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	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pheasant Ridge Nursing and Rehabilitation	4355 Pheasant Ridge Road 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 0658 Level of Harm - Actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review and facility policy review, the facility staff failed to provide care and services to meet professional standards of quality for 1 of 7 resident's in the survey sample, Resident #2. The findings included:The policy entitled Pain Management with a revised date of 09/24/2025 was reviewed and read in part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Under the heading Recognition the document read, 1. In order to help a resident maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated b. Evaluate the resident for pain and the cause(s) of pain upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. after a fall, change in behavior or mental status, new pain or an exacerbation of pain.) c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the residents goals and preferences. 2. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to: a. Change in gait (e.g. limping), skin color, vital signs (increased heart rate, respirations, and/or blood pressure) perspiration. B. Loss of function or inability to perform activities of daily living (ADL's) (e.g. rubbing a specific location of the body or guarding a limb or other body parts) c. Fidgeting, increased or recurring restlessness. d. Facial expressions e. behaviors such as resisting care, distressed pacing, irritability, depressed mood, or decreased participation in physical and/or social activities. f. Difficulty eating or loss of appetite. g. Weight loss h. Difficulty sleeping i. Negative vocalizations j. Decline in activity level. k. Skin conditions. Under the heading Pain Assessment read, 2. Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team (e.g. nurses, practitioner, pharmacists, and anyone else with direct contact with the resident) may necessitate gathering the following information, as applicable to the resident: a. History of pain and it's treatment (including nonpharmacological, pharmacological and alternative medicine and whether or not each treatment has been effective); b. History of addiction, past and/or ongoing and related treatment for opioid use disorder; c. Asking the patient to rate the intensity of pain using a numerical scale, a verbal or visual descriptor that is appropriate an preferred by the patient. d. Reviewing the residents current medical conditions (e.g. pressure injuries, diabetes with neuropathic pain, immobility, infections, amputations, oral health conditions, post cva (stroke), venous and arterial ulcers and multiple sclerosis.) e. Identifying key characteristics of the pain: I. Duration of the pain II. Frequency III. Location IV. Timing V. Pattern VI. Radiation of pain. f. Obtaining descriptors of the pain (e.g.) stabbing, aching, pressure, spasms). g. Identifying activities, resident care or treatment that precipitate or exacerbate pain and those that reduce or eliminate pain. h. Impact on pain on quality of life (sleeping, functioning, appetite and mood.) i. Current prescribed pain medications, dosages and frequency including medication for OUD (opioid use disorder). j. The resident's goals for pain management and his/her satisfaction with the current (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

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F 0658 Level of Harm - Actual harm Residents Affected - Few	level of pain control. k. Physical and psychosocial issues that may be causing or exacerbating the pain. l. Additional symptoms associated with pain (e.g. nausea, anxiety).The admission Record for Resident #2 revealed the facility admitted the resident on 04/17/2025. According to the admission Record Resident #2 had a medical history that included acute on chronic congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), muscle weakness, shortness of breath, moderate protein calorie malnutrition, hypertension, lower back pain, depression and anxiety.The admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 04/23/2025 assigned the resident a Brief Interview for Mental Status (BIMS) score of 08 indicating moderate cognitive impairment. Resident #2 was coded as having little interest or pleasure in doing things 2-6 days in the look back period and feeling down, depressed, or hopeless 2-6 days in the 2 week look back period. Resident #2 was coded as being independent prior to illness with self-care, indoor mobility and functional cognition but upon admission, required substantial/maximal assistance with toileting, bathing, dressing, personal hygiene, bed mobility and transfers from bed to chair. The resident was coded as being incontinent of bowel and bladder. Resident #2 was coded as having frequent pain that interfered with sleep, ability to participate in therapy and that limited day-to-day activities. Pain was coded as being as high as 9 on a 0-10 pain scale over the prior five days. Resident #2 was coded as having shortness of breath with exertion, when at rest and when lying flat. The comprehensive care plan was not completed prior to Resident #2's discharge on [DATE].The hospital discharge summary was reviewed. Resident #2's weight was documented as 115 lbs. during the discharge exam. Under Recommended Follow-Up Appointments the document read, Follow up with cardiology for consideration of nonischemic stress testing.The Documentation Survey Report where activities of daily living (ADL's) such as eating, toileting and bathing were documented for Resident #2 was reviewed. For eating, there was no documentation to support Resident #2 was provided lunch on 04/18/2025, breakfast or lunch on 04/19/2025, breakfast or lunch on 04/20/2025, breakfast or lunch on 04/23/2025, breakfast or lunch on 04/24/2025, breakfast or lunch on 04/28/2025, breakfast or lunch on 04/29/2025, breakfast or lunch on 05/02/2025. According to the Documentation Survey Report Resident #2 ate 0-25% for breakfast on 04/18/2025, 0-25% breakfast, lunch and supper on 05/03/2025 and 0-25% breakfast and lunch on 05/04/2025. Resident #2 was documented as eating only 26-50% for supper on 04/19/2025 and for all three meals on 05/01/2025.The medical provider notes were reviewed for the entirety of Resident #2's stay at the facility. The History and Physical note dated 04/18/2025 read in part, It is noted with the discharge summary that (resident) displayed some narcotic seeking behavior. (Resident) was found concealing a pill bottle containing home dose Percocet and gabapentin medications. The medications were confiscated and pain medicine was held. (Resident) became agitated and altered and was tachycardic, displaying signs of opioid withdrawal. The PDMP (prescription drug monitoring program) was reviewed, and it appears (resident was taking far too much opioid analgesia. (Resident) was started on a pain regimen that was half of prior to admission dosing, which resulted in improvement of her overall symptoms. Under the Assessment and Plan portion of the document the provider documented a plan for the diagnosis of acute on chronic heart failure that read: Plan: Continue losartan 25 mg daily and diuresis with Lasix 20 mg on Monday, Wednesday and Friday. Obtain BNP (B-type Natriuretic Peptide which is a hormone produced by the heart when it is under stress that is used to monitor and assess severity of heart failure) to assess patient's current heart failure status. Continue metoprolol succinate 25 mg daily for blood pressure control. Administer Aldactone 25 mg for diuresis. Obtain CBC (complete blood count), CMP (comprehensive metabolic panel) and magnesium levels to assess for any electrolyte dysfunction associated with diuresis. Replete electrolytes as indicated.The BNP was not located in the medical record.The daily SPN/Skilled notes were reviewed. Every daily skilled note for Resident #2 throughout the duration of the stay stated the resident had no chest pain, no edema, and no swallowing problems and GI (gastrointestinal) complaints are none. Many of the notes documented pain levels as high as 10/10 but did not include a location of the pain, pain characteristics, or (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	nonpharmacologic interventions offered.On 04/19/2025 at 12:57 PM the note read in part, Pain level: 7- 04/19/2025 09:44 AM Pain Scale: Numerical Rsd (resident) voiced c/o (complaints of) pain this shift. PRN (as needed) analgesics given and effective. According to the Medication Administration Record (MAR) for April 2025, resident had an order that read, Acetaminophen 500 mg give two tablets by mouth every 6 hours as needed for pain. This order was not signed as given on 04/19/2026 and was only administered one time on 04/18/2025 for complaint of generalized pain during the resident's stay at the facility. Resident #2 also had an order that read, nitroglycerin sublingual tablet 0.4 mg give one tablet sublingually every 5 minutes as needed for angina (chest pain) take one tab every 5 minutes for up to 15 minutes do not take more than 3 tabs in 15 minutes. This order was not administered to Resident #2 at any point during their stay according to the MAR.According to the daily skilled notes and MAR, Resident #2 complained of a pain level of 7 or higher on fifteen out of their seventeen day stay at the facility.The Treatment Administration Record (TAR) was reviewed and included an order that read, Assess resident for pain every shift: Nonpharmacological interventions: 1=relaxation, 2=light touch, 3=imagery, 4=exercises, 5=music, 6=N/A, 7=other see progress notes. Document corresponding code and pain level in supplemental documentation. The pain levels on the TAR did not consistently match the pain levels on the MAR or in the skilled notes.A Physical Therapy note dated 04/20/2025 read in part, Pt refused for more ex. (exercise) Pt refused for bed mobility. Pt c/o chest wall pain along with pain in stomach, ribs, back and pt's BP is also low, nurse informed. Pt educated on use of call bell for assistance. There was no nurses note to indicate the resident was assessed for chest pain or low blood pressure. The only note was a SPN/Skilled Note that indicated the blood pressure was 140/60, pain level was 9 but there was no location given for the pain and the note specifically said, no chest pain.On 04/20/2025 for the evening and night shift the pain scale and nonpharmacological intervention was blank on the TAR, but resident had complained of 9 out 10 pain on the evening shift and 6 out 10 on the night shift according to the MAR. The only nonpharmacological interventions documented as being performed was relaxation, light touch and imagery.A provider progress note dated 04/21/2025 read in part, (Resident) reports chest pain, gas pain, and acid reflux. Describes chest pain as burning sensation in the epigastric area. Worse after eating and drinking. Pain relieved with Tums. Denies SOB (shortness of breath), N/V (nausea and vomiting), syncope and headaches. Under the heading Assessment and Plan for the diagnosis of congestive heart failure the provider documented Plan: Continue Lasix 20 mg every Monday, Wednesday and Friday. Continue metoprolol succinate 25 mg daily. Continue spironolactone 25 mg daily. Start losartan 25 mg daily. Continue Nitrostat as needed for chest pain. Monitor for signs and symptoms of heart failure exacerbation. Follow up with cardiology for stress test. There was no evidence that a cardiology appointment/consultation was initiated by the facility. For the diagnosis hyperthyroidism the provider documented, patient has a history of hyperthyroidism and is on Synthroid 50 mg daily. Plan: continue Synthroid 50 mg daily. Obtain a TSH level to monitor thyroid function. There were no results for a TSH level in the medical record.A SPN/Skilled note dated 04/25/2025 read in part, BP 96/55 Pain level:10 Level of consciousness noted as oriented to person oriented to place lethargic. Skin is warm and dry. Swallowing problems are not noted. Mood status is flat affect tired/has little energy sluggish. GI (gastrointestinal) complaints are none. The last sentence read, Call light and fluids in reach. Patient is non-compliant with fluid restriction and refuses daily weight and states I am not getting up I am too tired. There was no evidence the low blood pressure, high pain level and lethargy were assessed or reported to the medical provider.A Physical Therapy Treatment Encounter Note dated 04/25/2025 read in part, Pt described nausea and vomiting earlier today and Pt refused further activity 2/2 (secondary to) visiting with family and upset stomach. The nurse documented GI complaints are none for the same day.A SPN/Skilled note dated 04/26/2025 read in part, BP 96/55 Pain level 10 level of consciousness noted as oriented to person oriented to place lethargic. Skin is warm dry. Swallowing problems are not noted tolerates pills whole. Mood status is flat affect sluggish. GI complaints are none. There was no evidence to support these (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	symptoms were further assessed or reported to the provider.A SPN/skilled note dated 04/27/2025 read in part, Pain level 10 Level of consciousness noted as oriented to person oriented to place lethargic. Skin warm dry. Swallowing problems are not noted tolerates pills whole. Mood status is flat affect tired/has little energy poor appetite. GI complaints are none. No evidence in the record of further assessment or notification of provider.A Weight Note dated 04/28/2025 entered by the Registered Dietician read, Resd (resident) reviewed for weight loss of 5.2# (pounds) x 9 days. Wt (weight) on admission 117# (04/17/2025). Regular, Mech (mechanical) soft, thin liquid diet order. 2000 ml (milliliters) fluid restriction. Resd appetite and PO (by mouth) intake is poor. Family bringing in some foods. Resident reports poor appetite. Family states ubw (usual body weight) of 140# prior to hospitalization. Resd dislikes mech soft textures. Currently receiving ST for dx (diagnosis) dysphagia (swallowing difficulty). PU (pressure ulcer) stage I to sacrum. MVI (multivitamin) with minerals in place for skin integrity. Prostat protein liquid increased ordered 3x daily for wound healing. Continue wts as ordered. Will recommend Magic Cup once daily between meals for wt stabilization.On 04/28/2025 and 04/29/2025 SPN/skilled note documented a blood pressure of 94/60 each day with no assessment or intervention documented.A nurse progress note dated 04/28/2025 read, Patient's weight loss was discussed with son and (physician's name omitted), loss of 6.3 lbs. (pounds) in one week- orders from (physician's name omitted); increase protein supplement from 1x (one time) a day to 3x (three times) r/t (related to) nutritional needs, ST to evaluate for swallowing issues. Medication to stimulate appetite was discussed but not found to be warranted at this time. Son was in agreement with this plan.A nurse progress note dated 04/29/2025 at 8:34 PM read, Dicyclomine HCL (anticholinergic/antispasmodic used to treat irritable bowel syndrome) 10 mg give one capsule by mouth every 8 hours as needed for pain for 14 days. Rsd (resident) c/o (complained of) stomach pain. Two non-pharmacological interventions ineffective. Administered med per order. A later note indicated the medication was effective.On 04/30/2025 the SPN/skilled note read in part, Pain level 10 Level of consciousness noted as oriented to person oriented to place. Skin warm dry. Swallowing problems are not noted tolerates pills whole. Mood state is flat affect poor appetite sluggish. GI complaints are none.The Speech Therapy (ST) evaluation and notes were reviewed. On 04/30/2025 ST documented in part, Patient remains at nutritional risk due to consistently low po intake and reported weight loss. Continued education and reinforcement of strategies remain essential to promote safe swallowing and adequate nutrition. Under the heading Summary of daily skilled services the note read in part, SLP (speech language pathologist) collaborated with physician about current status as pt (patient) is not eating. MD will write an order for ENT referral. An SLP Progress Report signed on 05/02/2025 read in part under Patient Progress, Patient continues to demonstrate variable cognitive performance with noted daily fluctuations, impacting progress toward cognitive-linguistic goals. Patient and staff report ongoing challenges with oral intake and weight loss. Earlier this week patient was unable to effectively masticate or swallow oral trials. Collaborative care has been implemented with nursing, dietician and physician actively involved. ENT referral has been made for further evaluation. The SPN/Skilled notes and nurse progress notes were reviewed again. The nurses caring for resident #2 on a daily basis documented swallowing problems are not noted daily in the skilled notes. There was no documentation by the medical providers that addressed weight loss or poor intake provided to the survey team.On 05/01/2025, Pain level 10 level of consciousness noted as oriented to person oriented to place lethargic. Skin warm dry. Swallowing problems are not noted. Mood status is tired/has little energy poor appetite sluggish. GI complaints are none.A nurse progress note dated 05/01/2025 at 6:00 PM and signed by the Assistant Director of Nursing (ADON) read, Patients condition was discussed at length in care plan meeting today with RP (name of responsible party omitted). Discussed ENT (ears, nose, throat) vs GI regarding swallowing issues, pain control for low back pain, hydration status r/t low intake. MD aware of concerns, new orders as follows: BMP-Aspercreme Lidocaine Patch 4% apply to lower back topically one time a day for pain and remove per schedule referral to ENT r/t swallowing issues/fear of swallowing.On 05/03/2025 BP 94/58 Pain (continued on next page)

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F 0658 Level of Harm - Actual harm Residents Affected - Few	level 4. No evidence the low blood pressure was further assessed or reported to the provider. A nurse progress note dated 05/04/2025 at 3:48 PM read, CNA (certified nursing assistant) notified this nurse that rsd had vomited and had diarrhea, that she cleaned (resident) up and that rsd didn't look well. Upon assessment rsd noted unresponsive, eyes/pupils fixated and scant amount of foam in corner of L side of mouth. No response from sternal rub. No palpable pulse noted. This nurse started chest compressions immediately. MD notified and NO (new order) given to send rsd to ER emergently. 911 notified per MD.Resident #2 was sent emergently to the hospital on [DATE] where she passed away a week later.On 05/07/2026 the ADON was asked to provide all labs. ADON provided the CBC, CMP, magnesium level ordered 4/18/25 and the BMP ordered 5/2/2025 and stated that was all the labs that were done. When asked about resident #2's c/o chest pain the ADON stated, She didn't have chest pain, she had low back pain, and she always said she was in pain but the scheduled pain medication was effective. In her hospital records it talks about her abusing pain medication and going through withdrawals When asked about daily physical assessment and pain assessment the ADON stated, Those are documented in the skilled notes, and the pain assessment is also on the MAR. When asked if they had noticed that the skilled notes in many cases seemed to be copied and pasted including vital signs they agreed that there were many similarities at times. When asked about the RD recommendation for a magic cup due to weight loss the ADON stated, That was discussed with (provider name omitted) and he elected to just increase the Prostat (liquid protein) instead. When asked if the provider was aware of the weight loss, ADON stated, He was.On 05/07/2025 the Director of Nursing (DON) was interviewed regarding resident #2's high pain levels, c/o chest pain and lack of daily pain assessments. The DON provided the MAR to show that the resident was asked about pain each shift and a pain level documented. When asked what the expectation for documenting location and pain characteristics she stated, I think they do that for the most part. When asked about standard of practice the DON stated, I think our policy covers that. When asked about basic nursing assessment the DON stated, They do those in their skilled notes. When asked about changes in vital signs such as low blood pressure or notes that read resident is lethargic if they would expect further assessment of the resident to determine if a change in condition is occurring they stated, I think we do that, it's in the notes.On 05/07/2026 at 2:40 PM the former facility Nurse Practitioner was interviewed. When asked about resident #2's chest pain she stated, (Resident) said it was epigastric and was worse after eating so we prescribed another medication for GERD (gastroesophageal reflux disease) which made sense at the time. When asked about appetite and weight loss she did recall poor appetite.On 05/07/2026 at 4:16 PM the former medical director and provider for resident #2 was interviewed. When asked about weight loss they stated, I don't recall that. I'm sure if the staff made a note that they notified me then I was aware. I don't recall anything about the RD or a magic cup. I'm not sure why I wouldn't have approved that, but I can't say for sure. Regarding pain, the provider stated the resident had a well-documented history of drug seeking and he was aware of the ongoing complaints of pain but felt the pain was being controlled by the medication prescribed. (Resident) was never going to say there was no pain. Did not recall being notified of low blood pressure or lethargy. On 05/07/2026 at 5:13 PM the survey team met with the DON, ADON and Administrator. These concerns were reviewed at that time. No further information was provided to the survey team prior to the exit conference.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. Based on staff interview and clinical record review, the facility staff failed to follow medical provider orders for one of seven residents in the survey sample, Resident #2.The findings included:For Resident #2 the facility staff failed to follow hold orders for the administration of Toprol XL (metoprolol). An admission Record revealed the facility admitted Resident #2 on 04/17/2025. According to the admission Record Resident #2 had a medical history that included acute on chronic congestive heart failure, chronic obstructive pulmonary disease, hypertension, coronary artery disease with a history of myocardial infarction and moderate protein-calorie malnutrition. The admission minimum data set (MDS) with an assessment reference date (ARD) of 04/23/2025 assigned the resident a Brief Interview for Mental Status (BIMS) score of 8 which indicated moderate cognitive impairment.'The Medication Administration Record (MAR) for May 2025 revealed an order that read, Toprol XL oral tablet extended release 24-hour 25 mg (Metoprolol Succinate) give one tablet by mouth one time a day for htn (hypertension) hold if HR (heart rate) <60 SBP (systolic blood pressure) <100 or DBP (diastolic blood pressure) <60. On 05/03/2025 Resident #2's blood pressure was documented as 94/58. Toprol XL was documented as given by the nurse despite both the systolic and diastolic blood pressure being outside parameters. According to Davis's Drug Guide.com Toprol XL is a medication used to treat hypertension and heart failure. The medication functions by reducing the heart rate and the blood pressure and should be held for a systolic blood pressure less than 100 or diastolic blood pressure less than 60. On 05/07/2026 at 5:13 PM the survey team met with the Assistant Director of Nursing (ADON) and the Director of Nursing (DON). The ADON reviewed the MAR and agreed that the medication was documented as given outside parameters. No further information was provided to the survey team prior to the exit conference.

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on staff interview and clinical record review, the facility staff failed to maintain acceptable levels of nutritional status resulting in a significant 16-pound weight loss for 1 of 7 residents in the survey sample, Resident #2. The findings included: The admission Record for Resident #2 revealed the facility admitted the resident on 04/17/2025. According to the admission Record Resident #2 had a medical history that included acute on chronic congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), muscle weakness, shortness of breath, moderate protein calorie malnutrition, hypertension, lower back pain, depression and anxiety.The admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 04/23/2025 assigned the resident a brief interview for mental status (BIMS) score of 08 indicating moderate cognitive impairment.The hospital discharge summary was reviewed. Resident #2's weight was documented as 115 lbs. during the discharge exam.The Documentation Survey Report where activities of daily living (ADL's) such as eating, toileting and bathing were documented for Resident #2 was reviewed. For eating, there was no documentation to support resident #2 was provided lunch on 04/18/2025, breakfast or lunch on 04/19/2025, breakfast or lunch on 04/20/2025, breakfast or lunch on 04/23/2025, breakfast or lunch on 04/24/2025, breakfast or lunch on 04/28/2025, breakfast or lunch on 04/29/2025, breakfast or lunch on 05/02/2025. According to the Documentation Survey Report Resident #2 ate 0-25% breakfast on 04/18/2025, 0-25% breakfast, lunch and supper on 05/03/2025 and 0-25% breakfast and lunch on 05/04/2025. Resident #2 was documented as eating only 26-50% for supper on 04/19/2025 and for all three meals on 05/01/2025.A provider progress note dated 04/21/2025 read in part, (Resident) reports chest pain, gas pain, and acid reflux. Describes chest pain as burning sensation in the epigastric area. Worse after eating and drinking. Pain relieved with Tums. Denies SOB (shortness of breath), N/V (nausea and vomiting), syncope and headaches. The note did not address poor intake or nutritional status.Daily weights began on 04/21/2025 and were recorded on the Treatment Administration Record (TAR). 04/21/2025 117.5 lbs., 04/22/2025 118.1 lbs. 04/23/2025 112.2 lbs. 04/24/2025 blank, 04/25/2025 111.8 lbs., blanks for 04/27/2025-04/29/2025 and on 04/30/2025 99 lbs. 05/01/2025 99.2 lbs., 05/02/2025 99 lbs., 05/03/2025 99.1 lbs.The SPN/Skilled Notes were reviewed. On 04/27/2025 the nurse documented, lethargic, flat affect, little energy/tired poor appetite. On 04/30/2025 flat affect poor appetite sluggish. There was no evidence that any alternatives were offered or the medical provider was notified.A Weight Note dated 04/28/2025 entered by the Registered Dietician read, Resd (resident) reviewed for weight loss of 5.2# x 9 days. Wt (weight) on admission 117# (04/17/2025). Regular, Mech (mechanical) soft, thin liquid diet order. 2000 ml (milliliters) fluid restriction. Resd appetite and PO (by mouth) intake is poor. Family bringing in some foods. Resd reports poor appetite. Family states ubw (usual body weight) of 140# prior to hospitalization. Resd dislikes mech soft textures. Currently receiving ST (speech therapy) for dx (diagnosis) dysphagia (swallowing difficulty). PU (pressure ulcer) stage I to sacrum. MVI (multivitamin) with minerals in place for skin integrity. Prostat protein liquid increased ordered 3x daily for wound healing. Continue wts as ordered. Will recommend Magic Cup once daily between meals for wt stabilization.A nurse progress note dated 04/28/2025 read, Patient's weight loss was discussed with son and (physician's name omitted), loss of 6.3 lbs. (pounds) in one week- orders from (physician's name omitted); increase protein supplement from 1x (one time) a day to 3x (three times) r/t (related to) nutritional needs, ST to evaluate for swallowing issues. Medication to stimulate appetite was discussed but not found to be warranted at this time. Son was in agreement with this plan.The Speech Therapy (ST) evaluation and notes were reviewed. On 04/30/2025 ST documented in part, Patient remains at nutritional risk due to consistently low po intake and reported weight loss. Continued education and reinforcement of strategies remain essential to promote safe swallowing and adequate nutrition. Under the heading Summary of daily skilled services the note read in part, SLP (speech language pathologist) collaborated with physician about current status as pt (patient) is not (continued on next page)

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	495325	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Pheasant Ridge Nursing and Rehabilitation	4355 Pheasant Ridge Road Roanoke, VA 24014

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F 0692 Level of Harm - Actual harm Residents Affected - Few	eating. MD will write an order for ENT referral.A nurse progress note dated 05/01/2025 at 6:00 PM and signed by the Assistant Director of Nursing (ADON) read, Patients condition was discussed at length in care plan meeting today with RP (name of responsible party omitted). Discussed ENT (ears, nose, throat) vs GI regarding swallowing issues, pain control for low back pain, hydration status r/t low intake. MD aware of concerns, new orders as follows: BMP- Aspercreme Lidocaine Patch 4% apply to lower back topically one time a day for pain and remove per schedule referral to ENT r/t swallowing issues/fear of swallowing.An SLP Progress Report signed on 05/02/2025 read in part under Patient Progress, Patient continues to demonstrate variable cognitive performance with noted daily fluctuations, impacting progress toward cognitive-linguistic goals. Patient and staff report ongoing challenges with oral intake and weight loss. Earlier this week patient was unable to effectively masticate or swallow oral trials. Collaborative care has been implemented with nursing, dietician and physician actively involved. ENT referral has been made for further evaluation. The SPN/Skilled notes and nurse progress notes were reviewed again. The nurses caring for resident #2 on a daily basis documented swallowing problems are not noted daily in the skilled notes. There was no documentation by the medical providers that addressed weight loss or poor intake provided to the survey team.On 05/07/2026 the ADON interviewed. When asked about the RD recommendation for a magic cup due to weight loss the ADON stated, That was discussed with (provider name omitted) and he elected to just increase the Prostat (liquid protein) instead. When asked if the provider was aware of the weight loss, ADON stated, He was.There was no documentation by a provider addressing the weight loss or poor appetite provided to the survey team.The survey team met with the Administrator, DON and ADON on 05/07/2026 and this concern was discussed. Resident #2 was on two diuretics for congestive heart failure but the documentation by the RD and the Speech Therapist indicate the resident experienced a true weight loss rather than changes in fluid volume.

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	495325	A. Building B. Wing	05/07/2026

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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 0697 Level of Harm - Actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. Based on staff interview, clinical record review and facility policy review, the facility staff failed to provide pain management to residents who require such services that are consistent with professional standards of practice for 1 of 7 residents in the survey sample, Resident #2. The findings included:The policy entitled Pain Management with a revised date of 09/24/2025 was reviewed and read in part, The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Under the heading Recognition the document read, 1. In order to help a resident maintain his/her highest practicable level of physical, mental and psychosocial well-being and to prevent or manage pain, the facility will: a. Recognize when the resident is experiencing pain and identify circumstances when the pain can be anticipated b. Evaluate the resident for pain and the cause(s) of pain upon admission, during ongoing scheduled assessments, and when a significant change in condition or status occurs (e.g. after a fall, change in behavior or mental status, new pain or an exacerbation of pain.) c. Manage or prevent pain, consistent with the comprehensive assessment and plan of care, current professional standards of practice, and the residents goals and preferences. 2. Facility staff will observe for nonverbal indicators which may indicate the presence of pain. These indicators include but are not limited to: a. Change in gait (e.g. limping), skin color, vital signs (increased heart rate, respirations, and/or blood pressure) perspiration. B. Loss of function or inability to perform activities of daily living (ADL's) (e.g. rubbing a specific location of the body or guarding a limb or other body parts) c. Fidgeting, increased or recurring restlessness. d. Facial expressions e. behaviors such as resisting care, distressed pacing, irritability, depressed mood, or decreased participation in physical and/or social activities. f. Difficulty eating or loss of appetite. g. Weight loss h. Difficulty sleeping i. Negative vocalizations j. Decline in activity level. k. Skin conditions. Under the heading Pain Assessment read, 2. Based on professional standards of practice, an assessment or evaluation of pain by the appropriate members of the interdisciplinary team (e.g. nurses, practitioner, pharmacists, and anyone else with direct contact with the resident) may necessitate gathering the following information, as applicable to the resident: a. History of pain and it's treatment (including nonpharmacological, pharmacological and alternative medicine and whether or not each treatment has been effective); b. History of addiction, past and/or ongoing and related treatment for opioid use disorder; c. Asking the patient to rate the intensity of pain using a numerical scale, a verbal or visual descriptor that is appropriate an preferred by the patient. d. Reviewing the residents current medical conditions (e.g. pressure injuries, diabetes with neuropathic pain, immobility, infections, amputations, oral health conditions, post cva (stroke), venous and arterial ulcers and multiple sclerosis.) e. Identifying key characteristics of the pain: I. Duration of the pain II. Frequency III. Location IV. Timing V. Pattern VI. Radiation of pain. f. Obtaining descriptors of the pain (e.g.) stabbing, aching, pressure, spasms). g. Identifying activities, resident care or treatment that precipitate or exacerbate pain and those that reduce or eliminate pain. h. Impact on pain on quality of life (sleeping, functioning, appetite and mood.) i. Current prescribed pain medications, dosages and frequency including medication for OUD (opioid use disorder). j. The resident's goals for pain management and his/her satisfaction with the current level of pain control. k. Physical and psychosocial issues that may be causing or exacerbating the pain. l. Additional symptoms associated with pain (e.g. nausea, anxiety).The admission Record for Resident #2 revealed the facility admitted the resident on 04/17/2025. According to the admission Record Resident #2 had a medical history that included acute on chronic congestive heart failure (CHF), chronic obstructive pulmonary disease (COPD), muscle weakness, shortness of breath, moderate protein calorie malnutrition, hypertension, lower back pain, depression and anxiety.The admission minimum data set (MDS) assessment with an assessment reference date (ARD) of 04/23/2025 assigned the resident a Brief Interview for Mental Status (BIMS) score of 08 indicating moderate cognitive impairment. (continued on next page)

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	495325	A. Building B. Wing	05/07/2026

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F 0697 Level of Harm - Actual harm Residents Affected - Few	Resident #2 was coded as having little interest or pleasure in doing things 2-6 days in the look back period and feeling down, depressed, or hopeless 2-6 days in the 2 week look back period. Resident #2 was coded as having frequent pain that interfered with sleep, ability to participate in therapy and that limited day-to-day activities. Pain was coded as being as high as 9 on a 0-10 pain scale over the prior five days.The medical provider notes were reviewed for the entirety of Resident #2's stay at the facility. The History and Physical note dated 04/18/2025 read in part, It is noted with the discharge summary that (resident) displayed some narcotic seeking behavior. (Resident) was found concealing a pill bottle containing home dose Percocet and gabapentin medications. The medications were confiscated and pain medicine was held. (Resident) became agitated and altered and was tachycardic, displaying signs of opioid withdrawal. The PDMP (prescription drug monitoring program) was reviewed, and it appears (resident was taking far too much opioid analgesia. (Resident) was started on a pain regimen that was half of prior to admission dosing, which resulted in improvement of her overall symptoms. The daily SPN/Skilled notes were reviewed. Every daily skilled note for Resident #2 throughout the duration of the stay stated the resident had no chest pain, no edema, and no swallowing problems and GI (gastrointestinal) complaints are none. Many of the notes documented pain levels as high as 10/10 but did not include a location of the pain, pain characteristics, or nonpharmacologic interventions offered.According to the Medication Administration Record (MAR) for April 2025, resident had an order that read, Acetaminophen 500 mg give two tablets by mouth every 6 hours as needed for pain. This order was not signed as given on 04/19/2026 and was only administered one time on 04/18/2025 for complaint of generalized pain during the resident's stay at the facility.According to the daily skilled notes and MAR, Resident #2 complained of a pain level of 7 or higher on fifteen out of their seventeen day stay at the facility.A Physical Therapy note dated 04/20/2025 read in part, Pt refused for more ex. (exercise) Pt refused for bed mobility. Pt c/o chest wall pain along with pain in stomach, ribs, back and pt's BP is also low, nurse informed. Pt educated on use of call bell for assistance. There was no nurses note to indicate the resident was assessed for chest pain or low blood pressure. The only note was a SPN/Skilled Note that indicated the blood pressure was 140/60, pain level was 9 but there was no location given for the pain and the note specifically said, no chest pain.The Treatment Administration Record (TAR) was reviewed and included an order that read, Assess resident for pain every shift: Nonpharmacological interventions: 1=relaxation, 2=light touch, 3=imagery, 4=exercises, 5=music, 6=N/A, 7=other see progress notes. Document corresponding code and pain level in supplemental documentation. The pain levels on the TAR did not consistently match the pain levels on the MAR or in the skilled notes. On 04/20/2025 for the evening and night shift the pain scale and nonpharmacological intervention was blank on the TAR, but resident had complained of 9 out 10 pain on the evening shift and 6 out 10 on the night shift according to the MAR.A provider progress note dated 04/21/2025 read in part, (Resident) reports chest pain, gas pain, and acid reflux. Describes chest pain as burning sensation in the epigastric area. Worse after eating and drinking. Pain relieved with Tums. Denies SOB (shortness of breath), N/V (nausea and vomiting), syncope and headaches. The progress note indicated Nitrostat as needed for chest pain.Resident #2's medical provider orders included an order for nitroglycerin sublingual tablet 0.4 mg give one tablet sublingually every 5 minutes as needed for angina (chest pain) take one tab every 5 minutes for up to 15 minutes do not take more than 3 tabs in 15 minutes. This order was not administered to Resident #2 at any point during their stay according to the MAR. SPN/Skilled Notes dated 04/25/2025, 04/26/2025, 04/27/2025, 04/30/2025, and 5/01/25 each revealed a documented pain level of 10 out of 10 with no evidence that the high pain levels were assessed or reported to the medical provider.A nurse progress note dated 05/01/2025 at 6:00 PM and signed by the Assistant Director of Nursing (ADON) read in part, Patients condition was discussed at length in care plan meeting today with RP (name of responsible party omitted). Discussed.pain control for low back pain.MD aware of concerns, new orders as follows.Aspercreme Lidocaine Patch 4% apply to lower back topically one time a day for pain and remove per schedule.On 05/07/2026 the ADON was (continued on next page)

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	495325	A. Building B. Wing	05/07/2026

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F 0697 Level of Harm - Actual harm Residents Affected - Few	interviewed. When asked about resident #2's c/o chest pain the ADON stated, (resident) didn't have chest pain, (resident) had low back pain, and always said (resident) was in pain but the scheduled pain medication was effective. In the hospital records it talks about her abusing pain medication and going through withdrawals When asked about daily physical assessment and pain assessment the ADON stated, Those are documented in the skilled notes, and the pain assessment is also on the MAR. When asked if they had noticed that the skilled notes in many cases seemed to be copied and pasted including vital signs, they agreed that there were many similarities at times.On 05/07/2025 the Director of Nursing (DON) was interviewed regarding Resident #2's high pain levels, c/o chest pain and lack of daily pain assessments. The DON provided the MAR to show that the resident was asked about pain each shift and a pain level documented. When asked what the expectation for documenting location and pain characteristics she stated, I think they do that for the most part. When asked about standard of practice the DON stated, I think our policy covers that. On 05/07/2025 at 5:15 PM the survey team met with the Administrator, DON and ADON. This concern was discussed at that time. No further information was provided to the survey team prior to the exit conference.

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	495325	A. Building B. Wing	05/07/2026

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F 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. Based on staff interview and clinical record review the facility staff failed to obtain medical provider ordered laboratory tests for one of seven residents in the survey sample, resident #2.The findings included:For Resident #2 the facility failed to obtain a BNP (B-type natriuretic peptide test) and a TSH (thyroid stimulating hormone) level ordered by the medical provider.An admission Record revealed the facility admitted Resident #2 on 04/17/2025. According to the admission Record Resident #2 had a medical history that included acute on chronic congestive heart failure, chronic obstructive pulmonary disease, hypertension, coronary artery disease with a history of myocardial infarction and moderate protein-calorie malnutrition.The admission minimum data set (MDS) with an assessment reference date (ARD) of 04/23/2025 assigned the resident a Brief Interview for Mental Status (BIMS) score of 8 which indicated moderate cognitive impairment.A History and Physical note dated 4/18/2025 and electronically signed by the facility Medical Director at the time, included an order that read, Plan: Continue losartan 25 mg daily and diuresis with Lasix 20 mg on Monday, Wednesday and Friday. Obtain BNP to assess patient's current heart failure status. Continue metoprolol succinate 25 mg daily for blood pressure control. Administer Aldactone 25 mg for diuresis. Obtain CBC (complete blood count), CMP (comprehensive metabolic panel) and magnesium levels to assess for any electrolyte dysfunction associated with diuresis. Replete electrolytes as indicated.A provider progress note dated 04/21/2025 read in part, .patient has a history of hyperthyroidism and is on Synthroid 50 mg daily. Plan: continue Synthroid 50 mg daily. Obtain a TSH level to monitor thyroid function . On 5/7/2026 at 3:20 PM the Assistant Director of Nursing (ADON) provided all lab results for Resident #2. They were unable to produce the BNP or the TSH. The ADON stated, I even called the lab.On 05/07/2026 at 4:16 PM the provider who ordered the tests was interviewed via telephone. When asked about the labs ordered he stated, I obviously don't remember orders that long ago but if the other labs were ordered and were done, I suspect the BNP should have been as well.On 05/07/2026 at 5:13 PM this concern was discussed with the Administrator, Director of Nursing and the ADON. No further information was provided to the survey team prior to the exit conference.

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	495325	A. Building B. Wing	05/07/2026

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F 0776 Level of Harm - Actual harm Residents Affected - Few	Provide timely, approved x-ray services, or have an agreement with an approved provider to obtain them. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview, clinical record review, facility document review and facility policy review, the facility staff failed to provide or obtain radiology services to meet the needs of its residents for 1 of 7 residents in the survey sample, Resident #5. This failure resulted in a delay in treatment for a left hip fracture sustained after a fall thus constituting harm.The findings included:A facility policy entitled, Radiology and other Diagnostic Services and Reporting, dated 11/07/2025, read in part, The facility must provide or obtain radiology and other diagnostic services when ordered by a physician, physician assistant, nurse practitioner or clinical nurse specialist in accordance with state law. 1. The facility must provide or obtain radiology and other diagnostic service to meet the needs of its residents. Under item 4. Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside the clinical reference range.The admission Record for Resident #5 indicated the facility admitted the resident on 01/07/2023. According to the admission Record Resident #5 had a medical history that included diagnoses of dementia with psychotic disturbance, lack of coordination, muscle weakness, abnormalities of gait and mobility and osteoporosis.The quarterly minimum data set (MDS) assessment with an assessment reference date (ARD) of 03/29/2026 assigned Resident #5 a Brief Interview for Mental Status (BIMS) score of 5 which indicated severe cognitive impairment. The MDS also indicated that the resident experienced frequent pain that limited day-to-day activities as high as a 10 on a 0-10 pain scale during the lookback period. The MDS revealed Resident #5 had not had any recent falls.A document in the clinical record for Resident #5 entitled, Change in Condition (SBAR) dated 06/23/2025 was reviewed. The document indicated that resident had a witnessed fall and complained of left hip pain that was worse with movement and rated 4 out of 10 on a 0-10 pain scale. The document indicated that the medical provider was notified and ordered a left hip x-ray and the resident was assisted up into a wheelchair and medicated with a PRN (as needed) medication. A Post Fall Documentation form dated 06/24/2025 at 3:21 PM documented a pain score of 0 but under section 7a. Describe injuries the document read, c/o (complained of) hip pain this nurse in to ask about pain level and fall today. Rsd (resident) doesn't remember. No c/o pain.On 06/25/2025 at 11:21 a nurse progress note read, Rsd c/o left hip pain this shift with ADLs (activities of daily living). Rsd unable to stretch left leg out w/o c/o pain. This nurse asked (name omitted) NP (nurse practitioner) to evaluate rsd. Rsd had a x-ray ordered on Monday and this nurse called to get an update on if it was completed or not because there was no results in system. (Name of x-ray vendor omitted) stated it was ordered to come today but they did not have a time. NP given order to send rsd out r/t (related to) left hip pain. (Name of guardian omitted) is made aware of situation.A note on 06/25/2025 at 2:46 PM read, Orthopedic surgeon called facility for RP information to give consent for surgery. Rsd admitted to (name of hospital omitted) for left hip fx (fracture).On 05/05/2026 at 4:35 PM Licensed Practical Nurse (LPN) #1 was interviewed. LPN #1 stated she witnessed the fall, (Resident #5) was trying to get out of the bed and was refusing help (resident) was agitated. I think (resident) refused everything, didn't want to go to see the doctor or anything, It's in my notes. Informed LPN #1 there were no progress notes from her on 06/23/2025, It's in risk management then. He refused everything I notified the doctor of everything. We got (resident) back up to the wheelchair. LPN #1 stated she could not remember who helped get the resident up. When asked if the resident complained of pain she stated yes, that's why we ordered the x-ray. When asked if she assessed range of motion she stated, Yes, I assessed (resident) for all of that. It should be in my note.On 05/06/2026 at 5:46 AM LPN #2 was interviewed via telephone. LPN #2 confirmed that she sent Resident #5 out to the hospital on [DATE]. LPN #2 stated, (resident) is not someone who complains so I knew it was a problem and something needed to be done when the aide told me (resident) had 10 out of 10 pain. (continued on next page)

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	495325	A. Building B. Wing	05/07/2026

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F 0776 Level of Harm - Actual harm Residents Affected - Few	They had told me in report he had fallen and when I went in the room to see about the pain (resident) told me (resident) had fallen. I went to look for the x-ray report and couldn't find where it had been done so I called them and they said it was scheduled to be done that day, but they were too busy to come. I called the NP and she ordered to send him out and it wasn't long before the hospital called and said the hip was broken.On 05/06/2026 at 10:10 AM the Director of Nursing (DON) was interviewed regarding the facility's fall process. When asked if falls, including resident assessments should be documented in progress notes, she stated, it's in risk management. When reminded the survey team does not have access to risk management; incident reports are not part of the clinical record she stated, there is a link in risk management that pulls the information to the notes. Requested she provide the notes including the physical assessment for Resident #5 for the 06/23/2025 fall with fracture. When asked if she would expect to see follow up documentation on the resident's pain on 06/23/2025 and 05/24/2025 she stated, He wasn't having pain until the 25th. Informed her that is not true, the resident had pain after the fall on the 23rd rated 4 out of 10 on a 1-10 pain scale as documented on the Change in Condition form, which was why an x-ray was ordered and Tylenol was administered per the medication administration record (MAR). When asked what the expectation for a time frame is when a resident falls, complains of pain and a hip x-ray is ordered, she stated, I would expect it to be done the same day and if not I would expect to call the doctor and follow orders to hopefully send them out for the x-ray.On 05/06/2026 at 11:20 AM the DON stated she had no explanation for the failure to obtain the x-ray and was unable to produce evidence that staff followed up on the x-ray on 06/24/2025. She also stated she was unable to produce evidence that a physical assessment was done post fall.On 05/06/2026 at 4:20 PM the Account Manager for the mobile x-ray company was interviewed. When asked what the timeframe should be from when an x-ray is ordered until it is done she stated, There is no official timeframe or expectation unless it is ordered stat (requiring immediacy), but it shouldn't take three days for a resident who fell and was having pain.On 05/07/2026 at 4:16 PM the Medical Director at the time of the fall was interviewed. When asked what the expected timeframe for a hip x-ray when a resident falls and complains of hip pain he stated, I'm not sure what the normal process is exactly but two or three days is definitely too long. (Resident) should have been sent out sooner and I am not sure why that didn't happen.On 05/07/2026 at 5:13 PM the survey team met with the Administrator, DON and Assistant Director of Nursing. This concern was discussed with them at that time.No further information was provided to the survey team prior to the exit conference.

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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	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. Based on observation, staff interview, clinical record review, and facility document review, the facility staff failed to maintain medical records in accordance with accepted professional standards and practices for 1 of 8 residents in the survey sample, Resident #8 (R#8). The findings included:On 5/5/26 at 1:59 pm, during a record review for Resident #4 (R#4), a wound progress note titled, patient visit record dated 3/17/2026 and a hospice consent dated 3/16/26 for Resident #8 (R#8) were observed uploaded in the chart of R#4. On 5/5/2026 at 3:10 pm an interview was conducted with the Medical Records Coordinator. She stated her procedure is to upload the records as soon as she receives them if possible, limiting who all uploads' records as to keep mistakes at a minimum. If a wrong record is uploaded into the wrong chart by staff the records are deleted immediately. She reports taking pride in her work and was upset when she was advised on the records for R#8 being uploaded into R#4's electronic record. It was noted that R#8 has a similar last name to R#4. On 5/6/2027, the facility staff provided the survey team with a copy of their policy titled, HIPPA Security Measures. This policy read in part, .It is the facility's policy to implement reasonable and appropriate measures to protect and maintain the confidentiality, integrity, and availability of the resident's identifiable information and/or records that are in electronic format. On 05/07/2026 at 5:13 PM the survey team met with the DON (Director of Nursing), ADON (Assistant Director of Nursing) and Administrator. These concerns were reviewed at that time. No further information was provided to the survey team prior to the exit conference.