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	11/21/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)

F 0573

Level of Harm - Minimal harm or potential for actual harm

Residents Affected - Few

Let each resident or the resident's legal representative access or purchase copies of all the resident's records.

NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY Based on interviews, clinical record review, and facility document review, the facility staff failed to respond to a request for a copy of clinical documentation in the required time frame for one (1) of nine (9) sampled residents (Resident #9).

The findings include:

It took the facility greater than two (2) working days to respond to a request for copies of Resident #9's clinical record by the Resident Representative (RR). Resident #9 had expired while a resident at the facility. This request for the clinical records was declined due to the need for supporting documentation indicating authority to access records on the resident's behalf.

Resident #9's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], was signed as completed on [DATE]. Resident #9 was assessed as able to make self understood and as able to understand others. Resident #9's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact or borderline cognition.

Resident #9's clinical record included a document that indicated the RR who requested the clinical records was Resident #9's Power of Attorney (POA) (Financial). The following information was found in Resident #9's Durable General Power of Attorney: My attorney is authorized to act for me as follows . To request, receive and review any information, verbal or written, regarding my physical or mental health, including but not limited to, medical and hospital records, and to consent to the disclosure of this information.

Facility documentation indicated the RR requested Resident #9's clinical record on [DATE]. Facility documentation indicated that the facility sent the request to their legal department on [DATE]. A letter, addressed to the RR, dated [DATE] stated: Your request has been denied because the request appears to be incomplete as it is missing the supporting documentation indicating authority to access records on the resident's behalf.

The Administrator sent the RR an email dated [DATE]. This email indicated the medical record request was denied due to proof of authority not being provided with the request. This email stated proof of authority typically would be death certificate and a copy of your ID.

The following information was found in a facility document titled Request for Medical Records / Release of Information (with a revision date of [DATE]):

(continued on next page)

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.

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

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	11/21/2024

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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F 0573 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- The information contained in a resident's medical record is confidential. Content will be released only to authorized individuals in accordance with state and federal law. The Company shall maintain legal compliance with record production requirements by adhering to all state or federal statutes or regulations related to an individual's right to access their medical record. - Personal Representative: Someone authorized under State or other applicable law to act on behalf of the individual in making health care related decisions. The Personal Representative stands in the shoes of the individual and has the ability to act for the individual and exercise the individual's rights.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
NAME OF PROVIDER OR SUPPLIER: Pheasant Ridge Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 4355 Pheasant Ridge Road, SW Roanoke, VA 24014	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 2. For Resident #8, facility staff failed to notify the resident's provider after the resident experienced a significant weight loss. Resident #8's medical diagnoses included but were not limited to noninfective gastroenteritis and colitis (inflammation of stomach, intestines, and colon), celiac disease (immune reaction to eating gluten), ulcerative pancolitis (inflammatory bowel disease effecting entire bowel), neuromuscular dysfunction of the bladder, and type 2 diabetes mellitus. Resident #8's minimum data set with an assessment reference date of 04/16/24 assigned a brief interview for mental status summary score of 12 out of 15 in Section C (cognitive patterns) indicating moderately impaired cognition. In Section GG (Functional Abilities and Goals) the resident was coded as a 06 under Eating - Resident completes the activity by him/herself with no assistance from helper. Resident #8's clinical record was reviewed for weights. The resident's weights were documented as: 04/10/24 = 158.8 lbs (mechanical lift) 04/11/24 = 161.2 lbs (mechanical lift) 04/12/24 = 159.8 lbs (mechanical lift) 04/13/24 = 161.0 lbs (mechanical lift) 06/04/24 = *139.2 lbs (sitting) - * indicated significant weight loss. There were no weights documented between 04/13/24 and 06/04/24. 06/11/24 = 139.4 lbs (sitting) 07/05/24 = 139.2 lbs (mechanical lift) last weight documented on 08/30/24 = 138.8 lbs (mechanical lift). The surveyor was unable to find evidence in Resident #8's clinical record the provider was notified of the weight loss documented on 06/04/24. The medical director (MD) was interviewed in person on 11/19/24 at noon. Although the doctor had a vague recollection of Resident #8, he felt the resident was seen by nurse practitioners (NPs) mostly. The MD recalled the resident had gastrointestinal issues and there was a concern about weight loss and acknowledged he was unable to recall details. The NP who documented Resident #8's condition the most often no longer worked at the facility therefore was unavailable for interview. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER Pheasant Ridge Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE 4355 Pheasant Ridge Road, SW Roanoke, VA 24014	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	When asked on 11/19/24 at 4:45 p.m., the director of nursing (DON) reported the only note found regarding Resident #8's weight loss was the registered dietician's progress note dated 07/02/24. The DON acknowledged there was no documentation found on or about the date of 06/04/24 (when Resident #8's weight showed a significant weight loss); the DON found no documentation a provider was consulted or notified of the weight loss. On 11/20/24 at 1:55 p.m., the DON was asked whether any other evidence was found regarding Resident #8's provider being notified of the significant weight loss, the DON stated, I gave you everything I found yesterday. The dietician progress note provided by the DON was dated 07/02/24 at 2:53 p.m. read in part, Resident's chart reviewed for weight change trigger. Height: 61 in Weight: 139.4 lb (6/11/24) BMI: 26.3 kg/m^2 - normal Per available weight records, resident w/ ~22 lb (13.4%) weight loss x 2 months (4/13/24-6/11/24) - considered nutritionally significant The policy and procedure with the subject of Notification of Change in Condition with a document name of N-105 with an effective date of 11/30/14 and revision date of 12/16/2020 was reviewed. The policy in part read, POLICY: The Center to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. PROCEDURE: • The nurse to notify the attending physician and Resident Representative when there is a(n): . • Significant change in the patient/resident's physical, mental, or psychosocial status • Document notification in the medical record. • Document resident/patient change in condition on 24 Hour Report • Complete SBAR as indicated (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During a meeting with the administrator, DON, and quality director on 11/21/24 at 12:40 p.m., Resident #8's weight loss and lack of evidence the provider was notified was discussed. The DON stated a significant weight loss would fall under the notification of change in condition policy. No further information was provided prior to the exit conference. Based on interviews, clinical record review, and facility document review, the facility staff failed to ensure a medical provider and/or a resident representative were promptly notified of a change in condition for two (2) of nine (9) sampled residents (Resident #8 and Resident #9). 1. The facility staff failed to promptly notify Resident #9's resident representative when the resident experienced a decline/change in condition. Resident #9's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/13/24, was signed as completed on 10/22/24. Resident #9 was assessed as able to make self understood and as able to understand others. Resident #9's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact or borderline cognition. The following information was found in a facility document titled Notification of Change in Condition (with a revision date of 12/16/20): - The Center [sic] to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. - The nurse [sic] to notify the attending physician and Resident Representative when there is a(n): . Significant change in the patient/resident's physical, mental, or psychosocial status . - In the event of an emergency situation, 911 [sic] to be called and the attending physician and the Resident Representative [sic] to be notified as soon as possible. - Document notification in the medical record. On 10/21/24 at 8:52 p.m., Resident #9's assessment was documented as Level of consciousness noted as oriented to person. Skin is warm dry [sic]. Swallowing problems are not noted. Mood is pleasant. On 10/22/24 at 9:25 a.m., Resident #9 was documented as having increased somnolence. Resident #9's nursing progress note included the following information: Patient with increased somnolence. This nurse asked patient if he would like medication patient states yes. Took medication in room and patient states, I don't want that just leave me alone. Nurse practitioner (name omitted) notified of refusal, behaviors, and increased somnolence. (continued on next page)

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F 0580 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/22/24 at 9:33 a.m., Resident #9 was documented to have experienced additional changes in his condition. Resident #9 was documented as being lethargic, having clammy skin, and having swallowing problems. Resident #9's nursing note included the following information: Level of consciousness noted as oriented to person lethargic. Skin is clammy. Swallowing problems are loss of liquids or solids from mouth when eating or drinking. Mood status is negative statements poor appetite sluggish . Respiratory status is shallow respiration . Lung sounds are wheezes no cough noted. Oxygen is not in use. This note did not document a medical provider notification of the additional changes in Resident #9's assessment from the previous assessment documented at 9:25 a.m. No documentation was found by or provided to the surveyor to indicate Resident #9's Resident Representative had been notified of the resident being somnolent and lethargic. On 10/22/24 at 11:45 a.m., Resident #9's progress note included the following information: This nurse and (nurse practitioner name omitted) went into patients' room for assessment. NP states to Narcan patient just in case somnolence caused by morphine and narcotic. NP notified by this nurse that patient had not received morning dose of morphine or oxycodone. (Nurse practitioner name omitted) administered Narcan dose x2 with No [sic] change noted to patient. [NAME] stoke breathing observed by this nurse and (nurse practitioner name omitted). order to apply oxygen for comfort per NP. Patient's son (name omitted) called by this nurse and patient's son states, I want to talk to a supervisor and a doctor. Informed (nurse practitioner name omitted) son would like to talk to her and (first name omitted) DON. Patients' son spoke with NP and DON. This Resident Representative notification occurred greater than two (2) hours after Resident #9 was assessed as: (a) having increased somnolence, (b) being lethargic, (c) having clammy skin, (d) having swallowing problems, and (e) having shallow respirations with wheezes. On 11/21/24 at 12:40 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Quality Assurance Nurse (QAN). During this meeting, the delay in notifying Resident #9's Resident Representative of the aforementioned changes in condition was discussed.

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide doctor's orders for the resident's immediate care at the time the resident was admitted. Based on interviews, clinical record review, and facility document review, the facility staff failed to ensure one (1) of the medications ordered to be continued after hospital discharge was promptly ordered when admitted to the facility for one (1) of nine (9) sampled residents (Resident #9). The findings include: One (1) of Resident #9's medications ordered to be continued when the resident was discharged from the hospital was not ordered until Resident #9's second day at the facility. This medication was Prednisone. This resulted in the resident missing a day's dose of the medication. No documentation was found by or provided to the surveyor to address why this medication had not been ordered with Resident #9's admission medication orders. Resident #9's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/13/24, was signed as completed on 10/22/24. Resident #9 was assessed as able to make self understood and as able to understand others. Resident #9's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact or borderline cognition. The following information was found in a facility document titled Physician Orders (with a revision date of 3/3/21): - The center will ensure that Physician orders are appropriately and timely documented in the medical record. - admission ORDERS: Information received from the referring facility or agency [sic] to be reviewed, verified with the physician and transcribed to the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that the physician sign and date the order during, or as soon as practicable after it is provided, to maintain an accurate medical record. Resident #9's General Medicine Discharge Summary included a list of medications for the resident to start taking after discharge from the hospital. This list included Prednisone 5mg tablets to be given for 'ulcerative pancolitis with other complication.' This medication was ordered on a taper schedule with eight (8) tablets being administered the first three (3) days followed by seven (7) tablets being administered the next seven (7) days. The Discharge Summary indicated Resident #9 had received eight (8) Prednisone 5mg tablets the day before they were discharged and had received eight (8) prednisone 5mg tablets on the day the resident was discharged to this facility. This indicated Resident #9 was to receive the third and final dose of eight (8) tablets of Prednisone 5mg on their second day at the facility; Resident #9 did not receive this dose. Resident #9's clinical documentation included an order for the eight (8) tablets of Prednisone. This order was written on the second day of the resident's stay to be started on the third day of the resident's stay at the facility. The Medical Director was interviewed on 11/19/24 at 11:55 a.m. The Medical Director confirmed Resident #9 did not receive Prednisone on the second day of their stay at the facility. The Medical Director reported the prescriber may have decided to restart the prednisone taper order. (continued on next page)

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F 0635 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 11/21/24 at 12:40 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Quality Assurance Nurse (QAN). During this meeting, the delay in starting Resident #9's prednisone at the time of admission was discussed.

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted Based on staff interview, record review and facility document review, the facility staff failed to develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care for three of nine residents in the survey sample, residents #1, #7 and #9. The findings included: 1. For resident #1 (R1) the facility staff failed to develop and implement a baseline care plan. R1's diagnoses included but were not limited to sepsis, diabetes, sleep apnea, generalized anxiety disorder, major depressive disorder, dementia, peripheral vascular disease, and COVID-19. The minimum data set (MDS) assessment with an assessment reference date of 10/16/24 assigned the resident a brief interview for mental status score of 3 out of 15 indicating severe cognitive impairment. Further review of the MDS revealed resident was incontinent of bladder, had a colostomy, was being treated for pressure ulcers and surgical wounds, and was on isolation during the lookback period. This surveyor was unable to locate a baseline care plan in the clinical record. The Director of Nursing (DON) was asked on 1/19/24 at 9:30 AM. They stated, They are done on paper and kept by the unit managers in binders. I will get them for you. On 11/20/24 at 9:05 AM this surveyor asked the DON for the baseline care plan for R7. They stated, We're still looking. On 11/21/24 at 12:40 PM the survey team met with the Administrator, DON, and the Quality Assurance Nurse. This surveyor asked if a baseline care plan had been located for R7. The DON stated, No, we don't have one. This surveyor requested and received the policy entitled, Plans of Care with a revision date of 9/25/2017. The document read in part, Develop and implement an individualized person-centered baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendations if applicable, and other areas needed to provide effective care of the residents that meets professional standards of care to ensure that the resident's needs are met appropriately until the comprehensive plan of care is provided. A blank copy of the baseline care plan the facility uses was provided as well. No further information was provided prior to the exit conference. 2. For resident #7 (R7) the facility failed to develop and implement a baseline care plan. R7's diagnoses included but were not limited to schizophrenia, major depressive disorder, diabetes, COVID 19, hypertension and colon cancer. (continued on next page)

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The minimum data set (MDS) assessment with an assessment reference date of 9/6/24 assigned the resident a brief interview for mental status (BIMS) score of 15 out of 15 indicating intact cognition. The MDS revealed that R7 was at risk for pressure ulcers, and had a surgical wound requiring the use of dressings and topical medications. R7 had pain frequently during the lookback period that limited day to day activities, and was taking opioid medication as well as antipsychotics, antidepressants, and diuretics. During review of the clinical record, this surveyor was unable to locate a baseline care plan. The Director of Nursing (DON) was asked on 1/19/24 at 9:30 AM. They stated, They are done on paper and kept by the unit managers in binders. I will get them for you. On 11/20/24 at 9:05 AM this surveyor asked the DON for the baseline care plan for R7. They stated, We're still looking. On 11/21/24 at 12:40 PM the survey team met with the Administrator, DON, and the Quality Assurance Nurse. This surveyor asked if a baseline care plan had been located for R7. The DON stated, No, we don't have one. This surveyor requested and received the policy entitled, Plans of Care with a revision date of 9/25/2017. The document read in part, Develop and implement an individualized person-centered baseline plan of care within 48 hours of admission that includes, but not limited to, initial goals based on the admission orders, physician orders, dietary orders, therapy services, social services, PASARR recommendations if applicable, and other areas needed to provide effective care of the residents that meets professional standards of care to ensure that the resident's needs are met appropriately until the comprehensive plan of care is provided. A blank copy of the baseline care plan the facility uses was provided as well. No further information was provided prior to the exit conference. 3. For Resident #9 the facility staff failed to develop and implement a baseline care plan. Resident #9's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/13/24, was signed as completed on 10/22/24. Resident #9 was assessed as able to make self understood and as able to understand others. Resident #9's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact or borderline cognition. This surveyor was unable to locate a baseline care plan in Resident #9's clinical record. On 11/21/24 at 12:40 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Quality Assurance Nurse (QAN). During this meeting, this surveyor asked for Resident #9's baseline care plan. On 11/21/24 at 3:55 p.m., the DON reported a baseline care plan for Resident #9 was unable to be found.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. Based on staff interview, clinical record review and facility document review, the facility staff failed to develop and implement a comprehensive person centered care plan for one of nine residents in the survey sample, resident #2. The findings included: For resident #2 (R2) the facility staff failed to develop and implement a comprehensive person centered care plan. R2's diagnoses included but were not limited to right hip fracture with surgical repair, unspecified protein calorie malnutrition, diabetes, chronic kidney disease, anemia, breast cancer and hypertension. The minimum data set (MDS) assessment with an assessment reference date of 10/3/24 assigned the resident a brief interview for mental status score of 13 out of 15 indicating mild cognitive impairment. The review of the MDS revealed that R2 was frequently incontinent of bowel and bladder, had occasional pain rated at 10/10 on the pain scale that interfered with sleep, therapy and day to day activities, received insulin injections, was at risk for pressure ulcers, had a surgical wound and was getting speech, occupational and physical therapy services. The MDS was signed as complete on 10/4/24. The Care Area Assessment (CAA) worksheets were reviewed and indicated that R2 would have care plans to address vision, communication, functional abilities (self-care and mobility), urinary incontinence, falls, pressure ulcer/injury and pain. The care plan was reviewed and included focuses for COVID- 19, activities, discharge plan, nutrition and do not resuscitate orders. No other care plans were observed in the record. On 11/18/24 at 5:15 PM this surveyor asked the Director of Nursing (DON) for R2's comprehensive care plan. They stated they would look for it. On 11/19/24 at 2:45 PM during a team meeting with the DON, Administrator and Quality Assurance Nurse this surveyor brought up this concern and asked if a comprehensive care plan had been located. The DON stated, There has been a miscommunication about who is responsible for writing the care plan. What is in the record is all we have. Going forward, the MDS Coordinator will be responsible. The surveyor requested and received the policy entitled, Plans of Care with a revision date of 9/25/2017. The document read in part, An individualized person-centered plan of care will be established by the interdisciplinary team (IDT) with the resident and/or resident representative(s) to the extent practicable and updated in accordance with state and federal regulatory requirements. Under the head Procedure the document read in part, Develop a comprehensive plan of care for each resident that includes measurable objectives and timetables to meet the resident's medical, nursing, mental and psychosocial needs that are identified in the comprehensive assessment. No further information was provided to the survey team prior to the exit conference.

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record review, and facility document review, the facility staff failed to appropriately respond to a decline/change in condition (lethargy, oriented to person only, clammy skin, Cheyne-Stokes labored irregular breathing) for one 1 of nine 9 sampled residents (Resident #9), resulting in death. The scope and severity was originally cited at Immediate Jeopardy, Level IV isolated, and was reduced to a Level III isolated after the facility was cleared of Immediate Jeopardy. The Administrator, Director of Nursing (DON), and Quality Assurance (QA) Nurse were notified on [DATE] at 1:45 p.m. that the survey team had identified Immediate Jeopardy in the area of Quality of Care. Upon verification of the removal plan, the Immediate Jeopardy was cleared on [DATE] at 2:45 p.m. The findings include: The facility staff failed to appropriately provide emergency care and timely transportation services, which aligned with the Resident #9's documented preferences, following a sudden decline in condition that subsequently resulted in the resident's death. Resident #9's decline was first documented on [DATE] at 9:25 am. Resident #9 died approximately 4 hours later, at 1:30 pm. Resident #9's clinical documentation included a DNR (Do Not Resuscitate order). Resident #9's clinical documentation did not contain information to indicate that the resident had requested additional limits for care other than the DNR order. Resident #9's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], was signed as completed on [DATE]. Resident #9 was assessed as being able to be understood and as able to understand others. Resident #9's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact cognition. Resident #9's diagnosis included Coronary Artery Disease, Hypertension, and Paroxysmal Atrial Fibrillation (intermittent irregular heartbeat). A nurse's progress note dated [DATE] at 9:25 a.m., documented that Resident #9 experienced a decline in condition. Resident #9 was documented as having increased somnolence (drowsiness), and refusing his medications. Resident #9's nurse documented that she notified the nurse practitioner (NP) of this change in condition. A nurse's progress note dated [DATE] at 9:33 a.m., documented Resident #9 as being lethargic, oriented to person, clammy skin, and having swallowing problems of loss of liquids or solids from mouth when eating or drinking. No documentation was found to indicate the resident's blood sugar level had been checked. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024

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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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	A nurse's progress note dated [DATE] at 11:45 a.m., documented interventions and additional changes in Resident #9's condition. This note indicated that the nurse practitioner (NP) administered two doses of Narcan (an opioid antagonist used to treat a known or potential opioid overdose) to Resident #9. The Narcan did not result in an improvement in the resident's condition; the nurse informed the NP that the resident refused his morning opioid medications. Resident #9 was documented as having labored, irregular breathing (Cheyne-Stokes respirations). This note indicated oxygen was applied for comfort by the NP; the amount of oxygen and the device used to deliver the oxygen was not documented. (During an interview, Licensed Practical Nurse (LPN) #2 reported that the NP applied a nasal cannula with, she thought, two (2) liters of oxygen.) Resident #9's son was notified of the change in condition. Resident #9's son requested to speak with the nurse practitioner and the Director of Nursing. On [DATE] at 2:27 p.m., the Director of Nursing (DON) provided the surveyor with an unsigned, draft copy of a nurse practitioner progress note for Resident #9 with a date of service of [DATE]. This draft copy included the following information: Altered level of consciousness: Patient was found unresponsive to voice command and tactile stimuli, including sternum rub . Physical examination revealed no JVD distention (bulging neck veins), clear lungs, and non-labored respirations. Despite administration of two doses of Narcan nasal spray, there was no change in the patient's level of consciousness. Plan: Given the patient's DNR status, aggressive interventions were not pursued. The patient's son was informed of the situation, and he declined hospitalization. The patient will continue to be monitored closely for any changes in consciousness or overall condition. DNR supported by son. On [DATE] at 3:20 p.m., the DON provided the surveyor with a copy of the nurse practitioner signed progress note for Resident #9 with a date of service of [DATE]; this note was signed on [DATE] (27 days after the Resident #9's death), at 2:42 p.m. This signed progress note included the following wording difference related to the nurse practitioners plan when compared to the aforementioned unsigned, draft version: The patient's son was informed of the situation, and he declined hospitalization and confirmed the DNR. On [DATE] at approximately 4:00 p.m., the nurse practitioner, who cared for Resident #9 on the day he died, reported they had talked with the residents' family, and the family was okay with the resident not being sent to the hospital. On [DATE] via a telephone interview, the nurse practitioner reported, early in Resident #9's stay at the facility, the resident had said he was ready to die but the nurse practitioner did not recall him making additional statements about not wanting to go to the hospital or limiting care/treatment. Resident #9's son was interviewed via telephone on [DATE] at 3:35 p.m. Resident #9's son was the only name (other than the resident's) listed under the contact section of Resident 9's clinical record. Resident #9's son reported he was called at 12:15 p.m., on the day his father died, by a nurse asking about a choice of mortuary due to his father was dying. Resident #9 stated he asked to speak with the attending physician. Resident #9's son stated the nurse practitioner called him back at 12:20 p.m. Resident #9's son reported the nurse practitioner discussed the resident's DNR and wanted to keep the resident at the facility. Resident #9's son said he did not agree to keep his father at the facility. Resident #9's son stated he heard the nurse practitioner tell someone to get the resident ready to send to the hospital. Resident #9's son reported he hung up with the nurse practitioner then called the facility back approximately 2 minutes later to confirm his request for Resident #9 to be sent to the hospital. (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495325	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 11/21/2024
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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Licensed Practical Nurse (LPN) #2 confirmed she had initially telephoned Resident #9's son on [DATE]. LPN #2 stated the son requested to speak to someone else. LPN #2 reported they heard the nurse practitioner speaking to Resident #9's son via the telephone. LPN #2 stated the nurse practitioner informed Resident #9's son that the resident wasn't doing well and stated the family should come in. LPN #2 stated they heard the nurse practitioner tell Resident #9's son the resident could be sent to the hospital. LPN #2 stated their understanding was Resident #9's son was okay with the resident remaining at the facility. LPN #2 stated she was not informed to prepare the resident for transport to the hospital by the nurse practitioner. LPN #2 reported Resident #9's son called the facility back after his telephone conversation with the NP. LPN #2 reported the son requested Resident #9 to be sent to the hospital. LPN #2 stated they notified the Medical Director of the son requesting to send Resident #9 to the hospital prior to LPN #2 and the Medical Director entering the room to assess Resident #9. The following nurse's note, dated [DATE] at 12:25 p.m., was documented by LPN #2: This nurse and (physician name omitted) entered room for new assessment of patient. (Physician name omitted) auscultated and assessed patient head to toe. Patient with continued [NAME] stoke breathing observed and cold to touch. Patient does not arouse to verbal stimuli at this time. Unable to obtain vital signs at this time. (Physician name omitted) called and left voicemail for son (Resident #9's son's name omitted). There is no Medical Director documentation of this interaction with Resident #9. During an interview on [DATE] at 11:55 a.m., the Medical Director reported that he had been notified by someone that Resident #9 had stated to a nurse that he was ready to die and did not want aggressive interventions. The Medical Director reported he attempted to contact Resident #9's son but was unsuccessful. The Medical Director stated he consulted with the Director of Nursing (DON) and another physician related to Resident #9's alleged request for no aggressive treatment. The Medical Director reported they were in the process of sending Resident #9 to the hospital when the resident died. A Medical Director progress note for Resident #9, with a service date of [DATE], was neither found by nor provided to the surveyor. The physician was unable to provide documentation to indicate the resident had made specific requests related to limiting treatment. Resident #9's chart only contained the DNR order. No documentation was found by or provided to the survey team to indicate the resident had requested to not be sent to the hospital. Resident #9's clinical record included a nursing progress note entered on [DATE] at 1:31 p.m., this note documented the facility staff pronouncing Resident #9 as being dead with the time of death being 1:30 p.m. No evidence was found that facility staff had made any effort to transport Resident #9 to the hospital, as Resident #9's son had requested. A review was conducted of the Change in Condition policy, with a revision date of [DATE]. An excerpt read: - The Center [sic] to promptly notify the Patient/Resident, the attending physician, and the Resident Representative when there is a change in the status or condition. - The nurse [sic] to notify the attending physician and Resident Representative when there is a(n): . Significant change in the patient/resident's physical, mental, or psychosocial status . - In the event of an emergency situation, 911 [sic] to be called and the attending physician and the Resident Representative [sic] to be notified as soon as possible. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	- Document notification in the medical record. On [DATE] at 12:40 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Quality Assurance (QA) Nurse. During this meeting, the surveyor discussed the failure of the facility staff to ensure that Resident #9 received timely medical care and/or emergency transport to a local hospital/emergency department in response to a decline/change in the resident's condition. After Immediate Jeopardy was called, the facility submitted the following IJ Removal Plan: All current residents will be assessed by a licensed nurse for a potential change in condition which may indicate the need for transport to an Emergency Department or hospital for a higher level of care. If a resident is identified, the physician/practitioner and the resident's representative will be notified and orders for care will be immediately implemented. The facility will educate all licensed nurses on care restrictions designated by a DNR (Do Not Resuscitate order) and the required staff action to ensure that resident preferences for emergency or end of life care or those indicated by their designated responsible party are honored and correctly documented in the resident's medical record. Education will begin [DATE] evening shift and additional staff will be educated prior to providing care at their assigned shifts. Newly hired licensed nurses and medical staff will be educated on DNR and Advance Directives during orientation. The facility will educate the medical staff [physician and nurse practitioners] including on-call providers on the care restrictions designated by a DNR and the required staff action to ensure that all residents' preferences for emergency or end of life care, or those indicated by their designated responsible party are honored and correctly documented. Education will begin [DATE] evening shift and additional staff will be educated prior to providing care at their assigned shifts. Current residents with written Advance Directives will be reviewed and orders will be validated and/or obtained to match the resident's preferences. The facility policy on Advance Directive has been reviewed and approved by the Medical Director. Date of Compliance: [DATE] 12:00 PM On the afternoon of [DATE], the survey team reviewed the documentation of the facility staff' audits of all current residents. These audits were looking for (a) a change in condition which required interventions and (b) an audit of current residents' advanced directive wishes to ensure accurate corresponding clinical documentation. No concerns were identified with these audits. The survey team reviewed the facility's training material related to addressing residents' change in conditions while correctly implementing the residents' documented advanced directives and/or DNR's. The survey team reviewed the documentation of the staff members who had already completed this training. (continued on next page)

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F 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	The survey team interviewed the facility's licensed nurses working on the afternoon of [DATE]. All the licensed nurses that were interviewed had evidence of receiving the aforementioned training. All the licensed nurses were able to appropriately explain what a DNR order requires and doesn't require when providing care for residents. (LPN #2 was interviewed via telephone. LPN #2 provided appropriate answers related to how a DNR order would and would not influence addressing residents' changes in condition.) The survey team interviewed the facility's current medical providers related to the advanced directives verses DNR orders. The medical providers were able to explain what the DNR order requires and the limitations of the DNR orders when addressing residents' changes in condition. Upon verification of the removal plan, the Immediate Jeopardy was cleared on [DATE] at 2:45 p.m.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, resident interview, staff interview, clinical record review and facility document review the facility staff failed to provide necessary respiratory services for 1 of 7 residents, Resident #101. The findings included: The facility staff failed to provide oxygen per the physician's order and failed to transcribe an order for a flutter valve breathing device. Resident #101's face sheet included diagnoses which included but not limited to acute respiratory failure with hypoxia. Resident #101's admission minimum data set had not yet been completed, but an interview revealed that resident was alert and oriented. Resident #101's baseline care plan was reviewed and read in part, Other Services/Orders: O2 2L (liters) @ bedtime. Resident #101's clinical record was reviewed and contained a physician's order summary which read in part, Oxygen at 2 L NC (nasal canula) at bedtime for SOB (shortness of breath). Resident #101's hospital Discharge summary dated [DATE] read in part, . (Resident #101) presented to the hospital with unresponsive episode. She was noted to be hypoxic which is likely the cause of unresponsive episode. She required intubation and was subsequently extubated to nasal cannula .Patient will need to continue use of flutter valve after discharge . Review of physician's order summary revealed no order for flutter valve. A flutter valve is respiratory therapy device used to aid in airway clearance. Surveyor spoke with Resident #101 on 01/15/25 at 8:30 am regarding use of flutter valve. Resident stated they have not had a flutter valve device since leaving the hospital. Surveyor spoke with licensed practical nurse (LPN) #2 on 01/15/25 at 8:35 am regarding Resident #101's flutter valve. LPN #2 stated that resident was not currently using a flutter valve. Surveyor spoke with regional director of clinical services (RDCS) on 01/15/25 at 9:50 am regarding Resident #101's flutter valve and hospital discharge orders. RDCS stated that use of flutter valve was not included in the special orders section of the discharge summary. Surveyor asked RDCS from what part of discharge summary orders were obtained from and RDSC stated discharge summary should be read in full and all orders approved by facility physician and transcribed to the physician's order summary. RDCS stated they have contacted the facility physician, and physician has now ordered an incentive spirometer for Resident #101. Surveyor observed Resident #101's room on 01/15/25 at 12:30 pm. No oxygen concentrator was observed in resident's room. Surveyor asked Resident #101 if they were using oxygen at night, and resident stated, maybe first day or two, but not since. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Surveyor spoke with registered nurse (RN) #2 regarding Resident #101's oxygen order. RN #2 stated resident has not used oxygen since they came from hospital. Review of Resident #101's electronic treatment administration record for the month of January 2025 revealed that facility staff have been initialing oxygen as being administered per physician's order. The concern of not transcribing order for flutter valve and not administering oxygen per the physician's order was discussed with the administrator, RDCS, and quality assurance nurse on 01/15/25 at 1:40 pm. No further information was provided prior to exit.

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure the resident's doctor reviews the resident's care, writes, signs and dates progress notes and orders, at each required visit. Based on interviews, clinical record review, and facility document review, the facility staff failed to ensure medical provider orders were signed by the provider when the orders were entered into the residents' clinical records by non-prescribing facility staff members. The findings include: Review of residents' clinical records revealed multiple orders that had not been signed by the prescribing medical provider. The following information was found in a facility document titled Physician Orders (with a revision date of 3/3/21): - The center will ensure that Physician orders are appropriately and timely documented in the medical record. - admission ORDERS: Information received from the referring facility or agency [sic] to be reviewed, verified with the physician and transcribed to the electronic medical record. The attending physician will review and confirm orders. Confirmation of admission orders requires that the physician sign and date the order during, or as soon as practicable after it is provided, to maintain an accurate medical record. - ROUTINE ORDERS: A Nurse may accept a telephone order from the Physician, Physician Assistant or Nurse Practitioner (as permitted by state law). The order will be repeated back to the physician, PA or ARNP for his/her verbal confirmation. The order is transcribed to all appropriate areas of the electronic health record (eMar/eTAR) [sic] . The ordering physician or physician extender will review and confirm orders. Confirmation of routine orders requires that the physician sign and date the order as soon as practicable after it is provided to maintain an accurate medical record. Review of Resident #9's clinical record revealed multiple medical provider orders which had not been sign by the prescriber who had given the orders. Some of these orders had been given by the Medical Director. On 11/19/24 at 11:55, the surveyor interviewed the Medical Director about the unsigned orders. The Medical Director reported they had been giving resident orders during this calendar year. The Medical Director was unable to provide information about the last time they had signed orders they had given to be entered by the facility staff members. The following orders were not signed by the prescribing providers: - Resident #8's order for barrier cream to the sacrum given by Prescriber #3 on 5/23/24. - Resident #8's order for Mode of Therapy CPAP given by Prescriber #2 on 4/17/24. - Resident #8's order for a regular diet with a dysphagia advanced texture given by Prescriber #1 on 8/28/24. - Resident #7's order for oxycodone (a medication) given by Prescriber #4 on 11/5/24. (continued on next page)

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F 0711 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- Resident #1's order for levofloxacin (a medication) given by Prescriber #1 on 10/9/24. - Resident #9's order for laboratory tests (a urinalysis and a complete blood count) given by Prescriber #4 on 10/18/24. - Resident #9's order for prednisone (a medication) given by Prescriber #1 on 10/10/24. The Director of Nursing (DON) provided the survey team with evidence of being made aware, on 11/14/24, of the facility having unsigned medical provider orders. On 11/21/24 at 2:36 p.m., the DON reported the extent of the unsigned medical provider orders at the facility had yet to be determined.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. Based on interviews, clinical record review, and facility document review, the facility staff failed to ensure a medication administered to Resident #9 (that had been dispensed by the pharmacy for another resident) was replaced to ensure its availability for the intended resident. The findings include: The facility staff failed to ensure medical provider prescribed medications were available to meet residents' needs. The facility staff was unable to identify which resident's Narcan nasal spray was administered to Resident #9 therefore the facility staff was unable to provide evidence the Narcan nasal spray had been replaced to make sure it was available for the intended resident. A nurse's note dated, 10/22/24 at 11:45 a.m., indicated Resident #9 had been administered two doses of Narcan by a nurse practitioner. Resident #9's clinical record did not include orders for Narcan. On the afternoon of 11/18/24, Licensed Practical Nurse (LPN) #2 reported the nurse practitioner wanted Narcan nasal spray and the as-needed medication stock only had injectable Narcan. LPN #2 reported the Narcan nasal spray was obtained and administered by the nurse practitioner. LPN #2 was unable to name the resident whose Narcan nasal spray had been used for Resident #9. The survey team met with the facility's Administrator, Director of Nursing (DON), and Quality Assurance Nurse (QAN) on 11/21/24 at 12:00 noon. The DON reported they were unable to identify which resident's Narcan nasal spray had been administered to Resident #9. The DON reported the nurse practitioner (NP) who had administered the Narcan nasal spray had come to a nurse, who was administering medications, and the NP obtained the Narcan nasal spray from the medication cart themselves. The DON confirmed that Narcan nasal spray was not kept as part of the as-needed medications therefore it would have been dispensed for a specific resident (not Resident #9). The DON confirmed that injectable Narcan was kept as part of the as-needed medications at the facility. On 11/21/24 at 12:40 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Quality Assurance Nurse (QAN). During this meeting, the surveyor discussed the absence of documentation to indicate the pharmacy was notified of Narcan nasal spray dispensed for one resident (an unknown resident) was administered to Resident #9 by a nurse practitioner.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interviews, clinical record review, and facility document review, the facility staff failed to maintain complete and/or accurate clinical records for one (1) of nine (9) sampled residents (Resident #9). The findings include: The facility staff failed to maintain a complete and/or accurate clinical record for Resident #9. Resident #9's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of [DATE], was signed as completed on [DATE]. Resident #9 was assessed as able to make self understood and as able to understand others. Resident #9's Brief Interview for Mental Status (BIMS) summary score was documented as a 14 out of 15; this indicated intact or borderline cognition. A nurse's note dated, [DATE] at 11:45 a.m., indicated Resident #9 had been administered two doses of Narcan. The route of administration was not documented. This note also indicated Resident #9 was provided oxygen for comfort per NP (nurse practitioner). The device used to provide Resident #9's oxygen was not documented. The amount of oxygen administered was not documented. Resident #9's clinical record included a set of vital signs (temperature, pulse, respiratory rate, and blood pressure) documented for [DATE] at 10:43 a.m. On [DATE] at 2:20 p.m., Licensed Practical Nurse (LPN) #2 reported they had been unable to obtain Resident #9's vital signs. LPN #2 stated the vital signs documented for [DATE] at 10:43 a.m. had been obtained earlier in the day by a certified nurse aide. LPN #2 confirmed the vital signs had not been obtained at 10:43 a.m. on [DATE]. (The following vital signs were documented for the incorrect time: temperature - 98.2 degrees Fahrenheit; pulse - 66 and regular; blood pressure 159/66; and respiratory rate - 17.) On [DATE] at 3:55 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), Regional Vice-President of Operations (RVPO), and Quality Assurance Nurse (QAN). During this meeting, the documentation of Resident #9's [DATE] vital signs for the incorrect time was discussed. The following information was found in a facility policy with the subject of Documentation (with a revision date of [DATE]): - Document daily what procedures were done . - Document accurately what was done . - Document the resident's response to [sic] procedure . Review of Resident #9's clinical record on the morning of [DATE] failed to reveal progress notes by the nurse practitioner or the physician for the day Resident #9 experienced a decline and subsequently expired. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER: Pheasant Ridge Nursing & Rehab Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 4355 Pheasant Ridge Road, SW Roanoke, VA 24014	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 11:55 a.m., the Medical Director reported that he had been notified by someone that Resident #9 had stated to a nurse that the resident was ready to die and did not want aggressive interventions. The Medical Director reported he attempted to contact Resident #9's son but was unsuccessful. The Medical Director stated he consulted with the Director of Nursing (DON) and another physician related to Resident #9's alleged request for no aggressive treatment. The Medical Director reported they were in the process of sending Resident #9 to the hospital when the resident died. A Medical Director progress note, for Resident #9, with a service date of [DATE] was neither found by nor provided to the surveyor. On [DATE] at 2:27 p.m., the surveyor was provided with a draft copy of the nurse practitioner note for Resident #9 with a date of service of [DATE] (no time was documented); this note had not yet been signed by the nurse practitioner. On [DATE] at 3:20 p.m., the surveyor was provided with the signed nurse practitioner progress note which had a date of service of [DATE]. This nurse practitioner progress note included the aforementioned vital signs that had been documented for the incorrect time; this progress note did not include a time for when the temperature, pulse, and heart rate were obtained. This nurse practitioner progress note had Resident #9's respiratory rate documented as being 17 on [DATE] at 2:43 p.m. (this was an hour after Resident #9's documented time of death). On [DATE] at 12:40 p.m., the survey team met with the facility's Administrator, Director of Nursing (DON), and Quality Assurance Nurse (QAN). During this meeting, Resident #9's nurse practitioners progress note, for [DATE], not being provided until the afternoon of [DATE] was discussed. The absence of a progress note by the Medical Director addressing Resident #9's care and/or provider actions, on [DATE], was discussed.