STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495325	A. BUILDING _____ B. WING _____	C 04/08/2021

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

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E 000	Initial Comments An unannounced Emergency Preparedness survey was conducted 04/06/2021 through 04/08/2021. The facility was in substantial compliance with 42 CFR Part 483.73, Requirements for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 04/06/21 through 04/08/21. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The census in this 101 certified bed facility was 84 at the time of the survey. The final survey sample consisted of 19 current resident reviews and 2 closed record reviews. Two complaints were investigated.	F 000		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to ensure that residents receive treatment and care by not following a physician ordered medication was	F 684	1. Resident #71 was interviewed on April 12, 2021 in regard to medication observed on her bedside table on April 6, 2021 to determine if she had received her medication. The charge nurse completed	4/20/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 04/30/2021

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F 684	Continued From page 1 kept under direct observation by the nursing staff until consumed by the resident for 1 of 23 of residents, Resident #71. The findings included: The facility staff failed to ensure Resident #71 consumed the medication Metoprolol. This medication was observed by the surveyor to be laying on the residents food tray during initial tour of the facility. Indicating the medication had not been administered per the physicians orders. Resident #71's (EHR) electronic health record included the diagnosis chronic diastolic congestive heart failure, essential primary hypertension, and diabetes. Section C (cognitive patterns) of the residents quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 03/22/2021 included a (BIMS) brief interview for mental status summary score of 15. Indicating the resident was alert and orientated. On 04/06/21 at 2:41 p.m., the surveyor observed a round blue pill with the imprint M47 laying on Resident #71's food tray. Resident #71 stated, "I'm sure that came from this morning..." On 04/06/21 at 2:55 p.m., (LPN) licensed practical nurse #1 identified the blue pill as Metoprolol and stated they did not notice the dropped medication. Resident #71's EHR electronic health record included a physicians order for Metoprolol 100 mg give one tablet by mouth two times a day related to essential primary hypertension.	F 684	a nursing assessment to ensure that resident had not had any change of condition on April 12, 2021. Residents attending physician and responsible party were notified related to medication variance on April 12, 2021. 2. The Director of Clinical Services/designee conducted a Quality Review on April 13, 2021 to ensure no medication was left at the bedside. The Director of Clinical Services /designee completed a Quality Review on April 14, 2021 for facility residents with a BIM score greater than 8 to ensure that licensed nurses are present until all medication is administrated. 3. The Director of Clinical Services/designee will re-educate the licensed nursing staff regarding proper administration of medication to ensure medications are not to be left at the bedside for the resident to self-administer and providing direct observation by nursing staff until medication is consumed by the residents . Residents identified as safe, using the self-administration evaluation form, will be permitted to self-administer specific medication identified by April 20, 2021. Any licensed nurses identified as not receiving the re-education on or by April 20, 2021 will receive prior to working next scheduled shift. 4. The Director of Clinical Services /designee will conduct quality monitoring audits of licensed nurses during their	

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F 684	Continued From page 2 A review of Resident #71's (eMAR) electronic medication administration record revealed that this medication was due to be administered at 9:00 a.m. and 6:00 p.m. Resident #71's (BP) blood pressure was documented as 130/63 at 12:07 p.m. on 04/06/2021 and as 128/63 on 04/07/2021 at 12:05 p.m. On 04/07/21 at 8:02 a.m., LPN #1 stated they discarded the medication. On 04/07/2021 at 4:30 p.m., the (DON) director of nursing, (ADON) assistant director of nursing, administrator, and regional nurse consultant were made aware of the issue regarding the residents medication being left at the bedside and not being administered. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 684	medication pass to ensure medications are not left unattended on five residents three times a week for two weeks, then bi- monthly for one month and then monthly for one months. Findings to be reported to QAPI committee monthly and updated as indicated. Quality monitoring schedule will be modified based on findings. 5. Allegation of Compliance April 20, 2021.	
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation the facility staff failed to	F 689	Past noncompliance: no plan of correction required.	4/30/21

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F 689	Continued From page 3 ensure that for 1 of 23 residents the environment was free of accident hazards in regards to a fall (Resident #276). The findings included: The facility staff failed to place a fall mat beside Resident #276 bed. On 02/09/2020, Resident #276 fell from the bed, hit their head, and was sent to a local hospital where they received 3 stitches. The resident's (CCP) comprehensive care plan included the intervention fall mats beside of bed date of initiation 01/22/2020. This was a closed record review. Resident #276's (EHR) electronic health record included the diagnoses, Alzheimer's disease, dementia, and hypertension. Section C (cognitive patterns) of the residents annual (MDS) minimum data set assessment with an (ARD) assessment reference date of 02/03/2020 had been coded 1/1/3 to indicate the resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. Section E (behavior) was coded to indicate the resident did not have any behaviors, Section G (functional status) was coded 4/3 (totally dependent on two persons) for bed mobility, transfers, toilet use, and personal hygiene. The resident was coded as using a wheelchair for mobility and as having an impairment on both sides of the upper and lower extremities in range of motion. Section J (health conditions) was coded with a 1 indicting the resident had a fall since admission with a non-major injury. Section P (restraints) was coded to indicate the resident did not use any	F 689		

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F 689	Continued From page 4 restraints but did have a wander/elopement alarm in place. The residents fall risk evaluation completed 11/06/2019 had a documented score of 15 (no risk). The fall risk evaluation completed on 01/31/2020 included a documented score of 30 (low risk). The residents CCP with a revision date of 10/31/2019 included the focus area at risk for falls related to Alzheimer's dementia, confusion, unaware of safety needs, vision/hearing problems, requires assistance with activities of daily living (ADL's) and incontinence. Recent fall. Interventions included, but were not limited to, fall mats beside of bed (01/22/2020), anticipate and meet the resident's needs (11/28/2018), be sure the residents call light is within reach and encourage the resident to use it for assistance as needed (11/28/2018). The EHR included physicians orders to indicate the resident had 2 1/4 side rails to bed. These side rails were discontinued on 01/12/2020. On 04/07/2021 at 7:55 a.m., the DON stated that the fall the resident sustained on 02/09/2020 was the residents first fall from the bed since they had been admitted. Side rail evaluation completed 01/12/2020-Indicated the side rails were not used for bed mobility, transfers, or did not assist the resident in avoiding rolling out of bed and did not assist the resident in providing a sense of security. This document was coded (yes) for the questions Could the use of bed rails create an	F 689		

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F 689	Continued From page 5 accident hazard or barrier for this resident, would the use of bed rails act as a physical restraint for this resident, impeding movement or limiting their daily activities, and would the use of bed rails have negative psychosocial outcomes for this resident such as feelings of isolation, increased agitation or anxiety, or alter resident's self-esteem. Recommendations: Side rails Not indicated. This form had been signed by (LPN) licensed practical nurse #4. Side rail evaluation completed 01/31/2020-Why is the use of a bed rail(s) being considered-family requested. This document was coded to indicate side rail(s) would assist the resident in bed mobility, transfers, avoid rolling out of the bed and providing a sense of security. Recommendations: Side rails recommended to help with positioning. This document had been signed by the (DON) director of nursing on 02/13/2020. On 04/07/2021 at 12:26 p.m., the DON stated the side rails were discontinued on 01/12/2020 and the side rail evaluation for 01/31/2020 contained incorrect documentation. The resident was not using side rails/bed rails at the time of the fall. Resident #276's EHR included the following progress note documented on 02/09/2020 at 6:11 a.m. by (licensed practical nurse) LPN #1. "4:40 Am (CNA) certified nursing assistant reported to this nurse that resident was on floor at time when got to room resident was lying on side beside her bed which was in low position at time with blood noted under head was not moved at time (11 (sic) dialed. Hospice aware at time and daughter aware at time. (EMS) emergency medical services attended her at time. left on stretcher accompanied by EMT staff at time. (VS) vital	F 689		

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F 689	Continued From page 6 signs 98.2-99-18 (B/P) blood pressure 170/83 (02) oxygen sat 92%." On 04/07/2021 at 9:30 a.m., the surveyor left a message for LPN #1 to call the surveyor. No return call was received prior to the exit conference. Per the DON, the CNA that was working at the time of the incident was no longer employed at the facility. The EHR included a physicians order dated 02/09/2020 to "send to (ER) emergency room eval. head wound." At 10:37 p.m. on 02/09/2020, LPN #2 documented "... (Rsd) resident (LOA) leave of absence at (ED) emergency department for laceration to head. Will return." On 02/09/2020, Resident #276 was treated in the ED at a local hospital and returned the facility. The facility provided the surveyor with ED notes that included the following documentation. Additional Patient, Scene, and Transport Information-"patient arrives by EMS due to fall, staff found patient, unknown downtime, hit head, quarter size indentation on forehead. bruising under right eye. mild bleeding from nose. hospice care, (hx) history dementia." ED Notes, ED Triage Notes, ED Provider Notes-"...Dried blood over patients face and left hand...." ED Course Sunday February 9, 2020 6:21 a.m. "Spoke to daughter, the patients power of attorney. She would not like to obtain a CT head or C-spine for the patient given her (DNR/DNI) Do not Resuscitate/Do not intubate status."	F 689		

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F 689	Continued From page 7 Discharge Instructions-"Today you are seen in emergency department after a fall. There is a large laceration to your forehead that was repaired with 3 sutures. Please have the sutures removed in 10 to 14 days. Please keep the area clean and dry...No CT scan of your head was done per the request of your daughter..." On 02/10/2020 at 2:27 a.m., LPN #1 documented "Resting, Staples in place to forehead. Resident alert when spoken to. Assisted as needed with (ADLS) activities of daily living, mat at bedside low bed in place. No (C/O,s) complaints of when checked. Call light in reach at all times." The facility provided the surveyor with a copy of an "EMPLOYEE CORRECTIVE ACTION FORM" in regards to CNA #1, date of infraction was documented as 02/09/2020. Description of violation-"Associate failed to put the fall mat back down for resident in _____ (room)." Witness statement from LPN #1 read in part, "on 2/9/20 440 am CNA ___ called me to room stated resident had fallen + had bleeding from head @ time ____ (room and resident name) We immediately called Supervisor _____ to unit to assist. I immediately dialed 911 at time. I did not move resident due (lg) large amt clotted blood under head with top head near bed____ stand. VS were obtained...fall mat was not on left side of bed at time of fall." The FRI (facility reported incident) revealed that the facility had completed an investigation on this fall and a five point POC (plan of correction) has been implemented. The surveyor asked the administration staff if a	F 689		

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F 689	Continued From page 8 POC had been completed. The DON provided the surveyor with a form titled, "Ad Hoc Quality Assurance & Performance Improvement Meeting" dated 02/11/2020. Reason for Ad Hoc Meeting Fall (Resident #276). Opportunity for Improvement-Failure to Implement Fall Intervention at bedside Data-Fall with Laceration Analysis (Root Cause Analysis)-Fall mat was not at bed side per c/p (care plan). Plan-Review all falls from previous 60 days to ensure that resident fall intervention are appropriate, in place, C/P and reflected on kardex. Provide 1:1 re-education with nursing assistant. Re-education all nursing staff related to ensure all inventions (sic) are in place prior to leaving resident. There was no date of compliance on this form. The executive director, director of clinical services, medical director, and 2 others had signed the bottom of this form on 02/11/2020. There was documentation on this form to indicate the next meeting would be held on 02/13/2020. This form did not clearly identify the title of the person responsible for implementing the POC. On 04/07/2021 at 1:52 p.m., the DON acknowledged there was no date of compliance on the POC form and stated their education was completed by 02/13/2020 and audits completed by 02/14/2020. The DON stated so the date of compliance was 02/14/2020. The facility provided the surveyor with copies of 3 in-service log sign-up sheets completed by the (ADON) assistant director of nursing. Specific for Resident in room _____. Four signature sheets all dated 02/10/2020.	F 689		

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F 689	Continued From page 9 Fall Mats & Bed Alarms. Six signature sheets dated 02/11/2020 and 02/12/2020. Abuse education. Five signature sheets dated 02/13/2020. Various staff were asked to identify their signature on the signature sheets/in-service logs provided to the surveyor. The DON and LPN #5 were unable to locate their signatures on the sheets specific for the resident or for the fall mats and bed alarm education. On 04/08/2021 at 1:54 p.m., the DON reviewed the signature sheets and stated she had been in-serviced by 02/14/2020. When asked if the expectation of whomever was in the in-service would have signed the in-service sheets the DON replied, yes. On 04/08/2021 at 2:18 p.m., during a meeting the (RNC) regional nurse consultant, ADON, and administrator. The RNC verbalized to the surveyor that not everyone signed every sheet of the in-service forms and the in-service on abuse was not part of their POC. The ADON stated all the in-services were completed together even though the dates did not reflect that. The RNC added that the Ad Hoc form was just minutes but it is what is considered our POC. On 04/08/2021 at 2:43 p.m., LPN #5 stated they attended the in-services and that there were so many sheets going around. LPN #5 stated they did the follow up audits after the fact and the training was about falls mats and alarms. LPN #5 stated it has been so far back and identified their signature on the in-service signature sheet on abuse. This was the in-service (education) that the RNC stated was not part of their POC.	F 689		

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F 689	Continued From page 10 No further information regarding this issue was provided to the survey team prior to the exit conference on 04/08/2021. The surveyor did a complete walkthrough of the facility on 04/07/2021 at approximately 7:00 a.m. and no problems with bed rails or floor mats were identified. Floor mats were observed to be in use. No similar complaints were received while on site. This is a complaint deficiency.	F 689		