		AND HUMAN SERVICES		PR	ENTED: 11/03/201
		MEDICAID SERVICES			FORM APPROVE( 1B NO. 0938-039
STATEMENT AND PLAN (	DF OEFICIENCIEE F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER	A. BUILO	TIFLE CONSTRUCTION IXX	OATE SURVEY COMPLETED
·		496092	5 «/NÖ_		C
VAME OF (	PROVIDER OF SUPPLIER			STREET AODRESS CITY STATE, ZIP CODE	08/10/2017
FRIENDS	HIP HEALTH AND REHA	AB CENTER		327 HERSHBERGER RO NW ROANOKE, VA. 24012	
JX4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF OBFICIENCIES CY MUST BE PRECEDED BY FULC LISC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION	)X6) COMPLETION DATE
F 000	INITIAL COMMENT	5	FO	00	·
F 155 SS=D	survey was conducted 08/10/17. Comptaint the survey. Correction compliance with 42 Corrections with 42 Corrections are requirement to survey/report with folial to the consisted of 28 curres (Residents 1 through record reviews formulate in experience of the region of the provision of medicinal services deemed medicinal requirements specified subpart 1 (Advance Direction 1 through 1 thro	is were investigated during ins are required for CFR Part 483 Federal Long ents. The Life Safety Code low.  If a certified bed facility was a survey. The survey sample int Resident reviews.  If and 33' and 5 closed dents 28 through 32', 1483.24(a)(3) RIGHT TO TE ADVANCE DIRECTIVES.  If a certified bed facility was a survey. The survey sample into the second facility of the control of the certified in or refuse important research, and to directive arranged should be of the resident to receive at treatment or medicat incally unnecessary or strongly with the din 42 CFR part 489, rectives).	; F 4 5	A. Resident #18 e complete and accurate "Durab Do not Resuscitate" (DDNR/Golden Rod) was obtained  B. Residents on affected unit have the opportunity have their "DDNR" be incomplete or inaccurate.  C. The Administrator will re-educate the providers accurately and completely complete the "DDNR" to prior to signing it.  D. The Nurse Manager or designee with audit all charts for complete and accurate "DDNR" forms. It findings will be reported to the Quality Assurance committee weekly times 8 waeks and then monthly times 4 months for 2 consecutive quarters.	9/22/2017 10 9/22/2017 20m 9/22/2017 he
j   	nform and provide wri residents concerning t medica) or surgical tre	s include provisions to iten information to all adult the right to accept or refuse atment and, at the utate an advance directive.			;

LABORATORY DIRECTOR'S CR PROVIOERISUPPLIER REPRESENTATIVE'S SIGNATURE

Administrator

9/22/2017

Any deficiency shallement ending with an asterisk (\*) denotes a deficiency which the institution may be accused 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 discloseble 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 discloseble 14 describes to the facility. If deficiencies are cited, an approved plan of correction are aquisite to continued program participation.

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AND BLAN OF CORRECTION IN IDENTIFICATION NUMBER:		·	A. BUILDING			(X3) DATE SURVEY COMPLETED C		
		495092	B. WING_			i i	/10/2017	
	ROVIDER OR SUPPLIER	3 CENTER		327	EET ADDRESS, CITY, STATE, ZIP CODE HERSHBERGER RD NW ANOKE, VA 24012			
IX4) ID PREFIX TA <b>G</b>	JEACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETION DATE	
F 155	Continued From page	<b>:</b> 1	F	155				
		ritten description of the plant advance directives law.		:				
:		<del>-</del>						
	time of admission and information or articula has executed an adva may give advance dir	ual is incapacitated at the d is unable to receive ate whether or not he or she ance directive, the facility rective information to the epresentative in accordance						
	provide this information or she is able to receing Follow-up procedures	relieved of its obligation to on to the individual once he ive such information, a must be in place to provide individual directly at the						
	including CPR, to a re emergency care prior medical personnel an	ride basic life support, esident requiring such to the arrival of emergency id subject to related the resident's advance						
	by: Based on staff interv Code of Virginia, it was facility staff failed to a "Durable Do Not Res	is not met as evidenced iew, clinical record, and the as determined that the accurately complete the uscitate" (DDNR)/Golden of 33 Residents in the						

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	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495092	B. WING_	B. WING		C 0 <b>8/10/201</b> 7	
	ROVIDER OR SUPPLIER HIP HEALTH AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP O 327 HERSHBERGER RD NW ROANOKE, VA 24012	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIAT		
F 155	that the "Durable Do (DDNR/Golden Rod) and accurate.  Resident #18 was ar admitted on 2/29/16. Included, but were not acute kidney injury, ratrial fibrillation, hear and adult failure to the sessment located Annual MDS assessing Reference Date (AR staff coded that Resident assistance (3/2) with (ADL's).  On August 8, 2017 areviewed Resident #1 of the clinical record Resuscitate" (DDNR/Golden Rod of the DDNR/Golden Rod of the DDNR/Golden Rod of Resident #18 was Calent Resident #18 was Calent Rod accurate.	dent #18.  dent #18.	F	155			
	withholding or withdr treatment or course	awing specific medical of medical treatment.					

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STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION  (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETED C		
		495092	B. WING			08/10/2017		
	OVIDER OR SUPPLIER	B CENTER		32	REET ADORESS, CITY, STATE, ZIP COOE 17 HERSHBERGER RD NW OANOKE, VA 24012			
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG	х	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)	3E !	(X5) COMPLETION DATE	
F 155	Durable Do Not Resulto Not Resuscitate Ophysician for his patie fide physician/patient the guidelines of the with the consent of the aminor or is otherwis informed decision regorder, upon the requite the person authorize behalf.  On August 9, 2017 a met with the Administrative Team DDNR/Golden Rod accurate. The surve DDNR/Golden Rod out that the DDNR/Golden Rod out the DDNR/Golden Rod out the DDNR/Golden Rod out the DDNR/Golden Rod readment. The DON the DDNR/Golden Rod Resident #18 was making an informed and accurate. The stee DDNR/Golden Rod accurate informed and accurate information that the DDNR/Golden Rod accurate information that the DDNR/Gol	Virginia § 512.1-2987.1.  Juscitate Orders. A. A Durable order may be issued by a sent with whom he has a bona at relationship as defined in Board of Medicine, and only the patient or, if the patient is se incapable of making an agarding consent for such an east of and with the consent of d to consent on the patient's  1 2:20 p.m. the survey team trator (Adm) and Director of surveyor notified the (AT) that Resident #18's was not complete and yor reviewed the with the DON and pointed solden Rod was not coded as #18 was Capable or an informed decision about g or withdrawing specific course of medical I verified that the section of od that certified whether or is Capable or Incapable of decision was not complete surveyor notified the AT that od was part of the clinical curate and incomplete.  In was provided to the team acility as to why the staff failed and accurate	F	155				
F 164		33.70(i)(2) PERSONAL	F	164	A. Resident #21 was removed from situati	on.	8/10/20 t7	

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Event IO: IN5911

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STATEMENT C	OF OEFICIENCIES	(X1) PROVIOER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO		
ANO PLAN OF	CORRECTION	IOENTIFICATION NUMBER:	A. BUILOING	G		С	
		495092	B. WING			8/10/2017	
NAME OF PE	ROVIOER OR SUPPLIER	<u> </u>		STREET AOORESS, CITY, STATE, ZIP CO	OE .		
FRIENDS	1)P HEALTH AND REHA	R CENTER		327 HERSHBERGER RD NW			
FRIENDSI	TIP REALINAND NERA	5 CLATE.		ROANOKE, VA 24012		1	
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F 164	Continued From pag	e 5	F 10	64		1	
	law enforcement pur	poses, organ donation		′			
	purposes, research	ourposes, or to coroners,					
İ		funeral directors, and to avert					
i		ealth or safety as permitted					
	by and in compliance	e with 45 CFR 164.512. T is not met as evidenced		•			
	i his requirement by:	I is not met as evidenced					
	Based on observativ	on, staff interview, facility					
	policy & clinical reco	rd review, it was determined		 		ļ	
	the facility staff failed	to ensure personl privacy	ļ				
	during toileting and I	ecordkeeping for 2 of 33					
	residents (Resident	#21 and 19).		1			
		esident #21 with personal	· ·				
	privacy during toileti	ng esident #19's electronic	i				
	clinical records were						
	Clinical records were	Rept private					
	Findings:		Ì				
1	1. Facility staff faile	d to ensure privacy during					
	toileting for Residen	t # 21. Resident #21's clinical					
Į	record review was c	onducted on 8/10/17 at 8:35					
	AM.						
	Posidont #21 was a	dmitted to the facility on					
		es included hypertension,				•	
	diabetes, dementia						
	The latest MDS ass	essment (dated 5/30/17)	ļ			İ	
	coded the resident	with mild cognitive	İ				
	impairment. She ne	eded staff assistance for nd bathing. The resident					
	required oversite of	ly to ambulate and eat. She					
		t of bowel and bladder.					
	Resident #21's CCF	(comprehensive care plan)		14		1	
	dated 6/7/17, docur	nented the problem,				ļ ,	
	"Self-care deficit in	performing ADLs r/t Dementia.					
	i ne interventions in	cluded, "Toilet use: staff	<u> </u>		<del></del>		

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	OF OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
	İ	495092	B. WING	B. WING		C 08/10/2017	
	ROVIOER OR SUPPLIER	3 CENTER	· I	3	STREET ADDRESS, CITY, STATE, ZIP CODE 127 HERSHBERGER RD NW ROANOKE, VA 24012	1 00	10/2017
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F t64	assist as needed."  On 8/9/17 at 12:40 PN observed to be assist I. The CNA closed the room door to the hally left the bathroom, Refrom the hallway, to b  CNA I returned to ass bathroom and opened exposing the resident This was observed froclosed the bathroom oback into her clothes hallway.  On 8/t0/17 at 10:00 A shared with the admir additional information 2. For Resident #19, protect private health to close/cover the conthe Resident's private during a medication p  Resident #19 was add 10/28/10 and readmit included but not limite stage renal disease, of hyperlipidemia, arthrit Alzheimer's disease, or psychotic disorder, so The most recent MDS an ARD (assessment)	M, Resident #21 was ed to the bathroom by CNA be bathroom door, but left the vay, open. When the CNA sident #2 t was observed, e seated on the toilet.  ist the resident to exit the if the bathroom door, still seated on the toilet.  om the hallway. CNA I then door to assist the resident before bringing her from the  MM this information was distrator and DON. No was provided prior to exit, the facility staff failed to care information by failing inputer screen containing healthcare information ass and pour observation.  mitted to the facility on ted on 07/26/t7. Diagnoses did to hypertension, end diabetes mellitus, is, osteoporosis, dementia, malnutrition, hizophrenia, and glaucoma.  6 (minimum data set) with reference date) of 05/14/t7 es 3 out of 17 in section C,	F	t64			

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	F OEFICIENCIES CORRECTION	(X1  PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILOING	E CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
		495092	B. WING	<del></del>	C 08/10/ <b>2017</b>	
NAME OF B	ROVIDER OR SUPPLIER	100002		STREET ADDRESS, CITY, STATE, ZIP COOE	00/10/2017	⊣
NAME OF FR	(UVIDER OR SUFFLIER			327 HERSHBERGER RD NW		
FRIENDS	IP HEALTH AND REHAL	B CENTER		ROANOKE, VA 24012		
(X4) IO PREFIX TAG	(EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYIN <b>G</b> INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCEO TO THE APPROPRI DEFICIENCY)		N
F 164	#19's medications on 0750 during a medica observation. RN #1 h open to Resident #19 administration record health care informatio walk away with anoth computer screen ope Resident #19's inform  The concern of the coopen/uncovered was	ed RN #1 preparing Resident 08/09/17 at approximately ution pass and pour ad the computer screen I's MAR (medication ), which contained private n. Surveyor observed RN #1 er staff person, leaving the n and uncovered, with	F 16	4		
F 309 SS=E	08/09/17 at approxim  No further information 483.24, 483.25(k)(l) F FOR HIGHEST WEL  483.24 Quality of life Quality of life is a fun applies to all care and residents. Each resid facility must provide 1 services 10 attain or n practicable physical, well-being, consisten	ately 1420.  In was provided prior to exit.  PROVIDE CARE/SERVICES  L BEING  damental principle that d services provided to facility dent must receive and the he necessary care and naintain the highest mental, and psychosocial t with the resident's ssment and plan of care.	F 30	Resident #16 vital order was darified, to them daily. Resident #19 received breakfast tray. Resident #32 discharged from facility.  B. Residents on affected units have the opp to miss dialysis or have physician orders no completed.  C. Nurses will be re-educated on the import pre and post dialysis documentation.  Nursing staff will be re-educated on followin physician orders and supporting documentat	8/9/2017 8/9/2017 sortunity 9/22/2017 ance of 9/22/2017	
	Quality of care is a fu applies to all treatme facility residents. Bas assessment of a resi that residents receive accordance with prof	indamental principle that int and care provided to sed on the comprehensive dent, the facility must ensure treatment and care in essional standards of nensive person-centered		include missed dialysis communication, documentation of vitals and medication administration.  D. Nurse Manager or designee will audit propost dialysis documentation for completion, adherence to vital sign orders, and random medication administration audits for comple eMAR and		,

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	IND DI AN OS CORRECTION INDESTREMENTAN NI IMPER		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495092	B. WING				0/2017	
NAME OF PE	ROVIDER OR SUPPLIER		··········	s	TREET ADDRESS, CITY, STATE, ZIP CODE			
FRIENDS	HIP HEALTH AND REHA	B CENTER			27 HERSHBERGER RD NW ROANOKE, VA 24012			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION OATE	
F 309	but not limited to the  (k) Pain Managemen The facility must ens provided to residents consistent with profe the comprehensive p and the residents' go  (l) Dialysis. The facil residents who require services, consistent of practice, the comp care plan, and the re preferences. This REQUIREMENT by: Based on observation interview, facility docurecord review, facility highest practicable w residents in the surve 19, and 32).  1. For Resident #5, that a resident who re such services, consistendards of practice person-centered care goals and preference	sidents' choices, including following:  It.  It.  It.  It.  It.  It.  It.  It	F	309	adherence of orders. The findings will be rethe Quality Assurance Committee will be weeks then monthly for 4 months for 2 conquarters.	eekly for 8		
	7/16/13 with diagnos mellitus with end stag hemodialysis, periph lower limb amputatio cardiopulmonary dise	es including diabetes ge renal disease with eral vascular disease post n, hypertension,			Teniku III. WAAASA		De( Paris 9 of 49	

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Facility ID: VA0089

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ANO PLAN OF CORRECTION IOENTIFICATION NUMBER:  A, BUILDING	RUCTION	X3) OATE SURVEY COMPLETEO	
		С	
495092 B. WING	B. WING		
FRIENOSHIP HEALTH AND REHAB CENTER	ADORESS, CITY, STATE, ZIP COOE SHBERGER RO NW OKE, VA 24012		
X4) IO   SUMMARY STATEMENT OF OEFICIENCIES   IO	PROVIOER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		
F 309  minimum data set assessment with assessment reference date 51/22/17, 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 71/1/15 assessed the resident as capable of medication self			

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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILOING			SURVEY LETEO
		495092	B. WING			08/	10/2017
	ROVIOER OR SUPPLIER  H)P HEALTH AND REHAL	3 CENTER		3:	TREET ADORESS, CITY, STATE, ZIP COOE 27 HERSHBERGER RD NW COANOKE, VA 24012	7	
(X4) IO PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		IO PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)		(X5) COMPLETION DATE
F 309	self-administering druce Clinical record review documentation of the hemodialysis was not The surveyor reviewed June, July, and Auguwas scheduled to have Thursday, and Saturd nursing note address 13, 15, 17, 20, July 6 29, 31, or August 1 or Communication form August 3 and 8. The of the Dialysis Commincomplete for June 3 27, and August 1.  The resident's care processes with dialy assessment were distant administrator and direst summary meeting on 2. For Resident #16 was a admitted to the facility and the summary meeting on	sked if a later one had ent was not capable of ligs.  If on 8/9/17 revealed that resident's condition after a consistent.  If the clinical record for set 1-9 2017. The resident we hemodialysis on Tuesday, day. The surveyor found no ling hemodialysis on June, 11, 15, 18, 20, 22, 25, 27, and 3. There was no Dialysis for June 1, July 8, 31, or facility post dialysis portion funication form was 3, 15, 20, July 1, 4, 15, 18, and did not directly address modialysis.  Is management and cussed with the facility staff failed to sered vital signs every shift.  If year old female who was you 2/20/17. Admitting but were not limited to: other placement, dorsalgia,	F	309			
	The most current Mir assessment located	nimum Data Set (MDS) in the clinical record was a					

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				(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) OATE SURVEY COMPLETEO	
		495092	B. WING		0	C 8/10/2017	
	OVIOER OR SUPPLIER P HEALTH AND REHAE	3 CENTER		STREET AOORESS, CITY, STATE, ZI 327 HERSHBERGER RO NW ROANOKE, VA 24012			
(X4) IO PREFIX TAG	(EACH OEFICIENC)	RTEMENT OF OEFICIENCIES  Y MUST BE PRECEOEO BY FULL  SC IOENTIFYING INFORMATION)	IO PREFI TAG		ACTION SHOULO BE TO THE APPROPRIATE	(X5) COMPLETION DATE	
	Reference Date (ARD staff coded that Reside Summary Score of 12 coded that Resident # assistance (3/3) with A (ADL's).  On August 9, 2017 at reviewed Resident #1 of the clinical record porders dated 6/29/17. Included, but were not (every) shift three times shift." (sic) The order Continued review of the July and August 2 Administration Record and Weight and Vitals these documents failed documentation that the physician ordered vitatimes a day).  On August 9, 2017 at the MDS Nurse, who (RN), that Resident # to obtain vital signs emotified the MDS Nurse, who into the the MDS Nurse, who into the MDS Nu	sment with an Assessment b) of 5/29/17. The facility lent #16 had a Cognitive c. The facility staff also c. The facility staff also c. The facility staff also c. The facility staff also c. The facility staff also c. The facility staff also c. The facility staff also c. The facility staff also c. The surveyor d. Singed physician orders d. Singed physician orders d. Ilmited to: "Vital signs 1 des a day for Vital signs 1 des a day for Vital signs q d. Company of the com	F	309			
	The surveyor specific physicians order to obshift. The surveyor al	record with the MDS Nurse.  ally pointed out the obtain the vital signs every less reviewed the 2017 less Notes and Weight and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING				TE SURVEY MPLETED		
		495092	B. WING		٥	C 8/10/2017
	ROVIDER OR SUPPLIER HIP HEALTH AND REHA	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(XS) COMPLETION DATE
F 309	Vital Summary with to Nurse was unable to the facility staff obtain vital signs every shift.  On August 9, 2017 an notified the Administ Nursing (DON) that is physician's order to in The surveyor notified (AT) that review of the produce documentation of the surveyor notified to follow physician of facility staff failed to signs every shift for 3. For Resident #19 follow physician's on the antidiabetic ager.  Resident #19 was act 10/28/10 and readmincluded but not limit stage renal disease, hyperlipidemia, arthrough Alzheimer's disease, psychotic disorder, so The most recent MD an ARD (assessment cognitive status. This The surveyor observes Resident #19's medical surveyor observes and the surveyor observes the surveyo	the MDS Nurse. The MDS locate documentation that ned the physician ordered t.  t 11:10 p.m. the surveyor rator (Adm) and Director of Resident #16 had a obtain vital signs every shift. If the Administrative Team the clinical record failed to tion of the vital signs every  In was provided to the team cility as to why the staff failed rders for Resident #16. The obtain physician ordered vital Resident #16. the facility staff failed to ders for the administration of the Metformin.  Idmitted to the facility on litted on 07/26/17. Diagnoses led to hypertension, end diabetes mellitus,	F 30			

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Event ID: IN5911

Facility ID: VA0089

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	DF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG		(X3) OATE SURVEY COMPLETED	
		495092	8. WING			C <b>08/10/2017</b>	
	ROVIOER OR SUPPLIER	3 CENTER		STREET ADDRESS, CITY, STATE, ZIP C 327 HERSHBERGER RO NW ROANOKE, VA 24012	COOE	06/10/2017	
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFII TAG	PROVIOER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCEO TO T OEFICIENC	TON SHOULO BE THE APPROPRIA		
	pour. One of the medi was Metformin. Resid administered whole w Resident #19's medic the clinical record on 0 0830. The clinical record (physician's order sun "Metformin HCI Tablet mouth one time a day Take with food". The Femedication administra and contained an entr "Metformin HCI Tablet mouth one time a day Take with food". Survey medication being admithe physician's order.  Surveyor requested an of a policy entitled "Adwhich read in part "Pube administered in a sas prescribed."  Surveyor spoke with the 08/09/17 at approxima Resident #19. Administered medications should hat food as ordered.  The concern of not follorders while administed discussed with the admineting on 08/09/17 at approximation and the second residual second residual administed discussed with the admineting on 08/09/17 at approximation and the second residual administed discussed with the administed discussed with the administer on 08/09/17 at approximation and the second residual administed discussed with the	cations being administered ent #19's medications were ith water.  ations were reconciled with D8/09/17 at approximately ord contained a signed POS marry) which read in part 500mg Give 1 tablet by for DM (diabetes mellitus). Resident's eMAR (electronic tion record) was reviewed y which read in part 500mg Give 1 tablet by for DM (diabetes mellitus). By a compart of	F	309			
			<u> </u>				

Facility IO: VA0089

If continuation sheet Page 14 of 49



	OVIOER/SUPPLIER/CLIA ITIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
	495092	B, WNG_			C 08/10/2017
NAME OF PROVIOER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTE	R		STREET AOORESS, CITY, STATE, ZIP 327 HERSHBERGER RO NW ROANOKE, VA 24012	COOE	30.102311
(X4) IO SUMMARY STATEMENT PREFIX (EACH OEFICIENCY MUST BI TAG REGULATORY OR LSC IOENT	PRECEOEO BY FULL	IO PREFIX TAG	PROVIDER'S PLAN O ( (EACH CORRECTIVE AC CROSS-REFERENCEO TO OEFICIEN	TION SHOULO BI	
follow physician's orders for the medications atenolol, cho Gleevec, Lasix, prednisone, I gabapentin, Carafate, Mestin supplements Ensure and Liquassessment of vital signs.  Resident #32 was admitted to 07/19/16 and readmitted on 0 included but not limited to and peripheral vascular disease, greflux disease, end stage rensepticemia, urinary tract infect thyroid disorder, osteoporosis.  The most recent MDS (miniman ARD (assessment referencoded the Resident as 14 out cognitive status. This is an active status. This is an active status and the series of the peripheral vascular disease, greflux disease, end stage rensepticemia, urinary tract infect thyroid disorder, osteoporosis.  The most recent MDS (miniman ARD (assessment referencoded the Resident as 14 out cognitive status. This is an active status. This is an active status. This is an active status and the series of the peripheral status. This is an active status and the series of the seri	lecalciferol, hydroxychloroquine, on, for the vicel and for the vicel and for the vicel and for the vicel and for the vicel and for the vicel and for the vicel and for the vicel and for the vicel and for the vicel and anxiety.  It was reviewed on vicel and vicel and anxiety.  Was reviewed on vicel and vic	F	509		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495092	B. WING				0 10/2017
NAME OF PE	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	00/	10/201/
EDIENDO	LID LICALTIL AND DELLAS	CENTER		3 <b>2</b> 7	HERSHBERGER RD NW		
FRIENDSF	1]P HEALTH AND REHAE	CENTER		RC	DANOKE, VA 24012		
(X4) ID PREFIX TAG	(EACH OFFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 309	(gastroesophageal retablet 60mg (pyridostitablet by mouth four tigravis, Ensure three to Liquicel three times a Liquicel 30cc TID (three signs on admission Q 08/06/2016-end date)  Resident #32's eMAR administration record) 2016 was reviewed at entries which read in Give 1 tablet by mouth (hypertension), choled Give 1 tablet by mouth supplement until 09/2: (Imatinib Mesylate). Give 1 tablet by mouth 20mg (fur psemide). Give 1 tablet pre time a day for edema, Give 1 tablet one time gravis, hydroxychlorod give 1 tablet pre time gravis, hydroxychlorod give 1 tablet by mouth myasthenia gravis, ga Give 1 capsule by moneuropathy, Carafate mouth before meals at (gastroesophageal retablet 60mg (pyridostitablet by mouth four tigravis, Ensure three tiliquicel three times a Liquicel 30cc TID (three signs on admission Q	flux disease), Mestinon gmine bromide). Give 1 imes a day for myasthenia imes a day for supplement, day for supplement, ee times a day), and vital (every) shift start date 10/28/2016".  I (electronic medication of for the month of August and contained the following part "atenolol tablet 25mg. In one time a day for HTN calciferol tablet 50000 unit. In on time a day every Fri for 3/16, Gleevec Tablet 400mg sive 1 tablet by mouth one enia gravis, Lasix tablet sive 1 tablet by mouth one prednisone tablet 10mg. It is a day for myasthenia quine sulfate tablet 200mg. If two times a day for tablet 1 gm. Give 1 tablet by not at bedtime for GERD flux disease), Mestinon gmine bromide). Give 1 mes a day for supplement, day for supplement, ee times a day), and vital (every) shift start date	F	309	DEFICIENCY)		
 	the atenolol, cholecald prednisone, hydroxycl	10/28/2016". The entries for ciferol Gleevec, Lasix, nloroquine, Carafate, and n initialed as having been					

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EvenIID: IN5911

Facility ID: VA0089

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NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER  (XA10   SUMMARY STATEMENT OF DEFICIENCIES   STREET ADDRESS, CITY, STATE, 2P CODE   327 HERSHBERGER RD NW ROANCK, VA 24012  X27 HERSHBERGER RD NW ROANCK, VA 24012  FREETX TAG   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCIES   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT OF DEFICIENCY   SUMMARY STATEMENT ST		IOCNITICIONALIMINADED			(X3) OATE SURVEY COMPLETEO		
FRIENDSHIP HEALTH AND REHAB CENTER    ACAJIO   SUMMARY STATEMENT OF OERGIENCIES (EACH OERGIENCY MUST SEE PRECISED BY TILL TAG   SUMMARY STATEMENT OF OERGIENCIES (EACH OERGIENCY MUST SEE PRECISED BY TILL TAG   PREFIX TAG		495092	B. WING_		· · · · · · · · · · · · · · · · · · ·		
FREEIX TAG  Cantinued From page 16 administered on 08/19/16 for the AM dose, The Cardate and Mesting been administered on 08/24/16 for the mid-day dose. The glabapentin and the Ensure had not been initialed as having been administered on 08/24/16 for the mid-day dose. The place of the mid-day dose in the glabapentin and the Ensure had not been initialed as having been administered on 08/24/16 for the mid-day dose. The place of the mid-day dose in the glabapentin and the Ensure had not been initialed as having been administered on 08/24/16 for the mid-day dose. The luquicel had not been initialed as having been administered on 08/24/16 for the mid-day of the mid-day or evening doses. Witsl 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 administrative team during a meeting on 08/10/17 at approximately 1255.  No further information was provided prior to exit.  F 314  Ass=D  (b) Skin Integrity-  (construction 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 314  Ass=D  (b) Skin Integrity-  (construction 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 314  Assident #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 finanger 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 veekly for a week them monthly for 4 months for 2 consecutive quarters.		B CENTER		327 HERS	HBERGER RD NW		
administered on 08/19/16 for the AM dose. The Carefate and Mestinon had also not been initiated as having been administered on 08/24/16 for the mid-day dose. The gabapentin and the Ensure had not been initiated as having been administered on 08/24/16 for the mid-day dose. The Liquicel had not been initiated as having been administered on 08/24/16 for the Am, mid-day or evening doses. Vital signs had not been recorded for 09/25/16 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 beam during a meeting on 08/10/17 at approximately 1255.  No further information was provided prior to exit. F 314 4. Resident #32 is no longer at the facility.  B. All residents on affected units have the opportunity for incomplete documentation.  (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 and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and  (iii) A resident with pressure ulcers neceives necessary treatment and services, consistent with professional standards of practice, to promote	(EACH OEFICIENC	Y MUST BE PRECEOEO BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA		COMPLETION
	administered on 08/1 Carafate and Mestino as having been admin mid-day dose. The ga had not been initialed administered on 08/2 The Liquicel had not been administered or mid-day or evening d been recorded for 08 08/27-28/16 for day s  The concern of not for for the administration supplements and rec discussed with the admeeting on 08/10/17  No further information 483.25(b)(1) TREATI PREVENT/HEAL PR  (b) Skin Integrity -  (1) Pressure ulcers comprehensive asse facility must ensure ti  (i) A resident received professional standard ulcers unless the ind demonstrates that the  (ii) A resident with pro- necessary treatment professional standard professional standard professional standard	9/16 for the AM dose. The on had also not been initialed inistered on 08/24/16 for the abapentin and the Ensure I as having been 4/16 for the mid-day dose, been initialed as having in 08/27/16 for the Am, oses. Vital signs had not /25/16 on night shift or shift.  Illowing the physician's order of medications, ording vital signs was dministrative team during a at approximately 1255.  In was provided prior to exit.  MENT/SVCS TO ESSURE SORES  Based on the ssment of a resident, the hat- s care, consistent with dos of practice, to prevent does not develop pressure ividual's clinical condition ey were unavoidable; and essure ulcers receives and services, consistent with ds of practice, to promote		A. Res B. All r opportu C. Nur adminic D. Nur Treatm physici Quality weeks	residents on affected units have the unity for incomplete documentation. rsing staff will be re-educated on treat stration and complete documentation are Manager or designee will audit (Thent Administration Record for adhere ian orders. The findings will be report Assurance committee will be weekly then monthly for 4 months for 2 cons	AR) ence to ted to the for 8	9/22/2017 9/22/2017
1		SUMMARY ST (EACH OFFICIENC REGULATORY OR I  Continued From page administered on 08/1 Carafate and Mestind as having been administered on 08/2 The Liquicel had not been administered or mid-day or evening d been recorded for 08 08/27-28/16 for day s  The concern of not for for the administration supplements and rec discussed with the admeeting on 08/10/17  No further information 483.25(b)(1) TREATI PREVENT/HEAL PR  (b) Skin Integrity -  (1) Pressure ulcers comprehensive asse facility must ensure to professional standard ulcers unless the ind demonstrates that the  (ii) A resident with professional standard pressure ulcers and ulcers unless the ind demonstrates that the	ROVIOER OR SUPPLIER  ### HEALTH AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEOE BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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. 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	A BUILON  495092  B. WING  SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 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. 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	CORRECTION  A95092  B. WNG  STREET AL 327 HERS ROANOK  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)  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 08/27/16 for the AM, mid-day or evening doses. Vital signs had not 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. 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	A BUILDING  495092  A BUILDING  B WING  STREET ADDRESS, CITY, STATE, ZIP CODE  327 HERSHBERGER RD NW  ROANOKE, VA 24012  SUMMARY STATEMENT OF DETICIENCIES  (EACH DETICIENCY SITE ES PERCEDOE OF FULL  REQUILATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 16  administered on 08/19/16 for the AM dose. The  Carrâte and Mestinon had also 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 08/24/16 for the aministered on 08/24/16 for the aminidation 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.  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 un avoidable, and  (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote necessary treatment and services, consistent with professional standards of practice, to promote	A BUILONG  495092  A STREET ADDRESS, CITY, STATE, 2IP CODE 327 HERSHERGERGE NO  BY HALTH AND REHAB CENTER  SUMMANY STATEMENT OF DEFIDIENCIES (EACH DEFIDIENCY OF THE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  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 globapentin 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 administrative on 08/24/16 for the mid-day dose. The Liquicel had not been initialed as having been administrative on 08/24/16 for the mid-day dose. The Liquicel had not been initialed as having been administrative on 08/24/16 for the mid-day dose. The Liquicel had not been initialed as having been administrative on 08/24/16 for the mid-day dose. The Liquicel had not been initialed as having been administrative on 08/24/16 for the mid-day dose. The Liquicel had not been initialed as having been 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. 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 stein individual's clinical condition demonstrates that they were un avoidable; and  (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote receives and dose not develop pressure ulcers and dose not develop pressure ulcers and dose not develop pressure ulcers and dose not develop pressure ulcers and solve the individual's clinical condition demonstrates that they were un avoidable; and

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	OF OEFICIENCIES CORRECTION	(Xt) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILOING		COM	E SURVEY PLETEO
		495092	B. WING_			1	C /1 <b>0/2017</b>
	ROVIOER OR SUPPLIER	3 CENTER		327 F	ET ADORESS, CITY, STATE, ZIP COOE HERSHBERGER RD NW NOKE, VA 24012	1 50	
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI) TAG	×	PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPI OEFICIENCY)	BE	(X5) COMPLETION OATE
F 314	by: Based on staff intervand in the course of a staff failed to provide treatments for the prefor 1 of 33 Residents. The findings included For Resident #32 the physician ordered trepressure areas. Resident #32 was ad 07/19/16 and readmit included but not limite peripheral vascular direflux disease, end st septicemia, urinary trethyroid disorder, oste The most recent MDS an ARD (assessment coded the Resident a cognitive status. This Resident #32's clinica 08/09/17. It contained order summary) for the which read in part "Clinomal saline), pat digauze, then to wound dressing QD (every dwound care -Start day (discontinue) Date- 0	is not met as evidenced  iew, clinical record review a complaint survey the facility physician ordered evention of pressure areas Resident #32.  :  facility staff failed to provide atments for the prevention of  mitted to the facility on ted on 08/07/16. Diagnoses ad to anemia, hypertension, isease, gastroesophageal age renal disease, act infection, hyperlipidemia, oporosis and anxiety.  6 (minimum data set) with reference date) of 07/24/16 s 14 out of 15 in section C, is an admission MDS.  al record was reviewed on d a signed POS (physician's ne month of August 2016 leanse sacral wound with NS ry. Apply MediHoney gel to d bed. Cover with dry lay) one time a day for te-08/07/16, Cleanse sacral	F	314			
		Ory. Apply Santyl to saline ply in wound bed and cover					

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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ` '	IPLE CONSTR	RUCTION		SURVEY PLETEO
		495092	B. WING			į į	C /10/2017
	ROVIOER OR SUPPLIER HIP HEALTH AND REHA	AB CENTER		327 HERS	DORESS, CITY, STATE, ZIP COOE HBERGER RD NW KE, VA 24012		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
(X4) IO PREFIX TAG	(EACH OEFICIEN	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFII TAG	(	PROVICER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPF OEFICIENCY)	ULD BE	(X5) COMPLETION OATE
F 314	with dry gauze and infor wound care -Stail -08/16/2016, Cleans Apply dakins saturated a day for wound care Date- 09/15/16, Limintervals. Assist with while in char two times acral wound -Start -10/28/2016, Air mand Date- 08/06/2016 -DC Calmazime Skin Proprotectants, Misc.) A topically every shift 08/06/2016 -D/C Date (bilaterally lower extraction for s/s (signs/symptomound care -Start Date- 08/06/2016 -D and reposition q 2 hrough administration recording to the contained an entry of sacral wound with Napply Medi Honey good bed. Cover with dry time a day for wound-D/C (discontinue) Date on 08/13-14/2016. The which read in part of the contained and the contained on 08/13-14/2016. The contained in part of the contained in the con	mepilex daily, one time a day th Date- 08/12/2016 -D/C Date the sacrum with NS. Pat dry. the diguize in wound bed. the and mepilex BID two times the -Start Date- 08/16/16 -D/C the time in chair to 2 hr the repositioning as needed these a day for Offloading to -Date- 08/162016 -D/C Date thress to bed every shift -Start th/C Date- 10/28/2016,	F	314			

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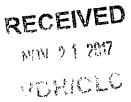
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	A. BUILOIN	G	COMPLETEO
		495092	B, WING	٠	08/10/ <b>2017</b>
	ROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE 327 HERSHBERGER RD NW ROANOKE, VA 24012	08/10/2017
(X4) IO PREFIX TAG	(EACH DEFICIEN	STATEMENT OF OEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API OEFICIENCY)	IOULO BE COMPLÉTION
F 314	-08/16/2016". This eleman comple eMAR contained an "Cleanse sacrum with saturated gauze in regauze and mepilex wound care - Start E 09/15/16". This entre having been comple 08/27 or 08/28/16 for evening entry which read in intervals. Assist with while in chair two tirt Sacral wound - Start -10/28/16". This entervals having been comple AM and 08/23, 08/2 The eMAR contained "Air mattress to bed 08/06/16 - D/C Date been initialed as hare 08/14, 08/19 or 08/20/16 contained an entry Skin Protectant Pass Apply to groin and program of the emark contained in the emark of the emark contained in the	chate- 08/12/2016 -D/C Date entry had not been signed as seted on 08/13-14/2016. The entry which read in part ith NS. Pat dry. Apply Dakin's wound bed. Cover with dry BID two times a day for oate- 08/16/16 -D/C Date-ty had not been signed as eted on 08/19, 08/20, 08/24, or AM and 08/23, 08/26, or g. The eMAR contained an part "Limit time in chair to 2 hr a repositioning as needed mes a day for Offloading to the complete on 08/19 or 08/20/16 for 6, or 08/28/16 for evenings. It every shift -Start Date-10/28/16". This entry had not ving been completed on 20/216 for AM and 08/23, for evenings. The eMAR which read in part "Calmazime ste (Skin Protectants, Misc.) over area topically every shift Start Date-08/06/2016 -D/C This entry had not been seen completed on 08/14, or AM, 08/23, 08/26, or gs and 08/25/16 for nights. Set an entry which read in part terally lower extremities) and /s (signs/symptoms) infection	F 3		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event IO: IN5911

Facility IO: VADD89

If continuation sheet Page 20 of 49



	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. SUILOII		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
				_		C	;
		495092	a. WING_			08/1	10/2017
NAME OF PE	ROVIOER OR SUPPLIER			ST	REET AOORESS, CITY, STATE, ZIP COOE		
_,				32	7 HERSHBERGER RD NW		
FRIENDS	IIP HEALTH AND REHAE	B CENTER		R	OANOKE, VA 24012		
(X4) IO	SUMMARY STA	ATEMENT OF OEFICIENCIES	IO		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST SE PRECEOEO SY FULL	PREFI	×	(EACH CORRECTIVE ACTION SHOULO & CROSS-REFERENCEO TO THE APPROPRIA		COMPLETION OATE
TAG	REGULATORY OR LSC IOENTIFYING INFORMATION) TAG		IAG		OEFICIENCY)		
				Ì			
F 314	Continued From page	20	F:	314			
	on 08/14, 08/19, or 08	3/20/ <b>1</b> 6 for days, 08/23,				ĺ	
		evenings and 08/25/16 for		ŀ			
	<b>~</b>	ntained an entry which read				1	
		pilateral heels and sides of		l			1
		t for prevention -Start Date-					
		e- 09/08/2016". This entry as having been completed					
		8/20/16 for days, 08/23,					
		r evenings and 08/25/16 for					
	•	ntained an entry which read				ļ	
1	. —	osition q 2 hrs every shift				ĺ	
	wound care -Start Da	te- 08/16/2016 D/C Date				:	
		ry had not been initialed as		ļ			
	·	ed on 08/19 or 08/20/16 for					
		r 08/28/16 for evenings and					
	08/25/16 for nights.						
	Surveyor spoke with t	the administrator regarding					
		tation of physician ordered					
	<del>-</del>	17 at approximately 1130.					
	The administrator cou	ıld provide no explanation					
	for the missing docun	nentation.					
	The concern of the tre	estments not heing					
		d was discussed during a					
		ninistrative staff during a		İ			
		at approximately 1255.					
	N 6 11 1 6 11 11 11 11 11 11 11 11 11 11						i
	Nor funner informatio	n was provided prior to exit.					
	This is a complaint de						
F 323	483.25(d)(1)(2)(n)(1)-	-(3) FREE OF ACCIDENT	F	323	A. Resident #6 bed and chair atarms were p	laced.	<b>8</b> /10/ <b>2</b> 017
SS=D	HAZARDS/SUPERVI	SION/DEVICES			Resident #18 gen-sleeves was placed.	.2004.	8/8/2017
	(d) Assidents			i		,	
	(d) Accidents. The facility must ensu	ire that -			<ul> <li>B. All residents on affected units have the opportunity for physician orders missed/not f</li> </ul>	ollowed	9/22/2017
	THE REGILTY HUSE GIST	are that			opportunity for physicial orders intesed/floct	-a-11-04.	WEELEOI1
	(1) The resident envir	ronment remains as free	:				
	İ		1				<u> </u>

NAME OF PROVICER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER    X3   D		STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '		CONSTRUCTION	(X3) OATE SURVEY COMPLETEO	
RAME OF PROVICER OR SUPPLIER  FRIENDSHIP HEALTH AND RENAB CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RO NW ROANOKE, VA 24012  SUMMARY STATEMENT OF GERICIENCES (EACH GERICIENCY MUST SEE PRECEDGE 98 YILL) REGULATORY OR LSC IDENTIFYING INFORMATION)  F 323  Continued From page 2 1 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 tements.  (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 fails.  The facility staff failed to ensure that physician			495092	B. WING			l .	
F323 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 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 residents 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 #8 the facility staff failed to ensure that physician ordered interventions to prevent falls. The facility staff failed to ensure that physician ordered interventions to prevent falls. The facility staff failed to ensure that physician			3 CENTER		3	27 HERSHBERGER RO NW	•	
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 lincluded:  1. For Resident #6 the facility staff failed to apply physician ordered interventions to prevent falls. The facility staff failed to ensure that physician	PREFIX	(EACH OFFICIENC)	Y MUST BE PRECEOEO BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULO E CROSS-REFERENCEO TO THE APPROPRI		
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	from accident hazard.  (2) Each resident record and assistance device and assistance device (n) - Bed Rails. The fappropriate alternative bed rail. If a bed or simust ensure correct is maintenance of bed resident to the following element (t) Assess the resident from bed rails prior to (2) Review the risks at the resident or reside informed consent prior (3) Ensure that the beappropriate for the resident or the resident or the resident or the resident or the resident or the resident for the resident or essentially to the resident for 2 of 33 R survey, Resident #6 at The Findings Include to the Findings Include to the Findings Include to the facility staff failed or dered bed alarm at Resident #6 was a 90 admitted on t/30/t7.	eives adequate supervision es to prevent accidents.  facility must attempt to use es prior to installing a side or ide rail is used, the facility installation, use, and ails, including but not limited ents.  Int for risk of entrapment installation.  and benefits of bed rails with int representative and obtain or to installation.  and's dimensions are sident's size and weight.  I is not met as evidenced  and, staff interview, clinical ined that the facility staff environment free of accident esidents in the sample and Resident #18.  d:  d:  d:  d:  d:  d:  d:  d:  d:  d	F	323	Importance to follow physician orders.  D. Nurse Manager or designee will audit be chair alarms and geri-sleeves to adherence physician order. The findings will be reported Quality Assurance committee will be weekly weeks then monthly for 4 months for 2 consistence.	to the d to the for 8	

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION (X1] PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2] MULTIF A. BUILOING	PLE CONSTRUCTION  G		(X3) OATE SURVEY COMPLETEO		
		495092	B. WING		<i>:</i>	C 08/10/2017		
	ROVIOER OR SUPPLIER	B CENTER		STREET ADORESS, CITY, STATE, ZIP COOE 327 HERSHBERGER RO NW ROANOKE, VA 24012	- I	00/15/25/1		
(X4] IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEOEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION]		IO PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	€OULO BE	(X5) COMPLETION DATE		
F 323	kidney disease witho  The most current Min assessment located in Quarterly MDS assess Reference Date (ARI coded that Resident is Score of 8. The facilities Resident #6 required assistance (3/2) with (ADL's).  On August 8, 2017 at observed Resident #1 the side of her bed. In member visiting with dressed in street clot observe a wheel chain conserved Resident #1 surveyor noted the with the bed. The surveyor half alarm on the wife the side of her bed. In her night clothes. Resurveyor she was was the surveyor did not on Resident #6's wheel Con August 9, 2017 at observed Resident #1 the side of her bed. In the side of her bed. On August 9, 2017 at observed Resident #1 the side of her bed at the side of her b	othyroldism and chronic out heart failure.  Jimum Data Set (MDS) In the clinical record was a sement with an Assessment of 19/9/17. The facility staff the had a Cognitive Summary by staff also coded that limited (2/2) to extensive Activities of Daily Living  12:25 p.m. the surveyor of sitting in her wheelchair at Resident #6 had a family her. Resident #6 was hes. The surveyor did not in alarm or a bed alarm.  17:15 a.m. the surveyor of 19/19 in bed asleep. The heelchair was at the foot of or did not observe a wheel heelchair or a bed alarm.  18:05 a.m. the surveyor of sitting in her wheelchair at Resident #6 was dressed in the sident #6 informed the liting on her breakfast tray, observe a wheelchair alarm	F 3:	23				

	FOEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MUL A. BUILO		(X3) OATE SURVEY COMPLETEO		
		495092	B. WING				
NAME OF PE	ROVIOER OR SUPPLIER	433032	D. 11110	- 5	TREET AOORESS, CITY, STATE, ZIP COOE	08/	10/2017
TOTAL C	to to Election of the citem				27 HERSHBERGER RD NW		
FRIENDS	IIP HEALTH AND REHAI	B CENTER			OANOKE, VA 24012		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRIA OEFICIENCY)		(X5) COMPLETION DATE
	On August 9, 2017 at reviewed Resident #6 the clinical record proorders dated 6/29/17 included, but were not PRECAUTIONS ever resident allows. Cha (sic)  Continued review of the Comprehensive of the CCP documented identified that Reside The CCP identified the "Interventions." "Foo withheld) has voiced s/p recent surgical refall prior to admission resident withheld) is a occurrence and injury fall prior to admission a fracture of the left helimited to extensive siand mobility self performations provides to mild impairmInterventions-Provideven floors free from adequate, glare free left free left in the comprehensive signal in the compr	a 23  10 a.m. the surveyor S's clinical record. Review of iduced signed physician Signed physician orders It limited to: "FALL y shift. Bed alarm as ir alarm as resident allows."  The clinical record produced Care Plan (CCP). Review of I that the facility staff Int #6 was at risk for falls. I following "Focus" and us- (name of resident experiencing pain/discomfort pair of fracture sustained in" "Focus-(name of at risk to have a fall I he has recent history of during which she sustained ip. Se currently requires taff assistance with transfers formance. Her sitting and air to poor. She may require pts at times for safety d/t ent stm/recall. Ide a safe environment with: spills and/or other clutter: ight, personal items within position for safe transfers,		323		ATE	DALE
	Further review of the August 2017 Medicat (MAR's), August 201 Records (TAR's) and	clinical record produced the ion Administration Records 7 Treatment Administration current Progress Notes. hts failed to document the					

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA (X2) I IOENTIFICATION NUMBER: A. BU			E CONSTRUCTION		(X3) OATE SURVEY COMPLETEO	
		40 222		R MANAGE			С	
		495092	B. WING				08/	10/2017
	ROVIDER OR SUPPLIER H(P HEALTH AND REHA)	B CENTER		;	STREET ADORESS, CITY, STATE, ZIP COOE  327 HERSHBERGER RO NW			
				L.,	ROANOKE, VA 24012			
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APP OEFICIENCY)	ULO BI		(X5) COMPLETION DATE
= 000								
F 323	Continued From page		F	323	3· · · · · · · · · · · · · · · · · · ·			
		e refusal by the resident of			İ			
	the physician ordered	d wheelchair and bed a(arm.						
	. On Assessed 0 2017 of	t 10:30 a m the surveyor						
		t 10:20 a.m. the surveyor se, who was a Registered						
		ident #6 had a physician	ļ		1			
	, ,,	ir alarm and a bed alarm.	į					
		ed the clinical record with the	1					
		veyor specifically pointed out						ļ
	i .	or the wheelchair and bed						
		informed the MDS Nurse						
		I not seen either of the						
		#6 on multiple occasions.						
		ted for the MDS Nurse to						
		eyor to Resident #6's room to						1
		e in place. The surveyor						
		ed to Resident #6's room						
		n. The MDS Nurse walked						
	1	wheelchair and observed						ļ
		The MDS Nurse was unable						İ
	L.							
	1	n ordered wheelchair or bed	İ					
	alarm.							
	!On August 9: 2017 a	t 11:10 p.m. the surveyor						
		ator (Adm) and Director of						
		Resident #6 had physician						
		air and bed alarm. The						
		Administrative Tam (AT) that						
	the physician ordered	· · ·	ļ					
		alarms, were not in place.						
İ								
	No further informatio	n was provided to the team						
		cility as to why the staff failed						
		ment free of accident						1
	t .	#6. The facility staff failed to						
	apply physician orde							
	2. For Resident #18,	the facility staff failed to						
	apply physician orde	red Geri-sleeves to the						1

STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	A. BUILO		CONSTRUCTION	COMPLETEO		
	.*	495092	B. WNG	B. WNG			C 08/10/2017	
	ROVIOER OR SUPPLIER	B CENTER	<u> </u>	STREET AOORESS, CITY, STATE, ZIP COOE 327 HERSHBERGER RD NW ROANOKE, VA 24012			10/2011	
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IO PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE OEFICIENCY)		(X5) COMPLETION DATE	
F 323	bilateral upper arms.  Resident #18 was an admitted on 2/29/16. included, but were no acute kidney injury, matrial fibrillation, heari and adult failure to th.  The most current Min assessment located i Annual MDS assessment located i Annual MDS assessme ference Date (ARD staff coded that Resident staff coded that Resident assistance (3/2) with (ADL's).  On August 8, 2017 at reviewed Resident #1 of the clinical record proders dated 6/30/17 included, but were no BUE (bilateral upper resident allows." (sic)  Continued review of the August 2017 Med Record (MAR's), Aug Administration Record August 2017 MAR's adocument the applicated Geri-sleeves.	86 year old male, who was Admitting diagnoses of limited to: bladder tumor, mild cognitive impairment, ing loss, cirrhosis of the liver rivB.  Immum Data Set (MDS) on the clinical record was an enent, with an Assessment of the facility dent #18 had a Cognitive of the facility staff also with a required extensive Activities of Daily Living or a clinical record. Review or oduced signed physician orders of the clinical record produced signed physician or extremities) for integrity as the clinical record produced dication Administration ust 2017 Treatment dication of the physician ordered clinical record produced the end TAR's failed to the end TAR's failed to clinical record produced the eview of the progress notes	F	323				
	Geri-sleeves or reside	ent refusal of the physician	<u> </u>		<u> </u>			

STATEMENT OF OEFICIENCIES IX1) PROVIOER/SUPPLIER/CLIA ANO PLAN OF CORRECTION IOENTIFICATION NUMBER:			IX2) MULTIPLE CONSTRUCTION  A. BUILOING		IX3  OATE SURVEY COMPLETEO		
		495092	B. WNG_	B. WING			0 10/ <b>2</b> 01 <b>7</b>
	ROVIOER OR SUPPLIER HIP HEALTH AND REHA	B CENTER		STREET ADORESS, CITY, STATE, ZIP COOE 327 HERSHBERGER RD NW ROANOKE, VA 24012			10/2011
(X4) IO PREFIX TAG	IX IEACH OEFICIENCY MUST BE PRECEOEO BY FULL		IO PREFI) TAG	<	PROVIOER'S PLAN OF CORRECTION IEACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)	BE :	(X5) COMPLETION DATE
F 323	the Comprehensive of Resident #18. Reviethat the facility staff in "Focus" and "Intervented for excessive bleeding anticoagulant medical (atrial fibrillation). (Realso at risk for compli (hypertension) and Vowas been treated for forearm by wound MI care to his arm Into (with) wound MD as of (and) encourage not sleeves/turbigrips as On August 8, 2017 at observed Resident #1 had his left arm exterinead. His right arm vovers. The surveyor Resident #18 had on Geri-sleeves.  On August 8, 2017 at met with the Administ Nursing (DON). The Administrative Team physician order for Gextremities. The surveyers Resident #18 did not ordered Geri-sleeves	the clinical record produced Care Plan (CCP) for wo of the CCP documented dentified the following nations."  8's name withheld) is at risk grit (related to) use of tion for the diagnosis of a-fib esident name withheld) is cations related to HTN it (vitamin) D deficiency. He a hematoma to his L (left) D. he receives preventative erventions- F/U (follow up) condered for a ST (skin tear) + to pick + wear preventative ordered." (sic)  2::20 p.m. the surveyor 18 lying in bed. Resident #18 ided up and behind his was lying on top of the did not observe that the physician ordered  4:20 p.m. the survey team rator (Adm) and Director of surveyor notified the (AT) that Resident #18 had a eri-sleeves to bilateral upper reyor notified the AT that have on the physician. The surveyor reviewed the a DON and specifically	F3	323			

STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION	COM	(X3) OATE SURVEY COMPLETEO	
		495092	B. WING_		ı	/10/2017	
	ROVIOER OR SUPPLIER	3 CENTER	STREET AOORESS, CITY, STATE, ZIP COOE 327 HERSHBERGER RD NW ROANOKE, VA 24012				
tX4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES †EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IO PREFIX TAG	(EACH CORRECTIVE ACTION SHO	PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIATE OEFICIENCY)		
F 329	August 2017 MAR's a notes with the DON.  No further information prior to exiting the fact to apply the physician Resident #18.  483.45(d)(e)(1)-(2) DIFROM UNNECESSA 483.45(d) Unnecessa Each resident's drug unnecessary drugs. drug when used  (1) In excessive dose therapy); or  (2) For excessive durus (3) Without adequate (4) Without adequate (5) In the presence of which indicate the dodiscontinued; or  (6) Any combinations	rveyor also reviewed the and TAR's and the progress  In was provided to the team cility as to why the staff failed ordered Geri-sleeves to  RUG REGIMEN IS FREE RY DRUGS  Intry Drugs-General.  Iregimen must be free from An unnecessary drug is any  (including duplicate drug ation; or	F3	A. Restdent #18 was monitored for an and anti-anxiety medication. Resident #7 was monitored for antianti-psychotic medication. Resident #16 was monitored for an medication.  B. All residents on affected unit who a anti-anxiety, anti-psychotic and antide medication have the opportunity to hardocumentation for specific behaviors, interventions, side effects and effectiv.  C. Nursing staff will be re-educated or monitoring of residents who receive an antidepressants and anti-psychotics.  D. Nurse Manager witt audit for compaccurate documentation for specific benursing interventions, side effects and for residents receiving anti-anxiety, and anli-psychotics. The findings will the Quality Assurance committee will weeks then monthly for 4 months for 2	-anxiety and ti-anxiety are prescribed pressant we incomplete nursing eness.  In the proper nti-anxiety, lette and ehaviors, leffectiveness attide pressants be reported to be weekly for 8	8/ t0/2017 8/10/2017 8/10/2017 9/22/2017 9/22/2017	
	resident, the facility n	ensive assessment of a		quarters.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		495092	B. WING		01	C 3/10/2017	
	ROVIDER OR SUPPLIER	B CENTER		STREET ADDRESS, CITY, STATE, ZIP CO 327 HERSHBERGER RD NW ROANOKE, VA 24012			
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 329	medication is necess condition as diagnos clinical record;  (2) Residents who us gradual dose reductinterventions, unless an effort to disconting This REQUIREMENT by:  Based on staff interverview, it was determ failed to ensure that sample survey were medications, Resident #7.  The facility staff faile psychotropic, antians use to include specifinterventions, side effortive interventions, and and specific behaviors, neffects and effectives.	hese drugs unless the ary to treat a specific ed and documented in the see psychotropic drugs receive ons, and behavioral clinically contraindicated, in ue these drugs; It is not met as evidenced view and clinical record nined that the facility staff 3 of 33 Residents in the free from unnecessary in #16, Resident #18 and did to monitor for the use of viety and antidepressant drug it behaviors, nursing fects and effectiveness.  Indicate the facility staff failed to m, an antidepressant, and nxiety drug use to include ursing interventions, side ness.  79 year old female who was by on 2/20/17. Admitting but were not limited to: other placement, dorsalgia,	F	329			

	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		_	(X3) OATE SURVEY COMPLETEO	
		495092	B. WING	B. WING		C	
	NAME OF PROVIOER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, S 327 HERSHBERGER RD ROANOKE, VA 24012	NW	1 08/1	10/2017
(X4) IO PREFIX TAG			IO PREFI TAG	X (EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULO BE RENCEO TO THE APPROPRIATE OEFICIENCY)		(X5) COMPLETION OATE
F 329	assessment located in Quarterly MDS assess Reference Date (ARE staff coded that Reside Summary Score of 12 coded that Resident # assistance (3/3) with (ADL's).  On August 9, 2017 at reviewed Resident # of the clinical record porders dated 6/29/17 included, but were not Hydrobromide Tablet mouth one time a day LORazepam Tablet 0 eight hours as neede.  Continued review of the July and August 2017 the facility staff administration Record July and August 2017 the facility staff administered the month of July 201 in August 2017 MAR's of staff administered the the month of July 201 in August 8/3/17 at 9 a.m., 8/6/17 at 8:04 a 9:09 p.m., and 8/8/17  Further review of the Progress Notes and 3 Summary's. These domonitoring for the use Citalopram, and the a	imum Data Set (MDS) In the clinical record was a sment with an Assessment IN of 5/29/ t7. The facility lent # t6 had a Cognitive IN The facility staff also It6 required extensive Activities of Daily Living IN State of Dai	F	329			

AND BLANDE CORRECTION LIGHTIGICATION NUMBER:		A. BUILOII		(X3) OATE SURVEY COMPLETEO			
		495092	B. WING_			C 08/10/2017	
	ROVIOER OR SUPPLIER	3 CENTER	,	STREET ADORESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RO NW ROANOKE, VA 24012			
(X4) IO PREFIX TAG	[EACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION [EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCED TO THE APPROPRI/ OEFICIENCY)		IX5) COMPLETION OATE
F 329	document medication the antidepressant, C antianxiety, Lorazepa behaviors, nursing in and side effects.  On August 9, 2017 at the MDS Nurse, who (RN), that Resident # and Lorazepam. The Nurse that review of the produce documentati antidepressant and a include specific behaviore defects and effect reviewed the clinical include specific behavior Observation Nurse was unable to Citalopram and Lorazem or August 9, 2017 at notified the Administr Nursing (DON) that Recitalopram and Lorazemotified the Administr facility staff were not the antidepressant and the service of the antidepressant and the antidepressant and the antidepressant and the service of the servic	the clinical record failed to a monitoring for the use of citalopram, and the am, to include specific terventions, effectiveness as a Registered Nurse as Registered Nurse as the clinical record failed to an of monitoring for the intianxiety drug use to viors, nursing interventions, etiveness. The surveyor record with the MDS Nurse, and the signed physician ress Notes and Target in Summary's. The MDS locate monitoring for the	F	329			
	prior to exiting the factor to ensure that Reside	n was provided to the team cility as to why the staff failed ent #16 was free from tions. The facility staff failed					

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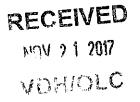
	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) OATE SURVEY COMPLETEO	
			1			С	
		495092	B. WING			08	/10/2017
NAME OF PR	ROVIOER OR SUPPLIER				STREET AOORESS, CITY, STATE, ZIP COOE		
FRIENDSHIP HEALTH AND REHAB CENTER					327 HERSHBERGER RO NW		
FRIENDSF	IIP HEALIN AND KENAS	BCENTER			ROANOKE, VA 24012		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IÓ PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	BE	(X5) COMPLETION DATE
F 329	Continued From page	e 31	F;	329	9		
	to monitor for antidep	ressant and anxiety drug					
	use to include specific	<del>-</del>					
	interventions, side eff	fects and effectiveness.					
	For additional informa refer to F Tags 309 ar	ation regarding Resident #16 nd 514.					
	2 For Resident #19	the facility staff failed to					
		e (antianxiety), Lexapro			1		
		Remeron (antidepressant)					
		pecific behaviors, nursing	ļ				
		fects and effectiveness.					
	admitted on 2/29/16. included, but were no acute kidney injury, m	ot limited to: bladder tumor, nild cognitive impairment, ing loss, cirrhosis of the liver					
	i The most current Min	imum Data Set (MDS)					
	assessment located i	n the clinical record was an					
		nent, with an Assessment					
	·	D) of 7/06/17. The facility	1				
		dent #18 had a Cognitive					
		The facility staff also #18 required extensive					
		Activities of Daily Living					
	(ADL's).	reduces of bany living					
	( //						
	On August 8, 2017 at						
		18's clinical record. Review			·		
		produced signed physician					
		. Signed physician orders					
		of limited to: "BusPIRone HCI					
	day for anxiety. Lexa	tablet by mouth two times a					. !
		e) Give 1 tablet by mouth					1
		epression. Lexapro 20mg po					
<u> </u>	5.15 tillo a day 101 be	-L	<u>. i </u>				<del></del>

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Event IO: IN5911

Facility IO: VA0089

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 11/03/2017 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED С 495092 B. WING 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 32T HERSHBERGER RD NW FRIENDSHIP HEALTH AND REHAB CENTER ROANOKE, VA 24012 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION OATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY 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

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and side effects.

and side effects.

"Interventions."

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

Additional review of the clinical record produced the Comprehensive Care Plan (CCP). The CCP

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

identified the following "Focus" and

Event ID: IN5911

Facility ID: VA0089

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) OATE SURVEY COMPLETEO		
		495092	B. WING	B. WING		C 0 <b>8/10/2017</b>	
	ROVIOER OR SUPPLIER	B CENTER		STREET AOORESS, CITY, STAT 327 HERSHBERGER RO NW ROANOKE, VA 24012	•		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF OEFICIENCIES (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		IO PREFI TAG	X (EACH CORRECT CROSS-REFERENC	OVIGER'S PLAN OF CORRECTION CORRECTIVE ACTION SHOULO BE REFERENCEO TO THE APPROPRIATE OEFICIENCY)		
F 329	He has also declined discussion with MD. increased agitation, Schanges, unable to sl changes in appetite, (signs and symptoms appetite, changes in sample, changes in swings, anxiety, unex Monitor for side effect medication-somnolem hypotension, tachyca amblyopia, constipation salivation, UTI joint particularly pain, changes in wellow numbers at the pain, changes in wellow numbers. Music of On August 8, 2017 at met with the Administ Nursing (DON). The Administrative Team receiving Buspirone, surveyor notified the AT that spinterventions, side effibe documented for the and antianxiety medical surveyor medical side of the AT that spinterventions, side effibe documented for the and antianxiety medical side of the AT that is provided the AT that spinterventions, side effibe documented for the and antianxiety medical side of the AT that is provided the AT that spinterventions, side effibe documented for the and antianxiety medical sides.	history of refusing to including skin are, weights, food and fluid. It's and a tube feeding per Interventions Monitor for Schortness of breath, behavior leep or concentrate, chest pain. Monitor for S/S of depression- decreased sleeping pattern, mood splained crying and isolation. Its of antipsychotic line, insomnia, orthostatic, rdia, peripheral edema, on, thirst, increase ain, and sweating Its of olence, insomnia, anxiety, navior changes, abdominal light, increased sweating. Counseling, psychiatry evalund relaxation in a quiet of interest." (sic)  4:20 p.m. the survey team rator (Adm) and Director of surveyor notified the (AT) that Resident #18 was Remeron and Lexapro. The AT that medication is of the medications could clinical record. The surveyor pecific behaviors, nursing fects and effectiveness must be use of the antidepressants cations.	F	329			
-	prior to exiting the fac	cility as to why the staff failed	1	English ID: MADDED			

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STATEMENT OF OEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IOENTIFICATION NUMBER: A. BUILDING		O	(X3) OATE SURVEY COMPLETEO		
		495092	B. WING_			C	
NAME OF PI	ROVIOER OR SUPPLIER		<u> </u>	STREET ADORESS, CITY, STATE, ZIP COOR	<u>.</u> :	08/10/2017	
CD/ENDO	UDUEAL THIAND DELLA	D OFFITTER		327 HERSHBERGER RD NW			
FRIENDSHIP HEALTH AND REHAB CENTER				ROANOKE, VA 24012			
(X4) ID		ATEMENT OF DEFICIENCIES	10	PROVIOER'S PLAN OF COR	RRECTION	(X5)	
PREFIX TAG	(EACH OEFICIENCY MUST BE PRECEOEO BY FULL			( (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE, OEFICIENCY)		COMPLETION	
F 329	Continued From page	∋ 34	F 3	329			
	to ensure that Reside					}	
		tions. The facility staff failed				İ	
1		ressam and anxiety drug					
i	use to include specifi	c behaviors, nursing					
i	interventions, side eff	fects and effectiveness.					
1							
	3 For Pecident #7 th	e facility staff failed to					
		nitoring for the antianxiety					
	medications Ativan ar						
j	antipsychotic medical						
1	Lithobid.	1					
!	Resident #7 was adm	nitted to the facility on ted on 07/17/17. Diagnoses					
	included but not limite			•			
!		n, hypokalemia, depression,					
í	diabetes mellitus type	2, hyperlipidemia, anxiety,					
İ	and bipolar disorder.	•					
		(minimum data set) with					
:		reference date) of 07/30/17					
	cognitive patterns. Th	s 15 of 15 in section C,					
į	cognitive patterns. Th	is is a quarterly MDS.	İ				
!	Resident #7's clinical	record was reviewed on					
		a signed POS (physician's					
		e month of July which read				İ	
ļ		0.5mg (Lorazepam). Give					
1		ne time a day for anxiety,					
1		m", "Ativan Tablet 0.5mg					
		.5 tablet by mouth one time					
1	a day for anxiety, cata						
	"Bupropion HCI ER (S	mg. Give 1 tablet by mouth	1				
		rig. Give i tablet by mouth xiety with depression",	]				
	"Lithobid Tablet Exten						
		R). Give 1 tablet by mouth					
		nizoaffective disorder", and					
<del> </del>	<del></del>	· · · · · · · · · · · · · · · · · · ·					

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Facility IO: VA0089

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STATEMENT OF OFFICIENCIES ANO PLAN OF CORRECTION		L IOENTIFICATION NUMBER:		IPLE	CONSTRUCTION		(X3  OATE SURVEY COMPLETEO	
						С		
		495092	B. WING_			08/	10/2017	
NAME OF PE	OVIOER OR SUPPLIER			Sī	TREET AOORESS, CITY, STATE, ZIP COOE			
FDIENDO	UD LIE ALTIL AND DELIAL	CENTED	:	32	27 HERSHBERGER RD NW			
FRIENDSHIP HEALTH AND REHAB CENTER				R	ROANOKE, VA 24012			
(X4) IO PREFIX TAG	SUMMARY ST. (EACH OEFICIENC REGULATORY OR I	IO PREFII TAG	Κ	PROVIOER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCEO TO THE APPROPI OEFICIENCY)	BE	(X5) COMPLETION OATE		
F 329	Continued From page	<b>3</b> 5	F3	329				
		mg. Give 1 tablet by mouth						
		(electronic medication						
		) for the months July and viewed and indicated that						
	Resident #7 was rece							
!	ordered by the physic	sian.						
	Resident #7's CCP (c	comprehensive care plan)						
		ntained a care plane for"						
·		ic medications r/t (related to)						
	, -	atric disorders including						
	• •	order, catatonic disorder of ECT (electroconvulsive					İ	
		tive disorder of the Bipolar						
		or this care plan were listed						
	as "Monitor for voiced	• • • • • • • • • • • • • • • • • • •						
	,	to harm self. Notify MD						
	•	ter medications as ordered. hanged by MD. Monitor			•			
	closely and documen				İ			
		r/record occurrence of for						
	target behavior symp							
		se to verbal communication,						
	and document per fac	unity protocor .	:					
		record contained "Target						
		Summary" forms. These						
	forms failed to docum							
	monitoring for the me	uications indicated.						
	The concern of not co	ompleting daily targeted						
	behavior monitoring v	was discussed with the						
		luring a meeting on 08/09/t7						
	at approximately 142							
F 441		n was provided prior to exit. (f) INFECTION CONTROL,	F	441	A. Resident #13 linens were changed.		8/10/2017	

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	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			COMP		
		495092	B. WING_			08/	10/ <b>20</b> 17
	ROVIDER OR SUPPLIER	3 CENTER		32	REET ADORESS, CITY, STATE, ZIP COOE 7 HERSHBERGER RD NW DANOKE, VA 24012		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
	Continued From page		F	141	Resident #1 linens were changed.		8/10/2017
SS=D	PREVENT SPREAD,  (a) Infection prevention	LINENS on and control program.			B. All residents on the affected units have the opportunity to have linens handled improper		9/22/2017
•	•	blish an infection prevention (IPCP) that must include, at ving elements:			C. Facility staff will be re-educated on infection practices, specifically not sitting on rebeds.		9/22/2017
	investigating, and cor communicable diseas volunteers, visitors, a providing services un arrangement based u conducted according	der a contractual pon the facility assessment to §483.70(e) and following ndards (facility assessment	ment wing		D. Infection Preventionist or designee will p random audits of proper handling of linen ar sitting on resident beds. The findings will be to eh Quality Assurance Committee will be v 8 weeks then monthly fo r4 months for 2 corquarters.	nd staff e reported weekly for	9/22/2017
		, policies, and procedures h must include, but are not					:
	possible communicat	llance designed to identify ble diseases or infections and to other persons in the		:			
	• •	m possible incidents of se or infections should be				•	
, ! !	(iii) Standard and trar to be followed to prev	nsmission-based precautions rent spread of infections;					
	(iv) When and how is resident; including bu	olation should be used for a t not limited to:					
	(A) The type and dura	ation of the isolation,		!			

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	STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRU					(X3) OATE SURVEY COMPLETEO		
		495092	B. WING		· · · · · · · · · · · · · · · · · · ·	08	C /10/2017	
	ROVIOER OR SUPPLIER	S CENTER	STREET ADORESS, CITY, STATE, ZIP COOE 327 HERSHBERGER RO NW ROANOKE, VA 24012					
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCEO TO THE APPROPE OEFICIENCY)	BE	(X5) COMPLETION OATE	
F 441	involved, and (B) A requirement that least restrictive possift circumstances.  (v) The circumstances must prohibit employed disease or infected sk contact with residents contact will transmit the (vi) The hand hygiene by staff involved in dir  (4) A system for recorunder the facility's IPC actions taken by the f  (e) Linens. Personne process, and transport spread of infection.  (f) Annual review. The annual review of its IF program, as necessar This REQUIREMENT by: Based on observatio policy review and clin determined the facility control precautions for (Residents #13 & #1) ~ Facility staff were of resident's beds while eat.	the isolation should be the ole for the resident under the sunder which the facility sees with a communicable in lesions from direct or their food, if direct ne disease; and reprocedures to be followed sect resident contact.  ding incidents identified CP and the corrective acility.  I must handle, store, it linens so as to prevent the refacility will conduct an PCP and update their ry, is not met as evidenced in, staff interview, facility ical record review it was a failed to follow infection in 2 of 33 residents	F	441				
	Findings:		<u> </u>					

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Facility IO: VA0089

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	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	A. BUILOII		NSTRUCTION		MPLETEO
		495092	B. WING			,	08/10/2017
	ROVIDER OR SUPPLIER HIP HEALTH AND REHA	B CENTER		327 H	ET ADORESS, CITY, STATE, ZIP COOE ERSHBERGER RD NW NOKE, VA 24012		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEOED BY FULL LSC IDENTIFYING INFORMATION)	IO PREFI) TAG	×	PROVIOER'S PLAN OF CORRECTI   EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	D BE	(X5) COMPLETION DATE
F 441	Resident #13's clinic 8/10/17 at 2:00 PM.  Resident #13 was ad 9/22/15. Her diagnos behavioral disturband dysphagia.  Resident #13's latest assessment, dated 6 with significant cogni required nursing staf (activities of daily living assistance.  The resident's CCP (revised 6/21/17, door of weight loss & maling progression." The int "Provide, serve diet a and record every me  Resident #13 had a produced texture. If a family to provide nothing to provide nothing to provide nothing to provide nothing to provide nothing to provide nothing to provide nothing her lunch was seated on the relunch.  On 8/10/17 at 8:15 A	observed seated on while feeding Resident #13. all record was reviewed  Imitted to the facility on es included dementia with the anemia, hypertension and of MDS (minimum data set) //11/17 coded the resident tive impairment. She flassistance for all the ADL's right, including feeding comprehensive care plan), umented the problem, "at risk autrition d/t dementia erventions included, as ordered. Monitor intake all".  Obysician's order, signed and order consisted of "fortified Thin consistency. Allow oursed items for quality of life on of patient for swallowing  M, Resident #13 was seated side. The overbed tray was in front of her. CNA I sident's bed feeding her	F4	341			

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	OF OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	(X2) MULTIPLE CONSTRUCTION  A. BUILOING			SURVEY PLETEO
		495092	B. WING			i	C 10/ <b>2017</b>
NAME OF P	ROVIDER OR SUPPLIER	1		ST	REET AOORESS, CITY, STATE, ZIP COOE	1 00/	10/2017
FRIENDSH	IP HEALTH AND REHA	B CENTER		1	7 HERSHBERGER RD NW DANOKE, VA 24012		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO B CROSS-REFERENCEO TO THE APPROPRI OEFICIENCY)		(X5) COMPLETION OATE
F 441	the surveyor's observe "They do not sit on the they're feeding them.  On 8/10/17 at 10:00 informed of the observe stated, "It's definitely encouraged, but it's chere and pat the bed.  The facility did not ham embers from sitting additional information survey team exit.  2. For Resident #1 the establish infection con Resident's bed while  Resident #1 was adm 12/29/11 and readmit included but not limite artery disease, Alzheir	M the DON was informed of rations. The DON stated, e resident's beds when It's a dignity issue".  AM the administrator was vation. The administrator not recommended or sk if they (residents) say sit."  I we a policy prohibiting staff on resident's beds. No was provided prior to the efacility staff failed to follow introl guidelines by sitting on assisting with feeding.  Initted to the facility on ted on 12/20/14. Diagnoses ed to anemia, coronary tension, gastroesophageal mer's disease, dementia, malnutrition, depression,	F	441	OEFICIENCY)  !		
	an ARD (assessment coded the Resident a term memory impairm decision making skills status coded the Reseating, which is the entity of the status coded the Reseating, which is the entity of the status coded the Reseating, which is the entity of the status coded the Reseating, which is the entity of the status coded the Reseating, which is the entity of the status coded the status coded the status coded the Reseating that the status coded the sta	S (minimum data set) with reference date) of 07/31/17 s having both long and short nent with severely impaired s. Section G, functional ident as 3/2 in 1he area of quivalent of extensive on physical assist. This is		ŀ			

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Event IO: IN5911

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	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	' '		CONSTRUCTION	(X3) OATE	LETEO
•		495092	B. WING_			0 <b>8</b> /1	0/2017
	ROVIOER OR SUPPLIER	3 CENTER		32	REET ADORESS, CITY, STATE, ZIP COOE 7 HERSHBERGER RD NW DANOKE, VA 24012		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	×	PROVIOER'S PLAN OF CORRECTION IEACH CORRECTIVE ACTION SHOULO BE CROSS-REFERENCEO TO THE APPROPRIA' OEFICIENCY)	SHOULO BE COMPLET	
F 441	Continued From page	40	F	141			
	breakfast on 08/09/17 CNA (certified nurse's Resident with eating, bed, with CNA seated beside Resident.  On 8/10/17 at 9:30 Althe DON (director of reseated on Resident #"They do not sit on the they're feeding them.  The administrator was observation on 8/10/14 AM. The administrator recommended or encoresident says sit here	s informed of the 7 at approximately t0:00 r stated, "It's definitely not ouraged, but it's ok if the e and pats the bed."  ve a policy prohibiting staff					
F 514 SS=E	bed was discussed di administrative staff on t255.  No further information 483.70(i)(t)(5) RES RECORDS-COMPLE	NA seated on Resident's uring a meeting with the 108/t0/t7 at approximately was provided prior to exit.	F <del>(</del>	5 t4	Residents #6, 16, 1 and 7 have signed driven reviews on their medical record char	-	8/10/2017
	standards and practic	n accepted professional es, the facility must ords on each resident that			B. All residents on affected unit have the opposite to have incomplete medical records.      C. All staff will be re-educated on the importation complete and accurate medical records.	oortunity	9/22/2017

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NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER  (X4) 10 PREFIX TAG  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;  (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	C (40/2017 (X5) COMPLETION DATE 9/22/2017
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER  (X4) IO PREFIX TAG	(X5) COMPLETION DATE
FRIENDSHIP HEALTH AND REHAB CENTER  (X4) IO PREFIX TAG  (KACH OEFIGENCY MUST SE PRECEDED SY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 514  Continued From page 41  (i) Complete; (iii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized (5) The medical record must contain- (ii) Sufficient information to identify the resident; (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	DATE
PREFIX TAG  (EACH OEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG  (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE OT OT THE APPROPRIATE OEFICIENCY)  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;  (iii) 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	DATE
(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;  (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	9/22/2017
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.	

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Event IO: IN5911

Facility IO: VA0089



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	OF OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETEO	
		495092	B. WNG		,	i	С
NAME OF PI	ROVIOER OR SUPPLIER	4000E	7 0. 1110		STREET AOORESS, CITY, STATE, ZIP COOE	1 08	/10/ <b>20</b> 17
FRIENDS	HIP HEALTH AND REHAL	3 CENTER			327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCEO TO THE APPROPE OEFICIENCY)	BE	(X5) COMPLETION DATE
F 514	Continued From page	42	F	514	4		
	The Findings Included	d:					
		e facility staff failed to 2017 Pharmacy Monthly wwas contained in the					
·	admitted on 1/30/17. included, but were no	t limited to: fractured femur, thyroidism and chronic	7.7.7				
	Quarterly MDS assessing Reference Date (ARD coded that Resident # Score of 8. The facility Resident #6 required	n the clinical record was a sment with an Assessment b) of 5/9/17. The facility staff 6 had a Cognitive Summary					
	the clinical record pro- Pharmacy Drug Regir	's clinical record. Review of duced the Monthly nen Reviews (DRR's). The esident #6 did not have a					
	notified the Administra Nursing (DON) that re clinical record failed to DRR. The surveyor re clinical record with the	produce a June 2017 eviewed Resident #6's					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IOCNITICIONAL NILLANDED:		IPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO			
		40,5000	B. WING			С		
	ON MOST OF CHIEF IS	495092	D. WING -	STREET ADDRESS, CITY, ST		08/10/2017		
NAME OF PE	ROVIOER OR SUPPLIER							
FRIENDS	IIP HEALTH AND REHAR	B CENTER		327 HERSHBERGER RO NW ROANOKE, VA 24012				
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F 5 t4	Continued From page	e 43	F.	514				
	delivered the June 20 The DON stated that member and support The surveyor notified monthly DRR was no record and therefore inaccurate.  No further information prior to exiting the fac to ensure that the clin June 20 t7 monthly D  2. For Resident #16 t ensure that the clinica and July 20 t7 Monthl Reviews (DRR's).  Resident #16 was a 7 admitted to the facility diagnoses included, b intravertebra( disc rep hypertension, hydron incontinence.  The most current Min assessment located i Quarterly MDS asses Reference Date (ARD staff coded that Resident s coded that Resident s	he facility staff failed to all record contained the June by Pharmacy Drug Regimen  79 year old female who was by on 2/20/17. Admitting but were not limited to: other blacement, dorsalgia,						
	(ADL's). On August 9, 2017 at reviewed Resident#	8:30 a.m. the surveyor t6's clinical record. Review						

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	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '			E SURVEY PLETEO	
		495092	B. WING		- U. W. A		C /10/2017
	ROVIOER OR SUPPLIER HIP HEALTH AND REHAE	3 CENTER		327 I	EET AOORESS, CITY, STATE, ZIP COOE HERSHBERGER RO NW ANOKE, VA 24012		
(X4) IO PREFIX TAG	(EACH OEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		PROVIOER'S PŁAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULO CROSS-REFERENCEO TO THE APPROPI OEFICIENCY)	BE	(X5) COMPLETION DATE
	Review of the DRR's and July 2017 DRR's On August 9, 2017 at the MDS Nurse, who (RN), that review of the produce the June and surveyor reviewed the MDS Nurse and spece Pharmacy DRR's. The clinical record did July 2017 DRR's.  On August 9, 2017 at notified the Administra Nursing (DON) that reclinical record failed to 2017 DRR's. The sur #16's clinical record we pointed out that Reside and July 2017 DRR's.  On August 9, 2017 at delivered the June an Resident #16. The DOR Records staff member gotten the DRR's. The that the June and July not contained in the contai	produced the Monthly men Reviews (DRR's). failed to produce the June  9 a.m. the surveyor notified was a Registered Nurse ne clinical record failed to I July 2017 DRR's. The eclinical record with the iffically reviewed the Monthly ne surveyor pointed out that not contained the June and  11:10 p.m. the surveyor ator (Adm) and Director of eview of Resident #16's produce the June and July reverse reviewed Resident with the DON. The surveyor dent #16 did not have a June  1:55 p.m. the DON hand d July 2017 DRR's for DN stated that the Medical r and support staff had a surveyor notified the DON y 2017 monthly DRR's were linical record and therefore	F	514			

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Facility IO: VA0089

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PRINTED: 11/03/2017 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-039 t STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495092 B. WING 08/10/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW FRIENDSHIP HEALTH AND REHAB CENTER ROANOKE, VA 24012 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 514 Continued From page 45 F 5 t4 3. For Resident # t8, the facility staff failed to ensure that June and July 20 t7 Monthly Pharmacy Drug Regimen Reviews (DRR) were contained in the clinical record. Resident #t8 was an 86 year old male, who was admitted on 2/29/t6. 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 t0. The facility staff also coded that Resident #18 required extensive assistance (3/2) with Activities of Daily Living

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 #t8 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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(ADL's).

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	B CENTER		327 HERSHB	ERGER RD NW	1 00/	10/2017
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delivered the July an DON did not deliver to DON stated that the member and support The surveyor notified DRR's were not contand therefore the clir No further information prior to exiting the facto ensure that the clir monthly DRR's for Resident #1 the monthly Pharmacy Dincluded in the clinical Resident #1 was admincluded but not limit artery disease, Alzhe Parkinson's disease, asthma, and dysphagathma, and dysphagathma and Cassessment coded the Resident attern memory impair decision making skills.  Resident #1's clinical 08/08/17. The surveymonthly Pharmacy Dmonth of July 2017.  The surveyor informed	d August 2017 DRR's. The the June 2017 DRR. The Medical Records staff a staff had gotten the DRR's. If the DON that the monthly ained in the clinical record was inaccurate. In was provided to the team cility as to why the staff failed nical record contained esident #18.  The facility failed to ensure the rug Regimen Review was all record.  The facility on the doing and short in the reference date) of 07/31/17 as having both long and short in the record was reviewed on ror could not locate a rug Regimen Review for the date ad the administrative staff.	F	514			
missing during a mee	eting on 08/08/17 at					
	SUMMARY ST (EACH DEFICIENC REGULATORY OR  Continued From pag delivered the July an DON did not deliver t DON stated that the member and support The surveyor notified DRR's were not cont and therefore the clir No further information prior to exiting the fact to ensure that the clir monthly DRR's for Re  4. For Resident #1 th monthly Pharmacy D included in the clinical Resident #1 was adn 12/29/11 and readmit included but not limit artery disease, hyper reflux disease, Alzhe Parkinson's disease, asthma, and dysphase The most recent MDS an ARD (assessment coded the Resident at term memory impair decision making skills  Resident #1's clinical 08/08/17. The survey month by Pharmacy D month of July 2017.  The surveyor informe that the July 2017 dre	ROVIOER OR SUPPLIER  HIP HEALTH AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDEO BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)  Continued From page 46  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, 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	ROVIDER OR SUPPLIER  HIP HEALTH AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IOENTIFYING INFORMATION)  Continued From page 46  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, mainutrition, 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	ROVIDER OR SUPPLIER  ROVIDER OR SUPPLIER  RIP HEALTH AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IOENTIFYING INFORMATION)  Continued From page 46  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 DRR's for Resident #18.  4. For Resident #1 the facility failed to ensure the monthly Dramacy Drug Regimen Review was included in the clinical record.  Resident #1 was admitted to the facility on 12/29/14. Diagnoses included but not limited to anemia, coronary arery disease, hypertension, gastroesophageal reflux disease, Alzheimer's disease, dementia, Parkinson's disease, mainutrition, 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	ROWDER OR SUPPLIER  495092  ROWDER OR SUPPLIER  3TREET ADDRESS, CITY, STATE, ZIP COOE 327 HERSHBERGER RD NW ROANOKE, VA 24012  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY WAS TEE PRECEDED BY FULL REGULATORY OR LSC IGENTIFYING INFORMATION)  Continued From page 46 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 falled 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 but not limited to anemia, coronary arrary disease, hypertension, gastroesophageal reflux diseases, elherimer's disease, dementia, Parkinson's disease, mainutrition, 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 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	A BUILDING  A BUILDING  B. WING  STREETADORESS, CITY, STATE, 2IP CODE  327 HERSHBERGER RD NW  ROANOKE, VA 24012  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY BUST SE PERCEDEO BY PULL REGULATORY OR ISC IDENTIFYING INFORMATION)  Continued From page 46  delivered the July and August 2017 DRR's. The DON stid 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 #1 the facility as to why the staff failed to ensure that the clinical record contained monthly DRR's for Resident george sain entity of partnersion, gastroesophageal reflux disease, Alzheimer's disease, dementia, Parkinson's disease, mainutrition, 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 impaliment with severely impaired decision making skills. This is quarterly MDS.  Resident #1's clinical record was reviewed on 000/08/17. 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

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STATEMENT OF OEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A, BUILDING			(X3) OATE SURVEY COMPLETEO			
		495092	B. WING _			C 98/10/2017
	ROVIOER OR SUPPLIER IIP HEALTH AND REHA	B CENTER		STREET AOORESS, CITY, STATE, ZIP CO 327 HERSHBERGER RO NW ROANOKE, VA 24012		
(X4) IO PREFIX TAG	(EACH OEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIOER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCEO TO TI OEFICIENC'	ON SHOULO BE HE APPROPRIATE	(X5) COMPLETION DATE
F 5 t 4	provided the surveyor #t's monthly drug regord July 20 t7. DON state drug regimen revisupport staff.  No further information 5. For Resident #7 the ensure the monthly From Review was included to the regimen and the folial terms of the folial term	eximately t350, the DON or with a copy of Resident gimen review for the month ated that she had received liew from medical records  In was provided prior to exit.  The facility staff failed to Pharmacy Drug Regimen  In the clinical record.  In the clinical record.  In the dinical record.  In the dinical record.  In the she facility on ted to schizoaffective on, hypokalemia, depression, at 2, hyperlipidemia, anxiety,  S (minimum data set) with the reference date) of 07/30/17 at 15 of 15 in section C, and is a quarterly MDS.  If record was reviewed on yor could not locate the noreviews for the months of the daministrative staff lay 2017 drug regimen reviews a meeting on 08/08/17 at the poximately t350, the DON	F5	14		
	provided the surveyo	or with a copy of Resident				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3  DATE SURVEY COMPLETED	
			A. Buildi	ING_	<del>.</del>		
		495092	B. WING			1	0/2017
NAME OF P	ROVIDER OR SUPPLIER			ŧ	STREET ADDRESS, CITY, STATE, ZIP CODE		
FRIENDSH	IIP HEALTH AND REHAE	CENTER			327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) IO	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	<u></u> `	PROVIOER'S PLAN OF CORRECTION		(X5)
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		uly 2017. DON stated that drug regimen review from					
	No further information	was provided prior to exit.	-				
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