DEPA CENT	RTMENT OF HEALTH ERS FOR MEDICARE	ANDIAN SERVICES 8 MEDICAID SERVICES		(PRINTED: 05/18/2017 FORM APPRUYED
CTATEME	NT OF OFFICIENCIES FOR CORPENINGS	(X1) PROVIDER/SUPPLIFICEIA IDENTIFICATICIN NUMBER	4 80% D	T PLE CONSTRUCTION	1 050-8600 ON BMO (x3) DATE EUVEY COMPLETED
AND THE PERSON NAMED OF PERSONS ASSESSED.	27V 1444 August 1	495421	B WING		0510410045
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F 000) INITIAL COMMENT	S	F 0	00	and the second s
	 standard survey was 5/4/17. Corrections 	itial Medicare/Medicaid s contlucted 05/2/17 through are required for compliance official Long Torm Care life Safety Code sen completed			
F 278 SS=D	time of the survey. 7 of 18 current Resider through #18) and 3 c through #21). 483.20(g)-(i) ASSES	20 bed facility was 103 at the The survey sample consisted of reviews (Residents #1 slosed records (Resident #19 SMENT DINATION/CERTIFIED	F 27	r8	
	(g) Accuracy of Asse nrust accurately refle	ssments. The assessment of the resident's status.			
	(h) Coordination A registered nurse m each assessment with participation of health	ust conduct or coordinate h the appropriate r professionals.			
	(i) Certification (1) A registered nurse the assessment is co	erroust sign and certify that orpleted.			
	(2) Each individual whas sessment must significant portion of the ass	no completes a portion of the n and certify the accuracy of essnrent.			***
	(j) Penally for Falsifica (1) Under Medicare ar who willfully and know	nd Medicaid, an individual			
	(i) Certifies a material	and false statement in a			

LABORATORY DIRECTOR'S OF PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any diliciancy statement ending with an asterisk (*) denotes a definiting which the institution may be excused from correcting providing it is determined that offsee sufficient protection to the patients. (See instructions.) Except for oursing homes, the findings stated above are disclosable 90 days days tollowing the date of survey whether or not a plan of correction is provided. For nutsing fromes, the above findings and plans of correction are disclosable 14 days tollowing the date those documents are made available to the facility. If deticiencies are cited, an approved plan of correction is requisite to continued

FORM CM3-2567(C2-99) Previous Versions Obsidero

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if continuation sheet Page, 1 of 55

PRINTED: 05/18/2017 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO, 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING _ 05/04/2017 B. WING 495421 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 JX5J COMPLETION OATE PROVIDER'S PLAN DF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (EACH CORRECTIVE ACTION SHOULD BE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) F 278 F 278 Continued From page 1 resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT Is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to maintain a complete and accurate Minimum Data Set (MDS) assessment for 1 or 21 residents in the survey sample (Resident #12). Resident #12 was admitted to the facility on

11/19/16 with diagnoses including end stage renal disease, generalized muscular weakness, diabetes mellitus type II with complications affecting kidneys, circulation, and eyes, pain, and hypertension. On the most recent MDS assessment with assessment reference date 1/30/17, the resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of dellrium, psychosis, or behaviors affecting others.

During clinical record review on 5/3/17, the surveyor noted physician orders dated 4/27 for Quetiapine Fumarate Tablet 50 mg(milligram) by mouth at bedtime for psychosis, and for Clonazepam tablet 0.5 mg by mouth one time a day for @HS (hour of sleep) anxlety and Clonazepam Tablet 0.5 mg by mouth every 12 hours as needed for anxiety. The Quetiapine

Facility ID: VA0419

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	CARE & MEDICAID SERVICES (X11 PROVIOGR/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILOING	(X2) MULTIPLE CONSTRUCTION A. BUILOING	
	495421	B, WING		05/04/2017
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F 278 Continued From page 2

order was a dosage increase from Quetiapine Flimarate 25 mg Give 1 tablet by mouth at bedtime for psychosis dated 11/19/16. The Clonazepam was a new medication.

The surveyor was unable to locate documentation of symptoms requiring the medications. There were no orders for behavior monitoring of symptoms or of potential side effects of the medications. Nurse's notes for Aprll and May 2017 did not mention symptom of psychosis or of anxiety. The surveyor was unable to locate physician notes documenting diagnoses of anxiety or psychosis. Psychosis was not listed on the diagnosis list in the clinical record or in the MDS dated 1/30/17. Pharmacy review notes for January, February, March, and Aprll 2017 requested a psychiatric evaluation for necessity of antipsychotic medications. The physician agreed with all four recommendations.

The Medication Administration Record (MAR) for April 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 4/29/17 at 0442. The MAR for May 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 5/2/2017 at 0507. The surveyor was unable to locate nursing documentation of the symptoms for which the medication was administered or whether the resident was offered non-pharmacologic interventions.

The surveyor discussed concerns with the director of nursing (DON) on 5/4/16. After investigation, the DON reported that the physician was diagnosing psychosis when signing the monthly order summary. The DON obtained a Geriatric Psychiatry Consult Note dated 4/26/17. Under Nursing Report, the physician

F 278

F 278 Accuracy/Coordination/Certified

1. Facility Residents #12 had revisions made to her two MDS assessments to include psychotic diagnosis for use of antipsychotic medication use, in accordance to the Centers for Medicare & Medicaid Services. (October 2016) Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual, Section I: Active Diagnosis, page I-2. Revisions made to facility Resident #12's MDS assessments were shared with onsite health inspectors at time of completion prior to exit conference.

5/4/2017

- All facility residents with antipsychotic medication use have the potential to be affected by this deficient practice. 5/4/2017
- Facility's MDS nurses were educated on Section I: Active Diagnosis in accordance to the Centers for Medicare & Medicaid Services. (October 2016) Long-term Care Facility Resident Assessment Instrument 3.0 User's Manual, Section I: Active Diagnosis.

5/23/2017

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F 278 Continued From page 3

wrote"Depressed. Patient currently on Seroquel with no supporting diagnosis. Anxious with transportation to dialysis". Under the Chief Complaint/reason for visit section, the physician wrote "f/u (followup) for chronic depression. Under the section HPI, the physician wrote "Pt's current TX reviewed. C/O staying bed "depressed", worrying, tired, and Also c/o being unable to sleep at night. States she still experiences auditory hallucinations (including her husband's voices). Trazodone not helping at all. Klonopin worked well previously. Under Medication Changes "1) d/c Trazodone 2)Clonazepam 0.5 mg qhs 3) [change] Zoloft to 150 mg qd (every day) 4) [change] seroquel to 50 mg qhs.

The surveyor was unable to determine when the physician ordered the Clonazepam 0.5 mg every 12 hours as needed for anxiety which the resident received on 4/29/17 and 5/2/17.

The facility policy titled Behavior Monitoring Policy (antipsychotic medications) stated under PROCEDURE: Nursing 6. Evaluation by a mental health professional will be completed for all residents that are: a. Admitted on an antipsychotic mediation used to control behavior 7. "A mental health profession will determine the proper diagnosis for antipsychotic medications. The diagnosis "will be sent to medical records and to the pharmacy."

Concerns were discussed with the administrator and DON during a summary meeting on 5/4/17. The DON stated there was no further information to offer concerning the lack of a psychiatric diagnosis on the MDS.

F 278

4. RAI Manager or designee will audit all residents with use of anti-psychotic medication will have the diagnosis for use of medication reflected in the current active diagnosis list in section I of their current MDS assessment. Findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

5/25/2017

DEPARTMENT OF HEALTH AND HOMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X2) MULTIPLE CONSTRUCTION (X1) PROVIDER/SUPPLIER/ČLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: A. BUILOING AND PLAN OF CORRECTION

(X3) OATE SURVEY COMPLETEO 05/04/2017 B. WING 495421 STREET ADORESS, CITY, STATE, ZIP COOE NAME OF PROVIOER OR SUPPLIER 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X5) COMPLETION DATE SUMMARY STATEMENT OF OFFICIENCIES (X4) IO PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG OFFICIENCY) F 309 F 309 Continued From page 4 F 309 483.24, 483.25(k)(I) PROVIDE CARE/SERVICES F 309 SS=E FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all trealment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not ilmited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

preferences.

by:

(I) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered

care plan, and the residents' goals and

This REQUIREMENT is not met as evidenced

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F 309	document review, a facility staff failed to and services to attracticable physical well-being, consist comprehensive as 5 of 21 residents (4)	age 5 tion, staff interview, facility and clinical record review, the p provide the necessary care ain or main(ain the highest al, mental, and psychosocial ent with the resident's sessment and plan of care for Resident #11, Resident #8, ident #12, and Resident #5).	1	309 F309 Pr being #1	ovide Care/Services For Highe	st Well
	The findings include	led:	'			
1. The facility staff failed to complete a pain assessment with non-pharmacological interventions for pain for Resident #11. The clinical record of Resident #11 was reviewed 5/2/17 and 5/3/17. Resident #11 was admitted to the facility 11/17/16 with diagnoses that included bul not limited to lower limb cellulitis, anemia, morbid obesity, dysthymic disorder, hypertension, cardiomyopathy, ventricular tachycardia, lymphedema, diverticulosis of large intestine, constipation, and long term use of anticoagulants.			2.	All facility residents have the to be affected by this deficie	n pain. Her address her ll be ns to /2017 potential nt practice.	
	assessment with a (ARD) of 4/18/17 cognitive summar evidence of behaviors of the section G Function Resident #11 was assistance of two transfers and had extremities. Sectively eviewed for pain	arterly minimum data set (MDS an assessment reference date assessed the resident with a y score of 12 and without viors, delirium or psychosls. nal Status was reviewed. assessed to need extensive people for bed mobility and impairment in both lower on J Health Conditions was management. Resident #11)	3.	Facility nursing staff will be en Pain Assessment and Manag Policy in particular regards to medication interventions per residents preference prior to medication as reflected on commedication.	ement o non- r the o use of

prn pain medications within the last 5 days of the ARD. Resident #11 was assessed to have not

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F 309 Continued From pa received non-medi	cation interventions for pain	F:	309			
during the 5 day low The current compring 12/2/16 and revise identified the focus had acute pain r/t (vascular disease, vascular disease, vadminister analges before treatments for pain relief and complaint of pain, characteristics eves severity (1 to 10 so onset; duration, agractors. Identify, reconditions which in discomfort- arthritic peripheral vascula call for assistance ask for medication experienced, tell ypain, and monitor (signs/symptoms) The April 2017 elegant the very 4 hours the very 4 hours the very 4 hours acute included an order the very 4 hours acute included and included an order the very 4 hours acute included and in	ehensive care plan initiated d 5/2/17 for Resident #11 area that read "Resident #11 (related to) arthritis, peripheral woundsInterventions: sia as per orders. Give ½ hour or care prn, anticipate my need respond immediately to any monitor/record pain ery shift and prn: quality cale); anatomical location; gravating factors; relieving ecord and treat my existing may increase pain and or is, neuropathies, osteoporosis, ar disease, ulcers; I am able to when in pain, reposition self, in, tell you how much pain is you what increases or alleviates (record/report to Nurse any s/sx of non-verbal pain." ectronic physician orders or that read "Oxycodone HCI grams) Give 0.5 mg tablet by urs as needed for pain" and an oxycodone HCI Tablet 5 mg		4.	DON or designee will audit 1 residents for use of medicat pain management to ensure medication interventions we attempted first per the reside preference weekly for 4 were monthly for 2 months. The be reported to the Quality & Committee monthly for 3 m consecutive quarter. 6/2	ions for non- ere dent's eks then findings will Assurance	

as needed for pain."

The April 2017 electronic medication

administration records (eMARs) were reviewed. Resident #11 received Oxycodone 2.5 mg prn (as needed) pain medications nine (9) times in April 2017 on 4/14/17, 4/15/17, 4/17/17, 4/18/17 (x2),

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F 309	Continued From pa #11 received Oxyc April 2017 on 4/16/	age 7 odone 5 mg three times (3) in (17, 4/17/17, and 4/28/17.	F 309		
	non-pharmacologic medication admini- listed dates in April not reveal pain ass include anatomical	gress notes did not reveal cal interventions prior to stration on any of the above 2017. The clinical record did sessments were done to location; onset; duration, s; relieving factors. The only documented was the numerical Aprit 2017 eMARS.			
	practical nurse #2 a.m. L.P.N. #2 as pain level. The re- something for pair inform Resident # pain so the nurse	erved wound care with licensed on 5/3/17 beginning at 9:25 ked Resident #11 about her sident stated she needed n. L.P.N. #2 stated she would 11's nurse of the complaints of could give her a pill. There macological interventions observation.			
	the above concern asked what her ex management inclu would expect the non-pharmacolog	med the director of nursing of n on 5/3/17 at 9:20 a.m. and spectations for pain uded. The DON stated she staff to offer ical interventions prior to giving nd document those			
	director of nursing complete pain assuse non pharmac resident complain and again on 5/4/	rmed the administrator and the g of the failure of the facility to sessments and to offer and/or ological interventions for at 11:20 a.m. The surveyor ility policy on pain managemen	ı. t.	and the local Action of th	If continuation sheet Page B 0

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F 309	Continued From page	age 8	F	309		
	management titled Management" on 8 "Assessing Pain: pain assessment gas indicated from representative): a treatment, includin non-pharmacolog Implementing Pain Non-pharmacolog appropriate alone medications." No further informace exit conference of	n Management Strategies: 15. jical interventions may be or In conjunction with ation was provided prior to the n 5/4/17.		F309 #2	 Facility Resident #8's applied by facility staff. All facility residents where the potential of the	5/4/2017 vith orders for ential to be
	The facility sta orders for TED ho	iff failed to follow physician ose for Resident #8.				5/4/2017
	The clinical recor 5/3/17. Resident 11/1/16 with diag limited to chronic	d of Resident #8 was reviewed #8 was admitted to the facility noses that included but not pain, dysphagia, cognitive leficit, hypothyroidism, dysthymia, sensorlneural hearing loss,	ic		3. Facility nursing staff on following practitions notification to practitio chooses not to accept of	er orders and ner if resident
	athorosclaratic hi	eart disease, angina pectoris,	al			6/9/2017
	reflux disease, co tract infections, a	ortic stenosis, gastroesophagea onstlpation, osteoarthritis, urina and long term use of aspirin.	ry		4. DON or designee wil residents for application	n of TED hose
	initiated 11/17/16 from our sister fa Resident #8 is a	rrent comprehensive care plan in read "Resident #8 was admitted acility for LTC (long term care). Hert and oriented and can make in. Interventions: TED			weekly for 4 weeks the months. The findings w the Quality Assurance monthly for 3 months f	vill be reported to Committee

quarter.

6/24/2017

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO	0938-0391
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F 309	Continued From page	age 9	F3	309			
1 309	every noc (night)."	190 0			•		
	The physician order allows. On in am (Rinse & dry at his integrity one time a "TED hose as resi (morning), off at his	sician orders were reviewed. er read "TED hose as resident (morning), off at hs (bedtime). and perform skin check for skin a day Place on in AM" and dent allows. On in am s (bedtime). Rinse & dry at hs check for skin integrity one time PM".					
	11:05 a.m. The rewheelchair in her white socks on boshe had her elastiunder the socks. helped her put the Resident #8 rolled bathroom and got the bottom drawe asked about the Twas the first days #8 and she was the socks.	erved Resident #8 on 5/3/17 at exident was sitting in her room. The surveyor observed th feet and asked the resident if c stockings (TED hose) on Resident #8 stated no one had see socks on for over a month. If the wheelchair into the a clean pair of TED hose from rof the vanity. C.N.A. #1 was TED hose. C.N.A. #1 stated this she was assigned to Resident not aware of the TED hose. If the couldn't put them on by					
	5/3/17 and 5/4/17 5/4/17 at 9:00 a.n been informed at Resident #8. She responsible for m	rviewed Resident #8's nurse for licensed practical nurse #3 on n. L.P.N. #3 stated she had pout the TED hose not placed or e was asked who was taking sure they were on the #3 stated the nurse was paking sure they were on and the sure the sure or and the					

she also stated between the nurses and the aides, she made sure they were on Resident #8.

DEPART	MENT OF HEALTH	A MEDICAID SEDVICES				0	<u>MB NO. 0938-0391</u>
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		10	F	309			
F 309	Continued From pa	age 10	,				
	The surveyor infor	med the administrator and the of the above concern on 5/3/17	,				
	at 2:12 p.m. and a	gain on 5/4/17 at 11:20 a.m.		#3			
]	No further informa	tion was provided prior to the			1.	Facility Resident #20	discharged
	exit conference or	5/4/17.				from facility on 3/27	
						Hom laciney and, 27,	5/4/2017
	The facility stat	ff failed to follow physician			2	All facility residents	
	orders for daily we	eights for Resident #20.			2.	•	
	The clinical record	d of Resident #20 was reviewed				daily weights with pa	
Į.	E10/47 and 5/4/17	Resident #20 was admitted to)			the potential to be a	ffected by this
	the facility 1/18/17	with diagnoses that included				deficient practice.	
	but not limited to (chronic diastolic heart failure, chanteric fracture of right femur					5/4/2017
	fall from chair, me	ethicillin resistant	•		3.	Facility nursing staff	will be
	etaphylococcus a	ureus (MRSA), type 2 diabetes				educated on following	ng practitioner
	mollitus obesity	maior depressive disorder,				orders, 5 Rights to a	medication
	hunortonsive heal	rt and chronic kidney disease				administration, and	
	with heart failure,	stage 4 chronic kidney disease ve pulmonary disease, atrial	•			practitioner if reside	
	fibrillation athern	sclerotic heart disease,				to follow order.	110 011000000 1100
	aortocoronary by	pass graft, and dependence on				to follow order.	6/0/2017
	oxygen.				_		6/9/2017
		designation minimum data set			4.	DON or designee wi	
	Resident #20's a	dmission minimum data set ent with an assessment				residents for daily w	=
	reference date //	ARD) of 1/25/1/ assessed the				notification to pract	itioner per
	recident with a Co	agnitive summary score or 10 or	ut			parameters weekly	for 4 weeks
	of 15 Decident:	#20 was without any signs of				then monthly for 2 i	months. The
	delirium, psycho	sis, or behaviors directed toward t #20 required extensive	_			findings will be repo	rted to the
	assistance of 2 t	people for bed mobility, transiers	s			Quality Assurance C	
	and toileting, and	d extensive assistance of other				monthly for 3 mont	
	person for perso	nal hygiene.				consecutive quarter	
	•		n			•	1
	Resident #20's of created 1/26/17	current comprehensive care plantified a focus area for weigh	nt			6/24/2017 :	

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					. 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES		TIOL (* ^)	ONSTRUCTION		TE SURVEY
STATEMENT AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	l · · ·		DISTRUCTION	CO	MPLETED
		495421	B. WING				/04/2017
NAME OF P	ROVIOER OR SUPPLIER				ET AOORESS, CITY, STATE, ZIP CO	ODE	
FRIENDS	HIP HEALTH AND RI	EHAB CENTER - SOUTH			STARKEY ROAD E SPRING, VA 24018	- TOTAL	
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE DEFICIENCY)	SHOULO BE	(X51 COMPLETION DATE
F 309	Continued From pa	nd notify MD/RD (medical	F	309			
	The January 2017	lietician) as needed. physician orders had an order sights one time a day start date 2/8/17."					
	summary sheet ar	ewed the weights and vitals and the January 2017 eMARs. corded weights for 4 days in 2/17, 1/21/17, 1/24/17, and					
	2/8/17 to this orde MD for weight gain 24 hours or > 5 pc	or daily weights was changed or r that read "Daily weights Notify n > (greater than) 3 pounds in bunds in 1 week 150.23 Acute c (congestive) heart failure one date 2/9/17."	1				
	was an "x" in the the box with the n	7 eMAR was reviewed. There 2/12/17 box and then a "5" in urse's initials. The legend at eMAR read "5≃Hold/See nurse as no progress note or physicial	s 1				
	pounds. On 2/15 as 239.2 pounds. gain in 24 hours. the nurse should the weight differe	4/17 was documented as 232 /17, the weight was documente Resident #11 had a 7.2 weigh Based on the physician order, have informed the physician of nce. The clinical record dld not so note for 2/15/17.	l				
	The weight obtain as 130.1 pounds-from the previous	ned on 2/16/17 was documente a difference of 109.1 pounds aday (2/15/17).	d				

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OCNITCIDO	EOD MEDICARE	& MEDICAID SERVICES					OMB MO. 0830-038
	FOEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING				(X3) OATE SURVEY COMPLETED
	į	495421	B. WING				05/04/2017
NAME OF PROVIOER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH			5647 S	TARKEY	SS. CITY, STATE, ZIP COOR (ROAO G, VA 24018	E	
IX4) IO PREFIX TAG	ACACH OFFICIENCY	ATEMENT OF OEFICIENCIES Y MUST 8E PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		IFACH	DVIOER'S PLAN OF CORRE I CORRECTIVE ACTION SH REFERENCEO TO THE APP DEFICIENCY)	IONFO RE CONSTRUIS
	February 2017 eM. summary. The weights record and 2/19/17 were and 2/19/17 were and 2/19/17 were are 2/20/17, 2/24/17 at 2/20/17, 2/24/17 at 2/20/17, 2/24/17 at 3/26/2 the weights and violating weights and violating weights are	arded weight for 2/17/17 on the AR or the weights and vitals ded on the eMAR for 2/18/17 130.1 pounds. Orded weight on the February ight and vitals summary for and 2/26/17. Forded weights for 3/15/17, 17 on the March 2017 eMAR or tals summary. From the director of nursing of its on 5/4/17 at 9:00 a.m. The party in the mornings by the faursing assistants but did not all a shift responsible for and the gof the fallure to follow the for Resident #20's weights on m. Sewere provided prior to the exit 4/17. For the director of nursing stated are the fallure to follow the for Resident #20's weights on m. Sewere provided prior to the exit 4/17. For the fall ty staff falled to obtain a sure and March 2017, and in facility policy, when the resident the facility with orders for		309 #4	2. <i>4</i>	Facility Resident #12 psychiatrist on 4/26, was provide to onsit inspectors prior to e All facility residents for a psychiatrist eva the potential to be a deficient practice.	/2017, which te health exit conference. 5/4/2017 with an order aluation have

Resident #12 was admitted to the facility on

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

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		O MEDICAID SERVICES		· · · · · · · · · · · · · · · · · · ·				
	CENTERS FOR MEDICARE	& MEDICALD SETTAISES		L CONCEDICTION	TAG (EXt	E SURVEY		
i	STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	tx2) MULTIPLE CONSTRUCTION				
	AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3				
l		495421	B. WING		0.5	/04/2017		
L				STREET ADORESS, CITY, STATE, ZIP CODE				
ľ	NAME OF PROVIOER OR SUPPLIER		i i	5647 STARKEY ROAD				
l	AMD DI	THAT CENTED SOUTH						
١	FRIENDSHIP HEALTH AND RI	EHAB CENTER - 300111	1	CAVE SPRING, VA 24018				
	TATION TEACH DEFICIENCY	N'EMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIOER'S PLAN OF CORRECTED TO THE ACTION SHOUND FOR CROSS-REFERENCED TO THE APPROFICIENCY)	JLD BE	(X5) COMPLETION OATE		

F 309 Continued From page 13

11/19/16 with diagnoses including end stage renal disease, generalized muscular weakness, diabetes mellitus type II with complications affecting kidneys, circulation, and eyes, pain, and hypertension. On the most receni MDS assessment with assessment reference date 1/30/17, the resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others.

During clinical record review on 5/3/17, the surveyor noted physician orders dated 4/27 for Quetiapine Fumarate Tablet 50 mg(milligram) by mouth at bedtime for psychosis, and for Clonazepam tablet 0.5 mg by mouth one time a day for @HS (hour of sleep) anxiety and Clonazepam Tablet 0.5 mg by mouth every 12 hours as needed for anxiety. The Quetiapine order was a dosage increase from Quetiapine Fumarate 25 mg Give 1 tablet by mouth at bedtime for psychosis dated 11/19/16. The Clonazepam was a new medication.

The surveyor was unable to locate documentation of symptoms requiring the medications. There were no orders for behavior monitoring of symptoms or of potential side effects of the medications. Nurse's notes for April and May 2017 did not mention symptom of psychosis or of anxiety. The surveyor was unable to locate physician notes documenting diagnoses of anxiety or psychosis. Psychosis was not listed on the diagnosts list in the clinical record or in the MDS dated 1/30/17. Pharmacy review notes for January, February, March, and April 2017 requested a psychiatric evaluation for necessity of antipsychotic medicalions. The physician agreed with all four recommendations.

F 309

- Facility nursing staff will be educated on following practitioner orders. Facility has contracted for additional psychiatric in house visits.
- 4. DON or designee will audit 100% of residents with orders for psychiatric evaluation and that the resident is seen timely, weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

6/24/2017

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
	495421	B. WING	STREET ADDRESS, CITY, STATE, ZIP CO	05/04/2017
NAME OF PROVIOER OR SUPPLIER FRIENDSHIP HEALTH AND RI	EHAB CENTER - SOUTH	:	5647 STARKEY ROAD CAVE SPRING, VA 24018	J.
(A4) IO (EACH DESICIENC)	NTEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE COMPLETION
F 309 Continued From pa	age 14	F	309	
April 2017 documed Clonazepam 0.5 m 0442. The MAR for resident received 0 on 5/2/2017 at 050 locate nursing documents of the surveyor disconstruction of nursing investigation, the locate of nursing period of the surveyor disconstruction of the surveyor disconstruction of the surveyor of nursing period of the survey of the surveyor of the s	ministration Record (MAR) for anted the resident received of for anxiety on 4/29/17 at or May 2017 documented lhe Clonazepam 0.5 mg for anxiety of The surveyor was unable to umentation of the symptoms cation was administered or ent was offered or interventions. Seed concerns with the (DON) on 5/4/16. After DON reported that the physician sychosis when signing the mary. The DON obtained a ry Consult Note dated 4/26/17. Port, the physician Patient currently on Seroquel diagnosis. Anxious with dialysis". Under the Chief for visit section, the physician in HPI, the physician wrote "Pt's red. C/O staying bed ying, lired, and Also c/o being thight. States she still tory hallucinations (including he). Trazodone not helping at all well previously. Under ges "1) d/c Trazodone 5 mg qhs 3) [change] Zoloft to y day) 4) [change] seroquel to 5 mg qhs 3) [change] zoloft to y day) 4) [change] seroquel to 5	n er		

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-0391				
		& WEDICAID SERVICES	AVOLKALII TIIDI	PLE CONSTRUCTION	(X3) DATE SURVEY		
STATEMENT ANO PLAN OI	OF OEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		G	COMPLETEO		
		495421		70.000	05/04/2017		
NAME OF P	PROVIOER OR SUPPLIER		I	STREET AOORESS, CITY, STATE, ZIP COOE			
		CHAR CENTER SOUTH	I .	5647 STARKEY ROAD			
FRIENDS	HIP HEALTH AND K	EHAB CENTER - SOUTH		CAVE SPRING, VA 24018			
(X4) IO PREFIX TAG	AT A CH OFFICIENCY	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FUI.L SC IOENTIFYING INFORMATION!	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APPI OEFICIENCY)	OULD BE COMPCETION		
F 309		age 15	F 309	9			
	received on 4/29/1	7 and 5/2/17.					
	The facility policy t	itled Behavior Monitoring Policy	F309)9			
	(antipsychotic med	lica(ions) stated under Irsing 6. Evaluation by a	#5				
	mental health prof all residents that a antipsychotic med 7. "A mental health proper diagrosis for the diagnosis will and to the pharma Concerns were diagnod DON during a The DON stated to offer concerning psychiatric evaluation by the second physician. 5. For Resident #5 was a 13/16 with diagramsiety, and pathon the quarterly residents with assessment.	essional will be completed for re: a. Admitted on an lation used to control behavior in profession will determine the or antipsychotic medications. I be sent to medical records acy." scussed with the administrator a summary meeting on 5/4/17, here was no further information githe delay in obtaining a lation as ordered by the lation as ordered by the lations. admitted to the facility on noses including hypertension, ological fracture of right femur. In minimum data set assessment reference date 2/20/17, the		 Facility Resident #5 order pressure parameters were for clarification to ensure compliance of the praction order. All facility residents with for blood pressure mediparameters have the post affected by this deficient. Facility nursing staff will educated on following orders. DON or designee will a residents with orders for pressure medication with parameters to ensure weekly for 4 weeks the 	ere reviewed itioner 5/17/2017 in an order ication with otential to be int practice. 5/17/2017 ill be practitioner 6/9/2017 udit 100% of or blood with compliance, en monthly		
	mental status and of delirium, behave During clinical resurveyor noted a for clonidine 0.1 reserves as hours as	4/15 on the brief Interview for d was assessed as without signs vior, or psychosis. cord review on 5/3/17, the physician order dated 9/21/16 mg (milligram) Glve 1 tablet needed for antihypertensive 8 hrs if SBP>170 (systolic blood		for 2 months. The find reported to the Qualit Committee monthly fo for 1 consecutive quan	y Assurance or 3 months		

pressure greater than).

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES					E STIDVEY
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		DNSTRUCTION		E SURVEY IPLETED
		495421	B. WING			05/	04/2017
NAME OF P	ROVIDER OR SUPPLIER				ET ADDRESS. CITY, STATE, ZIP CODE STARKEY ROAD		
FRIENDS	HIP HEALTH AND RI	EHAB CENTER - SOUTH			E SPRING, VA 24018		
(X4) ID PREFIX TAG	/EACH DEFICIENC	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPRODEFICIENCY)	DBE	(XS) COMPLETION DATE
F 309	Continued From pa	nge 16	F	309			
	April 2017 docume blood pressure wa clonidine was not a AM, SBP was 180, 180; 4/14/17, SBP 4/29/17, SBP=213	ministration record (MAR) for inted 5 dates when the systolic is greater than 170 and administered. On 4/27/17 at 6 at 10 PM on 4/9/17 SBP==179; 4/18/17, SBP=180; Neither nursing notes or medication had been					
F 319 SS=D	were notified of the meeting on 5/4/17 483.40(b)(1) TX/S	and director of nursing (DON) e concern during a summary . VC FOR DSOCIAL DIFFICULTIES	F	319			
The state of the s	483.40(b) Based of assessment of a rithat-	on the comprehensive esident, the facility must ensure	•				
	with mental disord difficulty, or who h post-traumatic streappropriate treatm assessed problem practicable menta This REQUIREME by:	who displays or is diagnosed er or psychosocial adjustment as a history of trauma and/or ess disorder, receives nent and services to correct the or to attain the highest I and psychosocial well-being. ENT is not met as evidenced terview and clinical record					
	assessment recor	ff failed to obtain a psychiatric mmended by the pharmacist e physician for 1of 21 residents ple (Resident #12).	;				
	Resident #12 was 11/19/16 with diag	admitted to the facility on gnoses including end stage rena	al				

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			(X3) OATE SURVEY
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IX2) MULTIPLE CONSTRUCTION A BUILOING		COMPLETEO
	495421	B. WING	- A result in the second secon	05/04/2017
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND R			STREET ADDRESS, CITY, STATE, ZIP COOE 5647 STARKEY ROAD CAVE SPRING, VA 24018	
(A4) IO /EACH OFFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULT CROSS-REFERENCED TO THE ALIPROP DEFICIENCY)	D BE COMPLETION
				-

F 319 Continued From page 17

disease, generalized muscular weakness, diabetes mellitus type II with complications affecting kidneys, circulation, and eyes, pain, and hypertension. On the most recent MDS assessment with assessment reference date1/30/17, the resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others.

During clinical record review on 5/3/17, the surveyor noted physician orders dated 4/27 for Quetiapine Fumarate Tablet 50 mg(milligram) by mouth at bedtime for psychosis, and for Clonazepam tablet 0.5 mg by mouth one time a day for @HS (hour of sleep) anxiety and Clonazepam Tablet 0.5 mg by mouth every 12 hours as needed for anxiety. The Quetiapine order was a dosage increase from Quetiapine Fumarate 25 mg Give 1 tablet by mouth at bedtime for psychosis dated 11/19/16. The Clonazepam was a new medication.

The surveyor was unable to locate documentation of symptoms requiring the medications. There were no orders for behavior monitoring of symptoms or of potential side effects of the medications. Nurse's notes for April and May 2017 dld not mention symptom of psychosis or of anxiety. The surveyor was unable to locate physician notes documenting diagnoses of anxiety or psychosis. Psychosis was not listed on the diagnosis list in the clinical record or in the MDS dated 1/30/17. Pharmacy review notes for January, February, March, and April 2017 requested a psychiatric evaluation for necessity of antipsychotic medications. The physician agreed with all four recommendations.

F 319

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

PRINTED: 05/18/2017 FORM APPROVED OMB NO. 0938-0391

	E & WEDICAID SERVICES	(VOLABILTI	PLE CONSTRUCTION	(X3) OATE SURVEY	
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 ' '	A. BUILOING		
	495421	B. WING _		05/04/2017	
NAME OF PROVIOUR OR SUPPLIE FRIENDSHIP HEALTH AND			STREET AOORESS, CITY, STATE, ZIP COOE 5647 STARKEY ROAO CAVE SPRING, VA 24018		
(EACH DEFICIEN	STATEMENT OF OEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	LOBE COMPLETION	

F 319 Continued From page 18

The Medication Administration Record (MAR) for April 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 4/29/17 at 0442. The MAR for May 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 5/2/2017 at 0507. The surveyor was unable to locate nursing documentation of the symptoms for which the medication was administered or whether the resident was offered non-pharmacologic interventions.

The surveyor discussed concerns with the director of nursing (DON) on 5/4/16. After Investigation, the DON reported that the physician was diagnosing psychosis when signing the monthly order summary. The DON obtained a Gerialric Psychiatry Consult Note dated 4/26/17. Under Nursing Report, the physician wrote"Depressed. Patient currently on Seroquel with no supporting diagnosis. Anxious with transportation to dialysis". Under the Chief Complaint/reason for visit section, the physician wrote "f/u (followup) for chronic depression. Under the section HPI, the physician wrote "PI's current TX reviewed. C/O staying bed "depressed", worrying, tired, and Also c/o being unable to sleep al night. States she still experiences auditory hallucinations (including her husband's voices). Trazodone not helping at all. Klonopin worked well previously. Under Modication Changes "1) d/c Trazodone 2)Clonazepam 0.5 mg qhs 3) [change] Zoloft to 150 mg qd (every day) 4) [change] seroquel to 50 ma ahs.

The surveyor was unable to determine when the physician ordered the Clonazepam 0.5 mg every 12 hours as needed for anxiety which the resident received on 4/29/17 and 5/2/17.

F 319

F319 Mental/Psychosocial Difficulties

- Facility Resident #12 was seen by psychiatrist on 4/26/2017, which was provide to onsite health inspectors prior to exit conference. 5/4/2017
- All facility residents with an order for a psychiatrist evaluation have the potential to be affected by this deficient practice. 5/4/2017
- Facility nursing staff will be educated on following practitioner orders. Facility has contracted for additional psychiatric in house visits.
- 4. DON or designee will audit 100% of residents with order for psychiatric evaluation to ensure the resident is seen timely, weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

6/24/2017

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DEPART	ACCONDIGATE	MEDICAID SERVICES			<u> </u>		0938-039
STATEMENT	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DAT COM	E SURVEY PLETEO		
		495421	B. WING		, una	05/	04/2017
	ROVIOER OR SUPPLIER	EHAB CENTER - SOUTH		5647	ET ADORESS, CITY, STATE, ZIP CODE STARKEY ROAD E SPRING, VA 24018		
(X4) IO PREFIX TAG	SUMMARY ST/	NTEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROL OEFICIENCY)	D BE	DATE
F 319	Continued From pa	age 19	F	319			
F 328 SS=D	(antipsychotic med PROCEDURE: Numental health profall residents that a antipsychotic med 7. "A mental health proper diagnosis for the diagnosis such and to the pharma Concerns were diand DON during a The DON stated to offer concernin assessment. 483.25(b)(2)(f)(g) FOR SPECIAL Number of the proper treatment and good foot health professional	scussed with the administrator a summary meeting on 5/4/17. here was no further information g delay of the psychiatric (5)(h)(i)(j) TREATMENT/CARE	F	328			
	medical condition (ii) If necessary, appointments with arranging for tranappointments	n(s) and assist the resident in making th a qualified person, and asportation to and from such					
	The facility must	reterostomy, or ileostomy care, ensure that residents who y, ureterostomy, or ileostomy s such care consistent with					

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DEPART	INICIAL OF HEVELO	A MEDICAID SECVICES				OMB NO) <u>. 0938-0391</u>
STATEMENT	OF OFFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	(X2) MULT A. BUILOIN		INSTRUCTION	(X3) OA CO	TE SURVEY MPLETED
		495421	B. WING _				5/04/2017
NAME OF	PROVIOER OR SUPPLIER				ET AOORESS, CITY, STATE, ZIP COOE STARKEY ROAD		
FRIENDS	SHIP HEALTH AND R	EHAB CENTER - SOUTH			E SPRING, VA 24018		
(X4) ID PREFIX TAG	/EACH OFFICIENC	NTEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	[PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APP DEFICIENCY)	OULO BE	(X5) COMPLETION DATE
F 328	Continued From page	age 20	F3	28			
1 520	professional stand	ards of practice, the					
	comprehensive pe	rson-centered care plan, and s and preferences.					
	receives the appro- to prevent com- inctuding but not ti- diarrhea, vomtting abnormalities, and (h) Parenteral Ftui administered consistandards of praci- physician orders.	ho is fed by enterat means priate treatment and services of cations of enterat feeding mited to aspiration pneumonia, dehydration, metabolic nasat-pharyngea) ulcers. ds. Parenteral fluids must be istent with professional ice and in accordance with the comprehensive					
	person-centered of goats and prefere	are plan, and the resident's nees.					
	and tracheat sucti that a resident wh tnotuding tracheos suctioning, is pro- professional stand comprehensive p residents' goals a this subpart.	e, including tracheostomy care oning. The facility must ensure oneds respiratory care, stomy care and tracheat yided such care, consistent with dards of practice, the erson-centered care plan, the nd preferences, and 483.65 of	1				
	resident who has and assistance, of standards of prace person-centered and preferences, prosthetic device	he facility must ensure that a a prosthesis is provided care consistent with professionat litice, the comprehensive care plan, the residents' goats to wear and be abte to use the ENT is not met as evidenced					

Based on observation, clinical record review, staff interview and facility document review, it was

by:

TH AND HUMAN SERVICES

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-0391
		& MEDICAID SERVICES	(X2) MH	TIPLE CONSTRUCTION	(X3) DATE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING	COMPLETED
		495421	B. WING		05/04/2017
NAME OF F	ROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE,	ZIP CODE
		EHAB CENTER - SOUTH		5647 STARKEY ROAD CAVE SPRING, VA 24018	
FRIENDS				PROVIDER'S PLAN O	F CORRECTION IX51
(X4) ID PREFIX TAG	TO A OUT DECIDIENC!	TEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG	IX (EACH CORRECTIVE AC	OTHE APPROPRIATE DATE
F 32 8	Continued From pa	age 21	F;	328	
	suction equipment	e facility staff failed to maintain in a clean and sanitary manner ample survey, Resident # 3.			=
	The Findings Inclu	ded:			
	suction machine e sanitary manner.	ne facility staff failed to maintain quipment in a clean and The facility staff also failed to sician's order was contained in to suction Resident #3.		·	
	admitted on 12/02 included, but were hernia with gangre communication de	an 84 year old female who was 1/16. Admitting diagnoses e not limited to: diaphragmatic ene, dysphagia, cognitive efficit, acute renal fallure, major et cancer, hypothyroidism, ucoma.			
	located in the clin Medicare MDS as Reference Date (, staff coded that R Summary Score (Minimum Data Set (MDS) Ideal record was a 14 Day Seesment with an Assessment ARD) of 3/19/17. The facility Resident #3 had a Cognitive of 9. The facility staff also ent #3 required extensive with Activities of Dally Living			
	Resident #3 lying suction machine 700cc's of frothy suction canister. On May 2, 2017 reviewed Reside the clinical record	at 3 p.m. the surveyor observed in bed. Resident #3 had a at the side of the bed with yellowish- white secretions in the at 3:05 p.m. the surveyor of #3's clinical record. Review of produced signed physician 9/17. Signed physician orders			If continuation sheet Page 22 of 6

PRINTED: 05/18/2017 FORM APPROVED OMB NO. 0938-0391

ACUTEDO COR MEDICAR	E & MEDICAID SERVICES			C1412 110	
STATEMENT OF OFFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILOING	(XZ) MULTIPLE CONSTRUCTION		TE SURVEY MPLETEO
	495421	B. WING			/04/2017
NAME OF PROVIDER OR SUPPLIE FRIENDSHIP HEALTH AND		56	REET AOORESS, CITY, STATE, ZIP COOE 47 STARKEY ROAO AVE SPRING, VA 24018		
(EACH OFFICIEN	TATEMENT OF OEFICIENCIES ICY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORREC'TIVE ACTION SHO CROSS-REFERENCEO TO THE APPI OEFICIENCY)	DULO BE	IX5 COMPLETION DATE

F 328 Continued From page 22

did not include a physician's order for the facility staff to suction Resident #3.

Continued review of the clinical record produced the Comprehensive Care Plan (CCP) that identified the following "Focus" and "Interventions." "Focus (name of Resident #3 withheld) had altered respiratory stalus/Dyspnea r/t (related to) history of respiratory failure, heart failure, allergies." "Interventions ... Maintain a clear airway by encouraging me to clear own secretions with effective coughing. If secretions cannot be cleared, suclion as ordered/required to clear secretions." (sic)

On May 3, 2017 at 8:25 a.m. the surveyor observed Resident #3 lying in bed. Resident #3 had a suction machine at the side of the bed with 700cc's of frolly yellowish-white secretions in the suction canister.

On May 3, 2017 at 10:25 a.m. the surveyor observed Resident #3 lying in bed. Resident #3 had a suction machine at the side of the bed with 700 cc's of frothy yellowish-white secretions in the suction canister.

On May 3, 2017 at 2:05 p.m. the surveyor observed Resident #3's room once again. Resident #3 had a suction machine at the side of the bed with 700 cc's of frothy yellowish-white secretions in the suction canister.

On May 3, 2017 at 2:15 p.m. the surveyor notified the Administrator (Adm) and Director of Nursing (DON) that Resident #3 had had a dirty suction machine/canister at the side of her bed since 5/2/17 at 3 p.m. The surveyor notified the Administrative Team (AT) that the suction canister

F 328

F328 Treatment/Care For Special Needs

- Facility Resident #3's orders were obtained to reflect the need for suctioning on 5/3/2017 and suctioning equipment was cleaned per policy. 5/4/2017
- All facility residents with suctioning needs have the potential to be affected by this deficient practice. 5/4/2017
- Facility nursing staff will be educated on Oropharyngeal Suctioning policy and procedure, which includes cleaning or disposing of equipment. 6/9/2017
- 4. DON or designee will audit 100% of residents with suction needs for order and equipment care weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

6/24/2017

PRINTED: 05/18/2017 FORM APPROVED

DEPART	MENT OF HEALTH	O MEDICAID SERVICES				OMB NO	. 0938-0391
STATEMENT OF DEPROCES (AT)		1''		ONSTRUCTION	(X3) OAT	E SURVEY MPLETED	
		495421	B, WING			05	/04/2017
NAME OF F	ROVIOER OR SUPPLIER				EET AOORESS, CITY, STATE, ZIP COOE		
FRIENDS	HIP HEALTH AND R	EHAB CENTER - SOUTH		1	/ STARKEY ROAD /E SPRING, VA 24018		
(X4) ID PREFIX TAG	JEACH DEFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG	IX	PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)	ILD BE	(X5) COMPLETION DATE
F 329	secretions since 5/ requested a copy of procedure for main surveyor also notifical record failed order to suction Reformation and the bed with 700 of secretions. On May 4, 2017 at observed Resident also observed the the bed with 700 of secretions. On May 4, 2017 at delivered a policy "Respiratory. Oxyonopharyngeal Supprocedure read in Suctioning The publical the upper air prevent the development of the complete facility that there procedure. Review facility protocol for 46. Empty and rinnecessary or as in No additional information as to physician's order 483.45(d)(e)(1)-(2)	of frothy yellowish- white 12/17 at 3 p.m. The surveyor of the facility policy and intaining suction equipment. The ied the AT that review of the ied to produce a physician's esident #3. 7:50 a.m. the surveyor that all ying in bed. The surveyor suction canister at the side of ic's of frothy yellow-whitish that and procedure titled, gen Administration and post in "Oropharyngeal repose of this procedure is to away of mucous secretions and promotioning." The policy and part "Oropharyngeal repose of this procedure is to away of mucous secretions and opment of respiratory distress. Is a physician's order for this withe physician's orders or the suctioning Equipment see the collection container if indicated by facility protocol" Transition was provided prior to as to why the facility staff failed or Resident #3. Furthermore the provide any additional why they failed to obtain a prior to suctioning Resident #3. DRUG REGIMEN IS FREE	i e	328			
F 329	physician's order 483.45(d)(e)(1)-(2 FROM UNNECES	DRUG REGIMEN IS FREE	, F	: 329			

Facility ID: VA0419

PRINTED: **0**5/18/2**0**17 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES	T		(X3) OATE SURVEY
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIOER/SUPPLIER/CI,IA IOENTIFICATION NUMBER		TIPLE CONSTRUCTION NG	COMPLETED
		495421	B. WING		05/04/2017
	ROVIOER OR SUPPLIER	EHAB CENTER - SOUTH		STREET AOORESS, CITY, STATE, ZIP 5647 STARKEY ROAD CAVE SPRING, VA 24018	COOE
FRIENDS				PROVIDER'S PLAN OF CO	ORRECTION (X5)
(X4) IO PREFIX TAG	COACH OFFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IOENTIFYING INFORMATION)	IO PREFIX TAG	TO A COLOR OF CALLED	N SHOULO BE COMPLETION E APPROPRIATE DATE
F 329	Continued From p	age 24	F3	29	
,	483 45(d) Unnece	ssary Drugs-General.			
	Fach resident's dr	ug regimen must be free from s. An unnecessary drug is any			
	(1) In excessive do therapy); or	ose (including duplicate drug			
	(2) For excessive	duration; or			
	(3) Without adequ	ate monitoring; or			
	(4) Without adequ	ate indications for its use; or			
, and the state of	(5) In the presence which indicate the discontinued; or	e of adverse consequences dose should be reduced or			
	(6) Any combinati paragraphs (d)(1)	ons of the reasons stated in through (5) of this section.			
	483.45(e) Psycho Based on a comp resident, the facili	troplc Drugs. Trehensive assessment of a By must ensure that			
	drugs are not give	o have not used psychotropic en these drugs unless the sessary to treat a specific nosed and documented in the			
	gradual dose red interventions, unl an effort to disco	o use psychotropic drugs receiv uctions, and behavioral ess clinically contraindicated, In ntinue these drugs; ENT is not met as evidenced			

by:

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-0391
		& MEDICAID SERVICES	(Y2) MUITIDLE (CONSTRUCTION	(X3) DATE SURVEY
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING		COMPLETED
		495421	B WING		05/04/2017
	ROVIDER OR SUPPLIER	400421	STR	EET ADDRESS, CITY, STATE, ZIP CODE	
				7 STARKEY ROAD	
FRIENDS	HIP HEALTH AND R	EHAB CENTER - SOUTH	CA'	VE SPRING, VA 24018	
(X4) ID PREFIX TAG	JEACH DESIGNA	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION I
F 329	Continued From particles and passed on staff intereview, it was detereview, it was detereved by a staff of the passes and itted on 12/6/included, but were emboli, cognitive hypothyroidism, depression, atrial.	age 25 erview and clinical record rmined that the facility staff at 8 of 21 Residents in the re free from unnecessary dent #2, Resident #3, Resident Resident #1, Resident #12, sident #4 and Resident #13.	F 329	DEFICIENCY)	
	Resident #2 requires assistance (3/2) (ADL's). On May 2, 2017 reviewed Resides the clinical record orders. Signed by	facility staff also coded that ired set up (1/1) to extensive with Activities of Daily Living at 2:40 p.m. the surveyor nt #2's clinical record. Review d produced signed physician hysician orders included, bull to "CeleXA Tablet 10 MG	of		
1	THE THE PERSON OF THE PERSON O			- 1110446	attaugation sheet Page 26 of

DEPARTMENT OF HEALT	HAND HUN, SERVICES		(OMB NO. 0938-039
CENTERS FOR MEDICAR	E & MEDICAID SERVICES	722) MILLITIDI	E CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION	X1 PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1 '		COMPLETED
	495421	B. WING		05/04/2017
NAME OF PROVIOER OR SUPPLIE	R		STREET AOORESS, CITY, STATE, ZIP C	OOE
			5647 STARKEY ROAD	
FRIENDSHIP HEALTH AND	REHAB CENTER - SOUTH	<u> </u>	CAVE SPRING, VA 24018	
(84) 10	STATEMENT OF OEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCEO TO THE DEFICIENCY)	I SHOULO BE
	26	F 32	9 .	
F 329 Continued From	page 20	, 02.		
(Citalopram Hydi	robromide) Give 1 tablet by a day for depression Celexa			
40 by mouth	avary day for debression,			
CEDOquel Table	st 25MG (QUEtiapine Fumarate)	•		
a s tablet by mai	rith one time a day for it sychiosis	5		
0	a land Sernquel Zomo to total			
37.5 mg) by mou	uth every day at QHS (bedtime). et 25 MG (QUEtiapine Fumarate	1)		
SEROquel Table	mouth one time a day for	.,		
Daughaele Take	Sernatiel Zonia and Seroquer			
12.5mg for total	dose of 37.5mg QHS." (sic)			
the April and Ma Records (MAR's	w of the clinical record produced by 2017 Medication Administrations). Review of the Aprll and May cumented that Resident #2 was puel 37.5 mg at bedtime and every morning.	ווע		
Eurther review	of the clinical record failed to			
- reduce medic	ation/hehavtor monitoring for			
appolitic hehavii	ors, interventions, side effects at	na		
ļ	f the Seroquel and Celexa.			
the Director of was receiving S bedtime and C surveyor notific medication/bel Seroquel and C clinical record. Residenl #2's	7 at 3:45 p.m. the surveyor notification of the Nursing (DON) that Resident #2 Seroquel 37.5 mg every night at elexa 10 mg every morning. The ed the DON that the navior monitoring for the use of the Celexa could not be located in the The surveyor and DON reviews clinical record. The surveyor especific physician orders for the surveyor and polysician orders for the surveyor and polysician orders.	e the ne ed		
Seroquel and	Celexa. The surveyor also Socil and May 2017 MAR's with the	he		
DON. The DO	N reviewed the clinical record as	IIG		

OF HEALTH AND HUMAN SERVICES

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					0938-0391
		& MEDICAID SERVICES (X1) PROVIOER/SUPPLIER/CLIA	(X2) MIRT	IPLE CON	ISTRUCTION	TAO (EX)	E SURVEY
STATEMENT OF DEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIDENSUPPLIENCES (X1) PROVIDENSUPPLIENCES (X1)	A. BUILOING			COM	IPI.ETED
		495421	B. WING		W.	05/	04/2017
	PROVIDER OR SUPPLIER	433421		STREË	T ADORESS, CITY, STATE.	ZIP COOE	
		-UAD OFNITED COUTH			TARKEY ROAD		
FRIENDS		HAB CENTER - SOUTH		CAVE	SPRING, VA 24018 PROVIDER'S PLAN O	E CORRECTION	/X5I
(X4) IO PREFIX TAG	/EACH OFFICIENC!	TEMENT OF OEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	(EACH CORRECTIVE AI CROSS-REFERENCEO TO OEFICIE	CTION SHOULD BE O THE APPROPRIATE	(XS) COMPLETION DATE
F 329	Continued From pa	age 27	F 3	329			
	Celexa.						
	the Administrator (#2 was receiving a Seroquel, and an a surveyor notified that review of the committering for the antidepressant drubehaviors, intervereffectiveness. No additional inforce existing the facility is served.	2:15 p.m. the surveyor notified Adm) and DON that Resident psychotropic medication, antidepressant, Celexa. The ne Administrative Team (AT) clinical record failed to produce use of the psychotropic and ug use to include specific intlons, side effects and mation was provided prior to as to why the facility staff failed oquel and Celexa drug use for					
	Resident #2. 2. For Resident # monitor for antide	3 the facility staff failed to pressant drug use, Lexapro, to g for specific behaviors, side ons and effectiveness					
	Resident #3 was admitted on 12/02 included, but were hernia with gangroommunication de	an 84 year old female who was 2/16. Admitting dlagnoses e not limited to: diaphragmatic ene, dysphagla, cognitive eficit, acute renal fallure, major et cancer, hypothyroidism,					
	located in the clir Medicare MDS as Reference Date (staff coded that F Summary Score	Minimum Data Set (MDS) sical record was a 14 Day ssessment with an Assessmen ARD) of 3/19/17. The facility Resident #3 had a Cognitive of 9. The facility staff also ent #3 required extensive with Activities of Daily Living	t		W. I.O. VADA415	If continuation sha	ant Dage 79 of 66

PRINTED: 05/18/2017

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		`` 	OMB NO. 0938-0391
STATEMENT	RS FOR MEDICARE OF OFFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION ING	(X3) OATE SURVEY COMPLETEO
		495421	B. WING		05/04/2017
NAME OF	PROVIOER OR SUPPLIER			STREET ADORESS, CITY, STATE, ZIP C 5647 STARKEY ROAD)OOE
FRIENDS	SHIP HEALTH AND R	EHAB CENTER - SOUTH		CAVE SPRING, VA 24018	
(X4) IO PREFIX TAG	A PARTICIPATION OF THE PROPERTY OF THE PROPERT	ATEMENT OF DEFICIENCIES Y MUST BE PRECEOED BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG		N SHOULD BE COMPERTION
F 329	Continued From page (ADL's).	age 28	F	329	
	reviewed Residenthe clinical record orders. Signed phywere not limited to (Escitalopram Oxonne time a day for Continued review the April and May Records (MAR's)	t 3:05 p.m. the surveyor t #3's clinical record. Review of produced signed physician ysician orders included, but o "Lexapro Tablet 10 MG alate) Give 1 tablet by mouth of depression." (sic) of the clinical record produced 2017 Medication Administratio Review of the April and May			
	receiving Lexapro	mented that Resident #3 was 10 mg every morning. the clinical record failed to on/behavior monitoring for s, Interventions, side effects an he Lexapro.	d		
	notified the Directory Resident #3 was morning. The sumedication/behave Lexapro could not record. The survey Resident #3's clippointed out the survey and May 2017 Ma	at 10:55 a.m. the surveyor tor of Nursing (DON) that receiving Lexapro 10 mg everyover notified the DON that vior monitoring for the use of that be located in the clinical reyor and DON reviewed nical record. The surveyor pecific physician orders for the reveyor also reviewed the April AR's with the DON. The DON ical record and was unable to extion/behavior monitoring for the record.	ne		,

On May 3, 2017 at 2:15 p.m. the surveyor notified the Administrator (Adm) and DON that the

DEPARTMENT OF HEALTH	AND TOWAR SERVICES			OMB NO. 0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
	495421	B. WING		05/04/2017
NAME OF PROVIOER OR SUPPLIER FRIENDSHIP HEALTH AND RI			STREET AOORESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	<u> </u>
(CACH DESIGNATION)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		OUTO BE COMPTELLOW
Team (AT) that rev to produce monitor antidepressant drubehaviors, interver effectiveness. No additional infor exiting the facility at to monitor for Lexa 3. The facility staf was free of unnecestaff failed to mon antianxiety medical used for depression. The clinical record 5/3/17. Resident 11/1/16 with diagn limited to chronic communication dedisorder, insomnia atherosclerotic hemon-rheumatic and reflux disease, contract infections, at Resident #8's cur initiated 11/17/16 depression and a antidepressant are at risk for SOB (so and mood swings risk for being sleet interventions: Moof depression-desileeping pattern, unexplained crying staff in the staff of the staff or some supportance of the staff or some sleeping pattern, unexplained crying staff or some staff or some sleeping pattern, unexplained crying staff or some staff or s	reyor notified the Administrative fiew of the clinical record failed ring for the use of the guse to include specific and mation was provided prior to as to why the facility staff failed apro drug use for Resident #3. If failed to ensure Resident #8 ressary medications. The facility iter the use of Xanax (an action) and Zoloft (a medication on) for effects and side effects. If of Resident #8 was reviewed #8 was admitted to the facility reses that included but not pain, dysphagia, cognitive efficit, hypothyroidism, dysthymical, sensorineural hearing loss, ratic stenosis, gastroesophageal enstipation, osteoarthritis, urinary and long term use of aspirin. Trent comprehensive care plan read "I have a diagnosis of nxiety. I am medicated with an and antianxiety medication. I am hortness of breath), isolation, s. I also have insomnla. I am a repy, lethargic during the day, conitor for s/s (signs/symptoms) creased appetite, changes in mood swings, anxiety, and and Isolation; monitor for side chotic medication-somnolence, which is a signal isolation; monitor for side chotic medication-somnolence, and continued to the comprehensive can be appetited to the day.	, , , , , , , , , , , , , , , , , , ,	329	onlinuation sheet Page 30 of

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES					O. 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES		TIDI C 00	ONSTRUCTION		ATE SURVEY
STATEMENT ANO PLAN O	OF OEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		JNSTRUCTION		OMPLETEO
		495421	B WING				5/04/2017
NAME OF F	ROVIOER OR SUPPLIER	Land the second			ET ADORESS, CITY, STATE, ZIP CO	OE	•
COICNIDS	HIP HEALTH AND RI	EHAB CENTER - SOUTH			STARKEY ROAD E SPRING, VA 24018		
FRIENDS			10	- OAV	PROVIDER'S PLAN OF CORE	RECTION	JX5I
(X4 IO PREFIX TAG	ACM DESIGNENCE	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION!	PREF		(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A OEFICIENCY)	SHQULO BE	COMPLE IION DATE
F 329	Continued From pa	age 30	F	329			
, 525	incompia orthosta	tic hypotension, tachycardia,					
	peripheral edema.	amblyopia, constipation, thirst,					
	increased sallvatio	n, UTI (urinary tract infection), g, leukopenia, weight gain,					
	increased cough, f	lu like syndrome and back					
	nain monitor side	effects of					
	antidepressant-sol	mnolence, insomnia, anxiety, nausea/vomiting), behavior					
	changes abdomin	nal pain, changes in weight,					
	increased sweatin	a: monitor symptoms from					
	antianxiety medica	ation-drowsiness, sedation, a, agitation, dizziness,					
	woakness denres	ssion, and headachte.					
	PharmacisI/MD (n	nedical doctor) to provide a se reduction) as needed."					
	The surveyor review	ewed the April 2017 electronic					
	medication admin	istration records (eMARs). s for Xanax Give 0.25 mg					
}	(milliorams) by me	outh every 24 hours as needed					
	for anxiety and Zo	oloft 25 mg give q1 tablet by					
	mouth one time a	day for depression.					
	Resident #8 had i	not received any prn Xanax					
	during the month	of April 2017. Resident #8 nad					
	received Zoloft 25	mg every day during April oth the April 2017 progress					
	notes and the Ani	ril eMARs had no evidence of			•		
	the monitoring of	the antidepressant's effects or					
	side effects.						
	licensed practical	erviewed the unit manager I nurse #1 on 5/3/17 at 1:30 p.m	٦,				
	The unit manage	r stated the staff monitored					
	medications mon	or observation sheet) when					
	(targeted behavior	s occurred.					
1							

The surveyor informed the administrator and the

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-03	391
		& MEDICAID SERVICES	(V2LEED TIL	PLE CONSTRUCTION	(X3) OATE SURVEY	
STATEMENT ANO PLAN O	OF OEFICIENCIES F CORRECTION	(X1 PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:		G	COMPLETEO	
		495421	B. WING _		05/04/2017	,
	ROVIOER OR SUPPLIER		L	STREET AOORESS, CITY, STATE, ZI	P COOE	
			ļ	5647 STARKEY ROAD		
FRIENDS	HIP HEALTH AND RI	EHAB CENTER - SOUTH		CAVE SPRING, VA 24018		
(X4 IO PREFIX TAG	(CYCH OFFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION	IO PREFIX TAG	PROVIOER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCEO TO T OEFICIENC	TION SHOULD BE COMPLETING DATE	TION
F 329	director of nursing psychotropic media meeting on 5/3/17 5/4/17 at 11:20 a.m. No further informatexit conference on 4. The facility staff was free of unnects aff failed to monordered mediation antidepressant) at [Quetlapine (Seromedications called The clinical record 5/2/17 and 5/3/17 the facility 11/17/1 but not limited to 1 morbid obesity, dycardlomyopathy, lymphedema, diviconstipation, and Resident #11's quassessment with (ARD) of 4/18/17	of the lack of monitoring of cation during the end of the day at 2:12 p.m. and again on n. tion was provided prior to the	, , , , , , , , , , , , , , , , , , ,	.9		
	evidence of beha Resident #11's cu Initiated 12/2/16 I psychotropic mer disorder, depress non-pharmacolog anxlety: changin	viors, delirium or psychosis. urrent comprehensive care plan had a focus area for the use of dications r/t (related to) anxiety sion. Interventions: Monitor for gical methods of relleving g temperature, 1:1 time with k for Incontinence, slow consult per order, administer				20 -40
L				English IO: VADA19	If continuation sheet Page	32 of 6

	LIH AND HUK A SERVICES			ON BIND	0938-0391
CENTERS FOR MEDIC	ARE & MEDICAID SERVICES (X1) PROVIOER/SUPPLIER/CLIA	(X2) MULTIPLE CO	NSTRUCTION	(X3) DAT	E SURVEY IPLETED
TATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILOING		CON	INCL I CD
				0.5	04/2017
	495421	B. WING	ET ADDRESS, CITY, STATE, ZIP COL		04/2017
NAME OF PROVIDER OR SUPP	LIER		STARKEY ROAD	-	
COLENDONIO HEALTH AN	ID REHAB CENTER - SOUTH		SPRING, VA 24018		
			PROVIDER'S PLAN OF CORR	ECTION	(X5)
(CAOU OFFIC	Y STATEMENT OF OEFICIENCIES IENCY MUST BE PRECEDEO BY FULL OR LSC IOENTIFYING INFORMATION)	IO PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE AF DEFICIENCY)	HOULD BE	COMPLETION DATE
F 329 Continued Fro	m page 32	F 329			
medications a effects and eff	s ordered. Monitor/document sid	e			
Celexa 20 mg Buspar 7.5 mg medications w #11's admissis 4/4/17 but we daily in April 2 Readmission mg one time a Furnarate 25 anxiety disord medications is and May 201' administration have docume as ordered for However, the monitoring of hospitalization and Seroque 2017 and Ma	s April 2017 physician orders real one lime a day for depression at gitwice a day for anxiety. These were discontinued upon Resident on to the acute care hospital on re documented to be administered to 17 from 4/1/17 through 4/4/17. physician orders read "Celexa 20 a day for depression and Quetian mg tablet at bedtime for general der/depression." Both of these had been entered on the April 2017 electronic medication in records (eMARs) and nursing sented that the resident received the surveyor was unable to locate the the Celexa and Buspar prior to an and the current order for Celex I. The surveyor reviewed the April 2017 progress notes and found the use of Celexa, Buspar and did been monitored for effects and	d ine taff nem a in in in in in in in in in			

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				D. 0938-0391
STATEMENT (S FOR MEDICARE OF DEFICIENCIES CORRECTION	& MEDICAID SERVICES (XI) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	1	TIPLE CONSTRUCTION	(X3) O/	TE SURVEY
ANO PENIO		495421	B. WING			5/04/2017
NAME OF PI	ROVIOER OR SLIPPLIER			STREET AODRESS, CITY, STA	TE, ZIP CODE	
		EHAB CENTER - SOUTH		5647 STARKEY ROAD CAVE SPRING, VA 2401		
(X4) IO PREFIX TAG	(EACH OFFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG	X (EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULO BE D TO THE APPROPRIATE CIENCY)	COMPLETION DATE
	and again on 5/4/1 No further informal exit conference on 5. For Resident # document indication administering a Planedication. Resident #1 was a 11/22/16 with diag weakness, cognitic coronary artery didisease, vascular vascular disease. Data Set assessed at 3/1/17, the rebrief interview for was assessed as resident was scorbehaviors, and de Clinical record rein April or May 20 indicating halluchts of the sext	eting on 5/3/17 at 2:12 p.m. 7 at 11:20 a.m. tion was provided prior to the 5/4/17. 1, facility staff failed to on and effectiveness for RN(as needed) antipsychotic admitted to the facility on proses including generalized execommunication deficit, sease, anxiety, cardiopulmonar dementla, and peripheral On the quarterly Minimum nent with assessment referencesident scored 10/15 on the mental status. The resident without signs of delirium. The red as having hallucinations, relusions. View revealed no nurse's notes that resident's orders did not ag of antipsychotic side effects of the status of the resident's orders did not ag of antipsychotic side effects of the status of the status of the resident's orders did not ag of antipsychotic side effects of the status of	ry e	329		
	The Targeted Be Summary(TBOS physical behavio document the be they placed the recould be easily desymptom, yelling was not document.	havior Observation) dated 4/15/17 documented r occurred daily, but did not shaviors that occurred, or wheth resident or others at or risk or lirected. Verbal behavior g out, was documented daily, bu inted as placing the resident or whether it was easily redirecte	ut			shoot Dage 24 of 6
L			04/7 []	Facility IO: VA0419	If continuation :	sheet Page 34

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OME	3 NO. 0938-0	<u> </u>
		& MEDICAID SERVICES	4701 14 "	TIDLE CO	NSTRUCTION		3) OATE SURVE	Y
STATEMENT ANO PLAN O	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:			142 LKGC 11014		COMPLETEO	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		495421	B WING				05/04/201	7
NAME OF C	PROVIDER OR SUPPLIER		<u> </u>	STRE	ET ADORESS, CITY, STATE, Z	IP COOE		
					STARKEY ROAD			
FRIENDS	SHIP HEALTH AND RI	EHAB CENTER - SOUTH		CAV	E SPRING, VA 24018			
(X4) IO PREFIX TAG	(EACH OFFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCEO TO OEFICIENC	TION SHOULO BI THE APPROPRIA	E COMPL ATE DA	ETION
	blank. The section was marked "None Wandering was blaw for whe listed behaviors, o behaviors affected behavior affected behavior were exempled behavior will respect to program will respect to plan of Additional Common the State of Physics of P	cially Disruptive behaviors was a for Refusal of care, shower, exhibited". The section for Psychosis ther the resident exhibited any other behaviors, whether the resident, and whether the other. How often those chibited was marked 1-3 days. It is a sandwich and edirect resident. The sections w/Side effects, Evaluation, care/ Recommendations, and ents sections were blank. The symptoms, Socially ruptive Behavior, Refusal of No descriptions of any of those commendations, and ents sections were blank. In the sections were blank of the sections w/Side effects, Evaluation, care/ Recommendations, and ents sections were blank. In the sections were blank of the sections w/Side effects, Evaluation, care/ Recommendations, and ents sections were blank. In the sections were blank of the concern that indications and ents sections were blank. In the sections were blank of the concern that indications and ents sections were blank. In the sections were blank of the concern that indications and ents sections were blank. In the sections were blank of the sections were blank.	g	329				
:	diabetes mellitus	type II with complications			PL 10: VA 0410	II continual	ion sheet Page	35 of 6

PRINTED: 05/18/2017 FORM APPROVED

		A MEDICAID GEDVICES			MR MO: 0338-038
		& MEDICAID SERVICES		TIOLE CONSTRUCTION	(X3) DATE SURVEY
STATEMENT OF OEF	ATEMENT OF OEFICIENCIES (X1) PROVIDER/SUPPLIER/CI.IA		1	TIPLE CONSTRUCTION	COMPLETEO
AND PLAN OF CORF	RECTION	IDENTIFICATION NOWDER	A. BUILOI	NG	
					05/04/2047
		495421	B WING		05/04/2017
NAME OF PROVIDE	FR OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP COOE	
				5647 STARKEY ROAD	
FRIENDSHIP H	EALTH AND R	EHAB CENTER - SOUTH		CAVE SPRING, VA 24018	
(X4] IO PREFIX (TAG R	(X4) IO SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH ATORY OR) SC IDENTIFYING INFORMATION		ID PREFI TAG	PROVIDER'S PLAN OF CORRECTI X (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPRO OEFICIENCY!	O BE COMPLETION
affect hype	rtension. On essment with a	age 35 circulation, and eyes, pain, and the most recent MDS assessment reference esident scored 13/15 on the	F3	329	

During clinical record review on 5/3/17, the surveyor noted physician orders dated 4/27 for Quetlapine Fumarate Tablet 50 mg(milligram) by mouth at bedlime for psychosis, and for Clonazepam tablet 0.5 mg by mouth one time a day for @HS (hour of steep) anxiety and Clonazepam Tablet 0.5 mg by mouth every 12 hours as needed for anxiety. The Quetlapine order was a dosage increase from Quetiapine Fumarate 25 mg Give 1 tablet by mouth at bedtime for psychosis dated 11/19/16. The Clonazepam was a new medication.

brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others.

The surveyor was unable to locate documentation of symptoms requiring the medications. There were no orders for behavior monitoring of symptoms or of potential side effects of the medications. Nurse's notes for April and May 2017 dld not mention symptom of psychosis or of anxiety. The surveyor was unable to locate physician notes documenting diagnoses of anxiety or psychosis. Psychosis was not listed on the diagnosis list in the clinical record or in the MDS dated 1/30/17. Pharmacy review notes for January, February, March, and April 2017 requested a psychiatric evaluation for necessity of antipsychotic medications. The physician agreed with all four recommendations.

The Medication Administration Record (MAR) for April 2017 documented the resident received

Facility IO: VA0419

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO	. 0938-0391
CENTER	S FOR MEDICARE	& MEDICAID SERVICES	T.,,,,,,,,		ONSTRUCTION		E SURVEY
STATEMENT ANO PLAN O	OF OEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			JNSTRUCTION	COV	MPLETED
		495421	B. WING			05	/04/2017
NAME OF F	ROVIDER OR SUPPLIER		_1	ľ	ET AODRESS, CITY, STATE, ZIP CODE		
		TURD CENTED SOUTH			STARKEY ROAD		
FRIENDS	SHIP HEALTH AND KI	EHAB CENTER - SOUTH		CAV	E SPRING, VA 24018	ION	1861
(X4) IO PREFIX TAG	/EACH OFFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAC	ΙX	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCEO TO THE APPR OEFICIENCY)	JLO BE	COMPLETION DATE
E 220	Continued From pa	age 36	F	329			
F 329	Continued From pa	ig for anxiety on 4/29/17 at		-			
	0442 The MAR fo	or May 2017 documented the					
	rocident received (Clonazepam 0.5 mg for anxiety					
	on 5/2/2017 at 050	17. The surveyor was unable to)				
	locate nursing doc	umentation of the symptoms cation was administered or					
	whether the reside	ent was offered					
	non-pharmacologi	c interventions.					
	The surveyor disc	ussed concerns with the					
	director of nursing	(DON) on 5/4/16. After					
	investigation, the l	DON reported that the physicial	n				
	was diagnosing ps	sychosis when signing the nmary. The DON obtained a					
	Monthly order sur	ry Consult Note dated 4/26/17.					
	Linder Nursing Re	port, the physician					
	wrote"Depressed.	Patient currently on Seroquel					
	with no supporting	dlagnosis. Anxious with dialysis", Under the Chief					
	Complaint/reason	for visit section, the physician					
	wrote "f/u (follows	in) for chronic depression.					
	Under the section	HPI, the physician wrote "Pt's					
	current TX review	ved. C/O staying bed ying, tired, and Also c/o being					
	"depressed, worr	t night. States she still					
	evperiences audi	tory hallucinations (including ne	er				
	husband's voices	 Trazodone not helping at all 	•				
	Klonopin worked	well previously. Under					
	Medication Chang	ges "1) d/c Trazodone 5 mg qhs 3) [change] Zoloft to					
	150 mg gd (ever)	day) 4) [change] seroquel to 5	60				
	mg qhs.						
	The surveyor was	s unable to determine when the	3				
	abusician orderes	d the Clonazepam 0.5 mg ever	У				
	12 hours as need received on 4/29.	ded for anxiety which the reside	ent				

TH AND HIMAN SERVICES

PRINTED: 05/18/2017

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY MPLETEO
		495421	B. WING		05	/04/2017
	ROVIOER OR SUPPLIER		<u> </u>	STREET AODRESS, CITY, STATE, 5647 STARKEY ROAD	, ZIP CODE	
FRIENDS	SHIP HEALTH AND RI	EHAB CENTER - SOUTH		CAVE SPRING, VA 24018		Ivel
(X4) ID PREFIX TAG	TEACH OFFICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG	(EACH CORRECTIVE A	CTION SHOULD BL O THE APPROPRIATE	LX21 COMPLETION DATE
F 329	PROCEDURE: Numental health profiall residents that a antipsychotic med 7. "A mental health proper diagnosis for The diagnosis "will and to the pharma" Concerns were diagnod DON during a The DON stated to offer concerning or lack of knowled medications were 7. The facility staff non-pharmacolog Resident #4. Resultanguard PRN indication of the anon-pharmacolog administration. The clinical record sold administered. The clinical record sold admitted to the fact that included but pressure, stroke, dysphagia and head anon-pharmacolog administration. A review of Resident was anonator of the quarterly the continuation of the quarterly the sold programment references and the sold property of the sold	lications) stated under rsing 7. Evaluation by a essional will be completed for re: a. Admilted on an iation used to control behavior in profession will determine the or antipsychotic medications. I be sent to medical records acy." scussed with the administrator is summary meeting on 5/4/17, here was no further information go the lack of routine monitoring administered. If failed to provide ical interventions for anxiety for sident #4 was administered (as needed) without any enterpt to use the facility staff failed to provide, toring when the anxiolytic was add of Resident #4 was reviewed 5/04/17. Resident #4 was reviewed acility on 5/24/16 with diagnoses not limited to: high blood osleoporosis, anxiety, asthma,	d	329		
	recident 14 out o	of a possible 15 indicating the philipping intively Intact. Section B coded		Facility IO: VADA19	If continuation sh	eel Page 38 of 6

DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO	. 0938-0391
		& MEDICAID SERVICES	(X2) MI II	TIPLE CO	ONSTRUCTION	(KX)	re survey
STATEMENT ANO PLAN O	OF OEFICIENCIES F CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				CO	MPLETEO
		495421	B. WING				/04/2017
NAME OF F	ROVIOER OR SUPPLIER				ET AOORESS, CITY, STATE, ZIP COO	E	[
		EHAB CENTER - SOUTH			STARKEY ROAD		
FRIENDS				CAV	E SPRING, VA 24018 PROVIOER'S PLAN OF CORR	ECTION	(X5)
(X4) IO PREFIX TAG	AC YOU OR EIGIENG	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL .SC IOENTIFYING INFORMATION)	IO PREF TAC		(EACH CORRECTIVE ACTION S CROSS-REFERENCEO TO THE Af OEFICIENCY)	HOULO BE	COMPLETION DATE
C 220	Continued From page	age 38	F	329			
F 329	the resident to uno	derstand and to be understood.					
	In section N she w antianxiety medica	as coded to have received					
	review date of 3/10 issue. However, the non-pharmacologilisted as an interview of the April and Maread in part: "Loratablet by mouth attimes a day) PRN the order was 7/2. The April and Mayadministration received as follows: 4/2/17	nprehensive care plan with a 0/17 included anxiety as a focuse surveyor did not see any local interventions for anxiety ention on the care plan. y 2017 physician order sheet azepam tablet 0.5 mg give 1 is needed for anxiety tid (three as needed" the start date for 3/16. y 2017 medication cords were reviewed. Resident red the PRN Lorazepam in April 4/16/17, 4/15/17, 4/16/17, 4/16/17, 4/15/17, 4/15/17, 4/16/17, 4/15/17, 4/15/17, 4/15/17, 4/16/17, 4/15/17, 4/	11 7,				
	have any docume administration of non-pharmacolog administration of	tes for April and May did not entation related to the the Lorazepam. There were no gical interventions prior to the the Lorazepam documented.					
	On 5/4/17 at 11:2 was informed of	on 5/4/17 at 11:20 a.m. 20 a.m., the administration staff the failure to monitor and viors and the gleal interventions for anxiety.					

DEPARTMENT OF HEALT	HAND HUMAN SERVICES			OMB NO 0938-0391
CENTERS FOR MEDICAR	E & MEDICAID SERVICES	T. vo	TIPLE CONSTRUCTION	(X3) OATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER		ING	COMPLETED
	495421	B WING		05/04/2017
NAME OF PROVIOER OR SUPPLIE	R		STREET AOORESS, CITY, STATE, Z S647 STARKEY ROAO	IP CODE.
FRIENDSHIP HEALTH AND	REHAB CENTER - SOUTH		CAVE SPRING, VA 24018	and the second s
LATITY (CARL DESIGNER	TATEMENT OF OEFICIENCIES CY MUST BE PRECEOEO BY FULL R LSC IOENTIFYING INFORMATION)	IO PREFI TAG		THE APPROPRIATE DATE
F 329 Continued From	page 39	F	329	
surveyor prior to 8. The facility sta			·	
The clinical recordered the resident was as assistance of 1-transfers, dress hygiene. The clinical recordered the resident was psychosis on 4/ The comprehend plan contained medicated with antidepressant of psychosis on decorded to the resident was psychosis on 4/ The comprehend plan contained medicated with antidepressant of psychosis definiculated to medicated to the resident was psychosis on 4/ The comprehend plan contained medicated with antidepressant of psychosis definiculated to medicated to medic	s admitted to the facility on agnoses of Parkinson's disease, assion, hypertension, insomnia, hageal reflux disease. Interly Minimum Data Set (MDS) date of 2/3/17 assessed the ognitive score of "10" of "15". The sessed requiring extensive 2 persons for bed mobility, ing, toileting, bathing, and ord was reviewed. The physciain dent to receive the antipsychotic oquel 25 mg daily dated 11/8/16 as given a new diagnosis of 27/17. Insive care plan was reviewed. The problem listed the resident was a antipsychotic and medication with a new diagnosis ited 4/27/17. The interventions inter for signs/symptoms of creased appetite, changes in slesswings, anxiety, unexplained cryi	ne s s	practice. 3. Facility nursing staf Behavior Monitorin documentation req medications are pro 4. DON or designee w residents on psychological properties.	2, #3, #8, #11, #1, 13 had monthly 15 pic medication 16 get behavior 17 ment. 18 receiving 18 tations have the 18 cted by this deficient 18 5/25/2017 19 will be educated on 19 policy, including 19 quirements when pro 19 ovided. 6/9/2017 19 vill audit 100% of 19 otic medications for 19 program weekly 19 nonthly for 2 months.

The clinical record did not contain any documentation of behavior monitoring, effectiveness of the medication, or side effects.

6/24/2017

for 3 months for 1 consecutive quarter.

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

PRINTED: 05/18/2017 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION		(X3) OATE SURVEY		
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		3000110011011	COMPLETEO		
		495421	B. WING		05/04/2017		
	ROVIOER OR SUPPLIER	EHAB CENTER - SOUTH	564	EET AOORESS. CITY, STATE. ZIP COOE 7 STARKEY ROAD VE SPRING, VA 24018			
FRIENDS				PROVIDER'S PLAN OF CORREC	CTION (X5)		
(X4) IO PREFIX TAG	ALAMI DEGICIENO	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP OEFICIENCY)	DULO BE COMPLETION		
F 329	Continued From p	age 40	F 329				
	The administrator	and director of nursing were ncern during a meeting with the	;				
F 371 S S =E	492 60(1)(1)-(3) F(DOD PROCURE, E/SERVE - SANITARY	F 371				
	(i)(1) - Procure for considered satisfa authorities.	od from sources approved or actory by federal, state or local					
	(i) This may include from local product and local laws or	de food items obtained directly ers, subject to applicable State regulations.					
	facilities from using	does not prohibit or prevent ng produce grown in facility to compliance with applicable food-handling practices.					
	(iii) This provision from consuming	n does not preclude residents foods not procured by the facility	y.				
	(i)(2) - Store, pre accordance with service safety.	pare, distribute and serve food i professional standards for food	n				
,	foods brought to visitors to ensure handling and co	cy regarding use and storage of residents by family and other safe and sanitary storage, nsumption. IENT is not met as evidenced	· -				
	by: Based on obser document reviev	vation, staff interview and facility, the facility staff failed to labelems when opened and failed to diray line temperatures.	y				
	The findings incl						

DEPARTMENT OF HEALTH AND HUL. A SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/18/2017 FORM APPROVED OMB NO. 0938-0391

	A COR MEDICARE	MEDICAID SERVICES				OMR D	10. 0930-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1		DNSTRUCTION		DATE SURVEY COMPLETGO
		495421	B MING				05/04/2017
	ROVIOER OR SUPPLIER H)P HEALTH AND RI	EHAB CENTER - SOUTH		5647	ET ADORESS, CITY, STATE, ZIP CODE STARKEY ROAD E SPRING, VA 24018		
(X4) IO PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCEO TO THE APPRO OEFICIENCY)		IX5 COMPLETION DATE
F 371	Continued From pa	age 41	F (371			
	beginning at 1:00 p	d the kitchen on 5/2/17 o.m. with the dietary manager vevor observed a bag of					

The surveyor toured lhe kitchen on 5/2/17 beginning at 1:00 p.m. wilh the dietary manager other #1. The surveyor observed a bag of croissants (approximately 25-30) in the walk in refrigerator. The bag had been opened; however, the bag was not labeled as to the contents or dated when opened. The dielary manager stated the staff must have taken a sleeve from the opened box of croissants. Also observed in the walk-in refrigerator were three covered Styrofoam cups. The dietary manager stated the cups contained homemade milkshakes. The cups were not labeled as to their contents or dated when made.

The surveyor observed in the reach-in refrigerator a Styrofoam container that contained coleslaw. The container was black in color, unlabeled and undated. The dietary manager stated the container must have been brought in from the outside. The dietary manager removed the container from the reach-in refrigerator.

The surveyor returned to the kitchen on 5/2/17 al 4:15 p.m. for tray line temperatures. After observing the tray line temperatures for cooked foods, the surveyor requested to check the temperatures of cold llems served. The dietary manager checked the temperature of a carton of milk (40 degrees), a bowl of applesauce, a bowl of mandarin oranges and a cup of yogurt. The applesauce temperature was 46 degrees, the mandarin oranges temperature was taken multiple times with the dietary manager stating the mandarin oranges were "airy" and a good temperature was unable to be taken, and the temperature of the yogurt was 44 degrees. None of the cold food temperatures were 41 degrees or

F371 - Food Procure, Store/Prepare/Serve - Sanitary

- Facility food storage was reviewed to make sure items were appropriately labelled and dated. 5/3/17
- All facility residents that consumed the unlabeled items had a potential to be affected by this deficient practice. 5/3/17
- Dining staff was educated on temperature logs and checking for dates for food storage.
 5/3/17
- 4. Dining Service Director, RD, or Designee will audit temperature logs and food storage, weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

HUMAN SERVICES

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-039
		& MEDICAID SERVICES	LYN MULTIDLE	CONSTRUCTION	(X3) OATE SURVEY
TATEMENT NO PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	CONSTRUCTION	COMPLETED
		495421	B WING		05/04/2017
NAME OF F	PROVIDER OR SUPPLIER		į	REET ADDRESS, CITY, STATE, ZIP CODE	
		EHAB CENTER - SOUTH	i	47 STARKEY ROAD	
FRIENDS			G/	AVE SPRING, VA 24018	27/04/
(X4) IO PREFIX TAG	AT A ALL MEDICIENS	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION!	IO PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APP OEFICIENCY)	OULD BE COMPLETION
F 371	Continued From p	age 42	F 371		
,	colder. The surve	vor asked the dietary manager			
	what the process \	was when food item			
	temperatures did r	not reach the minimum			
	temperature for se	erving. The dietary manager			
	stated the cold iter	ms would be put back in and			
	chilled and tempe	гацијез гезакен.			
	The surveyor and	the dietary manager reviewed			
	the temperature lo	ogs for April 2017 and May			
	2017 The survey	or noted on the April and May			
	2017 temperaturé	logs that there were no			
	recorded cold foo	d temperatures. The 4/1/1/	_		
	dinner tray line ter	mperatures were reviewed. The	3		
	cook had recorde	d temperatures for chicken and			
	dumplings and gr	een beans. The alternatives for eeseburgers and French fries.			
	Saturdays are che	corded temperatures for the			
	alternates There	were no recorded			
	temperatures for	mllk, fruit or any dessert. The			
	4/6/17 dinner tem	perature log had one recorded			
	temperature for D	eppers. There were no			
	recorded cold foo	id Item temperatures. The 1000			
	items on the men	u for 4/6/17 included yeast roll,	•		
	lemon meringue	ple, whole milk and beverage of	•		
	choice. The 4/11	/17 lunch tray line temperatures ures recorded for either cold or	•		
	had no temperati	The only temperature recorded			
	not tood items.	rnate list and that was colesiaw	<i>'</i> ,		
	The 4/14/17 lunc	h traviline temperatures nad no			
	documented tem	peratures. The 4/18/17 lunch			
	trav line tempera	tures had no temperatures			
	recorded for eithe	er cold or hot food items. The	_1		
	4/28/17 lunch for	od log did not have any recorder	0		
	tomporatures for	hot or cold foods. The only			
ĺ	recorded temper	atures were the alternates. The	5		
	5/1/17 lunch tray	line temperatures had no			
	documented tray	line temperatures. The 5/2/17 no documented cold			
	dinner meal had	hilk was on the menu. The 5/2/1	7		
	temperatures. IV	TIM WAS ON THE HIGHER THE O/27	·		- Carrallan about Dago 42 c

OF HEALTH AND HUMAN SERVICES

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					. 0938-0391
STATEMENT	RS FOR MEDICARE OF OEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	E		ONSTRUCTION	(X3) O AT	E SURVEY MPLETEO
ANO PLAN O	00.002011011	495421	B. WING				104/2017
NAME OF F	PROVIDER OR SUPPLIER				ET AOORESS, CITY, STATE, ZIP C	CODE	
FRIENDS	SHIP HEALTH AND RI	EHAB CENTER - SOUTH			STARKEY ROAD E SPRING, VA 24018	POSSTICAL	IVEI
(X4) IO PREFIX TAG	(CACU DEFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCEO TO THE OEFICIENCY)	N SHOULO BE	IXSI COMPLETION DATE
F 371	Iunch tray line temperatural line temperatures in the tray line temperatures in the manager stated by was how the cookenough or cold en manager stated he be obtained of cold the surveyor informative cold in the survey cold in the surveyor informative cold in the surveyor informative cold in the s	peratures had no documented		371			
	"Scope of Dletary read in part "Food perishable food significant proper/safe tempershall be kept with degrees and belot temperature of 13 items that are with of 42 degrees to discarded. 5) All an opening date of the surveyor also the registered distitled "Thermome Temperatures".	ewed the facility policy titled Services" on 5/3/17. The policy if Preparation 2) Prepared and hall be maintained at a erature until served. Cold items an internal temperature of 41 w. Hot food to be kept at a 35 degrees and above. Any foothin the temperature danger zor 134 degrees would need to be I Food Items shall be dated with and a use by date." or received the facility policy from etician on 5/4/17 at 8:00 a.m. eter Use & Safe Food The policy read in part "2) The II TTS foods (foods that require	s od ne:				

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

PRINTED: 05/18/2017 FORM APPROVED OMB NO. 0938-0391

		& MEDICAID SERVICES	(V2) MULTIE	PLE CONSTRUCTION	(X3) DATE SURVEY
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDEN (IFICATION NUMBER.		3	COMPLETED
MIND PLAIN OF	COMMENTAL	495421	B. WING		05/04/2017
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CON	E
		EHAB CENTER - SOUTH		5647 STARKEY ROAD CAVE SPRING, VA 24018	
FRIENDS				PROVIDER'S PLAN OF CORR	ECTION (X5)
(X4) ID PREFIX TAG	ATABU DEGICIENO	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE COMPLETION
C 371	Continued From p	age 44	F 37	11	
F 371	chacked and reco	rded prior to the start of each			
	mod corvice. The	holding temperature of all not			
	foods during meal	service will be maintained at > degrees F (Fahrenheit). The			
	holding temperatu	re of cold foods during meal			
	service will be < (ess than) 41 degrees F. The			
	cook is responsib	le for recording the			
	temperatures on t				
	The surveyor inte	rviewed the registered dietician			
	other #2 on 5/4/1"	7 at 8:05 a.m. The RD stated			
	she would expect	temperatures to be obtained or specially mllk before served to	•		
	the residents.				
		ation was provided prior to the			
	No further inform exit conference of	n 5/4/17.			
F 425	483 45(a)(b)(1) P	HARMACEUTICAL SVC -	F 4	25	
SS≃D	ACCURATE PRO	CEDURES, RPH			
	(a) Dracedures	A facility must provide			
	pharmaceutical S	ervices (including procedures			
	that assure the a	ccurate acquiring, receiving,			
	dispensing, and	administering of all drugs and eet the needs of each resident.			
1					
	(b) Service Cons	ultation. The facility must			
	employ or obtain	the services of a licensed			
	pharmacist who-				
	(1) Provides con	sultation on all aspects of the			
	provision of pha	macy services in the facility; MENT is not met as evidenced			
	bur				
	by: Based on staff i	nterview, facility document review	ew		
	and clinical reco	rd review, the facility stati falled			
	to oneura physic	ian ordered medications were			
- 1	available for use	e for 1 of 21 residents (Resident	•		

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIOER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) OATE SURVEY COMPLETEO
ANO PLAN OI	F CORRECTION	IOENTIFICATION NUMBER:	A. BUILOING	<u> </u>	
		495421	B. WING		05/04/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET AOORESS, CITY, STATE, ZIP CO	OOE
FRIENDS	H)P HEALTH AND RI	EHAB CENTER - SOUTH	1	5647 STARKEY ROAD CAVE SPRING, VA 24018	
			10	PROVIDER'S PLAN OF COR	RECTION JX51
(X4) IO PREFIX TAG	(EACH OFFICIENC)	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION : CROSS-REFERENCEO TO THE A OEFICIENCY)	SHOULO BE COMPLETION
F 425	Continued From pa	age 45	F 42	5	
	The findings includ	led:			
	The facility staff fail Tears solution was Resident #8 on 4/2	iled to ensure Natural Balance available for admInistration to 23/17.			
	5/3/17. Resident # 11/1/16 with diagnorm that to chronic programme to communication de disorder, insomnia atherosclerotic heronon-rheumatic aor reflux disease, contract infections, and Resident #8's curr	of Resident #8 was reviewed #8 was admitted to the facility oses that included but not pain, dysphagia, cognitive efficit, hypothyroidism, dysthymia, sensorineural hearing loss, art disease, angina pectoris, etic stenosis, gastroesophageanstipation, osteoarthritis, urlnared long term use of aspirin.	l Ty		
	from our sister fac Resident #8 is ale	read "Resident #8 was admitte clity for LTC (long term care). Int and oriented and can make Interventions: Administer rdered."	∙d		
	5/3/17. Resident read "Natural Bala Tear Solution) ins bedtime for dry ey "Natural Balance	d of Resident #8 was reviewed #8 had physician orders that ance Tears Solution (Artificial till 1 drop in both eyes at yes QHS (every bedtime)" and Tears Solution (Artificial Tear drop in both eyes three times a ba, 1p, 5p."	1		
	The progress not	ogress notes were reviewed. es for 4/23/17 at 13:21 (1:21 I p.m.) and 19:42 (7:42 p.m.) ance Tears Solution Instill 1 dro	ор		

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DEPARTMENT OF HEALTH	TALEDIAND DEDVICES				OMB NO. 0938-0391
CENTERS FOR MEDICARE	& MEDICAID SERVICES	(VO) 38 II	TIPLE CONS	TRUCTION	(X3) OATE SURVEY
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			TRUCTION	COMPLETEO
	495421	B. WING			05/04/2017
NAME OF PROVIOER OR SUPPLIER				AOORESS, CITY, STATE, ZIP COOE	
	THE CENTED SOUTH			ARKEY ROAD	
FRIENDSHIP HEALTH AND R	EHAB CENTER - SOUTH		CAVE S	PRING, VA 24018	riou
(AT) U	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL LSC IOENTIFYING INFORMATION)	IO PREFI TAG	×	PROVIOER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU ROSS-REFERENCEO TO THE APPR OEFICIENCY)	TED BE COMPLETION
5 p Medication unpharmacy" and "Ninstill 1 drop in both OHS Medication pharmacy". The surveyor and practical nurse #2 on 5/3/17 at 1:30 Balance Tears for reviewed. The both the bottom read "The entry for Natt was reviewed. The unit manage are delivered from through Friday are carrier between 8 #1 stated the megiven.	times a day for dry eyes 9a, 1p, available; on order from latural Balance Tears Solution th eyes at bedlime for dry eyes unavailable; on order from the unit manager licensed reviewed the April 2017 eMAR p.m. The entry for Natural three times a day was for 4/23/17 at bedtime had the nurse's initials. The legend at 5=Hold/See Nurses Notes". Ural Balance Tears at bedtime he box for 4/23/17 at mid-day in (5pm) had the number "5" and 5. The legend at the bottom	e ut	1. 2. 3.	Facility Resident #8 receiv	ved Natural /24/2017 the potential . 5/4/2017 the educated on hour's cluding le. 6/9/2017 lit 100% of the eks then the findings will ty Assurance

The surveyor informed the administrator and the director of nursing of the above concern on 5/4/17

obtaining medications on the weekend. The DON stated the nursing staff call the on-call pharmacist

Resident #8's eye drops were not available for three administration times on 4/23/17. The

surveyor asked the DON the process for

for the facility then go by those prompts. Walgreens is the back-up pharmacy.

consecutive quarter.

PRINTED: 05/18/2017 FORM APPROVED DEPARTMENT OF HEALTH AND HU **N SERVICES** OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES X3) OATE SURVEY (X2) MULTIPLE CONSTRUCTION (X1) PROVIOER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES COMPLETEO IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILOING _ 05/04/2017 B. WING 495421 STREET ADDRESS, CITY, STATE, ZIP COOE NAME OF PROVIOER OR SUPPLIER 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 IX5| COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCEO TO THE APPROPRIATE (X4) IO PREFIX FACH DEFICIENCY MUST BE PRECEOED BY FULL PRFFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG OEFICIENCY) F 425 F 425 Continued From page 47 at 11:20 and requested the facility policy on obtaining medications. No further information was provided prior to the exit conference on 5/4/17. F 428 483.45(c)(1)(3)-(5) DRUG REGIMEN REVIEW, F 428 SS=D REPORT IRREGULAR, ACT ON c) Drug Regimen Review (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety, and (iv) Hypnotic. (4) The pharmacist must report any irregularities to the attending physician and the

facility's medical director and director of nursing,

(i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

(ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a

and these reports must be acted upon.

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DEPART	MENT OF HEALIH	AND HUMAN SERVICES			OMB NO.	0938-0391
CENTER	CENTERS FOR MEDICARE & MEDICAID SERVICES			CONSTRUCTION	(X3) OAT	E SURVEY
STATEMENT	OF DEFICIENCIES F CORRECTION	[X1] PROVIDER/SUPPLIER/CI.IA IOENTIFICATION NUMBER:		CONSTRUCTION	COM	IPLETEO
		495421	B. WING		05/	04/2017
		493421	S	TREET ADORESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER			547 STARKEY ROAD		
FRIENDS	SHIP HEALTH AND R	EHAB CENTER - SOUTH		AVE SPRING, VA 24018		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO TEACH CORRECTIVE ACTION SHO CROSS REFERENCED TO THE APPLIANCE.	յսլ	(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFICION OF THE CONTROL OF T		DEFICIENCY)		
						i,
F 428	Continued From p	age 48	F 428			
	minimum, the resid	dent's name, the relevant drug	e .			
	and the irregularity	the pharmacist identified.				
	(iii) The attending	physician must document in th	ie			
	racident's medical	record that the identified				
	irrogularity has be	en reviewed and what, it any,				
	action has been to	aken to address it. If there is to	•			
	ho no change in the	ne medication, the attending				
	nhysician should	document his or her rationale if	n			
	the resident's med	dical record.				
	and procedures for review that includ frames for the difference the pharma identifies an Irregular protect the res	ust develop and maintain policion the monthly drug regimen e, but are not Ilmited to, time ferent steps in the process and cist must take when he or she ularity that requires urgent actident. ENT is not met as evidenced	j			
	review it was determined to follow up	nterview and clinical record ermined that the facility staff o on a pharmacy for 2 of 21 Residents in the Resident #2 and Resident #12.				
	The Findings Inc					
	admitted on 12/6 included, but we emboli, cognitive	an 84 year old female who was/16. Admitting diagnoses re not limited to: pulmonary communication deficit, diabetes mellitus, major al fibrillation and breast cancer.				
	The most currer	nt Minimum Data Set (MDS) ated in the clinical record was a	a			

Quarterly MDS assessment with an Assessment

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CENTERS FOR MEDICARE	& MEDICAID SERVICES			100,000,000
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	(X2) MULTIPLE CONSTRUCTION A. BUILOING		(X3) OATE SURVEY COMPLETED
	495421	B. WING		05/04/2017
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND RE	HAB CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP COOE 5647 STARKEY ROAO CAVE SPRING, VA 24018	
(A4) IO (EACH DEFICIENCY	TEMENT OF OEFICIENCIES MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFII TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROIO OEFICIENCY)	O BE COMPLETION
F 428 Continued From pa	age 49		328	
coded that Resident #2 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #2 required set up (1/1) to extensive			F 428 Drug Regimen Review, Repo	rt Irregular
assistance (3/2) wi (ADL's).	th Activities of Daily Living		#1	
•			1 Facility Recident #2 re	coirrod

On May 2, 2017 at 2:40 p.m. the surveyor reviewed Resident #2's clinical record. Review of the clinical record produced a pharmacy recommendation dated 4/18/17. The pharmacy recommendation requested for Resident #2's Seroquel 37.5 mg at bedtime to be decreased to Seroquel 25 mg at bedtime. The physician documented ... "I agree: Please write order(s)" (sic) The physician signed and dated the pharmacy recommendation on 4/26/17.

Continued review of the clinical record produced the April and May 2017 Medication Administration Records (MAR's). Review of the April and May 2017 MAR's documented that Resident #2 was still receiving Seroquel 37.5 mg at bedtime and not the pharmacy recommended and physician ordered Seroquel 25 mg at bedtime.

On May 2, 2017 at 3:55 p.m. the surveyor notified the Director of Nursing (DON) that Resident #2 had a pharmacy recommendation dated 4/18/17 that recommended for the Seroquel 37.5 mg at bedtime to be decreased to Seroquel 25 mg at bedtime. The surveyor notified the DON that the physician approved and signed off for the Seroquel to be reduced to 25 mg at bedtime on 4/26/17. The surveyor notified the DON that Resident #2 was still receiving Seroquel 37.5 mg at bedtime. The surveyor and DON reviewed Resident #2's clinical record. The DON verified that Resident #2 had a pharmacy recommendation on 4/18/17 to decrease the

- Facility Resident #2 received practitioner orders to follow pharmacy recommendations for gradual dose reduction and copy provided to onsite health inspectors exiting the facility. 5/2/2017
- All facility residents have the potential to be affected by this deficient practice. 5/4/2017
- Facility nursing staff will be educated on pharmacy recommendations having to be noted by the nurse prior to filing and night shift nurses will review charts for any new orders every night

6/9/2017

4. DON or designee will audit 100% of residents weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

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DEPART	MENT OF HEALTH	AND HUMAN SERVICES				OMB NO. 0938-039
		& MEDICAID SERVICES	(VOLUM	TIDLE CO	ONSTRUCTION	(X3) OATE SURVEY
STATEMENT ANO PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 .		, and the state of	COMPLETEO
		495421	B. WING			05/04/2017
LANE OF E	ROVIOER OR SUPPLIER				ET AODRESS, CITY, STATE, ZIP COO	E
					STARKEY ROAO	
FRIENDS	H(P HEALTH AND RI	EHAB CENTER - SOUTH		CAV	E SPRING, VA 24018	
X4) IO PREFIX TAG	OTACH OSCICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDEO BY FULL SC IOENTIFYING INFORMATION)	IO PREF TAG		PROVIOER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SI CROSS-REFERENCEO TO THE AP DEFICIENCY	OOFO RE COMPLETION
			F	428		
F 428	Continued From pa	age ou	•	#2		
	Seroquel to 25 mg	at bedtime. The DON also ysician had approved the		#Z		
	verified that the ph	rendation on 4/26/17. Lastly,			 Facility Resident #12 	was seen by
	the DON verified t	hat the April and May 2017			psychiatrist on 4/26/20	17, which was
	MAR's documente	d (hat Resident #2 was still			provided to onsite heal	th inspectors
	receiving Seroque	1 37.5 mg at bedtime.			prior to exit conference	
	On May 3, 2017 a	t 2:15 p.m. the surveyor notified	1			5/4/2017
	the Administrator ('Adm) and DON that the facility				5/4/2017
	staff failed to follow	w up on a pharmacy			2. All facility residents	with an order
	recommendation.	The surveyor notified the am (AT) that the pharmacy			2. All facility residents	ation have the
	Administrative rea	at Resident #2's Seroquel 37.5			for a psychiatrist evalu	ation have the
	ma at bedtime be	decreased to 25 mg at bedtime	9		potential to be affected	d by this deficient
	on 4/18/17. The s	surveyor notified the A1 that the	:		practice. 5/4	/2017
	physician approve	ed and signed off on the nendation on 4/26/17. The			3. Facility nursing sta	ff will be
	surveyor notified t	he AT that Resident #2 was still	1		educated on following	oractitioner
	receiving Seroque	el at 37.5 mg at bedtime.			orders. Facility has co	ntracted for
	_				orders. Facility has co	in house visits
	No additional info	rmation was provided prior to as to why the facility staff failed	i		additional psychiatric	
	to follow up on a p Resident #2.	pharmacy recommendation for				6/9/2017
	2 For Resident #	112, facility staff failed to follow			4. DON or design	nee will audit
	nharmacy recomi	mendations for psychotropic			100% of residents wit	h order for
	medications after	the physician agreed to the			psychiatric evaluation	to ensure the
	recommendations	5.			psychiatric evaluation	u wookly for A
	Decided #40 we	s admitted to the facility on			resident is seen timel	y, weekly 101 4
	11/10/16 with diag	gnoses including end stage rer	nal		weeks then monthly	for 2 months. The
	disease, generali	zed muscular weakness,			findings will be repor	ted to the Quality
	diabetes mellitus	type with complications			Assurance Committe	e monthly for 3
	affecting kidneys hypertension. Or	, circulation, and eyes, pain, an n the most recent MDS	Dı		months for 1 consec	utive quarter.
	assessment with	assessment reference date ent scored 13/15 on the brief				
1	1/30/17, the resid	GUE SCOLED TOLLS OF THE SHOP	_			6/24/2017

interview for mental status and was assessed as without symptoms of delirium, psychosis, or

DEPARTI	MENTOPHEALTH	AND HUW, IN SERVICES				. 0938-0391
CTAILMENI CIEUEFICIENCIES IIVII 1100 - 1100			TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		495421	B. WING			/04/2017
NAME OF P	ROVIOER OR SUPPLIER			STREET AODRESS, CITY	, STATE, ZIP COOE	
FRIENDS	HIP HEALTH AND RI	EHAB CENTER - SOUTH		5647 STARKEY ROAD CAVE SPRING, VA		
IX4) IO PREFIX TAG	ICACU DESICIENC	ATEMENT OF OEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IO PREF TAC	IEACH CORRE CROSS-REFERE	S PLAN OF CORRECTION CTIVE ACTION SHOULO BE NCEO TO THE APPROPRIATE OBFICIENCY)	DATE
F 428	surveyor noted phy Quetiapine Fumar mouth at bedtime Clonazepam table day for @HS (hou Clonazepam Table hours as needed forder was a dosag Fumarate 25 mg (bedtime for psych Clonazepam was of symptoms required by the confers of properties of		n	428		
	anxiety. The survey physician notes of anxiety or psychothe diagnosis list MDS dated 1/30/January, Februar requested a psycantipsychotic medication April 2017 docum Clonazepam 0.5 0442. The MAR resident received on 5/2/2017 at 05 locate pursing documents.	reyor was unable to locate ocumenting diagnoses of sis. Psychosis was not listed of in the clinical record or In the 17. Pharmacy review notes for y. March, and April 2017 histric evaluation for necessity dications. The physician agree	of d			

DEPART	O LOD MEDICARE	& MEDICAID SERVICES			OWB NO: 0838-038.
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	TIPLE CONSTRUCTION DING	(X3) OATE SURVEY COMPLETEO
		495421	B. WING		05/04/2017
	ROVIOER OR SUPPLIER	EHAB CENTER - SOUTH		STREET AOORESS, CITY, STATE, ZIP CO 5647 STARKEY ROAD CAVE SPRING, VA 24018	00E
(X4) ID PREFIX TAG	SUMMARY STA	ATEMENT OF OEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	ID PREF TAC	EACH CORRECTIVE ACTION	SHOULO BE COMPLETION
F 428	whether the reside non-pharmacological The surveyor discussive director of nursing investigation, the Example of the Surveyor discussive diagnosing parameter of the Surveyor derivation to a complaint/reason wrote "f/u (followu Under the section current TX review "depressed", worrunable to sleep at experiences audit husband's volces Klonopin worked Medication Chang 2)Clonazepam 0. 150 mg qd (everymg qhs. The surveyor was physiclan ordered 12 hours as need received on 4/29/20 (antipsychotic me PROCEDURE: Namel health pro all residents that antipsychotic me	ent was offered of interventions. Jussed concerns with the (DON) on 5/4/16. After DON reported that the physicial sychosis when signing the inmary. The DON obtained a ry Consult Note dated 4/26/17. Sport, the physician Patient currently on Seroquel diagnosis. Anxious with dialysis". Under the Chief for visit section, the physician in the physician wrote "Pt's red. C/O staying bed ying, tired, and Also c/o being thinght. States she still tory hallucinations (including he). Trazodone not helping at all. well previously. Under ges "1) d/c Trazodone 5 mg qhs 3) [change] Zoloft to y day) 4) [change] seroquel to 5 a unable to determine when the did the Clonazepam 0.5 mg every ded for anxiety which the resided (17 and 5/2/17). It titled Behavior Monitoring Policedications) stated under Jursing 6. Evaluation by a pressional will be completed for are: a. Admitted on an addiation used to control behavior digition used to control behavior in the control in the control behavior in the control in th	n 60 ey ent cy	428	
	r. Amentamea	Ith profession will determine the			If continuation sheet Page 53

DEPARTMENT OF HEALTH AND HU....AN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) OATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF OFFICIENCIES (X1) PROVIOER/SUPPLIER/CLIA COMPLETEO IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILOING _ 05/04/2017 495421 B. WING STREET ADORESS, CITY, STATE, ZIP COOE NAME OF PROVIOER OR SUPPLIER 5647 STARKEY ROAD FR)ENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 PROVIDER'S PLAN OF CORRECTION JX51 COMPLETION DATE SUMMARY STATEMENT OF OFFICIENCIES 10 (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX (EACH OFFICIENCY MIJST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG OFFICIENCY) F 428 F 428 Continued From page 53 proper diagnosis for antipsychotic medications. The diagnosis "will be sent to medical records and to the pharmacy." Concerns were discussed with the administrator and DON during a summary meeting on 5/4/17. The DON stated there was no further information to offer concerning the lack of a psychiatric evaluation after the physician agreed with the recommendations in January, February, and March 2017. F 502 F 502 483.50(a)(1) ADMINISTRATION ss=D (a) Laboratory Services (1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and limeliness of the services. This REQUIREMENT is not met as evidenced by: 2. The facility staff failed to obtain physician ordered laboratory test CMP (comprehensive metabolic panel) for Resident #4. Resident #4 was admitted to the facility on 5/24/16 with diagnoses that included but not limited to: high blood pressure, stroke, osteoporosis, anxiety, asthma, dysphagia and heart failure. A review of Resident #4's clinical record revealed on the most recent significant change minimum data set (MDS) with an assessment reference date of 3/3/17, the facility staff assessed the resident to understand and to be understood. She

Evenj IO: GNW711

was assessed to have a cognitive summary score

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of 15.

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DEPARTM	ENT OF HEALTH	AND HUMAN SERVICES				OMB NO. 0938-0391
		& MEDICAID SERVICES	(X2) MUT	IDLE CONS	STRUCTION	(X3) OATE SURVEY
STATEMENT OF ANO PLAN OF C	OEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COMPLETEO
		495421	B. WING			05/04/2017
	OVIOER OR SUPPLIER IP HEALTH AND RE	EHAB CENTER - SOUTH		S647 ST	AODRESS, CITY, STATE, ZIP COOE FARKEY ROAO SPRING, VA 24018	
(X4) IO PREFIX TAG	ACACH OFFICIENCS	ITEMENT OF DEFICIENCIES Y MUST BE PRECEOEO BY FULL SC IOENTIFYING INFORMATION)	IO PREFI TAG	×	PROVIDER'S PLAN OF CORREC LEACH CORRECTIVE ACTION SHO CROSS-REFERENCEO TO THE APP OEFICIENCY)	DULO BE COMPLETION
r	ecord revealed the order on for a CMF 1/23/16 read as following the control of the lab	v of Resident #4's clinical at the physician had given an P. The original order date of llows: Rouline CMP Q (every) 6 ne time a day every 6 months n 1 day for CVA/HTN."	i	502		
1 .	clinical record reve aboratory test.	ealed no results for the		502 Adm	ninistration/Lab	
	nurses (DON) was the missing lab te the chart. On 5/4/17, during	imately 3:00pm, the director of a saked to assist with locating st. She said she would check a meeting with the director of nurses, the DON		1.	Facility residents #4 & # reviewed and additiona obtained per practition indicated.	l lab orders
	Prior to exit on 5/4 information relate provided. Based on clinical interview, it was defailed to obtain of	at 11:20 the lab was not done. 4/17 at 12:00 noon, no further d to the laboratory test was record review and staff letermined that the facility staff lysician ordered labs for 2 of 21			 Facility nursing staff wi educated on laborator confirmation of practit 	d by this 4/2017 II be y process and ioner orders.
	Residents in the s Resident #4. The Findings Incl 1. For Resident s	sample survey, Resident #3 and	1		4. DON or designee will a residents weekly for 4 monthly for 2 months. will be reported to the Assurance Committee	weeks then . The findings e Quality

TSH on 4/6/17.

failed to obtain a physician ordered T3, T4 and

6/24/2017

months for 1 consecutive quarter.

DEPART	MENT OF HEALTH	AND HUMAN SERVICES			•		0938-0391
		& MEDICAID SERVICES	1X31 Mills	TIPLE CO	ONSTRUCTION	(X3) DAT	E SURVEY
STATEMENT ANO PLAN OI	OF OEFICIENCIES CORRECTION	(X1) PROVIOER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				COM	PLETEO
		495421	B. WING				04/2017
NAME OF P	ROVIOER OR SUPPLIER				ET AOORESS, CITY, STATE, ZIP CO	OE	
		EHAB CENTER - SOUTH			STARKEY ROAO E SPRING, VA 24018		
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F 502	included, bul were Iternia with gangre communication de depression, breast cataracts and glau. The most current I located in the clinic Medicare MDS as Reference Date (Astaff coded that Reside assistance (3/3) w (ADL's).	16. Admitting diagnoses not limited to: diaphragmatic one, dysphagla, cognitive ficit, acute renal failure, major cancer, hypothyroidism, acoma. Minimum Data Set (MDS) cal record was a 14 Day sessment with an Assessment ARD) of 3/19/17. The facility esident #3 had a Cognitive of 9. The facility staff also ant #3 required extensive with Activities of Daily Living		502			
	reviewed Residen the clinical record for Coumadin 4 m review of the clini- orders to obtain a and 3/13/17. The physician order to 4/6/17.	at #3's clinical record. Review of produced a physician's ordering by mouth daily. Continued cal record produced physician PT/INR on 4/24/17, 3/31/17 clinical record also produced a obtain a T3, T4 and TSH on the clinical record falled to the physician ordered					
PARTITION OF THE PROPERTY OF THE PARTITION OF THE PARTITI	PT/INR's for 4/24 Furthermore the T3, T4 and TSH i not contained in t	its for the physician ordered 1/17, 3/31/17 and 3/13/17, results for the physician ordered to be obtained on 4/6/17 were the clinical record. at 10:55 a.m. the surveyor	j				
	notified the Direct	tor of Nursing (DON) that physician orders to obtain 417, 3/31/17 and 3/13/17. The	1				•

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CENTERS F	OR MEDICARE	& MEDICAID SERVICES				CHO DATE CHEVEY
STATEMENT OF D AND PLAN OF CO	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		495421	B. WING		gage to the last term proprietted that the last term is the last term in the last term is the last term in the last term in the last term is the last term in t	05/04/2017
	DER OR SUPPLIER	EHAB CENTER - SOUTH		5647	ET ADDRESS, CITY, STATE, ZIP CODE STARKEY ROAD E SPRING, VA 24018	
- INICIADOTIII			ID	CAVI	PROVIDER'S PLAN OF CORRECTION	ON (X5)
(X4) ID PREFIX TAG	ACACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
	ntinued From pa		F	502		
Drd	ered for a T3, T	4 and TSH to be drawn on or notified the DON that review				
nf t	he clinical recor	rd failed to produce the results				
of t	the physician or	dered PT/INR's for 4/24/17, 7 and failed to produce the				
res	ults of the physi	ician ordered T3, T\$ and TSH				
on	4/6/17. The sur	veyor reviewed the clinical				•
red loc	ord with the DC ate the results f	N. The DON was unable to or the physician ordered labs.				
On	May 3, 2017 at	2:15 p.m. the surveyor notified				
the sta	e Administrator (aff failed to obtai	Adm) and DON that the facility in physician ordered labs on				
Re	sident #3. The	surveyor notified the				
Ad	ministrative Tea	am (AT) that the facility staff obtain PT/INR's on 4/24/17,				
3/3	1/17 and 3/13/1	The surveyor notified the				
AT	that the facility	staff were also supposed to nd TSH on 4/6/17. The surveyor				
l no	tified the AT tha	t the results of the physician				
1		d not be located in the clinical				
, ,	cord.					
No	additional infor	mation was provided prior to				
ex	iting the facility	as to why the facility staff failed nordered labs on Resident #3.				
F 504 48	3.50(a)(2)(i) LA	B SVCS ONLY WHEN	F	504		
SS=D OF	RDEŘÉĎ BÝ PH	HYSICIAN				
(a) Laboratory Se	rvices				
(2) The facility mu	ıst-				
(i)	Provide or obta	ain laboratory services only when	n			
or	dered by a phys	sician; physician assistant; nurse nical nurse specialist in	7			
) pi	cordance with	State law, including scope of				
	actice laws.					

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES			O	FORM APPROVE MB NO. 0938-039
CENTERS FOR MEDICARE	& MEDICAID SERVICES	(V21341)	יסוד	CONSTRUCTION	(X3) OATE SURVEY
STATEMENT OF OEFICIENCIES ANO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	A. BUILOING			COMPLETEO
	495421	B. WING			05/04/2017
NAME OF PROVIOER OR SUPPLIER				REET AODRESS, CITY, STATE, ZIP COOE	
FRIENDSHIP HEALTH AND RE	EHAB CENTER - SOUTH			47 STARKEY ROAD AVE SPRING, VA 24018	
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by: Based on clinical rinterview, it was defailed to obtain a pilabs for 2 of 21 Reight Resident #3 and Rinterview. The Findings Incluing	record review and staff etermined that the facility staff hysician order prior to obtain sidents in the sample survey, lesident #11. ded: 3 the facility staff failed to order prior to obtaining a 7. an 84 year old female who was /16. Admitting diagnoses e not limited to: diaphragmatic ene, dysphagia, cognitive eficit, acute renal failure, major at cancer, hypothyroidism, fucoma. Minimum Data Set (MDS) ical record was a 14 Day issessment with an Assessment ARD) of 3/19/17. The facility tesident #3 had a Cognitive of 9. The facility staff also ent #3 required extensive with Activities of Daily Living at 3:05 p.m. the surveyor of groduced the results of a		504		

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CENTERS	S FOR MEDICARE	& MEDICAID SERVICES			IX31 DA	TE SURVEY
STATEMENT O ANO PLAN OF	F OEFICIENCIES CORRECTION	IX1) PROVIOER/SUPPLIER/CLIA IOENTIFICATION NUMBER:	A. BUILOING	E CONSTRUCTION		MPLETEO
		495421	B. WING		05	/04/2017
Į.	OVIDER OR SUPPLIER	EHAB CENTER - SOUTH	50	TREET AOORESS, CITY, STATE, ZIP COOE 647 STARKEY ROAD AVE SPRING, VA 24018		
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F 504 Continued From page 58 on 3/3017.

On May 3, 2017 at 10:55 a.m. the surveyor notified the Director of Nursing (DON) that Resident #3 had the results of a PT/INR obtained on 3/30/17 in the clinical record. The surveyor notified the DON that review of the clinical record failed to produce a physician's order to obtain the PT/INR on 3/30/17. The surveyor and DON reviewed Resident #3's clinical record. The surveyor specifically pointed out the results of the PT/INR obtained on 3/30/17. The DON reviewed the clinical record and was unable to locate a physician's order to obtain the PT/INR on 3/30/17.

On May 3, 2017 at 2:15 p.m. the surveyor notified the Administrator (Adm) and DON that the facility staff had obtained a PT/INR on 3/30/17 without a physician's order.

No additional information was provided prior to exiting the facility as to why the facility staff obtained a PT/INR on 3/30/17 without a physician's order.

2. The facility staff failed to obtain a physician order prior to obtaining laboratory tests for Resident #11. The facility staff obtained a basic metabolic panel (BMP), a urinalysis (UA) and culture and sensitivity (C&S) on 3/31/17 without a physician order.

The clinical record of Resident #11 was reviewed 5/2/17 and 5/3/17. Resident #11 was admitted to the facility 11/17/16 with diagnoses that included but not limited to lower limb cellulitis, anemia, morbid obesity, dysthymic disorder, hypertension, cardiomyopathy, ventricular tachycardia, lymphedema, diverticulosis of large intestine, constipation, and long term use of anticoagulants.

F 504

F504 Lab SVCS only when ordered by physician

1. Facility residents #3 & #11 had labs reviewed and additional orders obtained per practitioner as prescribed.

5/4/2017

- 2. All facility residents have the potential to be affected by this deficit practice. 5/4/2017
- 3. Facility nursing staff will be educated on laboratory process and confirmation of practitioner orders.

6/9/2017

4. DON or designee will audit 100% of residents weekly for 4 weeks then monthly for 2 months. The findings will be reported to the Quality Assurance Committee monthly for 3 months for 1 consecutive quarter.

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

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CENTERS FOR MEDICARE & MEDICAID SERVICES			OMB NO. 0938-03				
STATEMENI	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NIJMBER:	1 ' '		DNSTRUCTION		TE SURVEY MPLETED
		495421	B WING			05	5/04/2017
	PROVIDER OR SUPPLIER	EHAB CENTER - SOUTH		5647	ET ADDRESS, CITY, STATE, ZIP CODI STARKEY ROAD E SPRING, VA 24018	Ξ	
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F 504	Continued From pa	age 59	F	504			
	assessment with a (ARD) of 4/18/17 a cognitive summary evidence of behavior the laboratory secrevealed results of culture and sensitive metabolic panel (BThe surveyor revieugenerated physician orders of physician orders for reviewed the physician orders for the laboratory, the note the order for the laboratory and the order for the laboratory and the laboratory of the laboratory and the laboratory of the						•
	manager licensed 10:45 a.m. After r unit manager L.P.I locate an order for	rested the assistance of the un practical nurse #1 on 5/3/17 a eviewing the clinical record, the N. #1 stated she was unable to the urinalysis, the culture and MP all obtained 3/31/17.	t e >				
	director of nursing	med the administrator and the of the above concern on 5/3/1 gain on 5/4/17 at 11:20 a.m.	7				
F 514 SS≈D	exit conference or			514			

(i) Medical records.

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		& WEDICAID SERVICES	782) MUI	TIPLE CONSTRUCTION	(X3) OATE SURVEY
STATEMENT AND PLAN O	OF OFFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	DING	COMPLETED
		495421	B. WING		05/04/2017
NAME OF P	PROVIOER OR SUPPLIER			STREET AOORESS, CITY, STATE,	ZIP COOE
FRIENDS	SHIP HEALTH AND R	EHAB CENTER - SOUTH		5647 STARKEY ROAD CAVE SPRING, VA 24018	
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F 514	Continued From p	age 60	F	514	
1 01-1	(1) In accordance	with accepted professional ctices, the facility must			
İ	maintain medical r are-	ecords on each resident that			
	(i) Complete;				
	(ii) Accurately doc	umented;			
	(iii) Readily access	sible; and			
	(iv) Systematically	organized			
	(5) The medical re	ecord must contain-			
	(i) Sufficient inforr	nation to identify the resident;			
	(ii) A record of the	resident's assessments;			
	(iii) The comprehe provided;	ensive plan of care and service	S		
	and resident revie	any preadmission screening w evaluations and inducted by the State;			
	(v) Physician's, no profes s ional's pro	urse's, and other licensed gress notes; and			
	services reports a This REQUIREM	adiology and other diagnostic as required under §483.50. ENT is not met as evidenced			
	review, facility sta for administration	iterview and clinical record off failed to document indication of PRN medications for 2 of 2 ourvey sample (Residents #5,	ns 1		

12).

DEPARTMENT OF HEALTH			C	MB NO. 0938-0391
CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES	[X1) PROVIOER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) OATE SURVEY
ANO PLAN OF CORRECTION	IOENTIFICATION NUMBER:	A. BUILOING		COMPLETEO
	495421	B. WING		05/04/2017
NAME OF PROVIOER OR SUPPLIER	, , , , , , , , , , , , , , , , , , ,		EET AOORESS, CITY, STATE, ZIP COOE	
FRIENDSHIP HEALTH AND RI	EHAB CENTER - SOUTH		' STARKEY ROAO /E SPRING, VA 24018	
			PROVIDER'S PLAN OF CORRECTION	0N IX51
PRESING 1EACH DEFICIENCY	NTEMENT OF OFFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	IQ PREFIX TAG	IEACH CORRECTIVE ACTION SHOUL CROSS-REFERENCEO TO THE APPROF OEFICIENCY)	D BE COMPLETION
F 514 Continued From pa 1. For Resident #5 physician ordered antihypertensive m	5, facility staff failed to follow parameters for administering	F 514	F 514 Records Complete/Accuarte/Accessil	o
Resident #5 was a	dmitted to the facility on		#1	
8/13/16 with diagnorm anxiety, and patho On the quarterly movith assessment regident scored 14 mental status and of delirium, behavi During clinical reconsurveyor noted a property 8 hours as noted as as not	oses including hypertension, logical fracture of right femur. Inimum data set assessment eference date 2/20/17, the /15 on the brief interview for was assessed as without signs or, or psychosis. ord review on 5/3/17, the physician order dated 9/21/16 g (milligram) Give 1 tablet eeded for antihypertensive hrs if SBP>170 (systolic blood		 Facility Resident #5 order pressure parameters we for clarification for compractitioner order. All facility residents with for blood pressure med parameters have the parameter by this deficient. 	ere reviewed pliance of 5/17/2017 h an order ication with otential to be nt practice. 5/17/2017
April 2017 docume blood pressure was clonidine was admithe documented by 16:40, administrat documented. On documented blood 07:30, administrat documented. The concern was nursing on 5/3/17, nursing offered a Administration No 07:31 the resident The director of nu hand-written blood	Iministration record (MAR) for ented 2 dates when the systolic is not greater than 170 and sinistered. On 4/6/17 at 14:00, lood pressure was 158/70. At ion of the medication was 4/7/17 at 06:00, the dipressure was 146/66. At ion of the medication was reported to the director of On 5/4/17, the director of copy of a eMAR Medication the indicating that on 4/7/17 at is blood pressure was 200/90. In sing also offered a dipressure for 4:39 on 4/6/17 of eyor was unable to confirm the		 Facility nursing staff wireducated on following orders. DON or designee will a residents with orders for pressure medication with parameters for complified to the monomorphis. The findings or reported to the Quality Committee monthly for 1 consecutive quains 	practitioner 6/9/2017 udit 100% of or blood vith ance, weekly thly for 2 will be ty Assurance or 3 months

ALTH AND HUMAN SERVICES

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DEPARTMENT OF HEALTH	AND HUMAN SERVICES			C	MB NO. 0938-0391	
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	495421	B. WING	··	AND THE PROPERTY OF THE PROPER	05/04/2017	
NAME OF PROVIOER OR SUPPLIER		1	STREE	T AOORESS, CITY, STATE, ZIP COOE		
FRIENDSHIP HEALTH AND RE	HAB CENTER - SOUTH			STARKEY ROAD SPRING, VA 24018		
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F 514 Continued From pa		F 5	14			
were notified of the meeting on 5/4/17. 2. For Resident #1	and director of nursing (DON) concern during a summary 2, facility staff falled to n and effectiveness for RN (as needed) Clonazepam.		#2	Facility Resident monthly review of psych medication completed w behavior observation ass	otropic ith target	
Resident #12 was admitted to the facility on 11/19/16 with diagnoses including end stage renal disease, generalized muscular weakness, diabetes mellitus type II with complications affecting kidneys, circulation, and eyes, pain, and hypertension. On the most recent MDS assessment with assessment reference date 1/30/17, the resident scored 13/15 on the brief interview for mental status and was assessed as without symptoms of delirium, psychosis, or behaviors affecting others.		1 .		 All facility reside Psychotropic medication potential to be affected I practice. Facility nursing s educated on Behavior M Policy, including docume 	5/2/2017 All facility residents receiving notropic medications have the nitial to be affected by this deficient ice. 5/25/2017 Facility nursing staff will be ated on Behavior Monitoring y, including documentation	
surveyor noted phy Clonazepam tablei day for @HS (hour Clonazepam Table hours as needed for was a new medica	ord review on 5/3/17, the ysician orders dated 4/27 for (0.5 mg by mouth one time a rof sleep) anxiety and (0.5 mg by mouth every 12 or anxiety. The Clonazepam tition. Unable to locate documentation the medication.	n		requirements when print are provided. 6/9/2017 4. DON or designee 100% of residents on psy medications for behavior program weekly for 4 we monthly for 2 months. Th	will audit rchotic monitoring teks then	
or symptoms requi	und me medication. There				5	

be reported to the Quality Assurance

consecutive quarter.

Committee monthly for 3 months for 1

diagnoses of anxiety.

were no orders for behavior monitoring of

symptoms or of potential side effects of the

medications. Nurse's notes for April and May

2017 did not mention anxiety. The surveyor was unable to locate physician notes documenting

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CENTERS FOR MEDICARE STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) OATE SURVEY COMPLETEO	
	495421	B. WING	A STATE OF THE STA	05/04/2017	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND R		i i	STREET AOORESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018		
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F 514 Continued From page 63

The Medication Administration Record (MAR) for April 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 4/29/17 at 0442. The MAR for May 2017 documented the resident received Clonazepam 0.5 mg for anxiety on 5/2/2017 at 0507. The surveyor was unable to locate nursing documentation of the symptoms for which the medication was administered or whether the resident was offered non-pharmacologic interventions.

The surveyor discussed concerns with the director of nursing (DON) on 5/4/16. After investigation, the DON reported that the physician was diagnosing psychosis when signing the monthly order summary. The DON obtained a Geriatric Psychiatry Consult Note dated 4/26/17. Under Nursing Report, the physician wrote Depressed. Patient currently on Seroquel with no supporting diagnosis. Anxious with transportation to dialysis". Under the Chief Complaint/reason for visit section, the physician wrote "f/u (followup) for chronic depression. Under the section HPI, the physician wrote "Pt's current TX reviewed. C/O staying bed "depressed", worrying, tired, and Also c/o being unable to sleep at night. States she still experiences auditory hallucinations (including her husband's voices). Trazodone not helping at all. Klonopin worked well previously. Under Medication Changes "1) d/c Trazodone 2)Clonazepam 0.5 mg qhs 3) [change] Zoloft to 150 mg qd (every day) 4) [change] seroquel to 50 mg qhs.

The surveyor was unable to determine when the physician ordered the Clonazepam 0.5 mg every 12 hours as needed for anxiety which the resident received on 4/29/17 and 5/2/17.

F 514

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

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CENTER	S FOR MEDICARE	& MEDICAID SERVICES			(TMR NO	. 0938-0391
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	ROVIDER OR SUPPLIER	EHAB CENTER - SOUTH		5647	ET ADDRESS, CITY, STATE, ZIP CODE STARKEY ROAD E SPRING, VA 24018		
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F 514	Continued From pa	age 64	F	514			
	The concern about was discussed with during a summary	the lack of documentation the administrator and DON meeting on 5/4/17.					