40-year-old-male who was y on 4/20/18 with a 8/27/18. Diagnoses included to, hypertension, major anxiety disorder, and benign ar Resident # 102 was at 12:42 pm. The most in data set) assessment was not with an ARD be date) of 12/4/18. Section the secognitive patterns. In acility staff documented that BIMS (brief interview for of 15 out of 15, which that # 102 was reviewed 8. The facility staff area for Resident # 102 as, alterations in pain R/T aia C5-C7, neuropathy, geal reflux disease), area vascular disease), aronic pain syndrome, low sms." Interventions limited to, "Medications per fy physician if interventions current complaint is a	F 69'	<ol> <li>DON/ADON/Unit Managers provided re-education to licensed nurses on the regulations and policy and procedure for effective pain management and following physician orders and medication administration 03/11/19.</li> <li>DON/ADON/Unit Managers will conduct Quality Monitori of pain medication to ensure medications are available as ordered by the Physician. Quality Monitoring will be completed 5 times weekly for 4 weeks, then monthly for 3 months and PRN as indicated. Findings to be reported to QAPI committee monthly by the DON and updated as indicated. Quality monitoring schedule modified based on findings.</li> <li>Date of Compliance: 03/20/19</li> </ol>	ng

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STREET ADDRESS, CITY, STATE, ZIP CODE  ASS PHEASANT RIDGE NURSING & REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES  (A4) ID PREFIX FEACH DEFICIENCY MUST RE PRECEDED SY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 697  Continued From page 11  Resident # 102 had current orders for "Methadone HCI Tablet 10 mg (milligram) Give 12 tablet by mouth one time a day for pain, which was initiated by the physician on 11/29/18. Resident # 102 slos had orders for Oxycodone HCI tablet 5 mg GMe 2 tablet by mouth every 6 hours as needed for pain related to low back pain," which was initiated by the physician on 12/6/18.  On 2/12/19 at 1:00 pm, the surveyor reviewed the February 2019 medication administration record for Resident # 102. According to the "Chart Codes/Follow Up Codes" 9 = "Other/ See Nurses Notes." Upon review of the progress notes for Resident # 102, the surveyor observed a "Medication Administration Note" for Resident # 102 documented on 2/11/19 at 10:16 am. The medication administration hote for Resident # 102 documented on 2/11/19 at 10:16 am. The medication administration hote for Resident # 102 documented on 2/11/19 at 10:16 am. The medication administration hote for Resident # 102 documented on 2/11/19 at 10:16 am. The medication administration hote for Resident # 102 documented on 2/11/19 at 10:16 am. The medication administration hote for Resident # 102 documented on 2/11/19 at 10:16 am. The medication administration hote for Resident # 102 documented on 2/11/19 at 10:16 am. The medication administration hote for Resident # 102 documented on 2/11/19 at 10:16 am. The medication administration hote for Resident # 102 documented on 2/11/19 at 10:16 am. The medication administration hote for Resident # 102 and not receive the physician ordered Methadone at 9:00 am on the morning of 2/11/19. The surveyor asked LPN # 2 with the facility called the	STATEMENT OF DEFICIENCIES (X1) PF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				TE SURVEY MPLETED
PRESANT RIDGE NURSING & REHAB CENTER  O(4) ID  SUMMARY STATEMENT OF DEFICIENCIES  EACH DEFICIENCY MUST BE PRECEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)  F 697  Continued From page 11  Resident # 102 had current orders for  "Methadone HCI Tablet 10 mg (milligram) Give 12 tablet by mouth one time a day for pain," which was initiated by the physician on 11/29/18. Resident # 102 had bard orders for Oxycodone HCI tablet 5 mg Give 2 tablet by mouth every 6 hours as needed for pain related to low back pain," which was initiated by the physician on 12/6/18.  On 2/12/19 at 1:00 pm, the surveyor reviewed the February 2019 medication administration record for Resident # 102. According to the "Chart Codes/Follow Up Codes" 9 = "Other/ See Nurses Notes," Upon review of the progress notes for Resident # 102, the surveyor observed a "Medication Administration note was documented as, "Methadone HCI Tablet 10 mg igne 12 tablet by mouth one time a day for pain notified pharmacy and md about order."  On 2/12/19 at 3:13 pm, the surveyor interviewed LPN # 2 (consed practical nurse) via telephone. LPN # 2 confirmed that she was responsible for administrating medication so Resident # 102 on 2/11/19, LPN # 2 stated that the facility colled the LPN # 2 stated that the facility colled the LPN # 2 stated that the facility colled the LPN # 2 stated that the facility colled the			495325	E. WING		R	
OAJ ID PRETIX REGULATORY OR LSC IDENTIFYING INFORMATION)  F 697  Continued From page 11  Resident # 102 had current orders for "Methadone HCI Tablet 10 mg (milligram) Give 12 tablet by mouth one time a day for pain," which was initiated by the physician on 11/29/18.  Resident # 102 pm, the surveyor reviewed the February 2019 medication administration record for Resident # 102. The surveyor observed a ""documented at the 9.00 am dose of Methadone for Resident # 102. According to the "Chart Cooks/Follow Up Codes" 9 = "Other/ See Nurses Notes." Upon review of the progress notes for Resident # 102 abserved a ""documented at the 9.00 am dose of Methadone for Resident # 102. According to the "Chart Codes/Follow Up Codes" 9 = "Other/ See Nurses Notes." Upon review of the progress notes for Resident # 102. The surveyor observed a ""documented on 2/11/19 at 10:16 am. The medication administration note was documented as, "Methadone HCI Tablet 10 mg give 12 tablet by mouth cne time a day for pain notified pharmacy and md about order."  On 2/12/19 at 3:13 pm, the surveyor interviewed LPN # 2 (clensed practical nurse) was telephone. LPN # 2 confirmed that she was responsible for administering medications to Resident # 102 to 2 and 2/11/19. The surveyor asked LPN # 2 why Resident # 102 that the facility called the physician ordered Methadone at 9:00 am on the morning of 2/11/19. LPN # 2 stated that the facility called the	NAME OF F	PROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP CODE		2/13/2019
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ordered Methadone at 9:00 am on the morning of 2/11/19. LPN # 2 stated, "He didn't have it there."  LPN # 2 stated that the facility called the		"Methadone HCI Ta tablet by mouth one was initiated by the Resident # 102 also HCI tablet 5 mg Givi hours as needed for pain." which was init 12/6/18.  On 2/12/19 at 1:00 p February 2019 medifor Resident # 102. documented at the 9 for Resident # 102. documented at the 9 for Resident # 102. Motes." Upon review Resident # 102, their "Medication administras, "Methadone HCI by mouth one time a pharmacy and materials and at 102 documented on medication administras, "Methadone HCI by mouth one time a pharmacy and materials at 13 p LPN # 2 (licensed pr. LPN # 2 confirmed tradministering medica 2/11/19. The surveyor	blet 10 mg (milligram) Give 12 etime a day for pain," which physician on 11/29/18, had orders for Oxycodone e 2 tablet by mouth every 6 r pain related to low back tiated by the physician on  om, the surveyor reviewed the ication administration record The surveyor observed a "9" dio 0 am dose of Methadone According to the "Chart odes" 9 = "Other/ See Nurses of the progress notes for surveyor observed a tration Note" for Resident # 2/11/19 at 10:16 am. The ration note was documented Tablet 10 mg give 12 tablet iday for pain notified bout order."  om, the surveyor interviewed actical nurse) via telephone. The progress of Resident # and the surveyor interviewed actical nurse of the progress of the				
charged and paid for the Methadone and the pharmacy delivered the Methadone to the facility.		2/11/19. LPN # 2 stat LPN # 2 stated that to pharmacy that mornic charged and paid for	ted, "He didn't have it there." he facility called the ng and the facility was the Methadone and the				-

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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		710/2019
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F 697	2 stated, "He didn't g surveyor asked LPN reported pain while h ordered Methadone. that he was hurting b oxycodone." "He was going to call the omb  On 12/13/19 at 12:00 was conducted with F presence of 3 survey that on Monday 2/11/ nurse to give him his stated that he usually because he was the Resident # 102 stated nurse kept skipping h Resident # 102 stated walked down the half nurse for his medication in were out of his medication in were out of his methad stated that he spoke 1 (registered nurse). RN # 1 informed him send his medication. he then told RN # 1 th nurses state that ther Methadone and that a written that Monday in # 102 stated that RN look into the situation that he was correct at Methadone had been	lethadone on 2/11/19. LPN # let it until 11 something." The # 2 if Resident # 102 let did not have the physician LPN # 2 stated, "He said let I gave him two sovery upset and said he was ludsman."  I pm, a Resident interview Resident # 102 in the lors. Resident # 102 stated (19, he was waiting for the medicine. Resident # 102 or received his medication first	F 697			

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TATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	PLE CONSTRUCTION G	(X3) DA	ATE SURVEY
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F 697	with anything for pain Resident # 102 stated him his pm (as neede surveyor asked Resid 10 mg helped to reliev that the facility did not Resident # 102 stated Methadone at one tim Resident # 102 to rate went without his Meth with zero being no pain he could imagine pain at a level of 9 out Resident # 102 what it tolerable for him. Resident # 102 stated was New Year's and I withdrawal." "I had to withdrawal." "I had to withdrawal."	facility staff provided him in place of the Methadone. If that the facility staff gave ad) oxycodone 10 mg. The itent # 102 if the oxycodone we his pain during the time thave the Methadone. If, "No, I take 12 tablets of ite." The surveyor asked is his pain during the time he adone on a scale of 0 to 10 in and 10 being the worst is. Resident # 102 rated his tof 10. The surveyor asked evel of pain is usually ident # 102 reported that a 0 was tolerable for him. "Last time this happened went into full blown wait for two days to get it and going to the bathroom	F 69			
	progress notes for Resobserved the following progress note docume was documented as, "I only 4 tablets. Refili wa Called pharmacy spokemployee's name with medication would be o Richmond line and was already been put in to I nurse notified that I sporegarding medication. I the cart awaiting delive aware."	Methadone in drawer is as not sent from pharmacy e with (pharmacy held) and she told me n next run. Also called sold medication had be sent on next run. 3-11				

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AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION	(X3) D	ATE SURVEY DMPLETED
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NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		02/13/2019
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F 697	pm, was document deliver methadone mg dose today. Be general mocdiness Pharm (pharmacy) until they receive n (Physician's name wrote a one day so called back and will A progress note do am was documented disintegrating 4 mg 6 hours as needed vomiting."	age 14 ted as, "Called pharmacy to . Pt. (patient) only received 40 shaviors cursing staff and s, refusing evening meds. was called would not send out ew script. On call DR (doctor) withheld) was called and she cript for 1/2/19. Pharmacy was I send out on 1/2/19 at 10:35 ad as "Zofran ODT tablet Give 1 tablet by mouth every for nausea given for nausea	F 69	7		
	disintegrating 4 mg hours as needed for Zofran prn administ A progress note documents 5 mg give 2 tablets needed for pain relace oxycodone 5 mg ev pain."  A progress note documents oxycodone 5 mg ev pain."	ed as, "Zofran ODT tablet give 1 tablet by mouth every 6 r nausea patient stated the ration was ineffective."  cumented on 1/2/19 at 11:12 ed as, "Oxycodone HCI tablet by mouth every 6 hours as ated to low back pain ery 6 hours prn 10/10 back cumented on 1/2/19 at 12:34 d as. "This nurse spoke with se's name withheld) from				
	methadone not arriv (Pharmacy employe medication was orded due to the holiday it next day nurse agai	thheld), manager, about ing in a timely manner. se's name withheld) verified ered on 12/31 online however could not be filled. Then the nicalled pharmacy again and cation. Pt. received 40 mg	The state of the s			

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NAME OF		495325	B. WING			02/13/2019	
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PHEASA	NT RIDGE NURSING & F	REHAB CENTER		355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
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F 697	which is what we had explained that they in being a holiday and in different pharmacy in the morning nurse requested it stat in with name withheld) at (pi stated it would be seen was still not here. Nut to (pharmacy employ she stated (pharmacy employ she stated (pharmacy employ she stated (pharmacy employ emp	d on hand. The pharmacy leeded new script due to it meeding to get med from a ecause it is controlled. Script again called pharmacy frich (Pharmacy employee's harmacy's name withheld) at 12 pm and medication are called back again spoke ree's name withheld) in which a perployee's name withheld) are colled back again spoke ree's name withheld) are many colled back again spoke ree's name withheld) are many colled back again spoke ree's name withheld) are many colled back again spoke ree's name withheld), assessed pt around 10 am. whoretic, states he is surse gave 4 mg Zofran. This is a figure of the state of the	F 697				

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

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		495325	8. WING		02/13/2019	
	ROVIDER OR SUPPLIER	REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP Of 4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	ODE	10,2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF [EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
F 697	"Pain Level Summal Resident # 102. The following times that I levels of 10 during the not available for dist 1/1/19 at 6:44 pm, Fpain level of 10 1/1/19 at 7:42 pm, Revel of 10 1/1/19 at 8:35 pm, Revel of 10 1/2/19 at 4:30 am, Revel of 10 1/2/19 at 11:12 am, I pain level of 10 1/2/19 at 2:00 pm, Revel of 10 1/2/19 at 2:00 pm, Revel of 10 1/2/19 at 2:21 pm, Revel of 10 1/2/19 at 3:08 pm the unit manager RN # 1 if she was aware Resident # 102 did nordered Methadone in administration. RN # of the incident but coordinated that occurred Resident # 102 did novillable in the facility stated, "Yes." RN # 1 come into the facility Resident # 102 and I withdrawals." RN # 1 was shaking, diaphodiarrhea. The survey	ry" in the clinical record for a surveyor observed the Resident # 102 reported pain the time the Methadone was ribution in the facility.  Resident # 102 reported a pain the esident # 102 reported a pain the esi	F 69	97		

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED		
		495325	B. WING		02/13/2019
	ROVIDER OR SUPPLIER	REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014	1 02/10/2019
(X4) ID PREF:X TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LD BE COMPLETION
F 697	Methadone was not RN # 1 informed the almost an incident" Resident # 102 got her. RN # 1 stated and the pharmacy a facility. The surveyor note for Resident # 1/2/19 at 12:34 pm, asked RN # 1 if she documented the progrecord for Resident had written the progrem. The surveyor as informed the physici in Resident # 102 as note on 1/2/19 at 12 she did notify the nurveyor and agreed physician notification 102's status on 1/2/1 asked RN # 1 who schange in Resident RN # 1 stated that sname withheld) award on 2/13/19 at 2:14 pm (Pharmacist name withheld) award on	available for administration. It surveyor that there was" on 2/11/19. RN # 1 stated that upset and came and spoke to that she called the physician and got the medication into the r then reviewed the progress 102 that was documented on with RN #1. The surveyor was the nurse that had gress note in the clinical # 102. RN # 1 stated that she ress note on 1/2/19 at 12:34 sked RN # 1 if she had an of the change of condition is documented in the progress :34 pm. RN # 1 stated that tree practitioner. RN # 1 ss note along with the id that she did not document in of change in Resident # 19 at 12:34 pm. The surveyor the made aware of the # 102's condition on 1/2/19. The made (Nurse practitioner's	F 697		

		AND HUMAN SERVICES  & MEDICAID SERVICES			FO	RM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT!! A BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		2/13/2019
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY PULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COVPLETION DATE
F 697	prescription was not 102's insurance rej pharmacist informed of Methadone was 11:22 am on 2/11/11. On 2/13/19 at 3:30 (Nurse Practitioner telephone in the prescription of Methadone in the prescription of th	e pharmacist stated that a new seeded because Resident # ected the refill order. The sid the surveyor that 60 tablets delivered to the facility at 9.  pm, the surveyor spoke with so name withheld) via esence of RN #1 and 2 other veyor asked (Nurse withheld) if he had been nange in Resident # 102's.  (Nurse practitioner's name (lo." RN #1 then interjected appractitioner's name withheld) day to make you aware of the ent # 102." (Nurse withheld) stated, "You est have forgotten." The enterprete of the practitioner's name dexpect the nurses to make estident's experience a change enterprete practitioner stated, "Yes."  If the nurse practitioner what as for Resident # 102 if he had of his change of condition on tractitioner stated. "Probably an." The surveyor asked the that is all that he would have at # 102. The nurse "Yes."  In "Notification of Change in documentation that included	F 69	7		

	CENTERS FOR MEDICARE & MEDICAID SERVICES				FC	DRM APPROVE	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	LE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED  R 02/13/2019		
		495325	B. WING				
	PROVIDER OR SUPPLIER  NT RIDGE NURSING & F	REHAB CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			02/10/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETION DATE	
	Significant change in physical, mental, or physical documentation that it to,"Procedure  1. Upon discovery inadequate supply of to a resident, facility initiate action to obtain pharmacy. If the med discovered at the time administration, facility take the action specifically nurse should pharmacy hours. If a medication should pharmacy hours are should pharmacy hours are should pharmacy in the next scheduled de 2.2. If the next available a missed dose in the schedule, facility nurse medication from the Eupply to administer to 2.3. If the medication should notify pharmacy emergency delivery.  3. If a medication shourmal pharmacy hours of the physical pharmacy hours. If a medication from the dication supply.	"Medication le Medications" contained included but was not limited that facility has an a medication to administer staff should immediately in the medication from ication shortage is a of medication is staff should immediately ied in Sections 2 or 3 of this bole. Inortage is discovered during irs: build call pharmacy to of the order. If the een ordered, the licensed lace the order to reorder for livery. ble delivery causes delay or resident's medication a should obtain the mergency Medication he dose. Is not available in the is not available in the is Supply, facility staff y and arrange for an ortage is discovered after is: nurse should obtain the	F 69				

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES				FORM AF	PROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT! A BUILDIN		INSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED	
		495325	B. WNG_			R	
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	02/13/2	019
PHEASA	NT RIDGE NURSING &	REHAB CENTER	-	4355	PHEASANT RIDGE ROAD, SW NOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENT/FYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E CO	(X5) MPLETION DATE
	the Emergency Mer facility nurse should answering service a registered pharmacy of action. Action ma 3.2.1 Emergence 3.2.2 Use of an emergence facility nurse should physician to obtain to obtain a facility nurse should physician to obtain to obtain a facility nurse should physician to obtain to obtain a facility nurse should physician to obtain be supplied from the obtain alternate physician alternate physician strength of the obtain alternate physician to obtain alternate physician strength of the obtain of the obtain of the obtain alternate physician strength of the obtain of the obtain alternate physician strength of the obtain	dication Supply, the licensed of call pharmacy's emergency and request to speak with the list on duty to manage the plan by include:  y delivery; emergency (back-up) third  y delivery is unavailable, contact the attending	F 69	7	E 609 Dialysis		
	This is a complaint d	eficiency.	-		F 698 Dialysis		
	CFR(s): 483.25(l)  §483.25(l) Dialysis. The facility must ensire quire dialysis received the professional star comprehensive personal star comprehensive personal star residents' goals at This REQUIREMENT by: Based on clinical receinterview, the facility	Γ is not met as evidenced	(F 698)	1.	On 02/13/19 the DON and Unit Manager spoke with the manager of the dialysis center requesting assistance from the Dialysis center, to complete the communication form on reside #108, for each dialysis appoint Requested information was received and communication for up-dated.	e nt ment.	

	OF DEFICIENCIES	MEDICAID SERVICES			OMB N	IO. 0938-03
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION  G		E SURVEY
NAME OF S		495325	B. WING		0	R 2/13/2019
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
PHEASA	NT RIDGE NURSING & R	EHAB CENTER		4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
	to the nursing facility survey sample, Resident Facility provided adequegarding care received Resident # 108.  Resident # 108 was a admitted to the facility included but were not stage renal disease), 2 diabetes mellitus, are The clinical record for reviewed on 12/12/19 recent MDS (minimum an admission assessment reference C of the MDS assesses Section C0500, the farmental status) score of indicated that Resident match. Section O of the treatments, procedured to 100 to 100, the facility staff Resident # 108 had rethe last 14 days since The plan of care for Resident # 108 received to ESRD shunt to R (resident # 108 received to ESRD shunt to R (resident # 108 received to ESRD shunt to R (received methods).	for 1 of 12 Residents in the lent # 108.  It to ensure that the dialysis uate communication ed at the dialysis facility for 172-year-old-male who was on 1/7/19. Diagnoses limited to, ESRD (end chronic kidney disease, type and congestive heart failure.  Resident # 108 was at 1:50 pm. The most of data set) assessment was ment with an ARD edate) of 1/14/19. Section as cognitive patterns. In cility staff documented that BIMS (brief interview for f 15 out of 15, which at # 108 was cognitively embs assesses special so, and programs. In Section of documented that ceived dialysis services in the 1/14/19 ARD.  Pesident # 108 was reviewed of the facility staff area for Resident # 108 as, we hemodialysis r/t (related fight) arm." Interventions imited to, "Monitor labs and	{F 698	2. On 02/12/25/19 the completed a Quality communication for current resident on Follow up based on 3. DON/ADON/Unit Maprovided re-educate nurses on the regular policy and procedur coordination of hem services and communication on 3/11/19.  4. DON/ADON/Unit Mawill conduct Quality on dialysis residents the communication completed upon retudialysis daily for 4 we then 5 times a week then monthly and PResults to be reported committee monthly and updated as indiced Quality monitoring symodified based on firms.  5. Date of Compliance: 6	y review of ms for dialysis. findings. anagers ation and re for the modialysis mication magers Monitoring to ensure form is arm from reeks, for 4 weeks, RN as indicated. Ed to QAPI by the DON rated. Schedule mings.	

		& MEDICAID SERVICES			OMB	VC. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495325	B. WING			2/13/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/13/2019
PHEASAI	NT RIDGE NURSING 8	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL PR LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
(F 698)	Continued From pa	age 22	{F 698	3)		
	orders that include "Hemodialysis ever Saturday at 5:45 ar	for Resident # 108 contained d but were not limited to, ry Tuesday, Thursday, and m at (facility name withheld)." initiated this order on 1/28/19.				
	facility "Dialysis Co Resident # 108. Up communication rec that the section hea Complete For Facil	pm, the surveyor reviewed the mmunication Record" for son review of the dialysis ord, the surveyor observed aded "Dialysis Center To ity" was incomplete for the 19/19, 2/1/19, 2/2/19, 2/5/19,				
	dialysis communica 108 with the directo surveyor asked the she would consider dialysis communica to be adequate. The stated, "From our e- been sending separ requested to see an	pm, the surveyor reviewed the tition records for Resident # or of clinical services. The director of clinical services if the documentation on the tition sheet for Resident # 108 or director of clinical services and yes, but the facility has rate sheets." The surveyor my information that had been sis facility for Resident # 108.				
	the director of clinic the nurse consultan services made the s had been having iss to complete the dial and that the unit ma with the dialysis faci	pm, the surveyor spoke with all services in the presence of t. The director of clinical surveyor aware that the facility sues getting the dialysis facility sysis communication sheets, magers had been speaking tility to try to get them to fill out nication sheets completely.				

Event ID: Y3F112

Facility ID: VA0208

If continuation sheet Page 23 of 45



## PRINTED: 03/06/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES. FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED 495325 B. WING 02/13/2019 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 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION! DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 698) Continued From page 23 (F 698) (licensed practical nurse) provided the surveyor with a copy of Resident information for Resident # 108 from the dialysis facility. The surveyor observed a time stamp at the top of the document that was dated 2/12/19 at 2:56 pm. LPN # 1 informed the surveyor that she had spoken to the dialysis facility several times regarding filling in the information on the dialysis communication sheets. The surveyor asked LPN # 1 when she had received the Resident information for Resident # 108 from the dialysis facility. LPN # 1 stated, "I received this today." The dialysis contract contained documentation that included but was not limited to. ... "C. Obligations of the ESRD Dialysis Unit and/or Company C. To provide the Long Term Care Facility information on all aspects of the management of the ESRD Resident's care related to the provision of Renal Dialysis Services, including directions on management of medical and non-medical emergencies, including but not limited to bleeding, infection, and care of dialysis access site." ... On 2/13/19 at 7:00 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey F-755 Pharmacy Services team prior to the exit conference on 2/13/19. {F 755} {F 755} Pharmacy Srvcs/Procedures/Pharmacist/Records 1. Unit Managers completed a SS=G | CFR(s): 483.45(a)(b)(1)-(3) MAR to medications audit for §483.45 Pharmacy Services resident # 102 on 02/13/19 to

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain

them under an agreement described in

ensure medications were available.

Resident #102 was interviewed on

		& MEDICAID SERVICES			OMB N	O. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	PLE CONSTRUCTION  G	COM	E SURVEY IPLETED
		495325	B. WING		1	R 2/13/2019
NAME OF	PROVIDER OR SUPPLIER	4	<del></del>	STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-	/13/2018
PHEASA	NT RIDGE NURSING & F	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIENC	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 755}	§483.70(g). The faci personnel to administ permits, but only und a licensed nurse.  §483.45(a) Procedur pharmaceutical servithat assure the accur dispensing, and administers by the facility.  §483.45(b) Service Comust employ or obtain pharmacist whose services of the provisiting the facility.  §483.45(b)(1) Provide aspects of the provisiting facility.  §483.45(b)(2) Establistic except and disposition sufficient detail to ena reconciliation; and services and that an accurate is maintained and per This REQUIREMENT by:  Based on clinical recinterview, staff interview, staff interview and during the course investigation, the facility.	cility may permit unlicensed ster drugs if State law der the general supervision of the second ster drugs if State law der the general supervision of the second supervision of the second stering of all drugs and the needs of each resident.  Consultation. The facility in the services of a licensed des consultation on all sion of pharmacy services in the services of a licensed on of all controlled drugs in able an accurate the second	(F 755	5) 02/14/19 to ensure he ordered medications on last 24 hours. Resident been discharged from the on 03/04/19.  2. On 02/14/19 Unit Mana completed a MAR to me audit Quality Review on residents. Follow up base on findings.  3. DON/ADON completed re-education to licensed on the regulation and pland procedure for order re-ordering medications the Pharmacy, medication availability, and effective medication administration 03/11/19.  4. DON/ADON/Unit Managowill conduct Quality Mosof MARs to medications are available as ordered the	ver the #102 has he facility  gers . edications current esed  d nurses olicy ring and s from e back n ee pain ion gers nitoring es, to	

The findings included

Event ID: Y3F112

Facility ID: VA0208

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PRINTED: 03/06/2019

		AND HUMAN SERVICES				ED: 03/06/2019 RM APPROVED
		MEDICAID SERVICES				NO 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDIN	IPLE CONSTRUCTION		TE SURVEY MPLETED
		495325	B. WING_		1 .	R 2/13/2019
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
PHEASA	NT RIDGE NURSING & I	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
{F 755}	The facility staff faile ordered Methadone available for administration incomplete and late caused Resident # 1 9/10 and 10/10, and symptoms because in the facility.  Resident # 102 was admitted to the facility readmission date of but were not limited depressive disorder prostatic hyperplasia.  The clinical record for reviewed on 2/12/19 recent MDS (minimula quarterly assessment referent C of the MDS assess Section C0500, the first Resident # 102 had a mental status) score indicated that Reside intact.  The plan of care for frank revised on 2/17/1/documented a focus "Resident # 102 has (related to) quadriple GERD (gastroesopha wounds, PVD (periph transverse myelitis, chack pain, muscle spincluded but were not included but were not include	d to ensure that the physician was in the facility and stration, which resulted in dose administrations. This 02 to report a pain scale of experience withdrawal of not having the Methadone a 40-year-old-male who was by on 4/20/18 with a 8/27/18. Diagnoses included to, hypertension, major anxiety disorder, and benign are resident # 102 was at 12:42 pm. The most m data set) assessment was ant with an ARD co date) of 12/4/18. Section ses cognitive patterns. In acility staff documented that a BIMS (brief interview for of 15 out of 15, which int # 102 was cognitively  Resident # 102 was reviewed 18. The facility staff area for Resident # 102 as, alterations in pain R/T gia C5-C7, neuropathy, igeal reflux disease), hronic pain syndrome, low	{F 75	times a week for 4 week weekly x 3 mos. and PRI indicated. DON will reporesults to QAPI committe monthly and updated as indicated. Quality moni schedule modified bases 5. Date of Compliance: 03/1	N as ort tee s itoring d on findings	

	and the second s	AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 03/06/2019 RM APPROVED NO: 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495325	B. WING			R 2/13/2019	
NAME OF P	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		2/13/2019	
PHEASAN	T RIDGE NURSING &	REHAB CENTER		355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	OCHPLETION DATE	
(F 755)	Continued From pa	ige 26	{F 755}				
	are unsuccessful or if current complaint is a significant change from resident's past experience of pain."						
	tablet by mouth one was initiated by the Resident # 102 also HCI tablet 5 mg Girhours as needed for pain," which was in 12/6/18.  On 2/12/19 at 1:00 February 2019 medication Administration administration administration and in the for Resident # 102. Codes/Follow Up Code	ablet 10 mg (milligram) Give 12 at time a day for pain," which is physician on 11/29/18. The had orders for Oxycodone we 2 tablet by mouth every 6 or pain related to low back itiated by the physician on pm, the surveyor reviewed the dication administration record. The surveyor observed a "9" 9:00 am dose of Methadone. According to the "Chart codes" 9 = "Other/ See Nurses of the progress notes for a surveyor observed a stration Note" for Resident # in 2/11/19 at 10:16 am. The tration note was documented of Tablet 10 mg give 12 tablet a day for pain notified.					
	On 2/12/19 at 3:13 LPN # 2 (licensed p LPN # 2 confirmed administering medi 2/11/19. The surver Resident # 102 did ordered Methadone 2/11/19. LPN # 2 st LPN # 2 stated that pharmacy that more	pm, the surveyor interviewed bractical nurse) via telephone. that she was responsible for cations to Resident # 102 on yor asked LPN # 2 why not receive the physician at 9:00 am on the morning of ated, "He didn't have it there." It the facility called the ning and the facility was or the Methadone and the					

DEPAR'	MENT OF HEALTH A	AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 03/06/201	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION	(X3) DA	NO. 0938-039 TE SURVEY MPLETED	
		495325	B. WING			R	
NAME OF F	PROVIDER OR SUPPLIER	1	STO	EET ADDRESS, CITY, STATE, ZIP CODE		2/13/2019	
PHEASA	NT RIDGE NURSING &	REHAB CENTER	435	5 PHEASANT RIDGE ROAD, SW ANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
	pharmacy delivered The surveyor asked # 102 received the M 2 stated, "He didn't g surveyor asked LPN reported pain while hordered Methadone, that he was hurting be oxycodone." "He was going to call the ombound on 12/13/19 at 12:00 was conducted with it presence of 3 survey that on Monday 2/11, nurse to give him his stated that he usually because he was the Resident # 102 stated nurse kept skipping he Resident # 102 stated walked down the hall nurse for his medication that he could not belied run out of his medication that he could not belied run out of his methad stated that he spoke was 1 (registered nurse). If RN # 1 informed him send his medication, he then told RN # 1 th nurses state that there Methadone and that a written that Monday m# 102 stated that RN a look into the situation,	the Methadone to the facility. LPN # 2 what time Resident Methadone on 2/11/19. LPN # get it until 11 something." The # 2 if Resident # 102 ne did not have the physician LPN # 2 stated, "He said but I gave him two s very upset and said he was sudsman."  D pm, a Resident interview Resident # 102 in the fors. Resident # 102 stated (19, he was waiting for the medicine. Resident # 102 received his medication first	{F 755}				

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				ED: 03/06/2019
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			46	NO. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495325	E. WING			R
NAME OF P	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		2/13/2019
PHEASA	NT RIDGE NURSING &	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION: CROSS-REPERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
	Resident # 102 starun out of my Meth Resident # 102 if the with anything for pure Resident # 102 starun out of my Meth Resident # 102 starun out of my helped to restart the facility did Resident # 102 starun out of the the facility did Resident # 102 starun out of the the facility did Resident # 102 starun out of the the facility did Resident # 102 starun out of the the facility did Resident # 102 starun out of the facility of	age 28  ated, "They should not let me hadone." The surveyor asked the facility staff provided him ain in place of the Methadone. Ated that the facility staff gave eded) oxycodone 10 mg. The sident # 102 if the oxycodone elieve his pain during the time not have the Methadone. The surveyor asked ate his pain during the time he ethadone on a scale of 0 to 10 pain and 10 being the worst ine. Resident # 102 rated his out of 10. The surveyor asked at level of pain is usually esident # 102 reported that a of 10 was tolerable for him. Ited, "Last time this happened d I went into full blown to wait for two days to get it ng and going to the bathroom to wait for two days to get it ng and going to the bathroom te I was going to die."  pm, the surveyor reviewed the Resident # 102. The surveyor ing progress notes. A mented on 1/1/19 at 9:21 am is, "Methadone in drawer is was not sent from pharmacy indheld) and she told me at on next run. Also called was told medication had to be sent on next run. 3-11 spoke with pharmacy in Resident received 4 pills in livery for full dose. Resident	{F 755			



Facility ID VA0206

Event (D: Y3F112

CENTER	S FOR MEDICARE	AND HUMAN SERVICES  & MEDICAID SERVICES			FO	ED: 03/06/20 RM APPROV NO: 0938-03
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A BUILDING	E CONSTRUCTION		TE SURVEY MPLETED
		495325	B WNG			R 2/13/2019
NAME OF PR	OVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		- 10-2015
PHEASAN	RIDGE NURSING 8	REHAB CENTER	1	4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STAYEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULO BE	COMPLETIC DATE
	pm, was document deliver methadone mg dose today. Be general moodiness Pharm (pharmacy) until they receive n (Physician's name wrote a one day so called back and will a progress note do am was document disintegrating 4 mg to hours as needed formation progress note do am, was document disintegrating 4 mg to hours as needed for a progress note do am, was document of the progress note door my was document of the	age 29  coumented on 1/1/19 at 6:24 ted as, "Called pharmacy to the Pt. (patient) only received 40 shaviors cursing staff and s, refusing evening meds. I was called would not send out thew script. On call DR (doctor) withheld) was called and she cript for 1/2/19. Pharmacy was Ill send out on 1/2/19."  commented on 1/2/19 at 10:36 and as "Zofran ODT tablet in Give 1 tablet by mouth every for nausea given for nausea  commented on 1/2/19 at 11:12 and as, "Zofran ODT tablet in give 1 tablet by mouth every 6 or nausea patient stated the tration was ineffective."  commented on 1/2/19 at 11:12 and as, "Oxycodone HCI tablet by mouth every 6 hours as ated to low back pain very 6 hours pm 10/10 back  commented on 1/2/19 at 12:34 and as. "This nurse spoke with the e's name withheld) from inthheld), manager, about ving in a timely manner. The result not be filled. Then the	{F 755}			

		AND HUMAN SERVICES  MEDICAID SERVICES			FO	ED: 03/06/201 RM APPROVE	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A BUILDING	CONSTRUCTION	(X3) DA	(X3) DATE SURVEY COMPLETED	
		495325	B. WING	12"		R 2/13/2019	
	ROVIDER OR SUPPLIER	REHAB CENTER	43	REET ADDRESS, CITY, STATE. ZIP CODE 85 PHEASANT RIDGE ROAD, SW DANOKE, VA 24014		271012012	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
{F 755}	next day nurse again requested the medic which is what we hat explained that they repeated the medic which is what we hat explained that they repeated it stat in which make withheld) at (postated it would be seen was still not here. Note (pharmacy employs stated (pharmacy employs stated (pharmacy employs stated (pharmacy employs stated (pharmacy employs manager. This nurse on himself all night. In the state of the state of medication in stat. Estate medication in state medicatio	in called pharmacy again and cation. Pt. received 40 mg of on hand. The pharmacy needed new script due to it needing to get med from a pecause it is controlled. Script exed med was not here 1/2/19 or again called pharmacy which (Pharmacy employee's charmacy's name withheld) and the scalled back again spoke yee's name withheld) in which exe called back again spoke yee's name withheld) in which exe called back again spoke yee's name withheld) order. Order was not in as amployee's name withheld), as assessed pt around 10 amployee's name withheld), as assessed pt around 10 amployeric, states he is not spoke yee's name withheld), as assessed pt around 10 amployeric, states he is not spoke yee's name withheld), and the state of the spoke yee's name withheld). Will avoid this again and get ducation provided to staff to be reordered when the 4th end and to order meds several tholiday. Per (Pharmacy thheld) this nurse could keep dering every week on wed ne following week on frium (Monday) on the third falls in line with insurance. Itanuary) 21st. State way per (Pharmacy thheld). Will continue to on plan of care. "The last there was no yesician notification of change	(F 755)				

		HAND HUMAN SERVICES  E & MEDICAID SERVICES			FO	ED: 03/06/20 RM APPROVE
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DA	NO. 0938-03 TE SURVEY MPLETED
		495325	B. WING		١.	R
NAME OF F	PROVIDER OR SUPPLIER		STR	EET ADDRESS, CITY, STATE, ZIP CODE		2/13/2019
PHEASA	NT RIDGE NURSING	& REHAB CENTER		5 PHEASANT RIDGE ROAD, SW ANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
{F 755}	Continued From p	page 31	(F 755)			
	On 2/13/19 at 1:50	0 pm, the surveyor reviewed the				
	"Pain Level Summ	nary" in the clinical record for				
	Resident # 102. T	he surveyor observed the				
	following times that	at Resident # 102 reported pain				
	not available for d	the time the Methadone was istribution in the facility.				
		-				
		, Resident # 102 reported a				
	pain level of 10	Resident # 102 reported a pain				
	level of 10	resident # 102 reported a pain				
	1/1/19 at 8:35 pm,	Resident # 102 reported a pain				
	level of 10					
	1/2/19 at 4:30 am, level of 10	Resident # 102 reported a pain				
		n, Resident # 102 reported a				
	1/2/19 at 2:00 pm, level of 10	Resident # 102 reported a pain				THE PERSON NAMED IN COLUMN TWO IS NOT THE PERSON NAMED IN COLUMN TWO IS NAMED IN COLUMN TW
	1/2/19 at 2:21 pm, level of 10	Resident # 102 reported a pain				
	On 2/13/19 at 3:08	pm, the surveyor interviewed				
1	the unit manager F	RN # 1. The surveyor asked RN				-
	Resident # 102 did	re of any incidents where I not have his physician				di la
	ordered Methadon	e in the facility for				
	administration. RN	# 1 stated that she was aware				
	of the incident but	could not recall the exact date.				
	The surveyor asker	d RN # 1 if there was an				
	Incident that occurr	red on New Year's Day when				
		not have his Methadone				
	stated "Yes " RN #	ility for administration. RN # 1 £ 1 stated that when she did				
	come into the facilit	ty she went in to assess				
	Resident # 102 and	d he was in "full blown				
		1 stated that Resident # 102				
		oretic, and was having				-

	OF DEFICIENCIES	& MEDICAID SERVICES				NO. 0938-039	
ND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION		ATE SURVEY OMPLETED	
		495325	B. WNG			R	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS CITY, STATE, ZIP COD		02/13/2019	
PHEASAN	IT RIDGE NURSING &	REHAB CENTER		4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COM (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	COMPLETION CATE	
(F 755)	Continued From pa	ge 32	{F 755				
	were any other incided Methadone was not RN # 1 informed the almost an incident" Resident # 102 gother. RN # 1 stated and the pharmacy a facility. The surveyor note for Resident # 1/2/19 at 12:34 pm, asked RN # 1 if she documented the progrecord for Resident had written the progrecord for Resident in Resident # 102 as note on 1/2/19 at 12 she did notify the nurveyor and agreed physician notification 102's status on 1/2/1 asked RN # 1 who sichange in Resident # 102 as note on 1/2/13/19 at 2:14 pkg mame withheld) award on 2/13/19 at 2:14 pkg (Pharmacist name w	eyor asked RN # 1 if there dents where Resident # 102's to available for administration. It is surveyor that there was a surveyor that there was on 2/11/19. RN # 1 stated that upset and came and spoke to that she called the physician and got the medication into the or then reviewed the progress 102 that was documented on with RN #1. The surveyor was the nurse that had agress note in the clinical # 102. RN # 1 stated that she ress note on 1/2/19 at 12:34 sked RN # 1 if she had an of the change of condition is documented in the progress and an of the change of condition is documented in the progress and that the practitioner. RN # 1 stated that the practitioner. RN # 1 stated that the practitioner. RN # 1 stated that the practitioner is not ealong with the in the she did not document in of change in Resident # 19 at 12:34 pm. The surveyor he made aware of the # 102's condition on 1/2/19, he made (Nurse practitioner's re.  In the surveyor interviewed ithheld) via telephone. The charmacist if a prescription					
	for Methadone had b 102. The pharmacist had been received al tablets of Methadone for Resident # 102. T	stated that a prescription stated that a prescription and on 1/2/19 at 2:09 pm 120 was delivered to the facility he surveyor asked the as an issue with the	-				

Methadone prescription for Resident # 102 that

		AND HUMAN SERVICES & MEDICAID SERVICES			FC	FED: 03/06/201	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495325	B. WING		R		
	PROVIDER OR SUPPLIER	REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		)2/13/2019	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	COMPLÉTION DATE	
{F 755}	would prevent the pi Methadone to the fa administration. The prescription was need 102's insurance reje pharmacist informed of Methadone was dulti-22 am on 2/11/19. On 2/13/19 at 3:30 p (Nurse Practitioner's telephone in the pressurveyors. The surveyors. The surveyoractitioner's name was made aware of a chace condition on 1/2/19, withheld) stated, "No and stated, "(Nurse pi called you on that dehange with Residen practitioner's name was probably did." "I mussurveyor asked (Nurswithheld) if he would him aware when Resin condition. The nurse in condition. The nurse practitioner asked the would have done been made aware of 1/2/19. The nurse pragive him some Ativan nurse practitioner if the ordered for Resident practitioner stated, "Yellow the facility policy on the facility policy on the surveyor asked the facility policy on the facility process of the	harmacy from delivering the cility to be available for pharmacist stated that a new aded because Resident # cted the refill order. The I the surveyor that 60 tablets delivered to the facility at  om, the surveyor spoke with a name withheld) via sence of RN #1 and 2 other ayor asked (Nurse withheld) if he had been ange in Resident # 102's (Nurse practitioner's name or RN #1 then interjected or actitioner's name withheld), lay to make you aware of the at #102" (Nurse vithheld) stated, "You thave forgotten." The se Practitioner's name expect the nurses to make sident's experience a change se practitioner stated, "Yes." the nurse practitioner what for Resident # 102 if he had his change of condition on actitioner stated, "Probably" The surveyor asked the nat is all that he would have # 102 The nurse fes."  "Notification of Change in documentation that included	(F 755)				

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES				RM APPROV NO. 0938-00	
ND PLAN C	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	ONSTRUCTION	(X3) DA	TE SURVEY MPLETED	
		495325	B. WING_			R	
NAME OF F	ROVIDER OR SUPPLIER		STR	REET ADDRESS, CITY, STATE, ZIP CODE	0	2/13/2019	
PHEASANT RIDGE NURSING & REHAB CENTER			435	5 PHEASANT RIDGE ROAD, SW ANOKE, VA 24014			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	COMPLETIC DATE	
	The nurse to notify Resident Represen Significant change in physical, mental, or The facility policy or Shortages/Unavailadocumentation that to, "Procedure 1. Upon discovery inadequate supply of to a resident, facility initiate action to obtain pharmacy. If the mediscovered at the time administration, facilitate the action specification of the pharmacy of the medication should pharmacy to 2.1 Facility nurse should a missed dose in the facility nurse should the next scheduled do 2.2 If the next availate a missed dose in the schedule, facility nurse should the next scheduled do 2.3 If the medication from the facility nurse should dose in the schedule, facility nurse should notify pharma emergency delivery. If a medication should notify pharmacy hourself and pharmacy hourself and pharmacy hourself pharmacy hourself pharmacy hourself.	the attending physician and tative when there is a (n): in the patient/resident's psychosocial status." in "Medication ble Medications" contained included but was not limited included but medication from dication shortage is discovered during but included but incl	{F 755}				

PRINTED: 03/06/2019 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 02/13/2019 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 (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION CATE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) {F 755} Continued From page 35 (F 755) Medication Supply. 3.2 If the ordered medication is not available in the Emergency Medication Supply, the licensed facility nurse should call pharmacy's emergency answering service and request to speak with the registered pharmacist on duty to manage the plan of action. Action may include: 3.2.1 Emergency delivery; Use of an emergency (back-up) third 3.2.2 4. If an emergency delivery is unavailable, facility nurse should contact the attending physician to obtain orders or directions. If the medication is unavailable from pharmacy or a third party pharmacy, and cannot be supplied from the manufacturer, facility should obtain alternate physician/prescriber orders, as necessary." ... On 2/13/19 at 7:00 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 2/13/19. This is a complaint deficiency. (F 761) Labei/Store Drugs and Biologicals (F 761) F 761 Label/Store Drugs SS=D | CFR(s): 483.45(g)(h)(1)(2) 1. The unit manager removed §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be and discarded the expired labeled in accordance with currently accepted medications for Resident professional principles, and include the appropriate accessory and cautionary #'s 113, 114 and 115 on instructions, and the expiration date when 02/13/19. Discarded

§483.45(h) Storage of Drugs and Biologicals

applicable.

medications were replaced

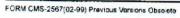
by the center for each resident.

03/12/2019 14:43 #372 P.043/051

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		495325	B. WING		02/13/2019	
	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	STREET ADDRESS, CITY, STATE, ZIP CODE  4355 PHEASANT RIDGE ROAD, SW  ROANOKE, VA 24014  D PROVIDER'S PLAN OF CORRECTION  EFIX (EACH CORRECTIVE ACTION SHOULD BE		
(F 761)	§483.45(h)(1) In acci Federal laws, the fact biologicals in locked temperature controls personnel to have ac §483.45(h)(2) The fallocked, permanently storage of controlled the Comprehensive Control Act of 1976 a abuse, except when package drug distrib quantity stored is min be readily detected. This REQUIREMEN' by: Based on observation staff failed to discard expiration date for 4 sample (Residents # medications on 1 of 1976 and the medication of 2/13/19 at 1:30 PM, inspecting the medications. The callottle of cetirizine 10 manufacturer's expired to 1976 and 1976	ordance with State and compartments under proper and permit only authorized coss to the keys.  cility must provide separately affixed compartments for drugs listed in Schedule II of Drug Abuse Prevention and and other drugs subject to the facility uses single unit ution systems in which the nimal and a missing dose can in it is not met as evidenced on and staff interview, facility medications after the of 16 residents in the survey 113-116) and bulk is medication carts.  The defined was evidenced to the survey of 12/19 at 2 per and 12/12/19 at 2 per and 13/14/19 at 2 per and 14/14/19 at 2 per and 14/14/19/14/19/14/19/14/19/14/19/14/14/14/14/14/14/14/14/14/14/14/14/14/	{F 76	2. A Quality review of medications and medications and medications was completed 02/26/19 by the DON. Follow up based on fin 3. DON/ADON provided re-education to license nurses on the regulation policy for storage and of medications on 3/1 4. DON/ADON/Unit Manawill conduct Quality Mof medications and moreoms for expired medications and moreoms for expired medications and moreoms for expired medications and then monthly x 3 as indicated. DON will results to QAPI commit monthly and updated a Quality monitoring schemodified based on fine 5. Date of Compliance: 03	dings.  dings.  dings.  dings.  dings.  dispersion of the control	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495325  B. WING  STREET ADDRESS, CITY. STATE, ZIP CODE 4355 PHEASANT RIDGE NURSING & REHAB CENTER  (X4) ID PREFIX  (X4) ID PREFIX  (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR ISC LIDENTIFYING INFORMATION!  TAG REGULATORY OR ISC LIDENTIFYING INFORMATION!  (X4) MULTIPLE CONSTRUCTION A. BUILDING  (X2) MULTIPLE CONSTRUCTION A. BUILDING  (X3) DATE SURV. COMPLETE  R  02/13/20  PREFIX  (S4) ID PROVIDER S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	CENTER	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			FO	ED: 03/06/201 RM APPROVE
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014  SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION)  FREFIX TAG  CONSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  (F 761)  CONTINUED From page 37  with 5 packages in the box with order date 8/14/17 and manufacturer's expiration date COctober 2018 for Resident #113; for Resident #114. a bilister package of ondansetron 4  milligram tablets with 4 remaining tablets with expiration date 12/7/18, and for Resident #15, a bottle of nitroglycerin 0.4 milligram sublingual tablets with 23 tablets remaining and manufacturer's expiration date January 19.  Facility staff made facility administration aware of the issue and the surveyor observed while a ficensed practical nurse (LPN) and a corporate level Quality Assurance representative inspected the medication car on the 200 hall for expired medications. They discovered a bilister package of hyoscyamine 0.125 milligrams tablets with 10 remaining tablets with expiration date 1/25/19.  The medication room on unit 1 contained no expired medications.	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	The state of the s	CONSTRUCTION	(X3) DA	
PHEASANT RIDGE NURSING & REHAB CENTER  SIMEET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014  (X4) ID PREPIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  FREFIX TAG  Continued From page 37 with 5 packages in the box with order date 8/14/17 and manufacturer's expiration date October 2018 for Resident #113; for Resident #114, a blister package of ondansetron 4 milligram tablets with 4 remaining tablets with expiration date 12/7/18; and for Resident #15, a bottle of nitroglycerin 0.4 milligram sublingual tablets with 23 tablets remaining and manufacturer's expiration date January 19. Facility staff made facility administration aware of the issue and the surveyor observed while a licensed practical nurse (LPN) and a corporate level Quality Assurance representative inspected the medications. They discovered a bilster package of hyoscyamine 0.125 milligrams tablets with 10 remaining tablets with expiration date 1/25/19. The medication room on unit 1 contained no expired medications.			495325	B. WING			
(X4) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 761)  Continued From page 37 with 5 packages in the box with order date 8/14/17 and manufacturer's expiration date October 2018 for Resident #113, for Resident #114, a blister package of ondensetron 4 milligram tablets with 4 remaining tablets with expiration date 12/7/18; and for Resident #15, a bottle of nitroglycerin 0.4 milligram sublingual tablets with 23 tablets remaining and manufacturer's expiration date January 19, Facility staff made facility administration aware of the issue and the surveyor observed while a licensed practical nurse (LPN) and a corporate level Quality Assurance representative inspected the medication. They discovered a blister package of hyoscyamine 0.125 milligrams tablets with 10 remaining tablets with expiration date 1/25/19.  The medication room on unit 1 contained no expired medications.	NAME OF F	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		2/13/2019
PROVIDERS   AN OF CORRECTION	PHEASA	NT RIDGE NURSING &	REHAB CENTER				
with 5 packages in the box with order date 8/14/17 and manufacturer's expiration date October 2018 for Resident #113; for Resident #114. a blister package of ondansetron 4 milligram tablets with 4 remaining tablets with expiration date 12/7/18; and for Resident #15, a bottle of nitroglycerin 0.4 milligram sublingual tablets with 23 tablets remaining and manufacturer's expiration date January 19. Facility staff made facility administration aware of the issue and the surveyor observed while a licensed practical nurse (LPN) and a corporate level Quality Assurance representative inspected the medication cart on the 200 hall for expired medications. They discovered a blister package of hyoscyamine 0.125 milligrams tablets with 10 remaining tablets with expiration date 1/25/19. The medication room on unit 1 contained no expired medications.	PREFIX	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE	BE	COMPLETION DATE
Resident #113 was admitted to the facility on 8/10/15 with diagnoses including anemia, Alzheimer's dementia, heart failure, and hypertension. The resident scored 9/15 on the brief interview for mental status on the latest minimum data set assessment.  Resident #114 was admitted to the facility on 9/22/2015 with diagnoses including anemia, hypertension, aphasia, cardiovascular accident, hemiplegia, malnutrition, anxiety, and bipolar disorder. The resident scored 14/15 on the brief interview for mental status on the latest minimum data set assessment.  Resident #115 was admitted to the facility on		with 5 packages in 8/14/17 and manufa October 2018 for Ro #114. a blister pack milligram tablets with expiration data 12/7 bottle of nitroglyceni tablets with 23 table manufacturer's expiration tablets with 23 table manufacturer's expiration and the sufficensed practical nulevel Quality Assuranthe medications. They conflict the medications of hyoscyamine 0.12 remaining tablets with The medications.  The issue was report during the summary.  Resident #113 was a 8/10/15 with diagnos Alzheimer's dementia hypertension. The rebrief interview for meminimum data set as Resident #114 was a 9/22/2015 with diagnos hypertension, aphasinhemiplegia, malnutritidisorder. The resident interview for mental sidata set assessment.	the box with order date acturer's expiration date esident #113; for Resident age of ondansetron 4 th 4 remaining tablets with 718; and for Resident #15, a in 0.4 milligram sublingual ats remaining and ration date January 19. actility administration aware of inveyor observed while a since (LPN) and a corporate ince representative inspected on the 200 half for expired discovered a blister package 25 milligrams tablets with 10 th expiration date 1/25/19. In on unit 1 contained no ded to facility administration meeting on 2/13/19.  Indiditted to the facility on es including anemia, a, heart failure, and sident scored 9/15 on the intal status on the latest sessment.  Indiditted to the facility on ones including anemia, a, cardiovascular accident, ion, anxiety, and bipolar it scored 14/15 on the brief tatus on the latest minimum	{F 761}			





Facility ID: VA0208

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

STATEMENT AND PLAN O	OF DÉFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495325	8 WNG_		02/13/2019
	PROVIDER OR SUPPLIER	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
{F 812} SS=F	1/17/2019 with dial failure, hypertensic cerebrovascular acresident had not ye assessment.  Resident #116 was 4/2/18 with diagnos dementia and deproducer the brief in the latest minimum Food Procurement, CFR(s): 483.60(i)(1) - Procurement food Procurement food Procurement food Procurement, CFR(s): 483.60(i)(1) - Procurement food facility must food food facilities from using gardens, subject to safe growing and food from consuming food from consuming food from foo	gnoses including anemia, heart on, peripheral vascular disease, ocident, and dementia. The et had a minimum data set admitted to the facility on ses including Alzheimer's ession. It is is a sessed as unable to interview for mental status on data set assessment. (Store/Prepare/Serve-Sanitary 1)(2) fety requirements.  Store food from sources ered satisfactory by federal, rities. It is food items obtained directly is, subject to applicable State guilations. Des not prohibit or prevent produce grown in facility compliance with applicable to d-handling practices. To oes not procured by the facility. It is prepare, distribute and dance with professional	{F 812	F 812 Food Procurement  1. Ice chests and scoops were	# 1 on ed to 14/19.

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	-	(X3) DATE SURVEY COMPLETED	
		495325	B. WING			02/13/2019	
	ROVIDER OR SUPPLIER  IT RIDGE NURSING & SUMMARY S	REHAB CENTER STATEMENT OF DEFICIENCIES	STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014  ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRE	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
(F 812)	staff and resident for refrigerator.  Findings:  On 2-12-19 at 11:30 hall on unit one, two observed to get ice hands holding the ice members (CNA I and cups then dropped to chest on top of the ice.  CNA I proceeded do observed to go in an arooms, filling cups from held with her bare had the scoop to the insignation on the bed of ice.  On 2-13-19 at 4:05 is pantry refrigerator we surveyor found a plastyrofoam meal dish were not labeled with the surveyor observed to go in an arooms, filling cups from the bed of ice.  On 2-13-19 at 4:05 is pantry refrigerator we surveyor found a plastyrofoam meal dish were not labeled with the surveyor observed to go. All items in the "Resident's name Anumber and "Today from today"  The surveyor asked and who it belonged guess I'm in trouble.	manner and commingled ods in the unit one pantry  AM during a tour of the 400 of staff members were from an ice chest with bare the scoop. The two staff of AO) put the ice into resident the ice scoop back into the ice scoop back into the ice scoop back into the ice chest which she ands. Each time she returned de of the chest by dropping it if the resident's Unit two reas reviewed for contents. The institute of the ice chest with the ice chest will be it in an ame or dated.  The interest is to be used for staff items will be thrown its refrigerator must include in include in an includ	{F 81	3. DON/ADO provided staff on the policy and distribution sanitary months of staff and on 3/11/4. DON/ADO will conduct Monitoria maintained a sanitary staff food with reside for 4 week 3 months Findings QAPI compand update Quality modified.	DN/Unit Managers deducation to nurs he regulation and diprocedure on the on of ice in a safe a manner and storage and resident foods (19. DN/Unit Managers uct Quality ing to ensure ice is ed and passed in y manner, and is not co-mingled dent food 5 x a weeks, then monthly for so, and PRN as indicated to be reported to mittee by the DOM ited as indicated. monitoring schedule based on findings. impliance: 03/20/1	ek or eted.	

TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES				NO. 0938-03
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) D	ATE SURVEY OMPLETED
		495325	B. WING			R
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP O		02/13/2019
PHEASA	NT RIDGE NURSING 8	REHAB CENTER		4356 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE HE APPROPRIATE	COMPLETION DATE
{F 812}	Continued From pa	age 40	{F 812	F 867 QAPI/QAA		
	CNN (corporate nu	as shared with the DON and urse consultant) at 6:30 PM.		Facility conducted a     AD-Hoc meeting of     to discuss the outc	02/15/19	
b fo s	The DON provided the surveyor with a policy for ice storage. The policy said the ice scoop should be stored in a separate container. No policy was found regarding the commingling of resident and staff foodbut the DON acknowledged staff were not to store food in resident refrigerators.  No additional info was provided prior to the			the annual survey	revisit and	
				plans to correct are 2. On 02/21/19 The Ex		
	survey team exit.			Director and the Interdisciplinary tea	_	1
(F 867) SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii)		(F 867)	completed a Root C	ause	
		assessment and assurance.		on 02/14/19.		
Transfer day	assurance committee	quality assessment and ee must: plement appropriate plans of		<ol> <li>The Divisional Direct Clinical Services pro</li> </ol>		
	action to correct ide This REQUIREMEN	intified quality deficiencies; IT is not met as evidenced		education to the Qu Assurance Performa	•	
	by: Based on observati interview, clinical red	ion, staff interview, resident cord review, comlaint		Improvement comm members regarding		
	investigation, and du evaluate the Plan of	uring a return survey to Correction of Deficiencies		regulation and polic	y for	
	rom the prior survey, facility staff failed to implement action plans to correct identified quality deficiencies in the areas of pressure ulcer			the roles, functions development of acti	on plans	
	care, hemodialysis,	medication availability, and infection control.		of QAPI committee on 02/21/19.		
	Those deficient prac	tices are detailed under the		4. ED/DON will conduct		
	concerns were discu	in this report. Continuing issed with the faacility of clinical services, and two		Monitoring of QAPI weekly for 6 weeks a		
1		or clinical services, and two		monthly and PRN as	indicated	

NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED CONTINUED TO THE APPROPRIED CONTINUED TO THE ACTION SHOULD CONTINUED TO THE APPROPRIED CONTINUED TO THE APPROPRE OF CONTINUED TO THE APPROPRIED CONTINUED TO THE APPROPRE OF CONTINUE TO THE APPROPRE OF CO	COMPLETED				
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 867)  Continued From page 41 (F 887)  Corporate representatives during a final conference on 2/13/19.  (F 880)  SS=E  (F 880)  SS=E  (F 880)  SS=E  (F 881)  STREET ADDRESS, CITY, STATE ZIP CODE  4355 PHEASANT RIDGE ROAD, SW  ROANOKE, VA 24014  PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)  Findings to be reported to Committee by the ED and updated as indicated.  (F 887)  GRAPH OF PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)  Findings to be reported to Committee by the ED and updated as indicated.  (F 880)  GRAPH OF PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)  FINDINGS to be reported to Committee by the ED and updated as indicated.  GRAPH OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)  Findings to be reported to Committee by the ED and updated as indicated.  GRAPH OF CROSS-REFERENCED TO THE APPROP DEFICIENCY  FINDINGS TO THE APPROP DEFICIENCY  F	1 -				
NAME OF PROVIDER OR SUPPLIER  PHEASANT RIDGE NURSING & REHAB CENTER  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 867)  Continued From page 41 (F 867)  Corporate representatives during a final conference on 2/13/19.  (F 880)  SS=E  (F	R				
PHEASANT RIDGE NURSING & REHAB CENTER   SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (F 867)  Continued From page 41  corporate representatives during a final conference on 2/13/19.  [F 880]  SS=E  CFR(s): 483.80(a)(1)(2)(4)(e)(f)  Findings to be reported to Committee by the ED and updated as indicated.  Quality monitoring schedule modified based on findings.  §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	02/13/2019				
(x4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  {F 867} Continued From page 41 (F 867) Corporate representatives during a final conference on 2/13/19.  {F 888} SS=E CFR(s): 483.80(a)(1)(2)(4)(e)(f)  SS=E S483.80 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					
SUMMARY STATEMENT OF DEFICIENCIES   ID PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED COMMITTEE BY TAG	And the second s				
Findings to be reported to Committee by the ED and updated as indicated.  [F 880] SS=E  CFR(s): 483.80(a)(1)(2)(4)(e)(f)  Findings to be reported to Committee by the ED and updated as indicated.  Quality monitoring schedule modified based on findings.  §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	PROVIDER'S PLAN OF CORRECTION (KS)				
corporate representatives during a final conference on 2/13/19.  [F 880]  SS=E  Committee by the ED and updated as indicated.  [F 880]  CFR(s): 483.80(a)(1)(2)(4)(e)(f)  [F 880]  SS=E  Committee by the ED and updated as indicated.  Quality monitoring schedule modified based on findings.  §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	D BE COMPL				
corporate representatives during a final updated as indicated.  {F 880} SS=E	QAPI				
conference on 2/13/19.  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  updated as indicated.  Quality monitoring schedule modified based on findings.  5. Date of compliance: 03/20/19  F880 Infection Prevention and F880 Infection Prevention and communicable					
SS=E 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  THOM MORE THE					
SS=E 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  modified based on findings.  5. Date of compliance: 03/20/19  F880 Infection Prevention a					
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					
infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable  F880 Infection Prevention a	9				
designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable					
comfortable environment and to help prevent the development and transmission of communicable					
	nd Control				
I diseases and intections					
1. 10 Nesacin # 203 Bases 0	T T				
§483.80(a) Infection prevention and control the most recent assessment					
program. by the Nurse Practitioner or					
The facility must establish an infection prevention and control program (IPCP) that must include, at	5				
a minimum, the following elements: or new infections were note	ed.				
Unit Manager reviewed the	!				
§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections facility infection control					
and communicable diseases for all residents. regulation, policy and					
staff, volunteers, visitors, and other individuals procedure with the manage	r				
providing services under a contractual arrangement based upon the facility assessment of the transportation					
conducted according to §483.70(e) and following company and the dialysis					
accepted national standards; clinic on 02/12/19. The					
§483.80(a)(2) Written standards, policies, and mechanical lift was					
procedures for the program, which must include, removed from resident					
but are not limited to:  (i) A system of surveillance designed to identify care area and was cleaned					
possible communicable diseases or and disinfected. Education					
infections before they can spread to other					
persons in the facility;  (ii) When and to whom possible incidents of dedicated equipment for					
communicable disease or infections should be isolation residents was	THE STATE OF THE S				
reported; isolation residents was completed 2/13/19.					

DEPAR	TMENT OF HEALTH RS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 03/06/201 FORM APPROVE		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
		495325	B. WING		R		
NAME OF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/13/2019		
PHEASANT RIDGE NURSING & REHAB CENTER			4365 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014				
PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NOT MUST BE PRECEDED BY FULL PR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION		
	(iii) Standard and treated to be followed to precident; including the content of the followed to president; including the content of the facility will conduct the facility staff failed to precautions were followed transport company of trans	ansmission-based precautions event spread of infections; solation should be used for a put not limited to: uration of the isolation, a infectious agent or organism that the isolation should be the sible for the resident under the less under which the facility yees with a communicable skin lesions from direct the disease; and a procedures to be followed lirect resident contact. The formation of the facility's IPCP and the ken by the facility.  In the facility of the facility of the facility is IPCP and the ken by the facility.	(F 880)	On 2/13/19 isolation signa	ors,		

Event ID: Y3F112

Facility ID: VA0208

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM APPROVED OMB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495325		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING		02/13/2019		
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 DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
	Resident #109 was a 2/12/19 with diagnost disease clostridium of heart failure, atrial fib and depression. At the 2/13/19, the resident data set completed, resident able to answ.  On 2/12/19 at 1:30 the resident was out of the door frame said "stop A cart outside the door masks, hair covers, retape. The surveyor a about the resident's for precautions. The unit was at dialysis. The representations and the unwhat type of precautions are type of the unwhat type of the unwhat type of precautions and the unwhat type of precautions are type of the unwhat type of th	for staff use for 1 of 16 by sample (Resident #109). Idmitted to the facility on a including end stage renal ifficile colitis, congestive rillation, diabetes mellitus, ne time of the review on had not had a minimum. The surveyor found the er questions about her care. It is essentially a surveyor noted the eroom. 3 magnets on the see nurse for instructions. It is contained gowns, gloves, and bags and clear dressing sked the unit manager said the resident esident was on contact in manager and not know one should be taken if the eroom or left the building, unit manager informed the ed the dialysis center and y to inform them the	{F 880	transportation services and the dialysis center of residen with isolation precautions including the use of dedicated equipment. Letters were sent out to families on 03/11/19 regarding facility Infection Control Policy and Procedure 4. DON/ADON/ Unit Managers will conduct Quality Monitori to ensure documentation is present that notification to transportation company and dialysis center is completed, random observation of visitors to maintain compliance with isolation precautions, and equipment for residents in isolation is dedicated to them and left in the room, 5 x week for 4 weeks then, monthly x 3 months. Findings to be reported to QAPI committee monthly by the DON and updated as indicated. Quality monitoring schedule modified based on fit 5. Date of Compliance: 03/20/19	t ts.	

When the surveyor returned from watching the

## PRINTED: 03/06/2019 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 02/13/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 4355 PHEASANT RIDGE ROAD, SW PHEASANT RIDGE NURSING & REHAB CENTER ROANOKE, VA 24014 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID. (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (F 880) Continued From page 44 (F 880) transporters exit, the lift was no longer in the room. The resident, when asked, said the lift was removed without being cleaned. The CNA reported it had been taken to another hall and cleaned with wipes. The CNA stated wipes were stored in a drawer in the nurse's station and aids get them from nurses when they need them. A nurse at the nurse's station said the wipes were stored in the medication cart. There were no wipes in the cart. Another nurse said they were locked in a drawer in the nurse's station. Staff found the disinfecting wipes 7 minutes after the CNA asked for them. The CNA showed the surveyor the caution notice on the package indicating they whould be kept from children and said that was why the wipes could not be kept on the isolation cart. On 2/13/19, a visitor arrived and delivered several bags of the resident's belongings, visited, then left. No staff member informed the visitor of the need to use PPE or thoroughly wash hands after visiting. The administrator and director of clinical services were notified of the concerns with contact precautions during a summary meeting on 2/13/19.