DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2017
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	496082	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	327 HERSHBERGER RD NW ROANOKE, VA 24012

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F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 08/08/17 through 08/10/17. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow.

The census in this 253 certified bed facility was 230 at the time of the survey. The survey sample consisted of 28 current Resident reviews (Residents 1 through 27 and 33) and 5 closed record reviews (Residents 28 through 32).

F 155 SS=D	483.10(c)(6)(8)(g)(12), 483.24(a)(3) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES	F 155	A. Resident #18 e complete and accurate "Durable Do not Resuscitate" (DDNR/Golden Rod) was obtained	8/8/2017
			B. Residents on affected unit have the opportunity to have their "DDNR" be incomplete or inaccurate.	9/22/2017
			C. The Administrator will re-educate the providers to accurately and completely complete the "DDNR" form prior to signing it.	9/22/2017
			D. The Nurse Manager or designee will audit all charts for complete and accurate "DDNR" forms. the findings will be reported to the Quality Assurance committee weekly times 8 weeks and then monthly times 4 months for 2 consecutive quarters.	9/22/2017

483.10
(c)(6) The right to request, refuse and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.

(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives).

(i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Douglas R. Wright | TITLE: Administrator | (X6) DATE: 9/22/2017

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 155	Continued From page 1	F 155		

(ii) This includes a written description of the facility's policies to implement advance directives and applicable State law.

(iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law.

(v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

483.24
(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives.
This REQUIREMENT is not met as evidenced by:
Based on staff interview, clinical record, and the Code of Virginia, it was determined that the facility staff failed to accurately complete the "Durable Do Not Resuscitate" (DDNR)/Golden Rod order sheet for 1 of 33 Residents in the

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F 155	Continued From page 2 sample survey, Resident #18. The Findings Included: For Resident #18, the facility staff failed to ensure that the "Durable Do Not Resuscitate" (DDNR/Golden Rod) order sheet was complete and accurate. Resident #18 was an 86 year old male, who was admitted on 2/29/16. Admitting diagnoses included, but were not limited to: bladder tumor, acute kidney injury, mild cognitive impairment, atrial fibrillation, hearing loss, cirrhosis of the liver and adult failure to thrive. The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment, with an Assessment Reference Date (ARD) of 7/06/17. The facility staff coded that Resident #18 had a Cognitive Summary Score of 10. The facility staff also coded that Resident #18 required extensive assistance (3/2) with Activities of Daily Living (ADL's). On August 8, 2017 at 2 p.m. the surveyor reviewed Resident #18's clinical record. Review of the clinical record produced a "Durable Do Not Resuscitate" (DDNR)/Golden Rod sheet. The DDNR/Golden Rod was dated 10/20/16. Review of the DDNR/Golden Rod sheet revealed that the DDNR/Golden Rod sheet was not accurate. The DDNR/Golden Rod had not documented whether Resident #18 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment.	F 155		

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F 155	Continued From page 3 Reference: Code of Virginia § 512.1-2987.1. Durable Do Not Resuscitate Orders. A. A Durable Do Not Resuscitate Order may be issued by a physician for his patient with whom he has a bona fide physician/patient relationship as defined in the guidelines of the Board of Medicine, and only with the consent of the patient or, if the patient is a minor or is otherwise incapable of making an informed decision regarding consent for such an order, upon the request of and with the consent of the person authorized to consent on the patient's behalf. On August 9, 2017 at 2:20 p.m. the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that Resident #18's DDNR/Golden Rod was not complete and accurate. The surveyor reviewed the DDNR/Golden Rod with the DON and pointed out that the DDNR/Golden Rod was not coded as to whether Resident #18 was Capable or Incapable of making an informed decision about providing, withholding or withdrawing specific medical treatment or course of medical treatment. The DON verified that the section of the DDNR/Golden Rod that certified whether or not Resident #18 was Capable or Incapable of making an informed decision was not complete and accurate. The surveyor notified the AT that the DDNR/Golden Rod was part of the clinical record and was inaccurate and incomplete. No further information was provided to the team prior to exiting the facility as to why the staff failed to ensure a complete and accurate DDNR/Golden Rod for Resident #18.	F 155		
F 164	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL	F 164	A. Resident #21 was removed from situation.	8/10/2017

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F 164 SS=D	Continued From page 4 PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility 1o provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings,	F 164	Resident #19 information was protected. B. Residents on affected units have the opportunity to have their privacy/confidentiality compromised. C. Staff will be re-educated on resident privacy to include toileting techniques and protecting private healthcare information. D. The Nurse Manager or designee will audit for acts of compromising privacy/confidentiality; specifically related to open doors and computer monitors. The findings will be reported to the Quality Assurance committee weekly times 8 weeks and then monthly times 4 months for 2 consecutive quarters.	8/9/2017 9/22/2017 9/22/2017 9/22/2017

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F 164	Continued From page 5 law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy & clinical record review, it was determined the facility staff failed to ensure personl privacy during toileting and recordkeeping for 2 of 33 residents (Resident #21 and 19). ~Failed to provide Resident #21 with personal privacy during toileting ~Failed to ensure Resident #19's electronic clinical records were kept private Findings: 1. Facility staff failed to ensure privacy during toileting for Resident # 21. Resident #21's clinical record review was conducted on 8/10/17 at 8:35 AM. Resident #21 was admitted to the facility on 5/8/17. Her diagnoses included hypertension, diabetes, dementia and depression. The latest MDS assessment (dated 5/30/17) coded the resident with mild cognitive impairment. She needed staff assistance for dressing hygiene and bathing. The resident required oversite only to ambulate and eat. She was totally continent of bowel and bladder. Resident #21's CCP (comprehensive care plan) dated 6/7/17, documented the problem, "Self-care deficit in performing ADLs r/t Dementia. The interventions included, "Toilet use: staff	F 164		

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F t64	Continued From page 6 assist as needed." On 8/9/17 at 12:40 PM, Resident #21 was observed to be assisted to the bathroom by CNA I. The CNA closed the bathroom door, but left the room door to the hallway, open. When the CNA left the bathroom, Resident #2 t was observed, from the hallway, to be seated on the toilet. CNA I returned to assist the resident to exit the bathroom and opened the bathroom door, exposing the resident still seated on the toilet. This was observed from the hallway. CNA I then closed the bathroom door to assist the resident back into her clothes before bringing her from the hallway. On 8/t0/17 at 10:00 AM this information was shared with the administrator and DON. No additional information was provided prior to exit. 2. For Resident # t9, the facility staff failed to protect private health care information by failing to close/cover the computer screen containing the Resident's private healthcare information during a medication pass and pour observation. Resident #19 was admitted to the facility on 10/28/10 and readmitted on 07/26/ t7. Diagnoses included but not limited to hypertension, end stage renal disease, diabetes mallitus, hyperlipidemia, arthritis, osteoporosis, Alzheimer's disease, dementia, malnutrition, psychotic disorder, schizophrenia, and glaucoma. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/14/ t7 coded the Resident as 3 out of 17 in section C, cognitive status. This is a quarterly MDS.	F t64		

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F 164	Continued From page 7 The surveyor observed RN #1 preparing Resident #19's medications on 08/09/17 at approximately 0750 during a medication pass and pour observation. RN #1 had the computer screen open to Resident #19's MAR (medication administration record), which contained private healthcare information. Surveyor observed RN #1 walk away with another staff person, leaving the computer screen open and uncovered, with Resident #19's information displayed. The concern of the computer screen being left open/uncovered was brought to the attention of the administrative staff during a meeting on 08/09/17 at approximately 1420. No further information was provided prior to exit.	F 164		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered	F 309	A. Resident #5 received dialysis. 8/10/2017 Resident #16 vital order was clarified, to obtain them daily. 8/9/2017 Resident #19 received breakfast tray. 8/9/2017 Resident #32 discharged from facility. 8/9/2017 B. Residents on affected units have the opportunity to miss dialysis or have physician orders not completed. 9/22/2017 C. Nurses will be re-educated on the importance of pre and post dialysis documentation. 9/22/2017 Nursing staff will be re-educated on following physician orders and supporting documentation to include missed dialysis communication, documentation of vitals and medication administration. D. Nurse Manager or designee will audit pre and post dialysis documentation for completion, adherence to vital sign orders, and random medication administration audits for completion of eMAR and 9/22/2017	

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F 309	Continued From page 8 care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. 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. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, resident interview, facility document review and clinical record review, facility staff failed to provide for the highest practicable well-being for 4 of 33 residents in the survey sample (residents #5, 16, 19, and 32). 1. For Resident #5, facility staff failed to ensure that a resident who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Resident #5 was admitted to the facility on 7/16/13 with diagnoses including diabetes mellitus with end stage renal disease with hemodialysis, peripheral vascular disease post lower limb amputation, hypertension, cardiopulmonary disease, mood disorder, psychotic disorder, and pain. On the quarterly	F 309	adherence of orders. The findings will be reported to the Quality Assurance Committee will be weekly for 8 weeks then monthly for 4 months for 2 consecutive quarters.	

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F 309	Continued From page 9 minimum data set assessment with assessment reference date 5/22/17, the resident scored 14/15 on the brief interview for mental status and was assessed with symptoms of disorganized thinking, fluctuating, and with delusions. During an interview on 8/9/17, the resident stated that he was often afraid to go to dialysis because he became so short of breath while there and he was not allowed to take a rescue inhaler with him. He stated that he sometimes had to wait for hours for the rescue inhaler when he requested it. The Medication Administration Record documented that the resident had not received the albuterol inhaler on 8/8/117 at midday (due to the resident being in hemodialysis per nursing note that day) and documented that the nebulizer had been administered on 8/5/17 at mid day (the nurse's note for that day documented the medication had been held due to the resident being in hemodialysis). The concern was related to LPN#1 on 8/9/17. LPN #1 stated the resident could not be trusted not to abuse a rescue inhaler, but the nurse would take the inhaler to the dialysis center if the resident needed it. The nurse was unable to locate any nurse's notes indicating that a nurse had ever taken a rescue inhaler to the resident in dialysis. During an interview on 8/10/17, the director of nursing stated that no nurse would have taken the resident an inhaler because facility staff were not allowed in the dialysis center. She stated that dialysis center should order a rescue inhaler for the resident if the resident needed one during dialysis. The surveyor stated that a Self Administration of Medication assessment dated 7/1/15 assessed the resident as capable of medication self	F 309		

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F 309	Continued From page 10 administration and asked if a later one had determined the resident was not capable of self-administering drugs. Clinical record review on 8/9/17 revealed that documentation of the resident's condition after hemodialysis was not consistent. The surveyor reviewed the clinical record for June, July, and August 1-9 2017. The resident was scheduled to have hemodialysis on Tuesday, Thursday, and Saturday. The surveyor found no nursing note addressing hemodialysis on June 13, 15, 17, 20, July 6, 11, 15, 18, 20, 22, 25, 27, 29, 31, or August 1 or 3. There was no Dialysis Communication form for June 1, July 8, 31, or August 3 and 8. The facility post dialysis portion of the Dialysis Communication form was incomplete for June 3, 15, 20, July 1, 4, 15, 18, 27, and August 1. The resident's care plan did not directly address assessment after hemodialysis. The issues with dialysis management and assessment were discussed with the administrator and director of nursing during a summary meeting on 8/10/17. 2. For Resident #16 the facility staff failed to obtain physician ordered vital signs every shift. Resident #16 was a 79 year old female who was admitted to the facility on 2/20/17. Admitting diagnoses included, but were not limited to: other intravertebral disc replacement, dorsalgia, hypertension, hydronephrosis and urine incontinence. The most current Minimum Data Set (MDS) assessment located in the clinical record was a	F 309		

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F 309	Continued From page 11 Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/29/17. The facility staff coded that Resident #16 had a Cognitive Summary Score of 12. The facility staff also coded that Resident #16 required extensive assistance (3/3) with Activities of Daily Living (ADL's). On August 9, 2017 at 8:30 a.m. the surveyor reviewed Resident #16's clinical record. Review of the clinical record produced signed physician orders dated 6/29/17. Singed physician orders included, but were not limited to: "Vital signs 1 (every) shift three times a day for Vital signs q shift." (sic) The order initiated on 6/21/17. Continued review of the clinical record produced the July and August 2017 Medication Administration Records (MAR's), Treatment Administration Records (TAR's), Progress Notes and Weight and Vitals Summary. Review of these documents failed to produce documentation that the facility staff obtained the physician ordered vital signs every shift (three times a day). On August 9, 2017 at 9 a.m. the surveyor notified the MDS Nurse, who was a Registered Nurse (RN), that Resident #16 had a physician's order to obtain vital signs every shift. The surveyor notified the MDS Nurse that review of Resident #16's clinical record failed to produce documentation that the vital signs were obtained as ordered by the physician. The surveyor reviewed the clinical record with the MDS Nurse. The surveyor specifically pointed out the physicians order to obtain the vital signs every shift. The surveyor also reviewed the 2017 MAR's, TAR's, Progress Notes and Weight and	F 309		

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Vital Summary with the MDS Nurse. The MDS Nurse was unable to locate documentation that the facility staff obtained the physician ordered vital signs every shift.

On August 9, 2017 at 11:10 p.m. the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that Resident #16 had a physician's order to obtain vital signs every shift. The surveyor notified the Administrative Team (AT) that review of the clinical record failed to produce documentation of the vital signs every shift.

No further information was provided to the team prior to exiting the facility as to why the staff failed to follow physician orders for Resident #16. The facility staff failed to obtain physician ordered vital signs every shift for Resident #16.
3. For Resident #19 the facility staff failed to follow physician's orders for the administration of the antidiabetic agent, Metformin.

Resident #19 was admitted to the facility on 10/28/10 and readmitted on 07/26/17. Diagnoses included but not limited to hypertension, end stage renal disease, diabetes mellitus, hyperlipidemia, arthritis, osteoporosis, Alzheimer's disease, dementia, malnutrition, psychotic disorder, schizophrenia, and glaucoma.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 05/14/17 coded the Resident as 3 out of 17 in section C, cognitive status. This is a quarterly MDS.

The surveyor observed RN #1 administering Resident #19's medications on 08/09/17 at approximately 0750 during a medication pass and

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F 309	Continued From page 13 pour. One of the medications being administered was Metformin. Resident #19's medications were administered whole with water. Resident #19's medications were reconciled with the clinical record on 08/09/17 at approximately 0830. The clinical record contained a signed POS (physician's order summary) which read in part "Metformin HCl Tablet 500mg Give 1 tablet by mouth one time a day for DM (diabetes mellitus). Take with food". The Resident's eMAR (electronic medication administration record) was reviewed and contained an entry which read in part "Metformin HCl Tablet 500mg Give 1 tablet by mouth one time a day for DM (diabetes mellitus). Take with food". Surveyor did not observe the medication being administered with food as per the physician's order. Surveyor requested and was provided with a copy of a policy entitled "Administering Medications" which read in part "Purpose: Medications shall be administered in a safe and timely manner, and as prescribed." Surveyor spoke with the administrator on 08/09/17 at approximately 0900 regarding Resident #19. Administrator stated that the medications should have been administered with food as ordered. The concern of not following the physician's orders while administering medications was discussed with the administrative team during a meeting on 08/09/17 at approximately 1420. No further information was provided prior to exit. 4. For Resident #32 the facility staff failed to	F 309		

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F 309	Continued From page 14 follow physician's orders for the administration of the medications atenolol, cholecalciferol, Gleevec, Lasix, prednisone, hydroxychloroquine, gabapentin, Carafate, Mestinon, for the supplements Ensure and Liquicel and for the assessment of vital signs. Resident #32 was admitted to the facility on 07/19/16 and readmitted on 08/07/16. Diagnoses included but not limited to anemia, hypertension, peripheral vascular disease, gastroesophageal reflux disease, end stage renal disease, septicemia, urinary tract infection, hyperlipidemia, thyroid disorder, osteoporosis and anxiety. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/24/16 coded the Resident as 14 out of 15 in section C, cognitive status. This is an admission MDS. Resident #32's clinical record was reviewed on 08/09/17. It contained a signed POS (physician's order summary for the month of August 2016 which read in part "atenolol tablet 25mg. Give 1 tablet by mouth one time a day for HTN (hypertension), cholecalciferol tablet 50000 unit. Give 1 tablet by mouth on time a day every Fri for supplement until 09/23/16, Gleevec Tablet 400mg (Imatinib Mesylate). Give 1 tablet by mouth one time a day for myasthenia gravis, Lasix tablet 20mg (furosemide). Give 1 tablet by mouth one time a day for edema, prednisone tablet 10mg. Give 1 tablet one time a day for myasthenia gravis, hydroxychloroquine sulfate tablet 200mg. give 1 tablet by mouth two times a day for myasthenia gravis, gabapentin capsule 300mg. Give 1 capsule by mouth three times a day for neuropathy, Carafate tablet 1 gm. Give 1 tablet by mouth before meals and at bedtime for GERD	F 309		

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(gastroesophageal reflux disease), Mestinon tablet 60mg (pyridostigmine bromide). Give 1 tablet by mouth four times a day for myasthenia gravis, Ensure three times a day for supplement, Liquicel three times a day for supplement. Liquicel 30cc TID (three times a day), and vital signs on admission Q (every) shift start date 08/06/2016-end date 10/28/2016".

Resident #32's eMAR (electronic medication administration record) for the month of August 2016 was reviewed and contained the following entries which read in part "atenolol tablet 25mg. Give 1 tablet by mouth one time a day for HTN (hypertension), cholecalciferol tablet 50000 unit. Give 1 tablet by mouth on time a day every Fri for supplement until 09/23/16, Gleevec Tablet 400mg (Imatinib Mesylate). Give 1 tablet by mouth one time a day for myasthenia gravis, Lasix tablet 20mg (furosemide). Give 1 tablet by mouth one time a day for edema, prednisone tablet 10mg. Give 1 tablet one time a day for myasthenia gravis, hydroxychloroquine sulfate tablet 200mg. give 1 tablet by mouth two times a day for myasthenia gravis, gabapentin capsule 300mg. Give 1 capsule by mouth three times a day for neuropathy, Carafate tablet 1 gm. Give 1 tablet by mouth before meals and at bedtime for GERD (gastroesophageal reflux disease), Mestinon tablet 60mg (pyridostigmine bromide). Give 1 tablet by mouth four times a day for myasthenia gravis, Ensure three times a day for supplement, Liquicel three times a day for supplement. Liquicel 30cc TID (three times a day), and vital signs on admission Q (every) shift start date 08/06/2016-end date 10/28/2016". The entries for the atenolol, cholecalciferol Gleevec, Lasix, prednisone, hydroxychloroquine, Carafate, and Mestinon had not been initialed as having been

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F 309	Continued From page 16 administered on 08/19/16 for the AM dose. The Carafate and Mestinon had also not been initialed as having been administered on 08/24/16 for the mid-day dose. The gabapentin and the Ensure had not been initialed as having been administered on 08/24/16 for the mid-day dose. The Liquicel had not been initialed as having been administered on 08/27/16 for the Am, mid-day or evening doses. Vital signs had not been recorded for 08/25/16 on night shift or 08/27-28/16 for day shift. The concern of not following the physician's order for the administration of medications, supplements and recording vital signs was discussed with the administrative team during a meeting on 08/10/17 at approximately 1255. No further information was provided prior to exit.	F 309		
F 314 SS=D	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers	F 314	A. Resident #32 is no longer at the facility. B. All residents on affected units have the opportunity for incomplete documentation. C. Nursing staff will be re-educated on treatment administration and complete documentation. D. Nurse Manager or designee will audit (TAR) Treatment Administration Record for adherence to physician orders. The findings will be reported to the Quality Assurance committee will be weekly for 8 weeks then monthly for 4 months for 2 consecutive quarters.	8/9/2017 9/22/2017 9/22/2017 9/22/2017

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F 314	Continued From page 17 from developing. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint survey the facility staff failed to provide physician ordered treatments for the prevention of pressure areas for 1 of 33 Residents, Resident #32. The findings included: For Resident #32 the facility staff failed to provide physician ordered treatments for the prevention of pressure areas. Resident #32 was admitted to the facility on 07/19/16 and readmitted on 08/07/16. Diagnoses included but not limited to anemia, hypertension, peripheral vascular disease, gastroesophageal reflux disease, end stage renal disease, septicemia, urinary tract infection, hyperlipidemia, thyroid disorder, osteoporosis and anxiety. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/24/16 coded the Resident as 14 out of 15 in section C, cognitive status. This is an admission MDS. Resident #32's clinical record was reviewed on 08/09/17. It contained a signed POS (physician's order summary) for the month of August 2016 which read in part "Cleanse sacral wound with NS (normal saline), pat dry. Apply MediHoney gel to gauze, then to wound bed. Cover with dry dressing QD (every day) one time a day for wound care -Start date- 08/07/16 -D/C (discontinue) Date- 08/17/16, Cleanse sacral wound with NS. Pat Dry. Apply Santyl to saline moistened gauze. Apply in wound bed and cover	F 314		

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F 314	Continued From page 18	F 314		

with dry gauze and mepilex daily, one time a day for wound care -Start Date- 08/12/2016 -D/C Date -08/16/2016, Cleanse sacrum with NS. Pat dry. Apply dakins saturated gauze in wound bed. Cover with dry gauze and mepilex BID two times a day for wound care -Start Date- 08/16/16 -D/C Date- 09/15/16, Limit time in chair to 2 hr intervals. Assist with repositioning as needed while in char two times a day for Offloading to Sacral wound -Start-Date- 08/162016 -D/C Date -10/28/2016, Air mattress to bed every shift -Start Date- 08/06/2016 -D/C Date- 10/28/2016, Calmazime Skin Protectant Paste (Skin Protectants, Misc.) Apply to groin and peri area topically every shift for skin protection -Start Date- 08/06/2016 -D/C Date- 10/28/2016, Observe BLE (bilaterally lower extremities) and sacrum Q shift for s/s (signs/symptoms) infection every shift for wound care -Start Date- 08/06/2016 -D/C Date- 10/28/2016, Ski prep to bilateral heels and sides of feet Q shift every shift for prevention -Start Date- 08/06/2016 -D/C Date- 09/08/2016, Turn and reposition q 2 hrs every shift wound care -Start Date- 08/16/2016 D/C Date 10/28/2016".

Resident #32's eMAR (electronic medication administration record) was reviewed and contained an entry which read in part "Cleanse sacral wound with NS (normal saline), pat dry. Apply MediHoney gel to gauze, then to wound bed. Cover with dry dressing QD (every day) one time a day for wound care -Start date- 08/07/16 -D/C (discontinue) Date- 08/17/16". This entry had not been initialed as having been completed on 08/13-14/2016. The eMAR contained an entry which read in part "Cleanse sacral wound with NS. Pat Dry. Apply Santyl to saline moistened gauze. Apply in wound bed and cover with dry gauze and mepilex daily, one time a day for

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wound care -Start Date- 08/12/2016 -D/C Date -08/16/2016". This entry had not been signed as having been completed on 08/13-14/2016. The eMAR contained an entry which read in part "Cleanse sacrum with NS. Pat dry. Apply Dakin's saturated gauze in wound bed. Cover with dry gauze and mepilex BID two times a day for wound care -Start Date- 08/16/16 -D/C Date- 09/15/16". This entry had not been signed as having been completed on 08/19, 08/20, 08/24, 08/27 or 08/28/16 for AM and 08/23, 08/26, or 08/28/16 for evening. The eMAR contained an entry which read in part "Limit time in chair to 2 hr intervals. Assist with repositioning as needed while in chair two times a day for Offloading to Sacral wound -Start-Date- 08/16/16 -D/C Date -10/28/16". This entry had not been signed as having been completed on 08/19 or 08/20/16 for AM and 08/23, 08/26, or 08/28/16 for evenings. The eMAR contained an entry which read in part "Air mattress to bed every shift -Start Date- 08/06/16 -D/C Date- 10/28/16". This entry had not been initialed as having been completed on 08/14, 08/19 or 08/20/216 for AM and 08//23, 08/26 and 08/28/16 for evenings. The eMAR contained an entry which read in part "Calmazime Skin Protectant Paste (Skin Protectants, Misc.) Apply to groin and peri area topically every shift for skin protection -Start Date- 08/06/2016 -D/C Date- 10/28/2016. This entry had not been initialed as having been completed on 08/14, 08/19 or 08/20/16 for AM, 08/23, 08/26, or 08/28/16 for evenings and 08/25/16 for nights. The eMAR contained an entry which read in part "Observe BLE (bilaterally lower extremities) and sacrum Q shift for s/s (signs/symptoms) infection every shift for wound care -Start Date- 08/06/2016 -D/C Date- 10/28/2016. This entry had not been initialed as having been completed

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F 314	Continued From page 20 on 08/14, 08/19, or 08/20/16 for days, 08/23, 08/26, or 08/28/16 for evenings and 08/25/16 for nights. The eMAR contained an entry which read in part "Skin prep to bilateral heels and sides of feet Q shift every shift for prevention -Start Date- 08/06/2016 -D/C Date- 09/08/2016". This entry had not been initialed as having been completed on 08/14, 08/19, or 08/20/16 for days, 08/23, 08/26, or 08/28/16 for evenings and 08/25/16 for nights. The eMAR contained an entry which read in part "Turn and reposition q 2 hrs every shift wound care -Start Date- 08/16/2016 D/C Date 10/28/2016". This entry had not been initialed as having been completed on 08/19 or 08/20/16 for days, 08/23, 08/26, or 08/28/16 for evenings and 08/25/16 for nights. Surveyor spoke with the administrator regarding the missing documentation of physician ordered treatments on 08/10/17 at approximately 1130. The administrator could provide no explanation for the missing documentation. The concern of the treatments not being completed as ordered was discussed during a meeting with the administrative staff during a meeting on 08/10/17 at approximately 1255. Nor further information was provided prior to exit. This is a complaint deficiency.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free	F 323	A. Resident #6 bed and chair alarms were placed. Resident #18 geri-sleeves was placed. B. All residents on affected units have the opportunity for physician orders missed/not followed.	8/10/2017 8/8/2017 9/22/2017

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F 323	Continued From page 21 from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, clinical record, it was determined that the facility staff failed to ensure and environment free of accident hazards for 2 of 33 Residents in the sample survey, Resident #6 and Resident #18. The Findings Included: 1. For Resident #6 the facility staff failed to apply physician ordered interventions to prevent falls. The facility staff failed to ensure that physician ordered bed alarm and chair alarm were in place. Resident #6 was a 90 year old female who was admitted on 1/30/17. Admitting diagnoses included, but were not limited to: fractured femur,	F 323	C. Nursing staff will be re-educated on the importance to follow physician orders. D. Nurse Manager or designee will audit bed and chair alarms and geri-sleeves to adherence to the physician order. The findings will be reported to the Quality Assurance committee will be weekly for 8 weeks then monthly for 4 months for 2 consecutive quarters.	9/22/2017 9/22/2017

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F 323	Continued From page 22 dysphagia, falls, hypothyroidism and chronic kidney disease without heart failure. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/9/17. The facility staff coded that Resident #6 had a Cognitive Summary Score of 8. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). On August 8, 2017 at 2:25 p.m. the surveyor observed Resident #6 sitting in her wheelchair at the side of her bed. Resident #6 had a family member visiting with her. Resident #6 was dressed in street clothes. The surveyor did not observe a wheel chair alarm or a bed alarm. On August 9, 2017 at 7:15 a.m. the surveyor observed Resident #6 lying in bed asleep. The surveyor noted the wheelchair was at the foot of the bed. The surveyor did not observe a wheel chair alarm on the wheelchair or a bed alarm. On August 9, 2017 at 8:05 a.m. the surveyor observed Resident #6 sitting in her wheelchair at the side of her bed. Resident #6 was dressed in her night clothes. Resident #6 informed the surveyor she was waiting on her breakfast tray. The surveyor did not observe a wheelchair alarm on Resident #6's wheelchair. On August 9, 2017 at 8:40 a.m. the surveyor observed Resident #6 sitting in her wheelchair at the side of her bed and she was preparing her breakfast tray. The surveyor did not observe a wheelchair alarm.	F 323		

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495092	A. BUILOING _____ B. WING _____	C 08/10/2017

NAME OF PROVIOER OR SUPPLIER	STREET AOORESS, CITY, STATE, ZIP COOE
FRIENDSHIP HEALTH AND REHAB CENTER	327 HERSHBERGER RD NW ROANOKE, VA 24012

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F 323	Continued From page 23 On August 9, 2017 at 10 a.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced signed physician orders dated 6/29/17. Signed physician orders included, but were not limited to: "FALL PRECAUTIONS every shift. Bed alarm as resident allows. Chair alarm as resident allows." (sic) Continued review of the clinical record produced the Comprehensive Care Plan (CCP). Review of the CCP documented that the facility staff identified that Resident #6 was at risk for falls. The CCP identified the following "Focus" and "Interventions." "Focus- (name of resident withheld) has voiced experiencing pain/discomfort s/p recent surgical repair of fracture sustained in fall prior to admission ...." "Focus-(name of resident withheld) is at risk to have a fall occurrence and injury. He has recent history of fall prior to admission during which she sustained a fracture of the left hip. Se currently requires limited to extensive staff assistance with transfers and mobility self performance. Her sitting and standing balance is fair to poor. She may require cues/reminders/prompts at times for safety d/t (due to) mild impairment stm/recall. ...Interventions-Provide a safe environment with: even floors free from spills and/or other clutter: adequate, glare free light, personal items within reach, bed in lowest position for safe transfers, beds wheels locked, etc." (sic) Further review of the clinical record produced the August 2017 Medication Administration Records (MAR's), August 2017 Treatment Administration Records (TAR's) and current Progress Notes. These three documents failed to document the	F 323		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	327 HERSHBERGER RD NW ROANOKE, VA 24012

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F 323	Continued From page 24 application and/or the refusal by the resident of the physician ordered wheelchair and bed alarm. On August 9, 2017 at 10:20 a.m. the surveyor notified the MDS Nurse, who was a Registered Nurse (RN), that Resident #6 had a physician order for a wheelchair alarm and a bed alarm. The surveyor reviewed the clinical record with the MDS Nurse. The surveyor specifically pointed out the physician order for the wheelchair and bed alarm. The surveyor informed the MDS Nurse that the surveyor had not seen either of the alarms on Resident #6 on multiple occasions. The surveyor requested for the MDS Nurse to accompany the surveyor to Resident #6's room to see if the alarms were in place. The surveyor and MDS Nurse walked to Resident #6's room and entered her room. The MDS Nurse walked behind Resident #6's wheelchair and observed Resident #6's bed. The MDS Nurse was unable to locate the physician ordered wheelchair or bed alarm. On August 9, 2017 at 11:10 p.m. the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that Resident #6 had physician orders for a wheelchair and bed alarm. The surveyor notified the Administrative Tam (AT) that the physician ordered fall interventions, wheelchair and bed alarms, were not in place. No further information was provided to the team prior to exiting the facility as to why the staff failed to ensure an environment free of accident hazards for Resident #6. The facility staff failed to apply physician ordered fall interventions. 2. For Resident #18, the facility staff failed to apply physician ordered Geri-sleeves to the	F 323		

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
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FRIENDSHIP HEALTH AND REHAB CENTER	327 HERSHBERGER RD NW ROANOKE, VA 24012

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F 323	Continued From page 25 bilateral upper arms. Resident #18 was an 86 year old male, who was admitted on 2/29/16. Admitting diagnoses included, but were not limited to: bladder tumor, acute kidney injury, mild cognitive impairment, atrial fibrillation, hearing loss, cirrhosis of the liver and adult failure to thrivB. The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment, with an Assessment Reference Date (ARD) of 7/06/17. The facility staff coded that Resident #18 had a Cognitive Summary Score of 10. The facility staff also coded that Resident #18 required extensive assistance (3/2) with Activities of Daily Living (ADL's). On August 8, 2017 at 2 p.m. the surveyor reviewed Resident #18's clinical record. Review of the clinical record produced signed physician orders dated 6/30/17. Signed physician orders included, but were not limited to: "Geri-sleeves to BUE (bilateral upper extremities) for integrity as resident allows." (sic) Continued review of the clinical record produced the August 2017 Medication Administration Record (MAR's), August 2017 Treatment Administration Record (TAR's). Review of the August 2017 MAR's and TAR's failed to document the application of the physician ordered Geri-sleeves. Further review of the clinical record produced the "Progress Notes." Review of the progress notes failed to document the application of the Geri-sleeves or resident refusal of the physician	F 323		

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F 323	Continued From page 26 ordered Geri-sleeves. Additional review of the clinical record produced the Comprehensive Care Plan (CCP) for Resident #18. Review of the CCP documented that the facility staff identified the following "Focus" and "Interventions." "Focus- (Resident #18's name withheld) is at risk for excessive bleeding r/t (related to) use of anticoagulant medication for the diagnosis of a-fib (atrial fibrillation). (Resident name withheld) is also at risk for complications related to HTN (hypertension) and Vit (vitamin) D deficiency. He was been treated for a hematoma to his L (left) forearm by wound MD. he receives preventative care to his arm .... Interventions- F/U (follow up) c (with) wound MD as ordered for a ST (skin tear) + (and) encourage not to pick + wear preventative sleeves/turbigrips as ordered." (sic) On August 8, 2017 at 2::20 p.m. the surveyor observed Resident #18 lying in bed. Resident #18 had his left arm extended up and behind his head. His right arm was lying on top of the covers. The surveyor did not observe that Resident #18 had on the physician ordered Geri-sleeves. On August 8, 2017 at 4:20 p.m. the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that Resident #18 had a physician order for Geri-sleeves to bilateral upper extremities. The surveyor notified the AT that Resident #18 did not have on the physician ordered Geri-sleeves. The surveyor reviewed the clinical record with the DON and specifically pointed out the physician order for the	F 323		

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F 323	Continued From page 27 Geri-sleeves. The surveyor also reviewed the August 2017 MAR's and TAR's and the progress notes with the DON. No further information was provided to the team prior to exiting the facility as to why the staff failed to apply the physician ordered Geri-sleeves to Resident #18.	F 323		
F 329 SS=E	483.45(d)(e)(1)-(2) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS 483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used-- (1) In excessive dose (including duplicate drug therapy); or (2) For excessive duration; or (3) Without adequate monitoring; or (4) Without adequate indications for its use; or (5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. 483.45(e) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that-- (1) Residents who have not used psychotropic	F 329	A. Resident #18 was monitored for antidepressant and anti-anxiety medication. Resident #7 was monitored for anti-anxiety and anti-psychotic medication. Resident #16 was monitored for anti-anxiety medication. B. All residents on affected unit who are prescribed anti-anxiety, anti-psychotic and antidepressant medication have the opportunity to have incomplete documentation for specific behaviors, nursing interventions, side effects and effectiveness. C. Nursing staff will be re-educated on the proper monitoring of residents who receive anti-anxiety, antidepressants and anti-psychotics. D. Nurse Manager will audit for complete and accurate documentation for specific behaviors, nursing interventions, side effects and effectiveness for residents receiving anti-anxiety, antidepressants and anti-psychotics. The findings will be reported to the Quality Assurance committee will be weekly for 8 weeks then monthly for 4 months for 2 consecutive quarters.	8/10/2017 8/10/2017 8/10/2017 9/22/2017 9/22/2017 9/22/2017

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F 329	Continued From page 28 drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; (2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to ensure that 3 of 33 Residents in the sample survey were free from unnecessary medications, Resident #16, Resident #18 and Resident #7. The facility staff failed to monitor for the use of psychotropic, antianxiety and antidepressant drug use to include specific behaviors, nursing interventions, side effects and effectiveness. The Findings Included: 1. For Resident #16 the facility staff failed to monitor for Citalopram, an antidepressant, and Lorazepam, an antianxiety drug use to include specific behaviors, nursing interventions, side effects and effectiveness. Resident #16 was a 79 year old female who was admitted to the facility on 2/20/17. Admitting diagnoses included, but were not limited to: other intravertebral disc replacement, dorsalgia, hypertension, hydronephrosis and urine incontinence.	F 329		

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F 329	Continued From page 29 The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/29/t7. The facility staff coded that Resident #t6 had a Cognitive Summary Score of t2. The facility staff also coded that Resident #t6 required extensive assistance (3/3) with Activities of Daily Living (ADL's). On August 9, 20t7 at 8:30 a.m. the surveyor reviewed Resident #t6's clinical record. Review of the clinical record produced signed physician orders dated 6/29/t7. Singed physician orders included, but were not limited to: "Citalopram Hydrobromide Tablet 20 MG Give t tablet by mouth one time a day for depression. LORazepam Tablet 0.5mg Give t tablet every eight hours as needed for Anxiety." (sic) Continued review of the clinical record produced the July and August 20t7 Medication Administration Records (MAR's). Review of the July and August 20t7 MAR's documented that the facility staff administered the Citalopram every day for depression. Review of the July and August 20t7 MAR's documented that the facility staff administered the Lorazepam almost daily in the month of July 2017 and on the following days in August: 8/3/t7 at 9:5t a.m., 8/5/t7 at 8:25 a.m., 8/6/t7 at 8:04 a.m. and 8:29 p.m., 8/7/t7 at 9:09 p.m., and 8/8/t7 at 8:40 a.m. and 9:t6 p.m. Further review of the clinical record produced the Progress Notes and Target Behavior Observation Summary's. These documents failed to document monitoring for the use of the antidepressant, Citalopram, and the antianxiety, Lorazepam, to include specific behaviors, nursing interventions,	F 329		

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F 329	Continued From page 30 effectiveness and side effects. Continued review of the clinical record failed to document medication monitoring for the use of the antidepressant, Citalopram, and the antianxiety, Lorazepam, to include specific behaviors, nursing interventions, effectiveness and side effects. On August 9, 2017 at 9 a.m. the surveyor notified the MDS Nurse, who was a Registered Nurse (RN), that Resident #16 was receiving Citalopram and Lorazepam. The surveyor notified the MDS Nurse that review of the clinical record failed to produce documentation of monitoring for the antidepressant and antianxiety drug use to include specific behaviors, nursing interventions, side effects and effectiveness. The surveyor reviewed the clinical record with the MDS Nurse. The surveyor reviewed the signed physician orders, MAR's, Progress Notes and Target Behavior Observation Summary's. The MDS Nurse was unable to locate monitoring for the Citalopram and Lorazepam drug use. On August 9, 2017 at 11:10 p.m. the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that Resident #16 was receiving Citalopram and Lorazepam. The surveyor notified the Administrative Team (AT) that the facility staff were not monitoring Resident #16 for the antidepressant and antianxiety drug use to include specific behaviors, nursing interventions, side effects and effectiveness. No further information was provided to the team prior to exiting the facility as to why the staff failed to ensure that Resident #16 was free from unnecessary medications. The facility staff failed	F 329		

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F 329	Continued From page 31 to monitor for antidepressant and anxiety drug use to include specific behaviors, nursing interventions, side effects and effectiveness. For additional information regarding Resident #16 refer to F Tags 309 and 514. 2. For Resident #18, the facility staff failed to monitor for Buspirone (antianxiety), Lexapro (antidepressant) and Remeron (antidepressant) drug use to include specific behaviors, nursing interventions, side effects and effectiveness. Resident #18 was an 86 year old male, who was admitted on 2/29/16. Admitting diagnoses included, but were not limited to: bladder tumor, acute kidney injury, mild cognitive impairment, atrial fibrillation, hearing loss, cirrhosis of the liver and adult failure to thrive. The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment, with an Assessment Reference Date (ARD) of 7/06/17. The facility staff coded that Resident #18 had a Cognitive Summary Score of 10. The facility staff also coded that Resident #18 required extensive assistance (3/2) with Activities of Daily Living (ADL's). On August 8, 2017 at 2 p.m. the surveyor reviewed Resident #18's clinical record. Review of the clinical record produced signed physician orders dated 6/30/17. Signed physician orders included, but were not limited to: "BusPIRone HCl Tablet 15 MG Give 1 tablet by mouth two times a day for anxiety. Lexapro Tablet 20 MG (Escitalopram Oxalate) Give 1 tablet by mouth one time a day for Depression. Lexapro 20mg po	F 329		

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F 329	Continued From page 32	F 329		

(by mouth) q-day (every day) for depression. Remeron Tablet 15 MG (Mirtazapine) Give 1 tablet by mouth one time a day for depression, appetite, sleep related to ADULT FAILURE TO THRIVE (R62.7); MAJOR DEPRESSIVE DISORDER, RECURRENT, UNSPECIFIED (F33.9)." (sic)

Continued review of the clinical record produced the August 2017 Medication Administration Record (MAR's). Review of the August 2017 MAR's documented that the facility staff were administering the Buspirone, Lexapro and Remeron as ordered by the physician.

Further review of the clinical record produced the Progress Notes and Target Behavior Observation Summary's. These documents failed to document monitoring for the use of the antidepressants, Lexapro and Remeron, and the antianxiety medication, Buspirone, to include specific behaviors, nursing interventions, effectiveness and side effects.

Continued review of the clinical record failed to document medication monitoring for the use of the antidepressant, Lexapro and Remeron, and the antianxiety, Buspirone, to include specific behaviors, nursing interventions, effectiveness and side effects.

Additional review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP identified the following "Focus" and "Interventions."

"Focus- (Resident #18's name withheld) is on an antidepressant medication for the diagnosis of Major depressive disorder. He is followed by

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F 329	Continued From page 33	F 329		

psychiatry. He has a history of refusing medications/treatments including skin assessments, ADL care, weights, food and fluid. He has also declined IV's and a tube feeding per discussion with MD. ... Interventions Monitor for increased agitation, Shortness of breath, behavior changes, unable to sleep or concentrate, changes in appetite, chest pain. Monitor for S/S (signs and symptoms) depression- decreased appetite, changes in sleeping pattern, mood swings, anxiety, unexplained crying and isolation. Monitor for side effects of antipsychotic medication-somnolence, insomnia, orthostatic, hypotension, tachycardia, peripheral edema, amblyopia, constipation, thirst, increase salivation, UTI joint pain, and sweating. ... Monitor for side effects of antidepressant-somnolence, insomnia, anxiety, tachycardia, N/V, behavior changes, abdominal pain, changes in weight, increased sweating. Nursing to offer 1:1, counseling, psychiatry eval and treat. Offer rest and relaxation in a quiet atmosphere. Music of interest." (sic)

On August 8, 2017 at 4:20 p.m. the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that Resident #18 was receiving Buspirone, Remeron and Lexapro. The surveyor notified the AT that medication monitoring for the use of the medications could not be located in the clinical record. The surveyor notified the AT that specific behaviors, nursing interventions, side effects and effectiveness must be documented for the use of the antidepressants and antianxiety medications.

No further information was provided to the team prior to exiting the facility as to why the staff failed

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FRIENDSHIP HEALTH AND REHAB CENTER	327 HERSHBERGER RD NW ROANOKE, VA 24012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)	(X5) COMPLETION OATE
F 329	Continued From page 34 to ensure that Resident #18 was free from unnecessary medications. The facility staff failed to monitor for antidepressant and anxiety drug use to include specific behaviors, nursing interventions, side effects and effectiveness. 3. For Resident #7 the facility staff failed to provide adequate monitoring for the antianxiety medications Ativan and bupropion and the antipsychotic medications risperidone and Lithobid. Resident #7 was admitted to the facility on 01/06/17 and readmitted on 07/17/17. Diagnoses included but not limited to schizoaffective disorder, hypertension, hypokalemia, depression, diabetes mellitus type 2, hyperlipidemia, anxiety, and bipolar disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/30/17 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #7's clinical record was reviewed on 09/08/17. It contained a signed POS (physician's order summary) for the month of July which read in part "Ativan Tablet 0.5mg (Lorazepam). Give 0.5 tablet by mouth one time a day for anxiety, catatonia. Take @ 5pm", "Ativan Tablet 0.5mg (Lorazepam). Given 0.5 tablet by mouth one time a day for anxiety, catatonia. Take @ 9am", "Bupropion HCl ER (SR) Tablet Extended Release 12 Hour 150mg. Give 1 tablet by mouth every 12 hours for Anxiety with depression", "Lithobid Tablet Extended Release 300mg (Lithium Carbonate ER). Give 1 tablet by mouth every 12 hours for schizoaffective disorder", and	F 329		

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F 329	Continued From page 35 "Risperidone Tablet 4mg. Give 1 tablet by mouth at bedtime for schizophrenia". Resident #7's eMAR (electronic medication administration record) for the months July and August 2017 were reviewed and indicated that Resident #7 was receiving medications as ordered by the physician. Resident #7's CCP (comprehensive care plan) was reviewed and contained a care plane for" ...multiple psychotropic medications r/t (related to) her extensive psychiatric disorders including major depressive disorder, catatonic disorder including hx (history) of ECT (electroconvulsive therapy), schizoaffective disorder of the Bipolar type". Interventions for this care plan were listed as "Monitor for voiced or not verbal sign of depression or desire to harm self. Notify MD immediately, Administer medications as ordered. May be adjusted or changed by MD. Monitor closely and document for side effects and effectiveness, Monitor/record occurrence of for target behavior symptoms catatonia, inappropriate response to verbal communication, and document per facility protocol". Resident #7's clinical record contained "Target Behavior Observation Summary" forms. These forms failed to document daily behavior monitoring for the medications indicated. The concern of not completing daily targeted behavior monitoring was discussed with the administrative team during a meeting on 08/09/17 at approximately 1420. No further information was provided prior to exit.	F 329		
F 441	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL,	F 441	A. Resident #13 linens were changed.	8/10/2017

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F 441 SS=D	Continued From page 36 PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation,	F 441	Resident #1 linens were changed. B. All residents on the affected units have the opportunity to have linens handled improperly. C. Facility staff will be re-educated on infection control practices, specifically not sitting on resident beds. D. Infection Preventionist or designee will perform random audits of proper handling of linen and staff sitting on resident beds. The findings will be reported to eh Quality Assurance Committee will be weekly for 8 weeks then monthly fo r4 months for 2 consecutive quarters.	8/10/2017 9/22/2017 9/22/2017 9/22/2017

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F 441	Continued From page 37 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility policy review and clinical record review it was determined the facility failed to follow infection control precautions for 2 of 33 residents (Residents #13 & #1). ~ Facility staff were observed sitting on both resident's beds while staff were assisting them to eat. Findings:	F 441		

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F 441	Continued From page 38 1. Facility staff were observed seated on Resident #13's bed while feeding Resident #13. Resident #13's clinical record was reviewed 8/10/17 at 2:00 PM. Resident #13 was admitted to the facility on 9/22/15. Her diagnoses included dementia with behavioral disturbance, anemia, hypertension and dysphagia. Resident #13's latest MDS (minimum data set) assessment, dated 6/11/17 coded the resident with significant cognitive impairment. She required nursing staff assistance for all the ADL's (activities of daily living), including feeding assistance. The resident's CCP (comprehensive care plan), revised 6/21/17, documented the problem, "at risk of weight loss & malnutrition d/t dementia progression." The interventions included, "Provide, serve diet as ordered. Monitor intake and record every meal". Resident #13 had a physician's order, signed and dated 12/12/16. The order consisted of "fortified diet, pureed texture. Thin consistency. Allow family to provide no-pureed items for quality of life with family supervision of patient for swallowing concerns". On 8/9/17 at 12:30 PM, Resident #13 was seated in a chair at her bedside. The overbed tray containing her lunch was in front of her. CNA I was seated on the resident's bed feeding her lunch. On 8/10/17 at 8:15 AM CNA was feeding Resident #13 her breakfast tray. The CNA was	F 441		

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F 441	Continued From page 39 again seated on the resident's bed. On 8/10/17 at 9:30 AM the DON was informed of the surveyor's observations. The DON stated, "They do not sit on the resident's beds when they're feeding them. It's a dignity issue". On 8/10/17 at 10:00 AM the administrator was informed of the observation. The administrator stated, "It's definitely not recommended or encouraged, but it's ok if they (residents) say sit here and pat the bed." The facility did not have a policy prohibiting staff members from sitting on resident's beds. No additional information was provided prior to the survey team exit. 2. For Resident #1 the facility staff failed to follow establish infection control guidelines by sitting on Resident's bed while assisting with feeding. Resident #1 was admitted to the facility on 12/29/11 and readmitted on 12/20/14. Diagnoses included but not limited to anemia, coronary artery disease, hypertension, gastroesophageal reflux disease, Alzheimer's disease, dementia, Parkinson's disease, malnutrition, depression, asthma, and dysphagia. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/31/17 coded the Resident as having both long and short term memory impairment with severely impaired decision making skills. Section G, functional status coded the Resident as 3/2 in the area of eating, which is the equivalent of extensive assistance, one person physical assist. This is quarterly MDS.	F 441		

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F 441	Continued From page 40 The surveyor observed Resident #t eating her breakfast on 08/09/t7 at approximately 0825 CNA (certified nurse's assistant) #t was assisting Resident with eating. Resident was sitting up in bed, with CNA seated on the side of the bed beside Resident. On 8/t0/t7 at 9:30 AM the surveyor spoke with the DON (director of nursing) regarding CNA seated on Resident #t's bed. The DON stated, "They do not sit on the resident's beds when they're feeding them. It's a dignity issue". The administrator was informed of the observation on 8/t0/t7 at approximately t0:00 AM. The administrator stated, "It's definitely not recommended or encouraged, but it's ok if the Resident says sit here and pats the bed." The facility did not have a policy prohibiting staff members from sitting on resident's beds. The concern of the CNA seated on Resident's bed was discussed during a meeting with the administrative staff on 08/t0/t7 at approximately t255. No further information was provided prior to exit.	F 441		
F 514 SS=E	483.70(i)(t)(5) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE (i) Medical records. (t) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-	F 5t4	A. Residents #6, 16, 1 and 7 have signed drug regimen reviews on their medical record chart. B. All residents on affected unit have the opportunity to have incomplete medical records. C. All staff will be re-educated on the importance of complete and accurate medical records.	8/10/2017 9/22/2017 9/22/2017

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F 514	Continued From page 41 (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record, it was determined that the facility staff failed to ensure complete and accurate clinical records for 5 of 33 Residents in the sample survey, Resident #6, Resident #16, Resident #18, Resident #1 and Resident #7. The facility failed to ensure that Pharmacy Monthly Drug Regimen Reviews (DRR's) were contained in the Residents clinical record.	F 514	D. Nurse Manager or designee will audit all medical records for current and accurate Drug Regimen reviews. the findings will be reported to the Quality Assurance committee will be weekly for 8 weeks then monthly for 4 months for 2 consecutive quarters.	9/22/2017

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F 514	Continued From page 42 The Findings Included: 1. For Resident #6 the facility staff failed to ensure that the June 2017 Pharmacy Monthly Drug Regimen Review was contained in the clinical record. Resident #6 was a 90 year old female who was admitted on 1/30/17. Admitting diagnoses included, but were not limited to: fractured femur, dysphagia, falls, hypothyroidism and chronic kidney disease without heart failure. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/9/17. The facility staff coded that Resident #6 had a Cognitive Summary Score of 8. The facility staff also coded that Resident #6 required limited (2/2) to extensive assistance (3/2) with Activities of Daily Living (ADL's). On August 9, 2017 at 10 a.m. the surveyor reviewed Resident #6's clinical record. Review of the clinical record produced the Monthly Pharmacy Drug Regimen Reviews (DRR's). The surveyor noted that Resident #6 did not have a June 2017 Monthly DRR. On August 9, 2017 at 11:10 p.m. the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that review of Resident #6's clinical record failed to produce a June 2017 DRR. The surveyor reviewed Resident #6's clinical record with the DON. The surveyor pointed out that Resident #6 did not have a June 2017 DRR.	F 514		

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F 5t4	Continued From page 43 On August 9, 20t7 at t:55 p.m. the DON hand delivered the June 20t7 DRR for Resident #6. The DON stated that the Medical Records staff member and support staff had gotten the DRR. The surveyor notified the DON that the June 20t7 monthly DRR was not contained in the clinical record and therefore the clinical record was inaccurate. No further information was provided to the team prior to exiting the facility as to why the staff failed to ensure that the clinical record contained the June 20t7 monthly DRR for Resident #6. 2. For Resident #t6 the facility staff failed to ensure that the clinical record contained the June and July 20t7 Monthly Pharmacy Drug Regimen Reviews (DRR's). Resident #t6 was a 79 year old female who was admitted to the facility on 2/20/t7. Admitting diagnoses included, but were not limited to: other intravertebra(disc replacement, dorsalgia, hypertension, hydronephrosis and urine incontinence. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 5/29/t7. The facility staff coded that Resident #t6 had a Cognitive Summary Score of t2. The facility staff also coded that Resident #t6 required extensive assistance (3/3) with Activities of Daily Living (ADL's). On August 9, 20t7 at 8:30 a.m. the surveyor reviewed Resident #t6's clinical record. Review	F 5t4		

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of the clinical record produced the Monthly Pharmacy Drug Regimen Reviews (DRR's). Review of the DRR's failed to produce the June and July 2017 DRR's.

On August 9, 2017 at 9 a.m. the surveyor notified the MDS Nurse, who was a Registered Nurse (RN), that review of the clinical record failed to produce the June and July 2017 DRR's. The surveyor reviewed the clinical record with the MDS Nurse and specifically reviewed the Monthly Pharmacy DRR's. The surveyor pointed out that the clinical record did not contained the June and July 2017 DRR's.

On August 9, 2017 at 11:10 p.m. the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that review of Resident #16's clinical record failed to produce the June and July 2017 DRR's. The surveyor reviewed Resident #16's clinical record with the DON. The surveyor pointed out that Resident #16 did not have a June and July 2017 DRR's.

On August 9, 2017 at 1:55 p.m. the DON hand delivered the June and July 2017 DRR's for Resident #16. The DON stated that the Medical Records staff member and support staff had gotten the DRR's. The surveyor notified the DON that the June and July 2017 monthly DRR's were not contained in the clinical record and therefore the clinical record was inaccurate.

No further information was provided to the team prior to exiting the facility as to why the staff failed to ensure that the clinical record contained the June and July 2017 monthly DRR's for Resident #16.

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F 514	Continued From page 45	F 514		

3. For Resident #18, the facility staff failed to ensure that June and July 2017 Monthly Pharmacy Drug Regimen Reviews (DRR) were contained in the clinical record.

Resident #18 was an 86 year old male, who was admitted on 2/29/16. Admitting diagnoses included, but were not limited to: bladder tumor, acute kidney injury, mild cognitive impairment, atrial fibrillation, hearing loss, cirrhosis of the liver and adult failure to thrive.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment, with an Assessment Reference Date (ARD) of 7/06/17. The facility staff coded that Resident #18 had a Cognitive Summary Score of 10. The facility staff also coded that Resident #18 required extensive assistance (3/2) with Activities of Daily Living (ADL's).

On August 8, 2017 at 2 p.m. the surveyor reviewed Resident #18's clinical record. Review of the clinical record failed to produce a monthly Pharmacy Drug Regimen Review (DRR) for the months on June and July of 2017.

On August 8, 2017 at 3:30 p.m. the surveyor met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) that Resident #18 did not have June and July 2017 monthly DRR's in the clinical record. The surveyor reviewed the clinical record with the DON and pointed out that the June and July 2017 monthly DRR were not in the clinical record.

On August 9, 2017 at 1:55 p.m. the DON hand

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F 514	Continued From page 46	F 514		

delivered the July and August 2017 DRR's. The DON did not deliver the June 2017 DRR. The DON stated that the Medical Records staff member and support staff had gotten the DRR's. The surveyor notified the DON that the monthly DRR's were not contained in the clinical record and therefore the clinical record was inaccurate.

No further information was provided to the team prior to exiting the facility as to why the staff failed to ensure that the clinical record contained monthly DRR's for Resident #18.

4. For Resident #1 the facility failed to ensure the monthly Pharmacy Drug Regimen Review was included in the clinical record.

Resident #1 was admitted to the facility on 12/29/11 and readmitted on 12/20/14. Diagnoses included but not limited to anemia, coronary artery disease, hypertension, gastroesophageal reflux disease, Alzheimer's disease, dementia, Parkinson's disease, malnutrition, depression, asthma, and dysphagia.

The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/31/17 coded the Resident as having both long and short term memory impairment with severely impaired decision making skills. This is quarterly MDS.

Resident #1's clinical record was reviewed on 08/08/17. The surveyor could not locate a monthly Pharmacy Drug Regimen Review for the month of July 2017.

The surveyor informed the administrative staff that the July 2017 drug regimen review was missing during a meeting on 08/08/17 at

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 08/10/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	327 HERSHBERGER RD NW ROANOKE, VA 24012

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	Continued From page 47 approximately 1530. On 08/09/17 at approximately 1350, the DON provided the surveyor with a copy of Resident #1's monthly drug regimen review for the month of July 2017. DON stated that she had received the drug regimen review from medical records support staff. No further information was provided prior to exit. 5. For Resident #7 the facility staff failed to ensure the monthly Pharmacy Drug Regimen Review was included in the clinical record. Resident #7 was admitted to the facility on 01/06/17 and readmitted on 07/17/17. Diagnoses included but not limited to schizoaffective disorder, hypertension, hypokalemia, depression, diabetes mellitus type 2, hyperlipidemia, anxiety, and bipolar disorder. The most recent MDS (minimum data set) with an ARD (assessment reference date) of 07/30/17 coded the Resident as 15 of 15 in section C, cognitive patterns. This is a quarterly MDS. Resident #7's clinical record was reviewed on 08/08/17. The surveyor could not locate the monthly drug regimen reviews for the months of June or July 2017. The surveyor informed the administrative staff that the June and July 2017 drug regimen reviews were missing, during a meeting on 08/08/17 at approximately 1530. On 08/09/17 at approximately 1350, the DON provided the surveyor with a copy of Resident	F 514		

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F 514	Continued From page 48 #7's monthly drug regimen reviews for the months of June and July 2017. DON stated that she had received the drug regimen review from medical records support staff. No further information was provided prior to exit.	F 514		