PRINTED: 05/19/2022 FORM APPROVED

State of Virginia

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOT	WIDER.	A. BUILDING: _		COMPLETED
		VA0208		B. WING	$ +$ $+$ \wedge	01/16/202 <u>0</u>
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
PHEASANT RIDGE NURSING & REHAB CENTER 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014					ROAD, SW	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE COMPLETE HE APPROPRIATE DATE
F 000	Initial Comments		F 000			
	Inspection was cond 1/16/2020. The facil with the Virginia Rule Licensure of Nursing	01 bed facility was 94 The survey sample cor	nce the at the			
F 001	Non Compliance			F 001		
	The facility was out of following state licens	of compliance with the sure requirements:				
	This RULE: is not met as evidenced by: The facility was not in compliance with the following Virginia Nursing Home Rules and Regulations: 12VAC5-371-140 E 3					
		n compliance with the les and Regulations fo Facilities: 12 VAC				
	review, facility staff fa	riew and facility docum ailed to obtain crimina within the required tim wly hired employees	I			
	The findings included	d:				
	reviewed files of 29 r	gh 1/16/2020, the survencewly hired employees ne surveyor noted the	•			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	VA0208		B. WING		01/	16/2020	
NAME OF R	ROVIDER OR SUPPLIER	STREET AND	RESS, CITY, STA	TE ZID CODE	N AT	. 0/202 <u>0</u>	
NAME OF F	NOVIDER ON SUFFLIER		SANT RIDGE				
PHEASAN	IT RIDGE NURSING & REHAB CENTER		, VA 24014	NOAD, ON			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE , CROSS-REFERENCED [*] DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE	
F 001	Continued From page 1		F 001				
	" Employee #13 had a criminal record verification dated for 2/26/19. The employed hire date was 4/1/19. " Employee #29 was hired on 8/5/19 and no criminal record verification. The administrator was notified of the above documented findings on 1/15 at 10:30 am by surveyor. The administrator stated, "when you asked for those files, we realized that we did have a background check on	the ou not byee for ere cy bject ng HR) t					
	12VAC5-371-250 F cross-reference to F6 12VAC5-371-220 C 5 cross-reference t						

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STATEMENT OF DEFICIENCIES

	PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
AND I DAN OF CONNECTION	SERVIII IOATION NOMBER.	A. BUILDING:			-120			
_P()(`	VA0208	B. WING		01/16/202 <u>0</u>				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
PHEASANT RIDGE NURSING & REHAB CENTER 4355 PHEASANT RIDGE ROAD, SW ROANOKE, VA 24014								
(X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST TAG REGULATORY OR LSC IDE	BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE			
12VAC5-371-300 L cross	s-reference to F756 s-reference to F761 s-reference to F775	F 001						