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 08/03/2022

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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 08/01/22 through 08/03/22. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 08/01/22 through 08/03/22. Three complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. VA00053833-unsubstantiated VA00053236-unsubstantiated VA00052466-unsubstantiated The census in this 101 certified bed facility was 88 at the time of the survey. The final survey sample consisted of 18 current Resident reviews.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to provide Activities of Daily Living (ADL) care for 2 of 18 residents. Resident #29 and Resident #68.	F 677	1. Resident #29-was offered to have her nails trimmed and she declined. An appointment with a podiatrist has been made and also a dermatologist. Resident #68-was immediately offered a shower and refused stating he would take one on his regular scheduled bath day. He provided a list of days he preferred to bathe to staff. Both have had their plans of care reviewed and updated as indicated.	8/24/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Mwombold | TITLE: ED | (X6) DATE: 8/15/22

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 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 677	Continued From page 1 1. Resident #29 was observed to have long, thick, and jagged fingernails and toenails. 2. Resident #68, the facility staff failed to provide ADL care in regards to bathing. The findings included: 1. Resident #29's diagnoses included, but were not limited to, hemiplegia and hemiparesis, contracture right and left hands, cerebrovascular (CVA) disease, bipolar disorder, and prediabetes. Section C (cognitive patterns) of Resident #29's quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/14/22 included a brief interview for mental status (BIMS) summary score of 14 out of a possible 15 points indicating the resident was alert and orientated. However, due to the residents communication deficit the surveyor was unable to interview this resident. Section G (functional status) was coded to indicate the resident was totally dependent on one person for personal hygiene (4/2) and as having impairment on both sides in the upper and lower extremities. Resident #29's comprehensive care plan included the focus area has an ADL self-care performance deficit related to CVA/Hemiparesis to left and right side, bilateral upper and lower contracture's. Non-compliant with care at times, showers, and chooses to get out of bed only rarely. Interventions included, but were not limited to, assist with ADL's as needed, encourage care, wait and re-approach at times, check nail length and trim and clean on bath day and as necessary. Report any changes to the nurse.	F 677	2. All residents have the potential to be impacted by the alleged deficient practice. A quality review was conducted by the DCS (Director of Clinical Services)/designee of nails needing cut including both fingers and toes. Those unable to be cut by staff will be referred to the podiatrist. A quality review was conducted by the DCS/ designee of residents receiving/refusing baths. 3. All nursing staff will be re-educated by the DCS/designee related to ADL care including nail care and bathing/showering as indicated. The IDT team will review ADL sheets in the AM clinical meeting to ensure residents are receiving baths/showers as indicated with nail care being provided during baths/showers. A list of those needing podiatry care or fingernail focus will be provided to the social services for follow up. 4. The ED (Executive Director)/DCS/ designee to conduct quality monitoring of 10 residents weekly x 6 weeks to ensure bathing and nail care is completed as indicated. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	

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08/02/22 8:33 a.m., Resident #29's fingernails were observed to long with debris present underneath the nails. Toenails observed to be long and thick.

08/02/22 12:14 p.m., Resident #29's fingernails and toenails remain long and thick.

08/02/22 4:30 p.m., during an end of the day meeting with the Administrator, Director of Nursing (DON), and Regional Director of Clinical Services the issue with Resident #29's nails was reviewed. The Administrator stated they would speak with this resident and see if they would allow the staff to cut their nails.

08/02/22 6:37 p.m., Licensed Practical Nurse (LPN) #3 documented in Resident #29's clinical record "...refused nail clipping at this time to this nurse. np (Nurse Practitioner) and rp (Responsible Party) made aware.

08/03/22 09:31 a.m., LPN #1 stated they attempted to cut the residents nails yesterday, it was difficult, and the resident acted as if it was painful. LPN #1 stated they had scheduled appointments for this resident in regards to their nails.

08/03/22, the facility staff provided the surveyor with copies of appointments that were scheduled for this resident regarding their nails. One appointment was with a dermatology office on August 10 and the other was with podiatry on August 15.

No further information regarding this issue was provided to the survey team prior to the exit conference on 08/03/22.

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2. Resident #68's diagnosis list indicated diagnoses, which included, but not limited to Quadriplegia, Chronic Respiratory Failure, Chronic Combined Systolic and Diastolic Heart Failure, Type 2 Diabetes Mellitus, Chronic Viral Hepatitis B, Chronic Viral Hepatitis C, Obstructive and Reflex Uropathy, Mood Disorder, Major Depressive Disorder, and Anxiety Disorder.

The most recent annual minimum data set (MDS) with an assessment reference date (ARD) of 7/14/22 assigned the resident a brief interview for mental status (BIMS) summary score of 15 out of 15 indicating the resident was cognitively intact. The resident was coded as being totally dependent on staff for bed mobility, dressing, eating, toileting, personal hygiene, and bathing.

Resident #68's current comprehensive person-centered care plan included a focus area stating "(Resident #68) has an ADL (activities of daily living) self-performance deficit r/t (related to) dx (diagnosis) of Functional Quadriplegia, Weakness, Impaired mobility, and contractures" with an intervention stating "Assist with ADL's as needed".

On 8/01/22 at 7:25 pm, surveyor observed Resident #68 lying in bed wearing a hospital gown, covered with clean linens, face was clean and hair was appropriately groomed. The resident stated they very seldom get a shower and their last shower was four days ago.

On 8/02/22 at 1:16 pm, the director of nursing (DON) provided the surveyor with Resident #68's shower/bathing documentation and stated that was all of the resident's documented showers for

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the requested time period of June through July 2022. Surveyor reviewed Resident #68's bathing documentation and according to the resident's "Documentation Survey Report v2" for the months of June 2022 and July 2022, the resident received three partial baths, one bed bath, and two showers from 6/01/22 through 8/01/22 with one documented refusal on 6/23/22. Resident #68 received the following baths/showers from 6/01/22 through 8/01/22:
6/20/22 - partial bath
6/30/22 - bed bath
7/07/22 - partial bath
7/11/22 - shower
7/14/22 - partial bath
7/25/22 - shower

On 8/02/22 at 4:32 pm, the survey team met with the Administrator, DON, and the Regional Director of Clinical Services and discussed of concern of Resident #68's showers/bathing.

On 8/03/22 at 9:36 am, surveyor spoke with the DON who stated Resident #68 was offered a shower last night but refused stating they just wanted back on their Wednesday/Saturday shower schedule. The DON provided a copy of a social services progress note date 8/02/22 at 6:03 pm which stated in part "Spoke to resident about (his/her) shower preferences and (he/she) would like for (his/her) shower days to stay the same Wed/Sat. (He/She) has requested that (he/she) get on the stretcher and go to the shower room on those days".

Surveyor requested and received the facility policy entitled "Bathing/Showering" which read in part "Assistance with showering and bathing will be provided at least twice a week and PRN (as

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F 677	Continued From page 5 needed) to cleanse and refresh the resident". No further information regarding this concern was presented to the survey team prior to the exit conference on 8/03/22.	F 677		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and clinical record review, the facility staff failed to ensure 1 of 18 residents, Resident #28 were free of accident hazards. Resident #28 did not have their physician ordered wanderguard or chair alarm in place. The findings included: Resident #28's diagnoses included, but were not limited to, Alzheimer's disease, dementia, palliative care, anxiety disorder, and restlessness and agitation. Section C (cognitive patterns) of Resident #28's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 06/11/22 was coded 1/1/3 indicating the resident had problems with long and short term memory	F 689	1. Resident #28 had an elopement risk assessment completed and no longer required the wander guard. An order was written to discontinue it. Additionally the IDT reviewed the resident's plan of care and falls history and determined the chair alarm was no longer indicated. An order was written to discontinue it. 2. All residents have the potential to be impacted by the alleged deficient practice. A quality review was conducted by the DCS (Director of Clinical Services)/designee of residents with wander guards and chair alarms to ensure they are appropriate and in place as ordered. 3. All nursing staff will be re-educated by the DCS/designee related to ensuring safety devices are in place as ordered. The IDT will review 24 hour report in AM meeting to capture any new orders for chair alarms/wander-guards to ensure they are put into place as ordered. The Quality Monitoring Team will audit their assignment and report in AM meeting that safety devices were in place as indicated on their assigned rounds. 4. The ED (Executive Director)/DCS/ designee to conduct quality monitoring of 10 residents weekly x 6 weeks to ensure safety devices are in place as ordered. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	8/24/2022

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and was severely impaired in cognitive skills for daily decision making. Section G (functional status) was coded to indicate the resident required extensive assist of 2 people (3/2) for transfers and used a wheelchair for mobility. Section O (restraints/alarms) was coded to indicate the resident used bed and chair alarms. Wander/elopement alarm was not coded as being used.

Resident #28's comprehensive care plan included the focus area at risk for falls. Interventions included, but were not limited to chair alarm.

Resident #28's physician orders included orders for chair alarm every shift (06/08/22) and wanderguard every shift (06/14/22).

A review of the residents treatment administration records revealed that Licensed Practical Nurse (LPN) #1 staff had signed that the wanderguard and chair alarm were in place 08/02/22.

08/02/22 10:30 a.m., hospice staff in room working with resident checked for placement of wanderguard with LPN #1 unable to locate.

08/02/22 10:43 a.m., the Director of Nursing (DON) made aware that wanderguard was not in place.

08/02/22 11:33 a.m., Resident #28 observed up in wheelchair in dining area. DON was unable to locate a chair alarm. LPN #1 stated the hospice employee had gotten Resident #28 up this am.

08/02/22 3:00 p.m., LPN #1 stated they had not worked since Friday and thought they had saw the wanderguard on the residents left wrist.

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F 689	Continued From page 7 08/02/22 3:10 p.m., the DON provided the surveyor with a copy of a fall risk assessment with an effective date of 08/01/22 the score was documented at 75/high risk. The DON also provided the surveyor with a copy of a progress note documented 08/02/22 that read, "...elopement risk assessment completed this shift, patient is not wandering or exit seeking at this time, new order received from np (nurse practitioner) to remove wander guard." 08/02/22 4:30 p.m., during an end of the day meeting with the Administrator, DON, and Regional Director of Clinical Services. The issues regarding Resident #28's wanderguard and chair alarm not being in place was reviewed. No further information regarding these issues were provided to the survey team prior to the exit conference on 08/03/22.	F 689		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its	F 757	1. Resident #45 was reviewed by the medical team with no new orders. 2. All residents prescribed medications with parameters are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the DCS (Director of Clinical Services)/designee of medications with parameters to ensure they are being provided as ordered.	8/24/2022

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F 757	Continued From page 8 use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure 1 of 18 residents in the survey sample was free of unnecessary medication, Resident #45. For Resident #45, the facility staff administered Metoprolol Tartrate, a medication used to treat high blood pressure, on four separate occasions when it should have been held. The findings included: Resident #45's diagnosis list indicated diagnoses, which included, but not limited to Cerebral Palsy, Cerebral Infarction, Tachycardia, Essential Hypertension, Generalized Idiopathic Epilepsy, and Adult Failure to Thrive. The most recent quarterly minimum data set (MDS) with an assessment reference date (ARD) of 6/29/22 coded the resident as being severely impaired in cognitive skills for daily decision making with short-term and long-term memory problems. Resident #45 was coded as being rarely/never understood. Resident #45's current comprehensive	F 757	3. All licensed nurses will be re-educated by the DCS/designee related to administering medications as ordered and adhering to parameters as ordered. The IDT will review those with medication parameters weekly to ensure medications are being provided as ordered and documentation is made accordingly. 4. The ED (Executive Director)/DCS/ designee to conduct quality monitoring of 5 residents weekly x 6 weeks to ensure medications are provided as indicated. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement Committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services) / designee.	

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person-centered care plan included a focus area stating "(Resident #45) is at risk for altered cardiovascular status r/t (related to) HTN (hypertension) and tachycardia" with an intervention stating "Medication per MD orders - See MAR (medication administration record)".

Resident #45's current physician's orders included an order dated 3/14/22 for Metoprolol Tartrate 25 mg two times a day, hold for heart rate below 60 or systolic blood pressure below 110 mmHg.

According to Resident #45's July 2022 MAR, the resident received Metoprolol Tartrate 25 mg when it should have been held on the following occasions:
7/02/22 5:00 pm - blood pressure was 108/54
7/04/22 9:00 am - heart rate was 55
7/13/22 9:00 am - blood pressure was 104/68
7/13/22 5:00 pm - blood pressure was 104/68

Each of the aforementioned Metoprolol Tartrate administrations were documented as being administered by the same nurse identified only by their initials on the July 2022 MAR. On 8/03/22 at 9:36 am, surveyor spoke with the director of nursing (DON) and requested to speak with nurse who administered the medication in error, however, the identity of the nurse was not provided to the surveyor prior to the exit conference on 8/03/22.

Surveyor requested and received the facility policy entitled "Administering Medications" which read in part "4. Medications are administered in accordance with prescriber orders ..."

On 8/03/22 at 11:53 am, the survey team met

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F 757	Continued From page 10 with the Administrator, DON, Regional Director of Clinical Services, and the Vice President of Operations and discussed the concern of Resident #45 receiving Metoprolol Tartrate on four separate occasions when it should have been held. No further information regarding this concern was presented to the survey team prior to the exit conference on 8/03/22.	F 757		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident	F 842	1. Resident #286's medical record was reviewed and a clarification note on the status of his dialysis port was made. Resident #84 no longer resides in the facility. 2. All residents on dialysis case load and those discharged are at risk to be impacted by the alleged deficient practice. A quality review was conducted by the DCS (Director of Clinical Services)/designee of residents on dialysis and their medical record for accuracy of documentation. A quality review was conducted by the SSD of residents discharged from the facility from 8/1/2022 to ensure inventory sheets are completed in their entirety.	8/24/2022

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 11 representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.	F 842	3. All Licensed nurses will be re-educated by the DCS/designee related to accuracy of medical records and completion of inventory sheets upon discharge. The IDT will review 24 hour documentation, orders and notes in AM meeting to ensure dialysis resident's medical record documentation is accurate. The IDT will review newly discharged records in AM meeting to ensure inventory sheet is completed accurately. 4. The ED (Executive Director)/DCS/ designee to conduct quality monitoring of dialysis residents to ensure access orders are accurate and match the type of dialysis access the resident has in place, and discharged residents' medical records to ensure inventory sheet documentation is signed and accurate weekly x 6 weeks. The findings of these quality monitoring's to be reported to the Quality Assurance/Performance Improvement committee monthly. Quality Monitoring schedule modified based on findings with quarterly monitoring by the RDCS (Regional Director of Clinical Services)/designee.	

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	495325	A. BUILDING _____ B. WING _____	C 08/03/2022

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This REQUIREMENT is not met as evidenced by:
Based on staff interview, Resident interview and clinical record review the facility staff failed to ensure a complete and accurate clinical record for 2 of 18 residents, Resident #286 and Resident #84.

1. For Resident #286, the facility staff documented that the resident has an arteriovenous (A-V) shunt for hemodialysis, when they do not. An A-V shunt is a connection, made by a surgeon, of a vein to an artery, in order to deliver hemodialysis treatments.

2. For Resident #84, the facility staff failed to follow their policy in regards to obtaining a signature on the inventory sheet upon discharge.

The findings included:

1. Resident #286's face sheet listed diagnoses which included but not limited to metabolic encephalopathy, cirrhosis of liver, end stage renal disease, and dependence on renal dialysis.

Resident #286 is a new admission and the minimum data set had not yet been completed, however the resident is alert and oriented to person, place, time and situation.

Resident #286's baseline care plan was reviewed and indicated that the resident received hemodialysis.

Surveyor spoke with Resident #286 on 08/02/22 at 8:30 am. Resident was resting in bed, alert and oriented. Surveyor spoke with resident about their dialysis treatments. Surveyor asked resident if

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they had an A-V shunt, and resident stated they do not, and pulled front of top down to show surveyor dialysis port, located on right side of upper chest. Resident also stated they thought they would be needing to get an A-V shunt in the future.

Resident #286's physician's order summary for the month of July 2022 were reviewed and contained an order, which read in part "Check AV shunt each shift assess for bruit and thrill every shift for monitoring". This order has a start date of 07/28/22.

Resident #286's treatment administration record for the month of July 2022 was reviewed and contained an entry, which read in part "Check AV shunt each shift assess for bruit and thrill every shift for monitoring". This entry was initialed as being completed from start date until 08/02/22.

Surveyor spoke with director of nursing (DON) on 08/02/22 at 11:45 am regarding Resident #286. DON stated that resident does not have an A-V shut, but has a port-a-cath for dialysis access. A port-a-cath is a device implanted under the skin, used to deliver treatments, blood transfusions and draw blood.

The concern of the inaccurate record was discussed with the administrator, regional nurse consultant and DON during an end of day meeting on 08/02/22 at 4:30 pm.

On 08/03/22 at 10 am the DON provided surveyor with an in-service training entitled "General Nursing Issues". This training read in part "Make sure you are documenting accurately when reviewing your orders from the MARS/TARS

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(medication administration records/treatment administration records). Make sure when putting in orders for portacaths, fistula's, permacath, etc., we are correctly identifying correctly what access we are dealing with to ensure we are putting in the appropriate orders. Falsifying documentation is very serious".

No further information was provided prior to exit.
2. Resident #84 was discharged to a local hospital in September 2021.

Diagnoses included, but were not limited to, progressive vascular leukoencephalopathy, unspecified dementia, muscle weakness, and cognitive communication deficit.

Section C (cognitive patterns) of Resident #84's admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 09/23/21 was 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.

08/02/22 8:42 a.m., the Director of Nursing (DON) was asked for information in regards to an allegation of missing items for Resident #84.

08/02/22, the DON provided the surveyor with a copy of Resident #84's inventory sheet completed on admit.

The facility staff were unable to provide the surveyor with Resident #84's discharge inventory document.

The facility staff provided the surveyor with a copy of their policy titled, Personal items Inventory"

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F 842	Continued From page 15 with an effective date of 11/30/2014. This policy read in part, "...Resident or Responsible Party will again sign the inventory at discharge to acknowledge receipt of personal property." No further information regarding this issue was provided to the survey team prior to the exit conference.	F 842		