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

PRINTED: 08/24/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE
5647 STARKEY ROAD
CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments	E 000		
	An unannounced Emergency Preparedness survey was conducted 7/31/18 through 8/2/18. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. Six complaint(s) were investigated during the survey.			
F 000	INITIAL COMMENTS	F 000		
	An unannounced Medicare/Medicaid Standard and Complaint survey was conducted 07/31/18 through 08/02/18. Six (6) Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements and Virginia Rules and Regulations for the Licensure of Nursing Facilities. The Life Safety Code survey/report will follow.			
	The census in this 120 certified bed facility was 115 at the time of the survey. The survey sample consisted of 40 current Resident reviews and 5 closed record reviews.			
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550	**F550** **Corrective Action(s):** Resident #29 has received proper silverware for her meals since this incident.	
	§483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section.		**Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. The Dietary Director has created an audit mechanism that allows dining staff to ensure proper silverware is on each resident tray prior to it leaving the kitchen. Negative findings identified will be corrected at time of discovery and forwarded to the Administrator for corrective action, if necessary.	
	§483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] | TITLE: Director of Operations | (X6) DATE: 9/1/18

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

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F 550	Continued From page 1 individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on Resident interview, group interview, staff interview, and clinical record review, the facility failed to ensure a dignified dining experience for one of 45 Residents, Resident #29. The findings included. The Facility staff failed to provide Resident #29 with silverware. The Resident was provided with	F 550	**Systemic Change(s):** The Dietary Director has in-serviced her staff on Resident Rights and ensuring that residents have a dignified dining experience. In the event of an emergency, whereby plastic cutlery is needed to be distributed to residents, the Dietary Director and the RD have in-serviced the dining staff on assisting the residents with opening the plastic cutlery package at tray delivery. The facility's current policy and procedure and Resident Rights list have been reviewed and no changes are warranted at this time. **Monitoring:** The Dietary Director is responsible for compliance. Results of the audit will be reviewed by the Administrator weekly for 3 months. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date:** September 16, 2018	

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F 550	Continued From page 2 plastic cutlery for meals. Resident # 29 stated it made her feel as if she was eating at a fast food restaurant. The record review revealed that Resident #29 had been admitted to the facility 08/13/16. Diagnoses included, but were not limited to, essential hypertension, constipation, and gastroesophageal reflux disease. Section C (cognitive patterns) of the Residents quarterly MDS (minimum data set) assessment with an ARD (assessment reference date) of 05/24/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points. Section G (functional status) was coded to indicate the Resident was independent with setup help only for eating. The Resident was coded as not having any functional limitation in range of motion in the upper or lower extremities. The CCP (comprehensive care plan) included the focus area is edentulous. Interventions included, but were not limited to, honor my rights preferences and observe for changes in daily consumption and weight changes and report. On 08/01/18 at 3:00 p.m., a group interview was held with seven alert and orientated Residents of the facility. During this meeting, Resident #29 stated she was given plastic cutlery with some of her meals. Resident #29 stated no one else has the issue and I hate it I feel like I am eating fast food. On 08/01/18 at 4:15 p.m., the surveyor interviewed the dietary manager. The dietary manager stated she was not aware Resident #29	F 550		

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F 550	Continued From page 3 was receiving plastic cutlery. The administrator and DON (director of nursing) were notified of this issue on 8/01/18 at approximately 4:45 p.m. On 08/02/18 at 8:08 a.m., Resident #29 stated it was difficult to get the plastic cutlery out of the plastic wrapper. On 08/02/18 at 8:20 a.m., CNA (certified nursing assistant) #1 was asked about the use of plastic cutlery CNA #1 stated she had noticed that Resident #29 had received plastic cutlery. However, she did not know why. CNA #1 stated that the silverware came out with the trays from the kitchen. 08/02/18 at 8:35 a.m., dietary aide #1 was asked about the use of silverware vs plastic cutlery. Dietary aide #1 stated I don't know why someone would get plastic cutlery you would need to talk to the dietary manager or the physician 08/02/18 at 8:36 a.m., during an interview with dietician and dietary manager neither staff could explain why the Resident was receiving plastic cutlery and stated it is not on her tickets (diet ticket) and we ran a history. The administrative staff were notified of the above during a meeting with the survey team on 08/02/18 at 8:35 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 550		
F 554	Resident Self-Admin Meds-Clinically Approp	F 554		

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F 554 SS=D	Continued From page 4 CFR(s): 483.10(c)(7)	F 554	**F554** **Corrective Action(s):** An assessment for self-administration of medications was completed for Resident #67. With no concerns being found, Resident #67 is able to keep these medications at bedside. Unit managers were in-serviced on the requirement that a medication self-administration assessment must be conducted prior to a resident self-administering a medication on their own.	

§483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate.
This REQUIREMENT is not met as evidenced by:
Based on observation, resident interview, staff interview, clinical record review and facility document review it was determined that the facility staff failed to assess 1 of 45 residents in the sample survey for safe self-medication administration, Resident # 67.

The Findings Included:

Resident #67 was a 60 year old male who was admitted on 6/20/17. Admitting diagnoses included, but were not limited to: multiple sclerosis, chronic lymphocyte leukemia of B-cell type, chronic diastolic heart failure and benign prostatic hyperplasia.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 6/28/18. The facility staff coded that Resident #67 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #67 was independent (0/0) to required extensive assistance (3/2) with Activities of Daily Living (ADL's).

On July 31, 2018 at 2:45 p.m., the surveyor interviewed Resident #67. Resident #67 was specifically interviewed about the facility staff administering Resident #67's medications. Resident #67 stated that the facility staff had too

Identification of Deficient Practices & Corrective Action(s):
All other residents with orders for self-administration of medication may have potentially been affected. The DON and/or unit managers will screen 100% of residents with orders for self-administration of medication to ensure proper safety assessments are in place. Any/all negative findings identified will be corrected at the time of discovery.

Systemic Change(s):
Current facility policy and procedures have been reviewed with no changes warranted at this time. All nursing staff will be inserviced by the DON or designee on the Self-Administration of Medications and Treatments Policy.

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F 554	Continued From page 5 many agency nurses and that are too many nurses trying to get the medications administered. Resident #67 stated that if there was an emergency everyone ran to the emergency and that his medications were not administered as ordered by the physician. Resident #67 stated that he kept some of his medications at the side of the bed. Resident #67 reached over, opened up his bedside table, and retrieved his Flonase nasal spray and his Imbruvica. Resident #67 stated his Imbruvica was for his leukemia and cost over $1200 per month. On August 1, 2018 at 2:10 p.m., the surveyor reviewed Resident #67's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Flonase Suspension 50MCG/ACT (Fluticasone Propionate) 2 sprays in both nostrils one time a day for allergies unsupervised self-administration Patient can keep at bedside. Imbrivica Tablet 140 MG (Ibrutinub) Give 1 tablet by mouth one time a day for leukemia **RESIDENT TO SELF ADMINISTER UNSUPERVISED, PREFERS TO TAKE BETWEEN 4-6AM. MAY KEEP IN ROOM/LOCKBOX**" (sic) Continued review of the clinical record failed to produce a safe self-medication assessment for Resident #67. On August 1, 2018 at 2:35 p.m., the surveyor notified the Director of Nursing (DON) that Resident #67 had medications, Flonase and Imbruvica, at the side of his bed that he was self-administering. The surveyor notified the DON that review of Resident #67's clinical record failed to produce a facility assessment for Resident #67 to safely self-administer his own medications.	F 554	**Monitoring:** The DON and/or Unit Managers are responsible for maintaining compliance. DON and/or Unit Managers will complete weekly audits to monitor that medication self-administration assessments have been conducted for residents wishing to self-administer medications. Negative findings will result in disciplinary action as required. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date:** September 16, 2018	

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F 554	Continued From page 6 The DON stated that Resident #67 should have a medication self-administration assessment on his clinical record. The DON stated she would review Resident #67's clinical record and see if she could find the assessment. The surveyor requested the facility policy and procedure for residents to safely self-administer their own medications. On August 1, 2018 at 3 p.m., the DON hand delivered the facility policy and procedure titled, "Self-Administration of Medications and Treatments." The policy and procedure read in part ... "Procedure: 1. Residents who wish to self-administer their own medications must demonstrate their ability to accomplish this task safely as measured by cognitive, physical, and visual parameters. Therefore, and interdisciplinary care plan team and attending physician will evaluate each resident by completing the "Assessment for Self-Administration of Medications. 2. Self-administration of drugs is permitted only after the above assessment and with the written order by the attending physician. The physician order must state, May self-administer medications-or Keep at Bedside." On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #67 had medications at the side of his bed that he was self-administering. The surveyor notified the AT that Resident #67 had not been assessed for safe medication administration.	F 554		

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F 554	Continued From page 7 No additional information was provided prior to exiting the facility as to why the facility staff failed to assess Resident #67 for safe self-medication administration.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, and	F 561	**F561** **Corrective Action(s):** Resident #61 has been informed by Social Services that she is allowed to go outside without signing out. She has been educated, however, that where she desires to go has been deemed an unsafe area because it is out of sight of staff and cameras and has a steep hill leading toward the parking lot. **Identification of Deficient Practices & Corrective Action(s):** All other residents may have potentially been affected. The Social Services Director will inform all residents of their right to navigate facility grounds, where it has been deemed safe to do so, without the need to sign out of the facility. **Systemic Change(s):** A policy and procedure for navigating the facility grounds has been created. The Policy identifies safe areas and areas deemed unsafe for residents. All staff and residents will be educated on this new policy by the Social Services Director.	

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F 561	Continued From page 8 clinical record review, the facility staff failed to promote and facilitate self-determination through support of resident's choice for 1 of 45 Residents in the survey sample, Resident # 61. The findings included: The facility staff failed to allow Resident # 61 to go outside on the facility property without signing a leave of absence form following a fall that occurred on 6/15/18. Resident # 61 was a 53-year-old female who was admitted to the facility on 3/9/17. Diagnoses included but were not limited to: anxiety disorder, muscle wasting and atrophy, depression, and benign neoplasm of the brain. The clinical record for Resident # 61 was reviewed on 8/1/18 at 11:25 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/29/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 61 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicates that Resident # 61 was cognitively intact. The current plan of care for Resident # 61 was reviewed and revised on 4/16/18. The facility staff documented a focus area for Resident # 61 as "I wish to maintain my psychosocial well-being and quality of life." Interventions for this focus area included, but were not limited to: "Encourage me to attend activities of my choosing." The facility staff also documented a focus area for Resident # 61 as "Resident # 61 has the potential for little group activity involvement related to preference	F 561	**Monitoring:** The Social Services Director is responsible for maintaining compliance. The Social Services Director will conduct weekly rounds to monitor for compliance and ensure residents understand the new policy. Any negative findings will result in disciplinary action as required. Aggregate findings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date:** September 16, 2018	

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F 561	Continued From page 9	F 561		

of own customary routine." Interventions included, but were not limited to: "My preferred activities are: Motorcycles, reading magazines (Glamour, People, Cosmopolitan), music, TV (television), tablet/smartphone, outdoors, dog visits, socials." and "Respect resident's rights, preferences, and customary routine."

On 8/1/18 at 9:23 am, the surveyor conducted an interview with Resident # 61. Resident # 61 expressed to the surveyor that she was upset because she was not able to go outside on the facility property without signing herself out LOA (leave of absence). The surveyor asked Resident # 61 why she had to sign out LOA if she was not actually leaving the facility grounds. Resident # 61 began to explain that she had a fall a few weeks ago and the facility staff wanted her to sign out LOA so they would not be held liable if she fell. Resident # 61 stated that she liked to go outside and sit in her wheelchair on the side of the building so that she could see inside of her room. Resident # 61 explained that on the day of the fall, she made an arrangement with a CNA (certified nursing assistant) to take her outside and that she would come back in 30 minutes to get her to bring her back inside. Resident # 61 stated that she told the CNA that she would use her cell phone to call if she wanted to come in sooner. Resident # 61 explained that she sat outside for a while but she dropped her cell phone and was unable to reach her phone to pick it up off the ground. Resident # 61 stated that she rolled up the sidewalk to a window where staff was present but was unable to get anyone's attention. Resident # 61 stated, "I guess I rolled over a rock or something," that she thought that her wheel on her wheelchair went off the sidewalk and her wheelchair tipped over.

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F 561	Continued From page 10 On 8/2/18 at 2:40 pm, the surveyor spoke with the administrator regarding Resident # 61 having to sign out LOA to be on the facility property. The surveyor explained to the administrator that Resident # 61 reported that the facility wanted her to sign out LOA to go outside on the facility grounds so that the facility would not be held liable if she fell again. The administrator stated that he did not feel that the area that Resident # 61 was in had been a safe area and this was his way of keeping up with where she was. The surveyor spoke with the administrator and recapped the fall that occurred on 6/15/18. The administrator agreed that Resident # 61 had a facility staff member take her outside therefore someone in the facility knew where she was. The administrator also agreed that Resident # 61 had arranged for a facility staff member to come back and take her in at a certain time. The surveyor asked the administrator if Resident # 61 was required to sign out LOA to go out on the facility grounds prior to the fall that occurred on 6/15/18 and the administrator responded "No." On 8/2/18 at 9:25 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 8/2/18.	F 561		
F 573 SS=D	Right to Access/Purchase Copies of Records CFR(s): 483.10(g)(2)(i)(ii)(3) §483.10(g)(2) The resident has the right to access personal and medical records pertaining to him or herself. (i) The facility must provide the resident with access to personal and medical records	F 573	**F573** **Corrective Action(s):** Social Services has met with resident #61 and given her the opportunity to review her medical record. Nurse #1 has been in-serviced on Resident Rights regarding access to medical records and the importance of communicating these requests to Medical Records, if need be.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 573	Continued From page 11 pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays); and (ii) The facility must allow the resident to obtain a copy of the records or any portions thereof (including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of: (A) Labor for copying the records requested by the individual, whether in paper or electronic form; (B) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media; and (C)Postage, when the individual has requested the copy be mailed. §483.10(g)(3) With the exception of information described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in paragraph (g)(2) of this section may be made available to the patient at their request and expense in accordance with applicable law. This REQUIREMENT is not met as evidenced by:	F 573	**Identification of Deficient Practices & Corrective Actions(s):** All other residents may have been potentially affected. The Social Services Director will inform residents of their rights to access their medical records. **Systemic Change(s):** Facility policy and procedures were reviewed with no changes warranted at this time. The Social Services Director will in-service the nursing staff on the facility policy & procedure regarding resident rights and access to personal and medical records pertaining to him or herself. **Monitoring:** Medical Records is responsible for compliance. The Medical Records will perform daily audits to monitor for record request compliance. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of the weekly audits will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. **Completion Date:** September 16, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 573	Continued From page 12	F 573		

Based on resident interview, staff interview, and clinical record the facility staff failed to provide access to medical records for 1 of 45 residents in the survey sample, Resident # 61.

The findings included:

The facility failed provide Resident # 61 with access to her medical record as requested.

Resident # 61 was a 53-year-old female who was admitted to the facility on 3/9/17. Diagnoses included but were not limited to: anxiety disorder, muscle wasting and atrophy, depression, and benign neoplasm of the brain.

The clinical record for Resident # 61 was reviewed on 8/1/18 at 11:25 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/29/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 61 had a BIMS score of 15 out of 15, which indicated that Resident # 61 was cognitively intact.

The current plan of care for Resident # 61 was reviewed and revised on 4/16/18. The facility staff documented a focus area for Resident # 61 as "I wish to maintain my psychosocial well-being and quality of life." Interventions for this focus area included but were not limited to: "Encourage me to attend activities of my choosing." The facility staff also documented a focus area for Resident # 61 as "Resident # 61 has the potential for little group activity involvement related to preference of own customary routine."
Interventions included but were not limited to: "My preferred activities are: Motorcycles, reading

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	495421		C 08/02/2018

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F 573	Continued From page 13 magazines (Glamour, People, Cosmopolitan), music, TV (television), tablet/smartphone, outdoors, dog visits, socials." and "Respect resident's rights, preferences, and customary routine." According to the facility care plan meeting signature sheet, the facility family nurse practitioner was present in the care plan meeting that was held on 6/13/18. On 8/1/18 at 9:23 am, the surveyor conducted an interview with Resident # 61. Resident # 61 expressed to the surveyor that she was upset because she was not able to go outside on the facility property without signing herself out LOA (leave of absence). The surveyor asked Resident # 61 why she had to sign out LOA if she was not actually leaving the facility grounds. Resident # 61 began to explain that she had a fall a few weeks ago and the facility staff wanted her to sign out LOA so they would not be held liable if she fell. Resident # 61 stated that she liked to go outside and sit in her wheelchair on the side of the building so that she could see inside of her room. Resident # 61 explained that on the day of the fall, she made an arrangement with a CNA (certified nursing assistant) to take her outside and that she would come back in 30 minutes to get her to bring her back inside. Resident # 61 stated that she told the CNA that she would use her cell phone to call if she wanted to come in sooner. Resident # 61 explained that she sat outside for a while but she dropped her cell phone and was unable to pick her phone up off the ground. Resident # 61 stated that she rolled up the sidewalk to a window where staff was present but was unable to get anyone's attention. Resident # 61 stated, "I guess I rolled over a rock or something," that she thought that her wheel on her wheelchair went off the sidewalk and her	F 573		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE
5647 STARKEY ROAD
CAVE SPRING, VA 24018

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F 573	Continued From page 14 wheelchair tipped over. Resident # 61 stated to the surveyor that she asked a nurse later on that night if "they could give me a report of the fall that was in my chart." Resident # 61 stated to the surveyor that the nurse replied, "We can't give you that." On 8/1/18 at 11:39 am, the surveyor reviewed the progress notes in Resident # 61's clinical record. A progress note that was written on 6/18/18 at 3:53 pm was documented as "Rsd (Resident) visibly emotional and upset this shift over the unexpected death of her father last night. Rsd has multiple outburst, complaints, and demands at staff. Rsd is requesting information from medical chart regarding her recent care stating she will be contacting attorney or APS (adult protective services) if medical information not received within 48 hours of request. Rsd informed medical information can be released by consulting medical records. Rsd replies, "this is bullshit, I am tired of how I am treated in this place and someone needs to know." Again, rsd informed that she would have to go through medical records to obtain the requested documentation. Rsd ststes, "the next time you will hear about this it will be from my attourney" Administered rsd requested medication and left room. Supervisor on duty notified of events." On 8/1/18 at 1:40 pm, the surveyor spoke with the administrator and the director of nursing regarding Resident # 61 requesting to see information regarding her fall in her clinical record. The administrator stated to the surveyor that he was under the impression that Resident # 61 wanted to see a FRI (facility reported incident) that was reported to the Office of Licensure and Certification. The administrator explained that he	F 573		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 573	Continued From page 15	F 573		

met with Resident # 61 and the local ombudsman and explained that the facility did not submit a FRI related to fall that occurred with Resident # 61. The surveyor informed the administrator and the director of nursing that Resident # 61 reported that she requested to see information in her chart related to the fall that occurred on 6/15/18. The surveyor asked the administrator and the director of nursing if Resident # 61 had been allowed access to her clinical record to obtain the information that she requested. The director of nursing replied "No." The director of nursing replied that Resident # 61 never went to medical records to get the information. The surveyor reviewed that Resident # 61 had made her needs known to the facility staff as evidenced by the progress note documented in Resident # 61's clinical record on 6/16/18 at 3:53 pm. The surveyor asked the administrator and director of nursing if the facility staff made any effort to contact medical records to assist Resident # 61 in obtaining the information that was requested. The director of nursing stated that she would get someone from medical records to come speak with the surveyor.

On 8/2/18 at 10:40 am, the surveyor spoke with the administrator and requested to speak with staff member from medical records.

On 8/2/18 at 2:43 pm, the surveyor spoke with the administrator and requested to speak with a staff member from medical records.

On 8/2/18 at 9:35 pm, the administrative team was made aware of the findings as stated above and that a staff member from medical records never spoke with the surveyor as requested.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 5647 STARKEY ROAD, CAVE SPRING, VA 24018

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F 573	Continued From page 16 No further information regarding this issue was provided to the survey team prior to the exit conference on 8/2/18.	F 573		
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph	F 580	**F580** **Corrective Action(s):** Resident number #54 and # 83's attending physician was notified of the significant weight gain. A facility Incident and Accident form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other residents with significant weight changes or residents with physician ordered weight change notifications may have potentially been affected. The DON and/or designee will conduct a 100% audit of all residents with significant weight changes or physician ordered weight change notifications within the last 60 days to ensure proper notification to the resident's attending physician. Negative findings will result in a proper notification to the attending physician and the completion of a facility Incident & Accident form.	

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	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580	Continued From page 17 (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to notify the physician for a significant weight gain for 2 of 45 Residents in the survey sample, Resident #54 and Resident #83. The Findings Included: 1. For Resident #54 the facility staff failed to notify the physician of a significant weight gain. Resident #54 was a 63 year old male who was admitted on 7/10/17 and readmitted on 5/16/18. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, diabetes mellitus and pneumonia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a	F 580	**Systemic Change(s):** Facility policy and procedures have been reviewed with no revisions warranted at this time. The DON or designee will in-service all licensed staff on the procedure for following physician order weight change notifications and properly notifying physicians in the event of a significant weight change. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will perform an audit during weekly risk management meetings to ensure proper notifications have occurred to physicians. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 580 Continued From page 18

F 580

Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/20/18. The facility staff coded that Resident #54 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #54 was independent with Activities of Daily Living (ADL's).

On August 2, 2018 at 7:40 a.m., the surveyor reviewed Resident #54's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Daily weight-gain of 2 pounds in 3 consecutive days or 5 lbs (pounds) in one week, call physician one time a day for Routine." (sic) The order originated on 5/16/18.

Continued review of the clinical record produced Resident #54's weight record. Resident #54's weight was documented as:

8/2/18 364.6 pounds
8/1/18 364 pounds
7/31/18 358.6 pounds
7/30/18 360 pounds
7/29/18 355 pounds
7/27/18 152 pounds
7/26/18 349 pounds
7/25/18 350.6 pounds
7/24/18 349.6 pounds

Further review of the clinical record failed to document that the facility staff notified the physician as Resident #54 had a 13.4 pound weight gain from 7/25/18 through 8/1/18, and a 9 pound weight gain from 7/24/18 through 7/31/18.

August 2, 2018 at 8:36 a.m., the surveyor notified the Director of Nursing (DON) that Resident #54 had a physician's order to notify the physician if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 19	F 580		

there was a 2 pound weight gain in 3 consecutive days or a 5 pound weight gain in a week. The surveyor notified the DON that review of Resident #54's clinical record documented that Resident #54 had significant weight gain over a week timeframe. The surveyor notified the DON that review of the Resident #54's failed to document that the facility staff notified the physician for Resident #54's significant weight gain on multiple occurrences. The surveyor reviewed Resident #54's record with the DON. The surveyor pointed out the specific physician order for physician notification of weight gain. The surveyor also reviewed Resident #54's weight record with the DON. The DON reviewed Resident #54's clinical record and was unable to locate documentation that the facility staff notified the physician of Resident #54's weight gain of over 5 pound weight gain from 7/25/18 through 8/1/18 and from 7/24/18 through 7/31/18.

On August 02, 2018 at 8:34 p.m., the survey team met with the Administrator (Adm), DON, Rehabilitation Director, Rehabilitation Assistant, Staff Coordinator and Housekeeping Director. The surveyor notified the Administrative Team (AT) that Resident #54 had a specific physician order to notify the physician if Resident #54 gained more than 2 pounds consecutively for 3 days or 5 pounds in a week. The surveyor notified the AT that Resident #54 gained more than 5 pounds in a week on several occasions and the facility staff had not notified the physician of the weight gain.

No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to notify the physician of Resident #54's significant weight gain as directed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 580 Continued From page 20

F 580

by the physician.
2. For Resident #83, the facility failed to notify the physician of weight changes.

The clinical record review revealed the Resident #83 had been admitted to the facility 06/10/18. Diagnoses included, but were not limited to, normal pressure hydrocephalus, ataxia, hypertensive heart disease with heart failure, unspecified convulsions, gastroesophageal reflux disease, and sleep disorder.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/17/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

The Residents clinical record included physician orders for daily weights for a gain of 2 pounds in three consecutive days or 5 pounds in one week, call physician. The order on this date was documented as 06/24/18.

A review of the eMARs (electronic medication administration records) revealed that the facility nursing staff had documented the Resident weighed 173 on 07/21 and 184.8 on 07/22/18. The surveyor was unable to find any documentation to indicate the facility staff had notified the physician of the weight change.

The staff had documented the following weights for the 7-day period preceding 07/21/18. 07/14-170.6, 07/15-174.6, 07/16-174.2, 07/17-175.8, 07/18-177, 07/19-176.6, and for 07/20-177.8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 5647 STARKEY ROAD, CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580	Continued From page 21 On 08/02/18 at 10:00 a.m., RN (registered nurse) #1 reviewed the weights with the surveyor, the clinical record, and the doctor's book and was unable to locate any information indicating the physician had been notified of the weight increase. The facility provided the survey team with a copy of a policy titled "NURSING DOCUMENTATION." This policy read in part "PURPOSE: 1. To substantiate daily care...WHAT TO CHART...4. All contact with the primary care provider..." The administrator and DON (director of nursing) were notified of the above during a meeting with the survey team on 08/02/18 at 8:35 p.m. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 580		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document	F 607	**F607** **Corrective Action(s):** The Administrator and Director of Nursing who were employed at the time of Resident #322's injury are no longer employed. The investigation, which occurred on 12/12/18, explained how the bruise occurred, albeit not in the timeframes mandated by regulation. A FRI is not warranted at this time. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have been affected. The DON and/or designee will review facility skin assessments from the past 2 months to ensure that all areas of injury and/or bruises were properly investigated and reported per the facility Policy & Procedure. Any/all negative findings will result in a proper investigation and reporting at that time.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 22 review, clinical record review, and during the course of a complaint investigation, the facility staff failed to implement their policy and procedure for investigating and reporting injuries of unknown origin to the appropriate state agencies for 1 of 45 residents, Resident #322. The findings included: A complaint was filed with the Office of Licensure and Certification on 1/4/2018. This complaint was investigated during an unannounced survey that took place onsite at the facility from 7/31/18 through 8/2/18. The complaint was investigated as a closed record. The complainant was contacted on 8/2/18 at 9:00 am. The complainant alleged that Resident # 322 obtained a giant bruise on her left abdomen. Resident # 322 was a 90-year-old-female that was originally admitted to the facility on 11/10/17 with a readmission date of 11/28/17. Diagnoses included but were not limited: chronic obstructive pulmonary disease, sleep disorder, atrial fibrillation, and heart failure. The closed clinical record for Resident # 322 was reviewed on 8/2/18 at 10:52 am. The most recent MDS (minimum data set) was a 14-day assessment with an ARD (assessment reference date) of 12/12/17. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 322 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated that Resident # 322 was cognitively intact. The plan of care for Resident # 322 was reviewed	F 607	**Systemic Change(s):** The Facility Policy and Procedure has been reviewed and changes are not warranted at this time. The Director of Operations will conduct in-services for all staff, including the Administrator and DON, on the reporting guidelines for abuse, neglect and misappropriations including time lines for reporting incidents. Any future negative findings will result in immediate corrective action. **Monitoring:** The Administrator and DON are responsible for monitoring compliance. The 24-hour report will be reviewed daily to monitor for injuries or bruises of unknown origin. Investigations and reporting of these events will follow reporting guidelines and facility Policy & Procedure. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

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F 607	Continued From page 23	F 607		

and revised on 12/12/17. The facility staff documented a focus area as "Resident # 322 has the potential for pressure ulcer development related to impaired mobility and occasional incontinence. Per Resident # 322, she has a history of bruising easily and is on Aspirin therapy. She will attempt to complete tasks on her own and has muscle weakness at this time that makes her unsteady." Interventions included but were not limited to: "Provide medications as ordered but monitor for side effects: such as uncontrolled bleeding or discolorations. Consult MD (medical doctor)/ NP (nurse practitioner) if occurs," and "Inform Resident # 322 and her family of any new areas of skin breakdown."

The physician signed the orders for Resident # 322 on 12/28/17. Resident # 322 had orders for "Aspirin EC (enteric coated) Tablet Delayed Release 81 MG (milligrams) Give 1 tablet by mouth one time a day for heart health."

On 8/2/18 at 11:15 am, the surveyor reviewed the progress notes in the closed clinical record for Resident # 322. A progress note documented on 12/9/17 at 8:36 pm stated, "Rsd (resident) has large bruise on left side = 12 cm (centimeters) x 5cm; smaller bruise 3cm x 2.5 cm. Noticed while dressing rsd this AM. Rsd ambulates in room and to the bathroom without assistance. Denies pain. Bed and chair alarms present and working. RP (responsible party) aware. Call bell within reach at all times."

On 8/2/18 at 1:03 pm, the surveyor spoke with the administrator and director of nursing regarding the bruised areas on Resident# 322's abdomen. The surveyor requested to see any reporting and investigations that were completed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 607	Continued From page 24 regarding this issue. The administrator and director of nursing informed the surveyor that this incident occurred prior to both of their employment with the facility however, they would do their best to locate the information. On 8/2/18 at 1:10 pm, the surveyor reviewed the facility reported incidents that had been submitted by the facility and did not locate a facility reported incident regarding bruises on Resident # 322. On 8/2/18 at 5:45 pm, the director of nursing provided the surveyor with a progress note from Resident # 322's closed clinical record that was documented on 12/12/17 at 11:48 am. The progress note stated "Notified regarding discoloration to "stomach" area. Upon assessment, I noted approx.. 2-3 cm discoloration to right side of abdomen near the hip area of the abdominal fold. I also noted approx. 5-6 cm discoloration to the left side of the abdomen near hip area of the abdominal fold. Discolorations are dark purple and blue in color with yellowish edges noted. There are no discolorations noted to her back along the waist line or several inches above or below the waist area. I noted in the front of her abdomen area around her waist, along on the abdominal fold there again were no discolorations. I noted that she has a colostomy that is positioned over an area of her left abdomen that protrudes out about the size of a large orange or grapefruit-again there was no discolorations noted in this area either. Resident had no signs of discomfort when assessing the discolorations and stated did not know they were there. I asked if she possibly knew how they occurred and she stated that she "always bruise easily." She was uncertain of how they happened, expressed that she did not feel it	F 607		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

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F 607	Continued From page 25	F 607		

was on purpose, she "may have bumped into something." I noted in room that she has a shelf next to left hand rail in the bathroom that has her toileting and ostomy supplies on it that is waist level. In her main living area, there is a stationary chair with padding added to the arms- staff reported that was added due to risk of her "bumping into the arm rests." Her wheelchair fits her without much additional room between the armrests to her sides/hip areas. I have contacted therapy to assess to ensure the wheelchair is the appropriate size for her. Staff report that resident will get up on her own related to decreased safety awareness due to dementia dx (diagnosis). Upon review of her medical chart, I noted she is on Aspirin daily and had been on Prednisone when she was first admitted for three days related to respiratory failure, which puts her at risk for discolorations and fragile skin. Will notify daughters of observations."
The director of nursing informed the surveyor that she was unable to locate any additional information regarding the incident of the bruising observed on Resident # 322.

According to the facility policy on "Unusual Occurrence Reporting," the policy contains documentation that includes but is not limited to ...." Procedure
1. Our facility will report the following events to the appropriate agencies:
i. Injuries of unknown origin;
2. Unusual occurrences shall be reported to appropriate agencies as required by current law and or regulations.
3. A written report detailing the incident actions taken by the facility after the event shall be communicated to the appropriate agencies as required by federal and state regulations.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 607	Continued From page 26	F 607		
	4. Facility administration will keep a copy of written reports on file."			
	On 8/2/18 at 9:35 pm, the administrative team was made aware of the findings as stated above.			
	No further information was provided to the survey team prior to the exit conference on 8/2/18.			
	This is a complaint deficiency.			
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4)	F 609	**F609** **Corrective Action(s):** The Administrator and Director of Nursing who were employed at the time of Resident #322's injury are no longer employed. The investigation, which occurred on 12/12/18, explained how the bruise occurred, albeit not in the timeframes mandated by regulation. A FRI is not warranted at this time. A facility Incident & Accident form has been completed for this incident. **Identification of Deficient Practice(s) and Corrective Action(s):** All other residents may have been affected. The DON and/or designee will review facility skin assessments from the past 2 months to ensure that all areas of injury and/or bruises were properly investigated and reported per the facility Policy & Procedure. Any/all negative findings will result in a proper investigation and reporting at that time.	
	§483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:			
	§483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.			
	§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 5647 STARKEY ROAD, CAVE SPRING, VA 24018

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F 609	Continued From page 27 accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review, and in the course of a complaint investigation, the facility staff failed to report an injury of unknown source to the appropriate agencies for 1 of 45 Residents in the survey sample, Resident # 322. The findings included: A complaint was filed with the Office of Licensure and Certification on 1/4/2018. This complaint was investigated during an unannounced survey that took place onsite at the facility from 7/31/18 through 8/2/18. The complaint was investigated as a closed record. The complainant was contacted on 8/2/18 at 9:00 am. The complainant alleged that Resident # 322 obtained a giant bruise on her left abdomen. Resident # 322 was a 90-year-old-female that was originally admitted to the facility on 11/10/17 with a readmission date of 11/28/17. Diagnoses included but were not limited: chronic obstructive pulmonary disease, sleep disorder, atrial fibrillation, and heart failure. The closed clinical record for Resident # 322 was reviewed on 8/2/18 at 10:52 am. The most recent MDS (minimum data set) was a 14-day assessment with an ARD (assessment reference date) of 12/12/17. Section C of the MDS assesses cognitive patterns. In Section C0500,	F 609	**Systemic Change(s):** The Facility Policy and Procedure has been reviewed and changes are not warranted at this time. The Director of Operations will conduct in-services for all staff, including the Administrator and DON, on the reporting guidelines for abuse, neglect and misappropriations including time lines for reporting incidents. Any future negative findings will result in immediate corrective action. **Monitoring:** The Administrator and DON are responsible for monitoring compliance. The 24-hour report will be reviewed daily to monitor for injuries or bruises of unknown origin. Investigations and reporting of these events will follow reporting guidelines and facility Policy & Procedure. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

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	495421		C 08/02/2018

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F 609	Continued From page 28 the facility staff documented that Resident # 322 had a BIMS (brief interview for mental status) score of 13 out of 15, which indicated that Resident # 322 was cognitively intact. The plan of care for Resident # 322 was reviewed and revised on 12/12/17. The facility staff documented a focus area as "Resident # 322 has the potential for pressure ulcer development related to impaired mobility and occasional incontinence. Per Resident # 322, she has a history of bruising easily and is on Aspirin therapy. She will attempt to complete tasks on her own and has muscle weakness at this time that makes her unsteady." Interventions included but were not limited to: "Provide medications as ordered but monitor for side effects: such as uncontrolled bleeding or discolorations. Consult MD (medical doctor)/ NP (nurse practitioner) if occurs," and "Inform Resident # 322 and her family of any new areas of skin breakdown." The physician signed the orders for Resident # 322 on 12/28/17. Resident # 322 had orders for "Aspirin EC (enteric coated) Tablet Delayed Release 81 MG (milligrams) Give 1 tablet by mouth one time a day for heart health." On 8/2/18 at 11:15 am, the surveyor reviewed the progress notes in the closed clinical record for Resident # 322. There was a note documented on 12/9/17 at 8:36 pm. Documentation states "Rsd (resident) has large bruise on left side = 12 cm (centimeters) x 5cm; smaller bruise 3cm x 2.5 cm. Noticed while dressing rsd this AM. Rsd ambulates in room and to the bathroom without assistance. Denies pain. Bed and chair alarms present and working. RP (responsible party aware. Call bell within reach at all times."	F 609		

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	495421		C 08/02/2018

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F 609 Continued From page 29

F 609

On 8/2/18 at 1:03 pm, the surveyor spoke with the administrator and director of nursing regarding the bruised areas on Resident# 322's abdomen. The surveyor requested to see any reporting and investigations that were completed regarding this issue. The administrator and director of nursing informed the surveyor that this incident occurred prior to both of their employment with the facility however, they would do their best to locate the information.

On 8/2/18 at 1:10 pm, the surveyor reviewed the facility reported incidents that had been submitted by the facility and did not locate a facility reported incident regarding bruises on Resident # 322.

On 8/2/18 at 5:45 pm, the director of nursing provided the surveyor with a progress note from Resident # 322's clinical record that was documented on 12/12/17 at 11:48 am. The progress note states "Notified regarding discoloration to "stomach" area. Upon assessment, I noted approx.. 2-3 cm discoloration to right side of abdomen near the hip area of the abdominal fold. I also noted approx. 5-6 cm discoloration to the left side of the abdomen near hip area of the abdominal fold. Discolorations are dark purple and blue in color with yellowish edges noted. There are no discolorations noted to her back along the waistline or several inches above or below the waist area. I noted in the front of her abdomen area around her waist, along on the abdominal fold there again were no discolorations. I noted that she has a colostomy that is positioned over an area of her left abdomen that protrudes out about the size of a large orange or grapefruit-again there was no discolorations

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	495421		C 08/02/2018

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STREET ADDRESS, CITY, STATE, ZIP CODE
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CAVE SPRING, VA 24018

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F 609	Continued From page 30	F 609		

noted in this area either. Resident had no signs of discomfort when assessing the discolorations and stated did not know they were there. I asked if she possibly knew how they occurred and she stated that she "always bruise easily." She was uncertain of how they happened, expressed that she did not feel it was on purpose, she "may have bumped inti something." I noted in room that she has a shelf next to left hand rail in the bathroom that has her toileting and ostomy supplies on it that is waist level. In her main living area, there is a stationary chair with padding added to the arms- staff reported that was added due to risk of her "bumping into the arm rests." Her wheelchair fits her without much additional room between the armrests to her sides/hip areas. I have contacted therapy to assess to ensure the wheelchair is the appropriate size for her. Staff report that resident will get up on her own related to decreased safety awareness due to dementia dx (diagnosis). Upon review of her medical chart, I noted she is on Aspirin daily and had been on Prednisone when she was first admitted for three days related to respiratory failure, which puts her at risk for discolorations and fragile skin. Will notify daughters of observations."
The director of nursing informed the surveyor that she was unable to locate any additional information regarding the incident of the bruising observed on Resident # 322.

The surveyor reviewed the documentation that was presented by the director of nursing and informed the director of nursing that while the documentation in the clinical record does have an assessment that was conducted on 12/12/17, the incident occurred on 12/9/17 which was 3 days prior to this documentation, therefore if the facility staff was unable to determine the cause of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

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STREET ADDRESS, CITY, STATE, ZIP CODE: 5647 STARKEY ROAD, CAVE SPRING, VA 24018

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F 609	Continued From page 31 bruising at that time this injury of unknown origin should have been reported to the appropriate agencies. According to the facility policy on "Unusual Occurrence Reporting," the policy contains documentation that includes but is not limited to ...." Procedure 1. Our facility will report the following events to the appropriate agencies: i. Injuries of unknown origin; 2. Unusual occurrences shall be reported to appropriate agencies as required by current law and or regulations. 3. A written report detailing the incident actions taken by the facility after the event shall be communicated to the appropriate agencies as required by federal and state regulations. 4. Facility administration will keep a copy of written reports on file." .... On 8/2/18 at 9:35 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team prior to the exit conference on 8/2/18. This is a complaint deficiency.	F 609		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve	F 637	**F637** **Corrective Action(s):** Resident #13 has improved in her ADL performance since 12/16/17 and her current MDS accurately reflects her health status. There is no need for a significant change assessment to be completed at this time. A facility Incident & Accident Form was completed for this incident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
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F 637	Continued From page 32 itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to complete a Significant Change Minimum Data (MDS) assessment for 1 of 45 Residents in the sample survey, Resident #13. The Findings Included: Resident #13 was a 102 year old female who was admitted on 5/17/17 and readmitted on 12/6/17 and 1/1/18. Admitting diagnoses included, but were not limited to: hypertension, chronic obstructive pulmonary disease, major depression, fracture of the neck of the left femur and an acute embolism of the left lower extremity. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly Assessment with an Assessment Reference Date (ARD) of 5/1/18. The facility staff coded that Resident #13 had a Cognitive Summary Score of 11. The facility staff also coded that Resident #13 required set up (1/1) to limited assistance (2/2) with Activities of Daily Living (ADL's). On August 2, 2018 at 9:40 a.m., the surveyor reviewed Resident #13's clinical record. Review of the clinical record produced nursing progress notes that documented that Resident #13 fell on 12/6/17 and was sent to a local hospital. The	F 637	**Identification of Deficient Practices & Corrective Action(s):** All residents who have discharged to the hospital and readmitted back to the facility may have been affected. Patients who have discharged and readmitted back to the facility within the last 60 days will have their charts reviewed to assess if a significant change in health status occurred during their time away from the facility and, if so, if a proper significant change assessment was completed. A facility Incident & Accident Form will be completed for each incident where a significant change assessment should have been completed and wasn't. **Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Director of Clinical Reimbursement has in-serviced the MDS staff on the need to complete a significant change assessment in situations where a patient has discharged from the facility and readmitted and a significant change in health has occurred. **Monitoring:** The Director of Clinical Reimbursement is responsible for compliance. Upon readmission to facility, a detailed review of the patient's health status will occur to determine if a significant change has occurred. If so, a significant change assessment will be completed. Findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

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	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 637	Continued From page 33 nursing progress notes also documented that Resident #13 was being admitted into the hospital for a hip fracture. Continued review of the clinical record produced two Physician Progress Notes. The Physician Progress Notes were dated 12/10/17 and 12/13/17. The Physician Progress note dated 12/10/17 documented "This 102-year-old lady who has been a resident of this facility is readmitted after hospitalization at (name of hospital withheld) on December 6th through 12/09/17, following a fall with acute left femoral fracture. She underwent successful insertion of an intramedullary hip screw and it was noted that her hospital course was complicated by anxiety, agitation and delirium." (sic) Further review of the clinical record produced a Quarterly MDS with an ARD 10/31/17. This MDS was the last MDS completed prior to Resident #13's fall on 12/6/17, hospitalization, hip fracture and surgical intervention to correct the hip fracture. On the Quarterly MDS with the ARD of 10/31/17, the facility staff coded that Resident #13 had a Cognitive Summary Score of 13. The facility staff also coded that Resident #13 was independent (0/0) to requiring limited assistance (2/2) with ADL's. The facility additionally coded that Resident #13 was occasionally incontinent of bladder and was continent of her bowels. Additional review of the clinical record produced a Quarterly MDS with the ARD of 12/16/17. The facility staff coded that Resident #13 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #13 required extensive (3/2) to total nursing care (4/2) with ADL's. The facility additionally coded that Resident #13 was	F 637		

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	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 5647 STARKEY ROAD, CAVE SPRING, VA 24018

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F 637	Continued From page 34 frequently incontinent on bladder and occasionally incontinent of her bowels. On August 2, 2018 at 10 a.m., the surveyor interviewed the MDS Nurse, who was a Licensed Practical Nurse (LPN). The surveyor notified the MDS Nurse that a Significant Change MDS should have been completed on Resident #13's readmission back into the facility on 12/9/17. The surveyor reviewed Resident #13's clinical record with the MDS Nurse. The surveyor pointed out that Resident #13 had a fall on 12/6/17 and was sent to the hospital. The surveyor reviewed the hospital documentation that identified that Resident #13 had a left hip fracture and required a surgical procedure to correct the left hip fracture. The surveyor then reviewed that Resident #13 returned to the facility on 12/9/17. The surveyor reviewed the Quarterly MDS's with the ARD's of 10/31/17 and 12/16/17 side by side with the MDS Nurse. The surveyor pointed out that the Quarterly MDS with the ARD of 12/16/17 should have been a Significant Change MDS as Resident #13 had had a change in all of her ADL's and a change in her bladder and bowel continence. The MDS Nurse did not verbalize that Resident #13's MDS with the ARD of 12/16/17 should have been a Significant Change MDS assessment. However, the MDS Nurse listened intently to what the surveyor was saying and occasionally the MDS Nurse would shake her head up and down, indicating that she agreed with what the surveyor was saying. On August 02, 2018 at 8:34 p.m., the survey team met with the Administrator (Adm), DON, Rehabilitation Director, Rehabilitation Assistant, Staff Coordinator and Housekeeping Director. The surveyor notified the Administrative Team	F 637		

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F 637	Continued From page 35 (AT) that Resident #13 had a fall that resulted with a hip fracture on 12/6/17. The surveyor notified the AT that when Resident #13 was readmitted back into the facility on 12/9/17 the facility staff should have completed a Significant Change MDS, however, the facility staff completed a Quarterly MDS on 12/16/17. No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to complete a Significant Change MDS on Resident #13 after a fall, hospitalization with a hip fracture and a surgical intervention to correct the hip fracture.	F 637		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in	F 657	**F657** **Corrective Action(s):** Resident #61's comprehensive care plan has been reviewed and revised to reflect appropriate fall interventions and approaches to address the resident's specific needs. A facility Incident & Accident Form was completed for this incident. **Identification of Deficient Practices & Corrective Action(s):** All residents who have experienced a fall may have potentially been affected. All residents with falls within the last 60 days will have their care plan reviewed by the Director of Clinical Reimbursement and/or designee to identify residents with inaccurate or incomplete comprehensive care plans. Resident identified with inaccurate or incomplete care plans will have their care plan reviewed and updated to reflect their current interventions and appropriate approaches to address their medical and treatment needs. A facility Incident & Accident Form will be completed for each incident where a care plan should have been revised and wasn't.	

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	495421		C 08/02/2018

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F 657	Continued From page 36 disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure that a care plan was prepared by and interdisciplinary team that consisted of the necessary members and review and revise the plan of care for 1 of 45 residents in the survey sample, Resident # 61. The findings included: The facility staff failed to failed to review and revise the plan of care following a fall for Resident # 61. Resident # 61 was a 53-year-old female who was admitted to the facility on 3/9/17. Diagnoses included but were not limited to: anxiety disorder, muscle wasting and atrophy, depression, and benign neoplasm of the brain. The clinical record for Resident # 61 was reviewed on 8/1/18 at 11:25 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/29/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 61 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicates that Resident # 61 was cognitively intact. Section J1900 of the MDS assesses the number of fall	F 657	**Systemic Changes:** The facility Policy and Procedure has been reviewed and no changes are warranted at this time. The Director of Clinical Reimbursement has in-serviced the MDS department and the IDT on the development, revision and implementation process of individualized care plans. **Monitoring:** The Director of Clinical Reimbursement is responsible for compliance. A daily review of falls will occur to communicate necessary revisions to care plans and an audit will be performed for 3 months to ensure that all falls have appropriate interventions updated on the plan of care. Any/all negative findings will be reported for immediate correction. Findings of the interdisciplinary team's audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

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	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5547 STARKEY ROAD CAVE SPRING, VA 24018

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F 657 Continued From page 37

since admission, entry or reentry or prior scheduled or OBRA assessment. The facility staff documented that Resident #61 had 1 fall with injury since her prior assessment.

On 8/1/18 at 9:23 am, the surveyor conducted an interview with Resident # 61. Resident # 61 expressed to the surveyor that she was upset because she was not able to go outside on the facility property without signing herself out LOA (leave of absence). The surveyor asked Resident # 61 why she had to sign out LOA if she was not actually leaving the facility grounds. Resident # 61 began to explain that she had a fall a few weeks ago and the facility staff wanted her to sign out LOA so they would not be held liable if she fell. Resident # 61 stated that she liked to go outside and sit in her wheelchair on the side of the building so that she could see inside of her room. Resident # 61 explained that on the day of the fall, she made an arrangement with a CNA (certified nursing assistant) to take her outside and that she would come back in 30 minutes to get her to bring her back inside. Resident # 61 stated that she told the CNA that she would use her cell phone to call if she wanted to come in sooner. Resident # 61 explained that she sat outside for a while but she dropped her cell phone and was unable to pick her phone up off the ground. Resident # 61 stated that she rolled up the sidewalk to a window where staff was present but was unable to get anyone's attention. Resident # 61 stated, "I guess I rolled over a rock or something," that she thought that her wheel on her wheelchair went off the sidewalk and her wheelchair tipped over.

The current plan of care for Resident # 61 was reviewed and revised on 7/9/18. The facility staff

F 657

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	495421		C 08/02/2018

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F 657	Continued From page 38	F 657		

documented a focus area for Resident # 61 as "Resident # 61 is a potential risk to have a fall occurrence related to debility and weakness. Resident # 61 has a recent fall with minor injury (abrasions, bruise)." Interventions documented as revised on 7/9/18 are documented as "Encourage Resident # 61 to have a staff member with her at all times when she wishes to go outside." The surveyor reviewed the plan of care entirely and did not locate any fall related interventions that were put into place following the fall on 6/15/18.

According to the facility policy for the "Falls program (Assessment/Documentation/Management)" the policy procedure contains documentation that included but was not limited to ..."13. The resident's care plan will be updated by MDS based on incident and as new individualized interventions are implemented after each fall." ...

On 8/2/18 at 1:45 pm, the surveyor spoke with the director of nursing in the presence of MDS Coordinator # 1 and RN (registered nurse) Supervisor # 1 regarding the updating of the plan of care for Resident # 61. The surveyor asked if it was appropriate to document interventions for a fall that occurred on 6/15/18 on 7/9/18. The director of nursing stated "No."

The administrative team was informed of the findings as stated above on 8/2/18 at 9:35 pm.

No further information regarding this issue was presented to the survey team prior to the exit conference on 8/2/18.

F 658 SS=F Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) — F 658

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F 658	Continued From page 39 §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation it was determined that the facility staff failed to follow Standards of Professional Practice related to medication administration for the facility's residents. The Findings Included: On July 31, 2018 at 2 p.m., the surveyor reviewed a document provided to the survey team about medication administration. The document was labeled, "(name of facility withheld) South Med (medication) Pass Times." The document read: "Our liberalized medication administration program establishes the following primary medication administration times: 1) Early from 5 am to 7 am 2) Morning from 8 am to 11 am 3) Mid-day from 2 pm to 5 pm 4) Evening 6 pm to 10 pm." (sic) During the survey process, the survey team interviewed the residents of the facility. The residents voiced concerns regarding timeliness of medication administration. The residents stated that that the facility had too many agency nurses and that they were often late getting their medications. On August 1, 2018 at 3 p.m., a surveyor had a	F 658	**F658** **Corrective Action(s):** The facility's medication administration program has been adjusted in two key areas. The medication block times have been altered so there is no overlap between time-frames. Further, the facility has worked with the facility's EHR provider to eliminate the time frames before and after each medication block, thereby reducing the time in which medications can be administered in a compliant manner. Adjustments made to the program have been approved by both the Medical Director and licensed Pharmacist, as well as Administration and Nursing. **Identification of Deficient Practices/Corrective Action(s):** All residents in the facility are affected by the facility's medication administration program. The Administrator and/or designee will meet with all residents to discuss the facility's medication administration program, including a dialogue regarding their concerns mentioned during survey. All residents expressing concerns during this meeting will be identified and their medication administration regime reviewed and altered, as appropriate.	

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CAVE SPRING, VA 24018

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F 658	Continued From page 40 Resident Council meeting with seven alert and oriented residents. The residents stated that the facility medication schedule is erratic. The residents stated that sometimes there is only one nurse per hall, and the facility has recently went to a staffing with agency nurses. The residents stated that having the agency nurses takes the personal part out of the medication administration, and that temporary people do not have a routine. The residents also stated that the medication window is too big. The residents stated that it bothers them that they have so many different nurses giving medications at the facility. On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team (AT) of a Complaint that was received in the State Agency regarding timeliness of medications. The survey team notified the AT that the residents stated that their medications were given erratically and that their medications were often late being given. The survey team reviewed the facility document about medication pass times. This surveyor asked for the facility's professional standards for medication administration. The DON and Adm did not acknowledge this surveyors' request for the professional standard for medication administration. The survey team informed the AT that professional standards do not allow the nursing staff a window of 3-4 hours as identified on the medication pass times form. The survey team notified the AT that professional standards only allow 1 hour before or one hour after the scheduled time for the medication administration. The survey team notified the AT that if the medication was administered outside of the two-	F 658	**Systemic Change(s):** The facility policy and procedure has been reviewed and revisions have been made in two areas; the medication block times have been altered so there is no overlap between time-frames and, further, the facility has worked with the facility's EHR provider to eliminate the time frames before and after each medication block, thereby reducing the time in which medications can be administered in a compliant manner. Licensed staff will be in-serviced by the DON and/or designee on these changes to the medication administration program. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will form Medication Review committee which will meet monthly, coinciding with the Quality Assurance meeting, to discuss issues and concerns with the facility's medication administration program. Attendants at this meeting will include nursing leadership, Administration, Pharmacy, Medical Director and at least representative from the resident populations. Aggregate findings of these meetings will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

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F 658	Continued From page 41 hour window, of one hour before or one hour after, then a medication error was made. The survey team informed the AT that professional standards do not allow a three or four hour window for medication administration. The surveyor requested the facility policy and procedure for medication administration. On August 2, 2018 at 10:30 a.m., the survey team met with the Adm, DON, Medical Director and Pharmacist. The survey team spoke to the AT about the facility's liberalized medication administration program. During the meeting the surveyor asked what was the facilities professional standard regarding medication administration. The AT did not answer the surveyors' question. The surveyor requested a professional reference either from the pharmacy or from the DON regarding professional standards related to medication administration. Once again, the AT did not acknowledge the surveyors' request for a professional standard related to medication administration. The AT hand delivered a policy and procedure titled, "Administering Medications." The policy and procedure read in part ... "Purpose: Medications shall be administered in a safe and timely manner, and as prescribed. Procedure: ...6. The individual administering the medication must check the label to verify the right medication, right dosage, right time and right method (route) of administration before giving the medication. " Reference: The institute for Safe Medication Practices (ISMP) - 2. Medications administered more frequently than daily but not more frequently than every 4 hours (e.g., BID, TID, q4h, q6h)	F 658		

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F 658	Continued From page 42 Administer these medications within 1 hour before or after the scheduled time. Current information technology associated with medication use may require vendor updates to: accommodate more than a single time interval to trigger an alert for delayed and early doses with bar-coding technology; change the appearance of a medication entry for delayed doses in electronic medication administration records (eMARs); and set different time limits for the removal of scheduled medications from automated dispensing cabinets. Challenges also exist with highlighting time-critical scheduled medications on eMARs and differentiating between first doses and subsequent scheduled doses when using these technologies. ISMP is aware of these limitations and has been encouraging vendors to address them in updated versions of their technology. No additional information was provided to the survey team prior to exiting the facility as to why the facility failed to follow/have a professional standard related to medication administration. The facility staff were administering the residents their medications outside of the two-hour window. The facility was allowing the facility staff a three to four hour window to administer medications, which was outside of the professional standards of practice related to medication administration. This is a Complaint Deficiency.	F 658		
F 675 SS=D	Quality of Life CFR(s): 483.24 § 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility	F 675	**F675** **Corrective Action(s):** Dining Room A and Dining Room B are now open for residents to enjoy their meals there if they so choose. **Identification of Deficient Practices & Corrective Action(s):** All residents may have potentially been affected. The Dietary Director, RD, and Social Services Director has informed the residents of their right to eat in the location of their choice, whether in their room or in the congregate dining setting.	

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F 675	Continued From page 43 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. This REQUIREMENT is not met as evidenced by: Based on Resident interview, group interview, and staff interview, the facility staff failed to promote and enhance the quality of life of the Residents by restricting their use of the common area dining room(s). The finding included. The facility did not provide dining services in the dining room on weekends or for the breakfast meal. On 08/01/18 at 3:00 p.m., a group meeting was held with seven alert and orientated Residents of the facility. During this meeting, the Residents stated that the dining room was not available for all meals. On 08/01/18 at 4:15 p.m., the concerns of the group regarding the use of the dining room for meals was shared with the DON (director of nursing) and administrator. The administrative staff stated they (the facility) did not offer the dining area on the weekends (Saturday/Sunday), Monday-Friday dining room service was not offered for breakfast, and the evening meal was offered in dining room A. When asked why the administrator stated that they had lost their dietary manager and had just employed a new one and they had consolidated in the evening	F 675	**Systemic Changes:** Dining Room A and Dining Room B are open for residents who wish to eat their meals in those locations. All staff have been in-serviced that residents have the right to eat in their private room or in the congregate dining setting at their discretion. A sign has been posted outside both Dining Room A and B to inform the residents that this is option is available to them. **Monitoring:** The Dietary Director is responsible for compliance The Dietary Director and/or designee will conduct weekly interviews with 5 patients over the next 3 months to ensure that they feel they are able to enjoy their meals in the location of their choosing. Any/all negative findings will be corrected at the time of discovery and forwarded to the QA committee for further review of the dining processes of the facility. **Completion Date:** September 16, 2018	

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F 675 Continued From page 44 F 675

because not a lot of Residents were showing up.

On 08/01/18 at 6:15 p.m., nine Residents were observed eating in the dining area.

Interviews-

08/01/18 6:07 p.m., CNA (certified nursing assistant) #2 stated the facility does not serve in the dining room on weekends.
08/01/18 6:11 p.m., interview with Dietary person #2. When asked why the dining room was not used on weekends/breakfast. He stated maybe staffing issues, sometimes the Residents do not come out for meals, and for breakfast, the Residents did not come out that early.
08/02/18 7:20 a.m., CNA #3 stated the dining room was just used Monday-Friday. She then stated I think some people would do better using it.
08/02/18 7:25 a.m., Group participant #1-When asked if she would go to the dining room to eat she stated "It's a nice outing-I enjoy it."
08/02/18 9:00 a.m., Group participant #2 stated she would go to the dining room especially on the weekends. She stated the weekends were sort of "blah." She then stated I think I would enjoy that probably several people would if it was offered.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 677 ADL Care Provided for Dependent Residents F 677
SS=D CFR(s): 483.24(a)(2)

§483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 5647 STARKEY ROAD, CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 45 personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review it was determined that the facility staff failed to provide fingernail care 2 of 45 Residents in the sample survey who were dependent on staff for Activities of Daily Living (ADL's), Resident #56 and Resident #86. The Findings Included: 1. Resident #56 was a 64 year old female who was originally admitted on 1/6/18 and readmitted on 7/17/18. Admitting diagnoses included, but were not limited to: polycystic kidney, kidney transplant, diabetes mellitus, hemiplegia and hemiparesis following a cerebral infarction, dysphasia due to cerebral infarction and a gastrostomy tube. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 6/27/18. The facility staff coded that Resident #56 Cognitive Summary Score was "99." The facility staff also coded that Resident #56 required extensive (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL's). The facility staff coded that Resident #56 required total nursing care (4/2) with personal care. On July 31, 2018 at 11:47 a.m., the surveyor observed Resident #56 lying in bed. The surveyor observed that Resident #56's fingernails were long. Resident #56's fingernails also had a brownish debris under the free edge of the fingernails.	F 677	**F677** **Corrective Action(s):** Resident #56 had her fingernails cleaned and cut appropriately on the afternoon of 8/1/18. Resident #86 has had her fingernails cleaned and her facial hair tended to appropriately. The C.N.A.'s who were assigned to these patients have been appropriately educated. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have potentially been affected. The DON and/or designee has completed an audit on all residents to ensure that fingernails are cut and cleaned appropriately and that proper grooming has occurred. Any/all negative findings discovered during the audit will be corrected at time of discovery. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The DON and/or designee will provide an in-service training to the CNA's to address the importance of providing proper grooming, to include fingernail care and facial grooming, to all residents.	

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F 677	Continued From page 46 On August 1, 2018 at 8:30 a.m., the surveyor observed Resident #56 lying in bed. The surveyor observed that Resident #56's fingernails were long and had a brownish debris under the free edge of the fingernail. On August 1, 2018 at 1:45 p.m., the surveyor observed a Registered Nurse (RN) walking down the hallway. The surveyor stopped the RN and asked the RN is she could accompany the surveyor into Resident #56's room. The RN stated she was headed to lunch and was not assigned to provide care to any of the residents on the unit. The RN set her lunch down and accompanied the surveyor into Resident #56's room. The surveyor pointed out that Resident #56's fingernails were long and dirty. The RN stated, "I can see that." The RN stated she would get someone to come and provide fingernail care to Resident #56. On August 1, 2018 at 2:55 p.m., the surveyor notified the Director of Nursing (DON) that Resident #56's fingernails were long and dirty. The DON stated, "They are taking care of that now." On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #56's fingernails were long and dirty. The surveyor notified the AT that Resident #56 had a brownish debris under the free edge of the fingernail and was dependent on staff for fingernail care. No additional information was provided prior to exiting the facility as to why the facility staff failed to provide fingernail care to Resident #56, who	F 677	**Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will perform grooming audits weekly on coinciding with the care plan calendar to insure that proper grooming, including fingernail care and facial grooming, has occurred for specific residents. Any/all negative findings will be reported to the DON for immediate correction. Detailed findings of these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for changes in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
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F 677	Continued From page 47	F 677		

was dependent on staff for fingernail care.
2. The facility staff failed to shave and clean fingernails for Resident # 86.

Resident # 86 was a 77-year-old-female who was originally admitted to the facility on 10/3/16 with a readmission date of 3/19/18. Diagnoses included but were not limited to: dysphagia, hypertension, type 2 diabetes mellitus, and obstructive sleep apnea.

The clinical record for Resident # 86 was reviewed on 8/1/18 at 11:24 am. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 7/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 86 had a BIMS (brief interview for mental status) of 15 out of 15, which indicated that Resident # 86 was cognitively intact. Section G assesses functional status. In Section G0110, the facility staff documented that Resident # 86 requires extensive assistance of two or more persons providing physical assistance with personal hygiene and bathing.

The current plan of care for Resident # 86 was reviewed and revised on 7/23/18. The facility staff documented a focus area as "Resident # 86 has a self-care deficit in performing ADL's (activities of daily living) r/t (related to) deconditioning, hemiplegia, limited mobility, nonambulatory status. She requires extensive to total assist with all ADL's except meals where she is independent with set up assistance needed. Although Resident # 84 prefers to stay in bed most of the time, she does rarely ask to get up and sit in her Broda chair in her room or the lounge in front of

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	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

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F 677	Continued From page 48 the nurse's station. At times, she will ask to be up in her chair, and then refuse when staff goes in to get her up." Interventions for this focus area included but were not limited to: "Personal hygiene/oral care: I require staff extensive assistance to complete personal hygiene and oral care." On 7/31/18 at 3:15 pm, the surveyor observed Resident # 86 lying in bed dressed in a hospital gown. The surveyor observed grey and black facial hair on Resident # 86's chin. The surveyor asked Resident #86 if the facial hair on her chin bothers her. Resident #86 stated, "Yes it does." Resident # 86 then stated that the facility does not shave her that her daughter does it when she comes. The surveyor observed brown debris observed underneath Resident # 86's fingernails. On 8/1/18 at 8:37 am, the surveyor observed Resident # 86 lying in bed on dressed in a hospital gown. The surveyor observed grey and black facial hair on Resident # 86's chin and brown debris underneath fingernails. On 8/01/18 at 12:13 pm, the surveyor went in to speak with Resident #86 and her daughter who was in to visit. Surveyor observed that the facial hair that was previously observed was gone from Resident # 86's chin. The surveyor asked Resident # 86 if staff shaved her. Resident # 86 stated that she had gotten a bath last night but staff did not shave her and, "They didn't do my nails, my daughter shaved me." Resident # 86's daughter verified that she shaved her mom when she came in to visit. The surveyor observed brown debris underneath Resident # 86's fingernails.	F 677		

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	495421		C 08/02/2018

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F 677	Continued From page 49 The surveyor reviewed the facility new orientation checklist and competency evaluation checklist for certified nursing assistants. Tasks that must be evaluated and checked off by an evaluator includes but is not limited to ..." "Shaving (male & female), Nail care (Trimming and cleaning where appropriate)." ... On 8/1/18 at 5:35 pm, the administrative team was made aware of the findings as stated above. No further information was provided to the survey team regarding this issue prior to the exit conference on 8/2/18.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review and in the course of a complaint investigation it was determined that the facility staff failed to follow physician orders for 11 of 45 Residents in the sample survey, Resident #36, Resident #54, Resident #55, Resident #66, Resident #67, Resident #110, Resident #12, Resident # 61, Resident #86, Resident #94 and Resident #317. The Findings Included:	F 684	**F684** **Corrective Action(s):** Residents #36's attending physician was notified that the facility failed to administer Tylenol 325mg medication and assess for pain as ordered by the attending physician. A facility Medication Error form was completed for this incident. Resident #54's attending physician was notified that the facility staff failed to administer Ativan medication as ordered by the physician, failed to apply ace wraps to BLE as ordered by the physicians, failed to apply skin repair cream to BLE Q day as ordered by the physician, and failed to cleanse the left 4th and right 5th toes with normal saline and treatment as ordered by the physician. A facility Medication Error form was completed for this incident. Residents #55's attending physician was notified that the facility failed to administer Lasix as ordered by the physician. A facility Medication Error form was completed for this incident.	

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	495421		C 08/02/2018

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F 684	Continued From page 50 1. Resident #36 the facility staff failed to follow physician orders for Tylenol 325 mg every six hours and to assess for pain assessments every shift. Resident #36 was an 84-year-old female who was admitted on 5/24/16. Admitting diagnoses included, but were not limited to: celiac disease, osteoporosis, hypertension, anxiety, ulcerative colitis and cerebral infarct. The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 6/2/18. The facility staff coded that Resident #36 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #36 required set up assistance (1/1) to extensive assistance (3/2) with Activities of Daily Living (ADL's). On July 31, 2018 at 12 noon, the surveyor spoke to Resident #36 regarding her complaint that was received in the State Agency on 5/30/18. Resident #36's allegation was that she is not getting her medications as ordered by the physician. Resident #36 stated that the facility staff are bring in her medicines late, the facility staff are bring in her afternoon pills with her supper medications and night time medications all at one time. Resident #36 stated that the facility staff are making medication errors with her medications. Resident #36 showed the surveyor a picture taken on 7/23/18 at 8:53 p.m. Resident #36 stated that she had separated the pills into three different sections to identify what time they were supposed to be given. The picture displayed 10 medications on her over the bed table.	F 684	Resident #66's attending physician was notified that the facility failed to monitor for bruising Q shift as ordered by the physician, failed to apply Neutral-shield to the buttocks as ordered by the physician, failed to obtain vital signs Q shift as ordered by the physician, and failed to apply Diclofenac to the knees QID as ordered by the physician. A facility Medication Error form was completed for this incident. Resident #67's attending physician was notified that the facility failed to apply TED hose as ordered by the physician. A facility Medication Error form was completed for this incident. Resident #110's attending physician was notified that the facility failed to obtain vital signs Q shift as ordered by the physician. A facility Medication Error form was completed for this incident. Resident #12's attending physician was notified that the facility failed to administer Effexor ER as ordered by the physician. A facility Medication Error form was completed for this incident. Resident #317's attending physician was notified that the facility failed to administer IV Vancomycin timely as	

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	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER
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STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 51 Resident #36 stated that she thought that the staff had made a medication error with her medications on 7/23/18 as her Tylenol 325 mg pills were round and on 7/23/18 the facility staff brought in 2 oblong Tylenol. Resident #36 stated she thought the Tylenol were 500mg tablets. Resident #36 stated she did not take the medications because she knew it was not what the physician had ordered. On July 31, 2018 at 1:29 p.m., the surveyor entered Resident #36's room and observed the local Ombudsman sitting at Resident #36's bedside. The Ombudsman stated that she had had several meeting with the Administration about Resident #36's concerns about her medications. Resident #36 stated that when the Ombudsman and she, Resident #36, had met with the Administration and things would get better for a day or so and then things would go back to how they were before she made the complaint. On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team of Resident #36's Complaint. The Adm stated that Resident #36 had made multiple complaints to the facility regarding the timeliness of medications. The Adm stated that the local Ombudsman had been involved with Resident #36's complaints and that the facility had done an investigation. The surveyor requested to see the facility investigation. On August 2, 2018 at 8 a.m., the surveyor reviewed Resident #36's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Tylenol 325mg (Acetaminophen) Give 2 tablet by	F 684	ordered by the physician. A facility Medication Error form was completed for this incident. Resident #61's attending physician was notified that the facility failed to administer multiple medications timely as ordered by the physician. A facility Medication Error form was completed for these incidents. Resident #94's attending physician was notified that the facility failed to administer Oxygen per the physician ordered rate. A facility Medication Error form was completed for this incident. Resident #86's attending physician was notified that the facility failed to maintain the head of the bed at 90 degrees during meals and failed to administer medications timely per the physician orders. A facility Medication Error form was completed for these incidents.	

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F 684	Continued From page 52 mouth every 6 hours as needed for Pain. Pain assessment q (every) shift for pain assessment." (sic) Continued review of the clinical record produced the July 2018 Medication Administration Records (MAR's). The July2018 MAR's failed to document that the facility staff assessed Resident #36 for pain on 7/5/18 on the day shift. On August 2, 2018 at 8:30 a.m., the Adm hand delivered the facility's investigation into Resident #36's ongoing concerns about her medication admiration. Review of the facility investigation documented a medication error related to the 7/23/18 Tylenol 500mg provided by the pharmacy. The investigation also included emails between the Adm and Resident #36's responsible party on 6/5/18, 6/14/18, 6/15/18, 7/25/18, 7/27/18, 7/28/18, 7/30/18, 7/31/18 and 8/1/18. On August 2, 2018 at 10:30 a.m., the surveyor met with the Adm, DON, Medical Director and Pharmacist. The survey team spoke to the Administrative Team (AT) about the facility's liberalized medication administration medication administration program. During the meeting, the Adm acknowledged that two medication errors were made on 7/23/18. The Adm stated that the pharmacy had sent the incorrect dosage of Tylenol. The Adm stated that Resident #36 was supposed to get Tylenol 325 mg and that the pharmacy had sent Tylenol 500mg tablets. The Adm stated that this has been an ongoing issue and that the AT has met with the Ombudsman and has been trying to resolve this issue. No additional information was provided to the survey team prior to exiting the facility as to why	F 684	**Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's over the past 30 days to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure has been reviewed and revisions have been made in two areas; the medication block times have been altered so there is no overlap between time-frames and, further, the facility has worked with the facility's EHR provider to eliminate the time frames before and after each medication block, thereby reducing the time in which medications can be administered in a compliant manner. Licensed staff will be in-serviced by the DON and/or designee on these changes to the medication administration program. The DON and/or designee will also in-service all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 5647 STARKEY ROAD, CAVE SPRING, VA 24018

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F 684	Continued From page 53 the facility staff failed to ensure that Resident #36's Tylenol 325mg was available for administration on 7/23/18. This is a Complaint Deficiency. 2. For Resident #54 the facility staff follow physician orders for the Ativan 1 mg every eight hours, ace wraps to bilateral lower extremities every day, applying skin repair cream to bilateral lower legs every day, cleansing the left 4th and right 5th toes with normal saline and treatment with dressing or ointments, Resident #54 was a 63-year-old male who was admitted on 7/10/17 and readmitted on 5/16/18. Admitting diagnoses included, but were not limited to: chronic obstructive pulmonary disease, hypertensive heart and chronic kidney disease with heart failure and stage 1 through stage 4 chronic kidney disease, diabetes mellitus and pneumonia. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/20/18. The facility staff coded that Resident #54 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #54 was independent with Activities of Daily Living (ADL's). On August 2, 2018 at 7:40 a.m., the surveyor reviewed Resident #54's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "ACE wraps to BLE (bilateral lower extremities) daily (2X 3in ea leg) (2 3inch wraps each leg) one time a day for Edema. Apply skin repair cream to	F 684	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly MAR/TAR and chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

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F 684 Continued From page 54

F 684

BLE prior to applying Tubi grips one time a day for dry skin. Cleansed Left 4th toe with NSS (normal saline solution), Pat Dry, Apply TAO (triple antibiotic ointment), cover with dry dressing QD (every day for protection, one time a day for protection. Cleanse R (right) lateral metatarsal with NS (normal saline), pat dry. Apply Aquacel AG into wound bed, cover with Metiplex 4 X4. Change Daily. Every day shift.

Continued review of the clinical record produced the July 2018 Treatment Administration Record (TAR). Review of the July 2018 TAR failed to document that the facility staff applied the physician ordered ACE wraps on 7/21/18 and on 7/30/18. The TAR's also failed to document that the physician ordered skin repair cream was applied on 7/15/18, 7/21/18 and 7/30/18. The July 2018 TAR's did not document that the facility staff cleansed the left 4th toe and provided the physician ordered treatment on 7/17/18, 7/25/18 and 7/26/18. The July 2018 also failed to document that the facility staff provided the treatment to the right 5th toe 7/5/18 and 7/16/18

August 2, 2018 at 8:36 a.m., the surveyor notified the Director of Nursing (DON) that the surveyor had reviewed Resident #54's clinical record. The surveyor notified the DON that the facility staff had not provided physician ordered treatments on the July 2018 TAR's. The surveyor and DON reviewed the clinical record to include the physician orders and the July 2018 TAR's. The surveyor pointed out that the facility staff had not provided the physician ordered treatments.

On August 02, 2018 at 8:34 p.m., the survey team met with the Administrator (Adm), DON, Rehabilitation Director, Rehabilitation Assistant,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 55

F 684

Staff Coordinator and Housekeeping Director. The surveyor notified the Administrative Team (AT) that the facility staff had not followed physician orders for Resident #54. The surveyor notified the AT that Resident #54's July 2018 TAR's failed to document that the facility staff provided physician ordered treatments.

No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to follow physician orders for Resident #54..

3. For Resident #55 the facility staff failed to follow physician orders for Lasix 40 mg every day for 7 days.

Resident #55 was a 96-year-old female who was admitted on 5/29/18. Admitting diagnoses included, but were not limited to: fall, benign neoplasm of meninges, bilateral osteoarthritis of knee and cognitive communication deficit.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 6/26/18. The facility staff coded that Resident #55 had a Cognitive Summary Score of 14. The facility staff coded that Resident #55 required set up assistance (1/1) to extensive assistance (3/3) with Activities of Daily Living (ADL's).

On August 1, 2018 at 3:26 p.m., the surveyor reviewed the clinical record. Review of the clinical record produced a physician order for Lasix 40 mg for 7 days.

Continued review of the clinical record failed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 56

F 684

produce the July 2018 Medication Administration Record (MAR's). Review of the July 2018 MAR's documented that the facility staff failed to administer the Lasix 40mg for 7 days. The July 2018 MAR's documented that the facility staff only administered the Lasix 40mg for one day on July 19, 2018.

On August 1, 2018 at 4:34 p.m., the surveyor notified the Director of Nursing (DON) that Resident #55 had a physician order for Lasix 40 mg for 7 days. The surveyor notified the DON that the facility staff only administered the Lasix 40 mg for one administration on 7/19/18.

On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #55 had a physician order for Lasix 40 mg for 7 days. The surveyor notified the AT that the facility staff had only administered the Lasix 40mg once, on 7/19/18.

On August 2, 2018 at 7:30 a.m., the DON hand delivered a medication error form that documented that the facility staff had administered the physician ordered Lasix for 7 days, and that the surveyor had identified the medication error.

No additional information was provided prior to exiting the facility as to why the facility staff failed to follow the physicians' order for Lasix 40 mg for 7 days for Resident #55.

4. For Resident #66 the facility staff failed to follow physician orders to monitor for bruising every shift, apply Neutral-shield to buttocks and sacrum every shift, obtain vital signs every shift

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 57 and apply Diclofenac to knees four times a day. Resident #66 was an 85-year-old female who was admitted on 2/3/18. Admitting diagnoses included, but were not limited to: atrial fibrillation, atherosclerotic heart disease, dementia without behaviors, hypertension, osteoarthritis and cognitive communication deficit. The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/26/18. The facility staff coded that Resident #66 had a Cognitive Summary Score of 14. The facility staff coded that Resident #66 was independent (0/0) to set up assistance (1/1) with Activities of Daily Living (ADL's). On August 1, 2018 at 10:20 a.m., the surveyor reviewed Resident #66's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Monitor/Observe any/all bruises Q day (every day) until resolved every shift. Vital Signs qshift every shift Ensure Vitals have been documented. Diclofenac Sodium Gel 1% Apply 4 gram transdermally four times a day for Pain Apply to both knees. Neutrashield cream Apply to buttocks & sacrum topically every shift for skin integrity. Neutrashield barrier creamto buttocks and sacrum Q (every) shift." (sic) Continued review of the clinical record produced the July 2018 Vital Signs Record (VSR) and Treatment Administration Records (TAR's). Review of the July 2018 VSR and TAR's failed to document that the facility staff obtained the physician ordered vital signs every shift on 7/5/18	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 58

on the day shift, on 7/23/18 on the night shift and on 7/26/18 on the day shift.

The July 2018 TAR's also failed to document that the facility staff applied the physician ordered Diclofenac to Resident #66's knees on 7/2/18 on the am medication pass and the evening medication pass, on 7/5/18 on the am medication pass, on 7/24/18 on the early medication pass time and on 7/26/18 on the am medication pass.

The July 2018 TAR's also failed to document that the facility staff monitored Resident #66 for bruises on 7/2/18 on the evening shift, on 7/5/18 on the day shift and on 7/26/1 on the day shift.

The July 2018 TAR's also failed to document that the facility staff failed to apply the physician ordered Neutra-shield cream to Resident #66's buttocks and sacrum on 7/2/18 on the evening shift, on 7/5/18 on the day shift and on 7/26/18 on the day shift.

On August 1, 2018 at 12 noon, the surveyor notified a Registered Nurse (RN), that Resident #66 had a physician orders for monitor for bruising, applying Neutra-shield cream to buttock and sacrum, obtaining the vital signs every shift and applying Diclofenac to Resident #66's knees four times a day. The surveyor notified the RN that review of the VSR and July 2018 TAR's failed to document that the facility staff had followed the physician orders for Resident #66. The surveyor reviewed the clinical record with the RN and reviewed the physician orders, July 2018 VSR and TAR's.

On August 1, 2018 at 4:38 p.m., the survey ream met with the Administrator (ADM) and DON. The

F 684

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 59	F 684		

surveyor notified the Administrative Team (AT) that the facility staff failed to follow physician orders for Resident #66. The facility staff failed to obtain vital signs every shift, failed to apply neutral-shield and Diclofenac and failed to monitor for bruising.

No additional information was provided prior to exiting the facility as to why the facility staff failed to follow physician orders for Resident #66.

5. For Resident #67 the facility staff failed to apply physician ordered TED hose.

Resident #67 was a 60 year old male who was admitted on 6/20/17. Admitting diagnoses included, but were not limited to: multiple sclerosis, chronic lymphocyte leukemia of B-cell type, chronic diastolic heart failure and benign prostatic hyperplasia.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 6/28/18. The facility staff coded that Resident #67 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #67 was independent (0/0) to required extensive assistance (3/2) with Activities of Daily Living (ADL's).

On August 1, 2018 at 2:10 p.m., the surveyor reviewed Resident #67's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "TED hose as resident allows. ON in AM, Off at HS (bedtime) Rinse &dry and perform skin check for skin integrity one time a day place on in am. TED hose as resident allows. ON in AM, Off at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 60

HS (bedtime) Rinse &dry and perform skin check for skin integrity one time a day Take off in PM." (sic)

Further review of the clinical record produced the July 2018 Treatment Administration Records (TAR's). Review of the July 2018 TAR's failed to document that the physician ordered TED hose were applied as ordered by the physician.

On August 1, 2018 at 2:35 p.m., the surveyor notified the Director of Nursing (DON) that Resident #67 had physician order for TED hose to be applied in the morning and taken off at night. The surveyor notified the DON that review of the July 2018 TAR's failed to document that the facility staff followed the physician order to apply the TED hose in the a.m. and to remove in p.m. The surveyor reviewed Resident #67's clinical record with the DON. The surveyor reviewed the physician orders and the July 2018 TAR's. The surveyor pointed out that the facility staff had not documented the application of the physician ordered TED hose on multiple occurrences.

On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that the facility staff failed to apply the physician ordered TED hose to Resident #67 on multiple occurrences in July 2018.

No additional information was provided prior to exiting the facility as to why the facility staff failed to follow physician orders on Resident #67. The facility staff failed to apply the physician ordered TED hose on Resident #67.

6. For Resident #110 the facility staff failed to

F 684

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 61 follow physician orders to obtain vital signs every shift.	F 684		

Resident #110 was a 92-year-old female who was admitted on 7/13/18. Admitting diagnoses included, but were not limited to: asthma, hypertension, atrial fibrillation, depression, dementia without behaviors,

No Minimum Data Set (MDS) assessment was available due to Resident #110's recent admission.

On July 31, 2018 at 3:20 p.m., the surveyor reviewed Resident #110's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to the following: "Vital Signs QShift (every shift) for Vital Signs were Obtained and verified by Nurse." (sic)

Continued review of the clinical record produced the July 2018 Treatment Administration Records (TAR's). Review of the July 2018 TAR's did not document that the facility followed the physician order to obtain Resident #110's vital signs every shift. The July 2018 TAR's did not document that the vital signs were obtained on: 7/19/18 on the evening shift, of 7/26/18 on the day shift and on 7/31/18 on the night shift.

On July 31, 2018 at 3:45 p.m., the surveyor notified a Registered Nurse (RN) that Resident #110 had a physician order to obtain vital signs every shift. The surveyor notified the RN that review of the July 2018 TAR's failed to document that the facility staff had obtained the physician ordered vital signs every shift. The surveyor reviewed Resident #110's clinical record with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 62

F 684

RN. The surveyor reviewed the physician orders and the July 2018 TAR's. The RN was unable to locate the vital signs for the missing time frames listed above.

On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #110 had a physician order for the facility staff to obtain vital signs every shift. The surveyor notified the AT that review of Resident #110's clinical record failed to produce documentation that the facility staff obtained the physician ordered vital signs on several instances in July 2018.

No additional information was provided prior to exiting the facility as to why the facility staff failed to follow a physician order to obtain vital signs every shift for Resident #110.

7. For Resident #12, facility staff failed to ensure physician orders for an antidepressant medication resulting in the resident receiving a higher dose than ordered.

Resident #12 was admitted to the facility on 7/14/17. Diagnoses included diabetes mellitus with neuropathy, insulin use, hypertensive heart disease with heart failure, peripheral venous insufficiency, and depression. On the quarterly minimum data set assessment with assessment reference date 4/30/18, the resident scored 13/15 on the brief interview for mental status and was assessed as without delirium, psychosis, or behaviors affecting others. The resident scored 1/37 on the mood assessment (higher scores indicate greater presence of depressive symptoms).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 63	F 684		

During clinical record review, the surveyor noted a physician order dated 6/14/18 for Effexor XR 24 hour 75 mg (milligram) (venlafaxine hydrochloride extended release) Give 1 capsule PO (by mouth) QD (daily) for 7 days then increase dose to 150 mg PO QD, with start date 6/15/18 0800 and discontinue date 7/5/18 1111. The MAR (medication administration record) documented the medication was administered daily 6/15 through 7/3, or 19 days. Another physician order dated 6/14/18 with start date 6/22/18 for Effexor XR 24 hour 150 mg (milligram) (venlafaxine hydrochloride extended release) Give 1 capsule PO (by mouth) QD (daily). The MAR indicated the resident received a 150 mg capsule daily 6/22 through 8/2 (the date of the survey). Staff administered 225 mg of Effexor ER from 6/22 through 7/3.

The surveyor reported the concern to the director of nursing and administrator during a summary meeting on 8/2/18.
8. The facility staff failed to administer physician ordered IV Vancomycin at the appropriate time for Resident # 317.

Resident # 317 was a 77-year-old-male who was admitted to the facility on 7/20/18. Diagnoses included but were not limited to: MRSA (Methicillin-resistant Staphylococcus aureus), atrial fibrillation, hypertension, and coronary artery disease.
The clinical record for Resident # 317 was reviewed on 8/1/18. At the time of the survey there was no completed MDS (minimum data set) assessment.

The interim plan of care for Resident # 317 was reviewed and revised on 7/27/18. The facility staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 64	F 684		

documented MRSA in the focus are for infection alert. Interventions include but are not limited to: ..."(handwritten) Vanco. (Vancomycin) IV (intravenously)/Labs as ordered.

Resident # 317 has current orders that were signed by the physician on 8/1/18 for "Vancomycin HCL Solution Reconstituted 1000mg (milligrams) intravenously every 12 hours for MRSA Run it over 2 hours in 250 ml bag. Resident # 317 has had orders for Vancomycin IV since admission. Upon admission to the facility on 7/20/18, Resident # 317's orders were "Vancomycin HCL solution Reconstituted 750 mg intravenously every 12 hours for MRSA for 6 weeks 750 mg in 250 ml of Normal Saline to be administered over 1 hour." The medication administration record reflected that Resident # 317 was to receive his IV Vancomycin at 9:00 am and 9:00 pm.

On 8/1/18 at 3:23 pm, the surveyor observed Resident # 317 while in his room. The surveyor observed a single lumen PICC line in Resident # 317's right upper arm. Resident # 317 informed the surveyor that he has to take antibiotics through his IV every 12 hours.
Upon review of the medication administration record for Resident # 317, the surveyor observed the following dates and times were out of compliance for medication administration of IV Vancomycin as ordered by the physician

7/20/18 ordered at 9:00 pm, administered at 11:51 pm
7/22/18 ordered at 9:00 am, administered at 10:11 am
7/27/18 ordered at 9:00 am, administered at 10:08 am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 65	F 684		

7/27/18 ordered at 9:00 pm, administered at 10:46 pm
7/29/18 ordered at 9:00 am, administered at 10:17 am
7/29/18 ordered at 9:00 pm, administered at 11:12 pm
7/30/18 ordered at 9:00 pm, administered at 10:39 pm
8/1/18 ordered at 9:00 pm, administered at 10:35 pm.

On 8/2/18 at 10:35 am, the survey team met with the administrator director of nursing, pharmacist, and the medical director regarding the issues with the medication administration times. The director of nursing provided the survey team with a typed packet dated 1/4/16, which she stated is the facility "liberalized medication policy." The packet contains information that includes but is not limited to ..."Our liberalized medication administration program establishes the following medication administration times:

1) Early from 5 am to 7 am
2) Morning from 8 am to 11 am
3) Mid-day from 2 pm to 5 pm
4) Evening from 6 pm to 10 pm

The survey team expressed concerns about resident safety with the current facility practice and the way medications were being administered and requested to see a standard of practice that the liberalized medication pass was based on. The director of nursing stated that the standard of practice was the liberalized medication administration policy. The pharmacist spoke of studies that have been conducted and referenced a research article that had been included with the packet that was presented to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 66

F 684

the survey team and assured the team that the way that medications were being administered within the facility is safe. The pharmacist stated that if there are medications that the physician write specific time parameters to be given the facility can put and actual time into the computer program. The director of nursing then stated that the nurses would be held to the 1 hour before and 1 hour afterward standard of practice for administering medications in these cases.

Within the packet that was presented to the survey team along with the typed letter with the liberalized medication administration times was the facility policy on "Administering Medications" policy date is 1/2017. Printed on the policy is "Supersedes all prior policies." The "Purpose" of the policy states, "Medications shall be administered in a safe and timely manner and as prescribed." The procedure contained documentation that included but was not limited to ..." 6. The individual administering the medication must check the label to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication.

On 8/2/18 at 9:35 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 8/2/18.

9. The facility staff failed to administer medications to Resident # 61 during the physician ordered times.

Resident # 61 was a 53-year-old female who was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 67

admitted to the facility on 3/9/17. Diagnoses included but were not limited to: anxiety disorder, muscle wasting and atrophy, depression, and benign neoplasm of the brain.

The clinical record for Resident # 61 was reviewed on 8/1/18 at 11:25 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/29/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 61 had a BIMS score of 15 out of 15, which indicates that Resident # 61 was cognitively intact.

The current plan of care for Resident # 61 was reviewed and revised on 7/30/18. The facility staff documented a focus area as "Resident # 61 has the potential for chronic pain r/t (related to) spasticity and impaired mobility. She needs muscle spasm meds H.S, (hour of sleep) TID (3 times daily), nerve pain meds TID (three times daily), PRN (as needed) pain meds (Oxycodone) She has schedule for baclofen pump to be placed 7/30/18." Interventions included but were not limited to, "Anticipate Resident # 61's need for pain relief and respond immediately to any complaint of pain," and "Administer analgesia as per orders. Give ½ hour before treatments or care prn."

On 8/1/18 at 9:23 am, the surveyor conducted an interview with Resident # 61. During the interview Resident # 61 stated, "They don't get my medicines to me in time." A few weeks ago on a Saturday I get medicines at 9, 1, 5, and bedtime." I went to the nurse's station at 7:49 and said I need my pills (employee's name withheld) I said I can't leave without my pills, it was after 8 o'clock

F 684

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 68

F 684

before I got my 5 o'clock pills and I had to demand them."

The surveyor reviewed the progress noted for Resident # 61. The facility staff documented in the progress notes a late entry on 6/30/18 at 8:15 pm. The surveyor reviewed a calendar and 6/30/18 was on a Saturday. The progress note documented in Resident # 61's clinical record stated, " Rsd (resident) has displayed inappropriate behaviors (yelling, cursing at staff in hallway, calling nurses station cursing at staff with demands when her needs are not met immediately when she requests assistance. Rsd informed calmly via telephone after receiving her phone call that staff was attending to an emergency on floor with 3 other residents and she would be assisted as soon as possible. States, "I don't care, I have to have my medication for muscle spasms on a timely basis." Again explained to rsd that staff would attend to her needs quickly after attending to emergency needs. Rsd called nurses station approximately 5 minutes later stating, "I know someone died, they died because they were not being taken care of." Rsd then proceeded to come to the nurse's station and wait at desk yelling for staff to help her. Rsd was propelled in w/c (wheelchair) by staff to rsd room to assist her in care and nurse provided her requested medication."

The surveyor reviewed the facility medication administration audit report for Resident # 61 from 6/30/18. The following medications were not administered at the appropriate time as per physician's orders:

Xarelto Tablet 20 mg Give 1 tablet by mouth every 24 hours for anticoagulant with dinner-

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

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F 684	Continued From page 69 scheduled time 5:00 pm, time administered 7:45 pm Baclofen Tablet Give 20 mg by mouth every 24 hours for muscle spasms @ (at) 5pm- scheduled time 5:00 pm, time administered 7:48 pm Gabapentin Tablet 600 mg Give 1 tablet by mouth three times a day for pain - scheduled time 6:00 pm, time administered 7:74 pm Baclofen Tablet 10 mg Give 1 Tablet by mouth every 24 hours for muscle spasms/stiffness @ 9pm total dose 30 mg per neurology-scheduled time 9:00 pm, time administered 7/1/18 at 12:42 am. Baclofen Tablet Give 20 mg by mouth every 24 hours for muscle spasms @ 9pm-scheduled time 9pm, time administered 7/1/18 at 12:42 am. Keppra Tablet 500 mg Give 1 tablet by mouth every 12 hours for seizures- scheduled time 9:00 pm, time administered 7/1/18 at 12:42 am Lexapro Tablet 20 mg Give 20 mg by mouth at bedtime for depression-scheduled time 9:00pm, time administered 7/1/18 at 12:43 am Ranitidine HCL Tablet 150 mg Give 1 tablet by mouth at bedtime for GERD (gastroesophageal reflux disease) scheduled time 9:00 pm, time administered 7/1/18 at 12:42 am Zanaflex Tablet Give 8 mg by mouth at bedtime for muscle spasms-scheduled time 9:00 pm, time administered 7/1/18 at 12:42 am Crestor Tablet 5 mg Give 1 tablet by mouth at	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

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F 684	Continued From page 70 bedtime for high cholesterol-scheduled time 9:00 pm, time administered 7/1/18 at 12:42 am Biofreeze Gel 4 % Apply to bilateral ankles and feet topically at bedtime for pain/stiffness-scheduled time 9:00 pm, time administered 7/1/18 at 12:46 am Probiotic Capsule Give 1 capsule by mouth at bedtime for supplement-scheduled time 9:00 pm, time administered 7/1/18 at 12:43 am Zyrtec allergy tablet 10 mg Give 1 tablet by mouth at bedtime for allergies-scheduled time 9:00 pm time administered 7/1/18 at 12:42 am According to the facility policy on "Administering Medications," the ..."Purpose" of the policy states, "Medications shall be administered in a safe and timely manner and as prescribed." The procedure contains documentation that includes but is not limited to ..." 6. The individual administering the medication must check the label to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication." ... On 8/2/18 at 9:35 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/2/18. 10. The facility staff failed to administer oxygen per physician ordered rate for Resident # 94. Resident # 94 was an 88-year-old-male who was	F 684		

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	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

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F 684	Continued From page 71 admitted to the facility on 6/27/18. Diagnoses include but are not limited to: chronic obstructive pulmonary disease, atrial fibrillation, type 2 diabetes mellitus, and dysphagia. The clinical record for Resident # 94 was reviewed on 8/1/18 at 11:27 am. The most recent MDS (minimum data set) assessment was a 14-day assessment with an ARD (assessment reference date) of 7/11/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 94 had a BIMS (brief interview for mental status) of 13 out of 15, which indicated that Resident # 94 was cognitively intact. The current plan of care for Resident # 94 was reviewed and revised on 7/27/18. The facility staff documented a focus area for Resident # 94 as "Resident # 94 has altered respiratory status/dyspnea r/t (related to) COPD (chronic obstructive pulmonary disease), sleep apnea, pneumonitis 2/2 inhalation of food/emesis. Interventions included but were not limited to: "Provide oxygen as ordered." Resident # 94 had a current order that was initiated on 6/27/18 for "Oxygen continuous 5L/min (liters per minute). May titrate to keep O2 (oxygen) sats above 88% every day and night shift." On 7/31/18 at 2:33 pm, the surveyor observed Resident # 94 lying in bed receiving oxygen via nasal cannula. Upon observation of the oxygen setting, the surveyor observed that Resident # 94 is receiving O2 at 3 liters via nasal cannula at this time. The surveyor asked Resident # 94 if he was having any breathing difficulties and Resident #	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 684	Continued From page 72 94 replied "No."	F 684		

On 8/01/18 at 11:45 am, the surveyor observed Resident # 94 is sitting up in bed receiving O2 via nasal cannula. The surveyor observed oxygen being delivered at 4 liters.

On 8/2/18 at 5:25 pm, the surveyor observed Resident # 94 in his room receiving oxygen via nasal cannula. The surveyor observed that oxygen is being delivered at 4 liters via nasal cannula.

On 8/2/18 at 5:30 pm, the surveyor spoke with LPN # 1 (licensed practical nurse) and asked to verify the oxygen orders for Resident # 94. LPN # 1 reviewed the orders along with the surveyor and verified that Resident # 94 oxygen orders were to be at 5 liters per minute. LPN # 1 went into Resident # 94's room along with the surveyor and observed that Resident # 94's oxygen was being delivered at 4 liters per minute. LPN # 1 stated that she would assess Resident # 94's vital signs.

The surveyor reviewed the electronic treatment administration record for Resident # 94 from 7/31/18 through 8/2/18. The facility staff documented that Resident # 94 was receiving oxygen at 5 liters per minute. The surveyor reviewed the progress notes and did not find any documentation that supported the titration of the oxygen to maintain oxygen saturations above 88%.

According to the facility policy on "Administering Medications," the ..."Purpose" of the policy states, "Medications shall be administered in a safe and timely manner and as prescribed." The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 73

F 684

procedure contains documentation that includes but is not limited to ..." 6. The individual administering the medication must check the label to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication." ...

On 8/2/18 at 9:35 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 8/2/18.

11. The facility staff failed to ensure that the head of bed was at 90 degrees during meals and failed to administer medications per the physician ordered times for Resident # 86.

Resident # 86 was a 77-year-old-female who was originally admitted to the facility on 10/3/16 with a readmission date of 3/19/18. Diagnoses include but were not limited to: dysphagia, hypertension, type 2 diabetes mellitus, and obstructive sleep apnea.

The clinical record for Resident # 86 was reviewed on 8/1/18 at 11:24 am. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 7/3/18. Section C assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 86 had a BIMS (brief interview for mental status) of 15 out of 15, which indicates that Resident # 86 was cognitively intact.

The current plan of care for Resident # 86 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE
5647 STARKEY ROAD
CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 74 reviewed and revised on 7/23/18. The facility staff has documented a focus area for Resident # 86, as "Resident #86 has no natural teeth remaining. She wears dentures and reports no oral discomfort or difficulty chewing. She states that her dentures "need some work" Per SLP Resident # 86 tolerates meals without difficulty as long as dentures are in place. Resident # 86 is at low risk for development of dental complications. Aspiration precautions. Although patient has been educated and verbalized understanding on the importance/risks/of not elevating HOB/sitting up during eating, the patient still at times refuses to eat with HOB elevated or sit up." Interventions included but were not limited to: "Keep HOB elevated 45 degrees while eating drinking. Encourage patient to sit up." The facility staff also documented a focus area as "Resident # 86 has diabetes mellitus." Interventions for this focus area included but were not limited to: "Diabetes medication as ordered by doctor. Monitor/document side effects and effectiveness." The physician signed the current physician's orders for Resident # 86 on 6/7/18. Orders include but are not limited to: "1. Dentures in for all meals 2. 90 degree angle for all meals 3. C.N.A. to assist with oral care after each meal every shift related to dysphagia," and "Lantus SoloStar Solution Pen-Injector 100 unit/ML Inject 26 unit subcutaneously at bedtime" which was initiated on 6/14/18. On 7/31/18 at 3:34 pm, the surveyor observed Resident # 86 in her room in bed. Resident # 86 had her lunch tray at this time was observed feeding herself without difficulty. Resident # 86's HOB was observed to be at 45 degrees while eating. Resident #86 informed the surveyor that she eats very slowly.	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 684 Continued From page 75

F 684

On 8/1/18 at 12:13 pm, the surveyor observed Resident # 86 in her room in bed. Resident # 86 was feeding herself a salad without difficulty. The surveyor observed that Resident # 86's HOB was elevated at 45 degrees while eating.

Upon review of the treatment administration record. The surveyor observed that facility staff had documented that Resident # 86's HOB was at 90 degree angle during meals on 7/31/18 and 8/1/18.

Upon review of the "Location of Administration report for Lantus Solostar, the surveyor observed that the facility did not administer the medication within the appropriate time frame as ordered by the physician on the following dates:

7/4/18 scheduled time 9:00 pm, time administered-10:13 pm
7/5/18 scheduled time 9:00 pm, time administered-10:15 pm
7/11/18 scheduled time 9:00 pm, time administered-10:36 pm
7/18/18 scheduled time 9:00 pm, time administered-11:04 pm
7/21/18 scheduled time 9:00 pm, time administered-10:38 pm
7/22/18 scheduled time 9:00 pm, time administered-11:15 pm
7/23/18 scheduled time 9:00 pm, time administered-10:15 pm
7/24/18 scheduled time 9:00 pm, time administered-7/25/18 at 12:11 am
7/26/18 scheduled time 9:00 pm, time administered-10:17 pm
7/28/18 scheduled time 9:00 pm, time administered-7/29/18 at 12:32 am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE
5647 STARKEY ROAD
CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 76 7/30/18 scheduled time 9:00 pm, time administered-11:27 pm According to the facility policy on "Administering Medications," the ..."Purpose" of the policy states, "Medications shall be administered in a safe and timely manner and as prescribed." The procedure contains documentation that includes but is not limited to ..." 6. The individual administering the medication must check the label to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication." ... On 8/2/18 at 9:35 pm, the administrative team was made aware that facility staff had documented that Resident #86's HOB was at 90 degree angle when in fact the HOB was elevated at a 45 degree angle and that insulin had been administered to Resident # 68 outside of the physician ordered time frames. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/2/18.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives	F 686	**F686** **Corrective Action(s):** Resident #86's attending physician was notified that the facility staff failed to properly reposition resident per physician orders. Resident #86 has had her orders reviewed to reflect current needs. The C.N.A. assigned to care for Resident #86 on 8/1/18 has been given a disciplinary action for failure to reposition the resident. A facility Incident & Accident form was completed for this incident.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE
5647 STARKEY ROAD
CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 77 necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and clinical record review, it was determined that the facility staff failed to implement interventions to prevent the development of a pressure ulcer by failing to turn and position 1 of 45 Residents in the sample survey, Resident #86 The findings included: The facility staff failed to turn and reposition Resident # 86 every 2 hours. Resident # 86 was a 77-year-old-female who was originally admitted to the facility on 10/3/16 with a readmission date of 3/19/18. Diagnoses included but were not limited to: dysphagia, hypertension, type 2 diabetes mellitus, and obstructive sleep apnea. The clinical record for Resident # 86 was reviewed on 8/1/18 at 11:24 am. The most recent MDS (minimum data set) assessment was an annual assessment with an ARD (assessment reference date) of 7/3/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 86 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicates that Resident # 86 was cognitively intact. Section G of the MDS assesses functional status. In Section G0110, the facility staff documented that Resident # 86 requires extensive assistance of two or more persons for bed mobility.	F 686	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents at high risk for skin breakdown may have been potentially affected. The DON, ADON and/or Unit Manager will conduct daily audits to monitor for proper repositioning of residents per resident need and/or physician orders. Any negative findings will be addressed immediately and disciplinary action taken as indicated. A facility Incident and Accident form will be completed each negative finding. **Systemic Change(s):** The facility Policy and Procedure for Wound Care has been reviewed and no changes are warranted at this time. The C.N.A. staff will be in-serviced by the DON and/or designee on the facility's wound care program, including the preventative benefits of repositioning often. **Monitoring:** The DON is responsible for compliance. The DON and/or designee will complete two random audits weekly on residents at high risk of skin breakdown to ensure repositioning of residents is occuring. Any/all negative findings will be addressed at time of discovery and additional inservice training and/or disciplinary with will be administered at that time. The results of the audits will be sent to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ___ B. WING ___	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 78 The current plan of care for Resident #86 was reviewed and revised on 7/23/18. The facility staff documented a focus area as "Resident # 86 is at risk for pressure ulcer development related to hx (history) of pressure ulcers, hx of MASD (moisture associated skin dermatitis), incontinence, and limited mobility. Resident # 86 has an area of excoriation to the left gluteal fold, which at times peels. The area then heals, and returns. Recurrent. Not classified as PU (pressure ulcer). Currently receiving Calazime Cream for protection/prevention to this area and B/L (bilateral) buttocks as well. She is receiving skin prep to right lateral aspect of right foot/lower portion of pinky toe for protection." Interventions included but were not limited to: "I need monitoring/reminding/assistance to turn/reposition at least every 2 hours, more often as needed or requested." The physician signed the current orders for Resident # 86 on 6/7/18. The physician's orders included but were not limited to: "Turn & position q (every) 2 hours as needed for skin integrity," and "Calazime q shift to L (left) gluteal fold and BIL (bilateral) buttocks every shift." On 7/31/18 at 3:05 pm, the surveyor observed Resident #86 lying in bed on her back. The surveyor observed an air mattress on her bed. The surveyor conducted an interview with Resident # 86. The surveyor asked if Resident # 86 has any sores or open areas on her body. Resident # 86, "I have a sore on my hip." The surveyor asked Resident # 86 if the staff cares for her sore on her hip. Resident # 86 stated, "They put cream on it." The surveyor asked if the staff turns and repositions her. Resident # 86 stated, "No they don't turn me."	F 686		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 686 Continued From page 79

F 686

On 7/31/18 at 5:15 pm, the surveyor observed Resident # 86 lying in bed positioned on her back.

On 8/1/18 at 8:37 am, Resident # 86 was observed lying in bed dressed in a hospital gown lying on her back.

On 8/1/18 at 10:45 am, Resident # 86 was observed lying in bed dressed in a hospital gown lying on her back.

On 8/1/18 at 12:13 pm, Resident # 86 was observed lying in bed dressed in hospital gown. Resident # 86 was lying on her back. The surveyor asked Resident # 86 if facility staff had come in to turn her. Resident # 86 stated "No."

Upon review of the facility competency evaluation check list for certified nursing assistants, the facility must be evaluated and checked off on tasks that include but is not limited to: that there is a demonstration and verbal understanding of, "Checking on residents every 2 hours," and "Repositioning resident during check."

On 8/1/18 at 5:35 pm, the administrative team was made aware of the findings as stated above.

No further information regarding this issue was provided to the survey team prior to the exit conference on 8/2/18.

F 689 SS=D Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)

F 689

§483.25(d) Accidents.
The facility must ensure that -
§483.25(d)(1) The resident environment remains

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 5647 STARKEY ROAD, CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 80 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility failed to ensure an environment free of accident hazards for 3 of 45 Residents in the sample survey, Resident #55, Resident #66 and Resident #110. The facility staff failed to implement safety interventions. The Findings Included: 1. For Resident #55 the facility staff failed to implement a physician ordered chair alarm. Resident #55 was a 96-year-old female who was admitted on 5/29/18. Admitting diagnoses included, but were not limited to: fall, benign neoplasm of meninges, bilateral osteoarthritis of knee and cognitive communication deficit. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 6/26/18. The facility staff coded that Resident #55 had a Cognitive Summary Score of 14. The facility staff coded that Resident #55 required set up assistance (1/1) to extensive assistance (3/3) with Activities of Daily Living (ADL's). In Section J. 1900. Falls Since Admission the facility staff documented that Resident #55 had had one fall without injury since admission into the facility.	F 689	**F689** **Corrective Action(s):** Resident #55's attending physician has been notified that facility staff failed to ensure a physician ordered chair alarm was in place as ordered. A facility incident and accident form has been completed for this incident. Resident #66's attending physician has been notified that facility staff failed to check placement of a physician ordered wander-guard every shift. A facility Incident and Accident form has been completed for this incident Resident #110's attending physician has been notified that facility staff failed to ensure a physician ordered chair and bed alarm was in place as ordered. A facility incident and accident form has been completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered chair or bed alarms and wander-guards may have been affected. An audit tool has been created that will allow DON and/or designee to review all residents with physician ordered bed or chair alarms and wander-guards to ensure that they are in place. A daily review of the treatment administration record (TAR) will show if the documentation corresponds with the visual audit. Negative findings will be corrected at the time of discovery with disciplinary action given, as appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 5647 STARKEY ROAD, CAVE SPRING, VA 24018

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F 689	Continued From page 81 On August 1, 2018 at 3:26 p.m., the surveyor reviewed the clinical record. Review of the clinical record produced a physician orders. Physician orders included, but were not limited to: "Chair alarm as resident allows every day and night shift." (sic) Continued review of the clinical record produced the August 2018 Treatment Administration Records (TAR's). The facility staff had documented that the chair alarm had been applied on the August 1, 2018 TAR's. On August 1, 2018 at 3:40 p.m., the surveyor observed Resident #55 sitting up in her chair. The surveyor did not observe a chair alarm in place. The surveyor went to the nurses' desk and informed a Registered Nurse (RN) that Resident #55 had a physician order for a chair alarm. The surveyor notified the RN that the chair alarm was not in place. The surveyor reviewed the clinical record with the RN and pointed out the specific physician order for the chair alarm. The surveyor and RN walked down to Resident #55's room and entered Resident #55's room. The surveyor pointed out that Resident #55 was up in her chair and that a chair alarm could not be located. The RN attempted to locate a chair alarm on Resident #55. On August 1, 2018 at 4:34 p.m., the surveyor notified the Director of Nursing (DON) that Resident #55 had a physician order for a chair alarm when up in the chair. The surveyor notified the DON that the chair alarm was not in place earlier in the day. On August 1, 2018 at 4:38 p.m., the survey team	F 689	**Systemic Change(s):** The facility policy and procedure for fall prevention and management and elopement has been reviewed and no revisions are warranted at this time. The DON and/or designee will in-service all nursing staff regarding proper use of and application of fall intervention equipment to include chair and bed alarms and the importance of the wander-guard checks. **Monitoring:** The DON is responsible for maintaining compliance. The DON and/or designee will perform daily audits of all residents with physician order chair or bed alarms and wander-guards to monitor for compliance for the next 3 months. An audit of the TAR will show if documentation supports the visual audit. Any/all negative findings will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these reviews will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

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F 689 Continued From page 82

F 689

met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #55 had a physician order for a chair alarm and that the chair alarm had not been in place.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure an environment free of accident hazards for Resident #55. The facility staff failed to implement a physician ordered chair alarm.

2. For Resident #66 the facility staff failed to follow physician orders to check the placement of a wander-guard every shift.

Resident #66 was an 85-year-old female who was admitted on 2/3/18. Admitting diagnoses included, but were not limited to: atrial fibrillation, atherosclerotic heart disease, dementia without behaviors, hypertension, osteoarthritis and cognitive communication deficit.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS assessment with an Assessment Reference Date (ARD) of 6/26/18. The facility staff coded that Resident #66 had a Cognitive Summary Score of 14. The facility staff coded that Resident #66 was independent (0/0) to set up assistance (1/1) with Activities of Daily Living (ADL's).

On August 1, 2018 at 10:20 a.m., the surveyor reviewed Resident #66's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Check for wanderguard placement qshift (every shift). every shift for Checking Placement." (sic)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689	Continued From page 83	F 689		

Continued review of the clinical record produced the July 2018 Treatment Administration Records (TAR's). Review of the July 2018 TAR's revealed that the facility staff did not check for placement of the wander guard on July 2, 2018 on the 3-11 shift, on July 5, 2018 on the 7-3 shift and on July 26, 2018 on the 7-3 shift.

On August 1, 2018 at 12 noon, the surveyor notified a Registered Nurse (RN), that Resident #66 had a physician order for a wander-guard and for the staff to check placement of the wander-guard every shift. The surveyor notified the RN that review of the July 2018 TAR's failed to document that the wander guard was checked every shift as ordered by the physician. The surveyor reviewed Resident #66's clinical record with the RN. The surveyor pointed out the physician order for the wander-guard and to check for placement every shift. The surveyor then reviewed the July 2018 TAR's with the RN. The surveyor pointed out that the facility staff failed to check for the wander-guard placement several times during the month of July 2018.

On August 1, 2018 at 4:38 p.m., the survey ream met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #66 had physician orders for a wander-guard. The surveyor notified the AT that the physician ordered for the wander-guard to be checked every shift for placement. The surveyor notified the AT that the wander-guard was not checked for placement on several days in July 2018.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 689 Continued From page 84

F 689

to ensure an environment free of accident hazards. The facility staff failed to monitor of placement of the physician order wander-guard several times in July 2018.

3. For Resident #110 the facility staff failed to ensure that a physician ordered chair and alarm were in place.

Resident #110 was a 92-year-old female who was admitted on 7/13/18. Admitting diagnoses included, but were not limited to: asthma, hypertension, atrial fibrillation, depression, dementia without behaviors,

No Minimum Data Set (MDS) assessment was available due to Resident #110's recent admission.

On July 31, 2018 at 3:20 p.m., the surveyor reviewed Resident #110's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to the following: "bed alarm s resident tolerates for safety every shift for safety. chair alarm as resident tolerates for safety every shift for safety." (sic)

Continued review of the clinical record produced the July 2018 Treatment Administration Records (TAR's). Review of the July 2018 TAR's did not document that the facility staff placed the bed alarm on Resident #110 on 7/26/18 on the 7-3 shift and on 7/31/18 on the 11-7 shift. The July 2018 TAR's also failed to document that the chair alarm was in place on 7/26/18 on the 7-3 shift and on 7/31/18 on the 11-7 shift.

On July 31, 2018 at 3:45 p.m., the surveyor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

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F 689	Continued From page 85 notified a Registered Nurse (RN) that Resident #110 had physician orders for a bed and chair alarm for safety. The surveyor notified the RN that the facility staff had not documented that the bed alarm and chair alarm were applied on 7/26/18 on the 7-3 shift and on 7/31/18 on the 11-7 shift. The surveyor reviewed the clinical record with the RN. The surveyor reviewed the physician orders and the July 2018 TAR's. The surveyor pointed out that the July 2018 TAR's failed to document the application of the physician ordered bed and chair alarm. On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #110 had physician orders for a bed and chair alarm. The surveyor notified the AT that the physician ordered bed and chair alarm were not documented as being in place on several days in July 2018. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure an environment free of accident hazards. The facility staff failed to ensure that the bed/chair alarm was in place on several days in July 2018.	F 689	**F690** **Corrective Action(s):** Resident #61's Foley catheter orders have been reviewed and updated to include orders for the proper bulb and balloon size. Additionally, the foley is now anchored per policy and procedure to ensure it is off the floor to prevent infection and injury.	
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690	**Identification of Deficient Practice(s) and Corrective Action(s):** All other residents with a Foley catheter may have been potentially affected. The DON and/or designee will conduct a 100% review of all residents with a Foley catheter to identify residents at risk. Residents identified will be corrected at time of discovery and a Facility Incident & Accident Form will be completed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER
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5647 STARKEY ROAD
CAVE SPRING, VA 24018

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F 690	Continued From page 86 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, clinical record review and facility document review, it was determined that the facility staff failed to obtain physician orders for care and treatment for a Foley catheter to include a bulb and balloon size for 1 of 45 residents in the sample survey, Resident #61. Additionally, the facility staff failed to anchor the indwelling Foley catheter to prevent excessive tension on the urinary meatus for Resident #61.	F 690	**Systemic Change(s):** The facility Policy and Procedure for Foley Catheter usage and Foley Catheter Care has been reviewed and no changes are warranted at this time. The nursing staff will be in-serviced by the DON on the policy and procedures for proper Foley Catheter Orders, to include proper bulb and balloon size, and care to include the proper anchoring of Foley catheter tubing. **Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will make weekly audits audits of all Foley Catheter's to ensure compliance with anchoring of tubing and to ensure orders are comprehensive. All negative findings will be corrected at time of discovery. Detailed findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

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	495421		C 08/02/2018

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F 690 Continued From page 87

F 690

The findings included

Resident # 61 was a 53-year-old female who was admitted to the facility on 3/9/17. Diagnoses included but were not limited to: anxiety disorder, muscle wasting and atrophy, depression, and benign neoplasm of the brain.

The clinical record for Resident # 61 was reviewed on 8/1/18 at 11:25 am. The most recent MDS (minimum data set) assessment was a quarterly assessment with an ARD (assessment reference date) of 6/29/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 61 had a BIMS (brief interview for mental status) score of 15 out of 15, which indicates that Resident # 61 was cognitively intact.

Resident # 61 had an order that was signed by the physician on 8/1/18. The order was documented as "Foley usage for (Urinary Retention) including French size & ml balloon. The surveyor observed that there is no catheter and bulb size documented with the order.

On 8/01/18 at 9:59 am, the surveyor was given permission by Resident # 61 to look at her foley catheter. The surveyor observed an 18FR (French) with 10cc (cubic centimeter) bulb. The surveyor observed the Foley catheter lying across Resident # 61's left leg unsecured.

According to the facility policy on "Foley catheter care" The procedure included documentation that stated but was not limited to ..."7. Replace catheter into Cath-secure device, ensure catheter bag is placed below bladder level and that drain

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

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F 690	Continued From page 88 bag and catheter tubing are not touching the floor." Changing Foley catheter included documentation that stated but was not limited to ... "3. To reinsert catheter: Assemble items needed, (correct size catheter and catheter kit) using sterile technique insert catheter, replace and reconnect clean drainage bag, document date and time catheter changed, note catheter and balloon size being inserted." ... On 8/1/18 at 5:35 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/2/18.	F 690		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, and clinical record review, the facility staff failed to ensure that respiratory care equipment was maintained in a sanitary manner for 1 of 45 residents in the survey sample. Resident # 94. The findings included:	F 695	**F695** **Corrective Action(s)** Resident #94's Nebulizer and Bi-Pap masks have been replaced with new ones and were dated and stored in a clear plastic bag for storage when not in use. A facility Incident & Accident form was completed for this incident. **Identification of Deficient Practice & Corrective Action(s):** All other resident receiving physician ordered nebulizers or Bi-Paps may have potentially been affected. A 100% review of all residents with physician ordered nebulizers of Bi-Paps was conducted to identify any/all residents at risk. Any negative findings were corrected at time of discovery and new equipment was obtained and dated and stored correctly. A facility Incident &Accident form will be completed for each negative finding.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

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F 695	Continued From page 89 The facility staff failed to ensure that the nebulizer and bi-pap masks were maintained in a sanitary manner for Resident # 94. Resident # 94 was an 88-year-old-male who was admitted to the facility on 6/27/18. Diagnoses included but were not limited to: chronic obstructive pulmonary disease, atrial fibrillation, type 2 diabetes mellitus, and dysphagia. The clinical record for Resident # 94 was reviewed on 8/1/18 at 11:27 am. The most recent MDS (minimum data set) assessment was a 14-day assessment with an ARD (assessment reference date) of 7/11/18. Section C of the MDS assesses cognitive patterns. In Section C0500, the facility staff documented that Resident # 94 had a BIMS (brief interview for mental status) of 13 out of 15, which indicated that Resident # 94 was cognitively intact. The current plan of care for Resident # 94 was reviewed and revised on 7/27/18. The facility staff documented a focus area for Resident # 94 as "Resident # 94 has altered respiratory status/dyspnea r/t (related to) COPD (chronic obstructive pulmonary disease), sleep apnea, pneumonitis 2/2 (secondary to) inhalation of food/emesis. Interventions included but were not limited to: "Administer medications/breathing treatments as ordered," and "Bipap per order. Do not remove Velcro from headgear when removing mask use magnetic quick release mechanism at bottom of mask." Resident # 94 had current orders that was initiated by the physician on 6/27/18. Orders included but were not limited to, "DuoNeb Solution 0.5-2.5 (3) mg (milligram)/3ML(milliliter) 3ml Inhale orally via nebulizer four times a day for	F 695	**Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. All Nursing staff will be in-serviced by the DON on the proper procedure for cleaning, changing and storing of Nebulized and Bi-Pap equipment to include cleaning and storage of nebulizer and Bi-Pap masks appropriately. **Monitoring:** The DON and/or Unit Manager is responsible for maintaining compliance. The DON and/or designee will conduct a weekly audit to monitor for compliance. Any negative findings will be corrected at time of discovery and disciplinary action will be taken as warranted. All negative findings will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

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F 695	Continued From page 90 resp (respiratory) failure, COPD, SOB (shortness of breath)" and " BiPap Settings-Large facemask, Ipap (inspiratory positive airway pressure) 14 Epap, (expiratory positive airway pressure) 7, Oxygen 5LPM (liters per minute), SPO2 (peripheral capillary oxygen saturation) 50%. Rsd (resident) to wear Bipap QHS (every hour of sleep) and PRN (as needed)." On 7/31/18 at 2:33 pm, the surveyor observed a nebulizer mask upright attached to nebulizer machine uncovered and a bi-pap mask on the nightstand uncovered. On 8/01/18 at 11:45 am, the surveyor observed a nebulizer mask and bipap mask on Resident # 94's nightstand uncovered. The surveyor interviewed Resident # 94 and asked him if the facility staff uses the nebulizer mask and bi-pap mask that is on the nightstand when providing care and Resident # 94 responded "Yes." On 8/2/18 at 5:30 pm, the surveyor along with LPN (licensed practical nurse) # 1 was in Resident # 94's room and observed the nebulizer mask and the bipap mask on Resident # 94's nightstand uncovered. On 8/2/18 at 9:35 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was provided to the survey team prior to the exit conference on 8/2/18.	F 695		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management.	F 697		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

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F 697	Continued From page 91 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. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, facility staff failed to follow physician orders for Pain medication resulting in the resident receiving a higher dose than ordered for 1 of 32 current residents reviewed (Resident #12). Resident #12 was admitted to the facility on 7/14/17. Diagnoses included diabetes mellitus with neuropathy, insulin use, hypertensive heart disease with heart failure, peripheral venous insufficiency, and depression. On the quarterly minimum data set assessment with assessment reference date 4/30/18, the resident scored 13/15 on the brief interview for mental status and was assessed as without delirium, psychosis, or behaviors affecting others. The resident scored 1/37 on the mood assessment (higher scores indicate greater presence of depressive symptoms). During clinical record review, the surveyor noted a physician order dated 2/12/18 for Oxycodone hydrochloride tablet 5 mg (milligram) Give 5 mg by mouth TID (three times a day) as needed for pain. The MAR (medication administration record) documented the medication was administered on 7/8/18 at 00:35, 11:24, 16:48, and 22:42. The resident received four doses on 7/8/18. There was no evidence that the physician was	F 697	**F697** **Corrective Action(s):** Resident #12's attending physician was notified that the facility administered four doses of Oxycodone on 7/8/18. A medication error form has been completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving pain medications may have been potentially affected. The DON, ADON, and/or Unit Manager will conduct a 100% audit of all resident's receiving pain medications to identify residents at risk for having obtained medication errors related to their administration. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedures have been reviewed and revised as such; the "bedtime" block for medication administration has been adjusted so that medications given after 12:00am are now considered late, thereby resulting in disciplinary actions, as appropriate. The DON and/or designee will in-service all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 5647 STARKEY ROAD, CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 697	Continued From page 92 notified of the extra dose of pain medication. The surveyor reported the concern to the director of nursing and administrator during a summary meeting on 8/2/18.	F 697	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs	F 755	**F755** **Corrective Action(s):** Residents #36's attending physician was notified that the facility failed to administer Tylenol 325mg medication as ordered by the attending physician. A facility Medication Error form was completed for this incident. Resident #55's attending physician was notified that the facility failed to administer Centrum Silver as ordered by the physician. A facility Medication Error form was completed for this incident.	

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F 755	Continued From page 93 is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, facility document review and in the course of a complaint investigation, it was determined that the facility staff failed to ensure that physician ordered medications were available for administration for 2 of 45 Residents in the sample survey, Resident #2 of 45 Residents in the sample survey, Resident #36 and Resident #55. The Findings Included: 1. For Resident #36 the facility staff failed to ensure that physician ordered Tylenol 350mg was available for administration. Resident #36 was an 84-year-old female who was admitted on 5/24/16. Admitting diagnoses included, but were not limited to: celiac disease, osteoporosis, hypertension, anxiety, ulcerative colitis and cerebral infarct. The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 6/2/18. The facility staff coded that Resident #36 had a Cognitive Summary Score of 14. The facility staff also coded that Resident #36 required set up assistance (1/1) to extensive assistance (3/2) with Activities of Daily Living (ADL's). On July 31, 2018 at 12 noon, the surveyor spoke to Resident #36 regarding her complaint that was received in the State Agency on 5/30/18. Resident #36's allegation was that she is not getting her medications as ordered by the	F 755	**Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON and Unit Managers will conduct a 100% audit of all resident's physician orders and MAR's over the past 30 days to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding. **Systemic Change(s):** The facility policy and procedure for obtaining physician ordered medication has been reviewed and no changes are warranted at this time. The DON and/or designee will in-service all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. The licensed staff will also be in-serviced on the policy and procedure for After Hours and Emergency Pharmacy Services, to include how to contact and remedy a situation in which pharmacy has not delivered a medication or delivered the wrong dosage.	

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F 755	Continued From page 94 physician. Resident #36 stated that the facility staff are bring in her medicines late, the facility staff are bring in her afternoon pills with her supper medications and night time medications all at one time. Resident #36 stated that the facility staff are making medication errors with her medications. Resident #36 showed the surveyor a picture taken on 7/23/18 at 8:53 p.m. Resident #36 stated that she had separated the pills into three different sections to identify what time they were supposed to be given. The picture displayed 10 medications on her over the bed table. Resident #36 stated that she thought that the staff had made a medication error with her medications on 7/23/18 as her Tylenol 325 mg pills were round and on 7/23/18 the facility staff brought in 2 oblong Tylenol. Resident #36 stated she thought the Tylenol were 500mg tablets. Resident #36 stated she did not take the medications because she knew it was not what the physician had ordered. On July 31, 2018 at 1:29 p.m., the surveyor entered Resident #36's room and observed the local Ombudsman sitting at Resident #36's bedside. The Ombudsman stated that she had had several meeting with the Administration about Resident #36's concerns about her medications. Resident #36 stated that when the Ombudsman and she, Resident #36, had met with the Administration and things would get better for a day or so and then things would go back to how they were before she made the complaint. On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (Adm) and Director of Nursing (DON). The surveyor notified the Administrative Team of Resident #36's Complaint. The Adm stated that Resident #36 had made	F 755	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly MAR and chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

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F 755 Continued From page 95

multiple complaints to the facility regarding the timeliness of medications. The Adm stated that the local Ombudsman had been involved with Resident #36's complaints and that the facility had done an investigation. The surveyor requested to see the facility investigation.

On August 2, 2018 at 8 a.m., the surveyor reviewed Resident #36's clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to: "Tylenol 325mg (Acetaminophen) Give 2 tablet by mouth every 6 hours as needed for Pain." (sic)

On August 2, 2018 at 8:30 a.m., the Adm hand delivered the facility's investigation into Resident #36's ongoing concerns about her medication admiration. Review of the facility investigation documented a medication error related to the 7/23/18 Tylenol 500mg provided by the pharmacy. The investigation also included emails between the Adm and Resident #36's responsible party on 6/5/18, 6/14/18, 6/15/18, 7/25/18, 7/27/18, 7/28/18, 7/30/18, 7/31/18 and 8/1/18.

On August 2, 2018 at 10:30 a.m., the surveyor met with the Adm, DON, Medical Director and Pharmacist. The survey team spoke to the Administrative Team about the facility's liberalized medication administration medication administration program. During the meeting, the Adm acknowledged that two medication errors were made on 7/23/18. The Adm stated that the pharmacy had sent the incorrect dosage of Tylenol. The Adm stated that Resident #36 was supposed to get Tylenol 325 mg and that the pharmacy had sent Tylenol 500mg tablets. The Adm stated that this has been an ongoing issue and that the AT has met with the Ombudsman

F 755

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F 755	Continued From page 96 and has been trying to resolve this issue. No additional information was provided to the survey team prior to exiting the facility as to why the facility staff failed to ensure that Resident #36's Tylenol 325mg was available for administration on 7/23/18. This is a Complaint Deficiency. 2. For Resident #55 the facility staff failed to ensure that physician ordered Centrum Silver was available for administration. Resident #55 was a 96-year-old female who was admitted on 5/29/18. Admitting diagnoses included, but were not limited to: fall, benign neoplasm of meninges, bilateral osteoarthritis of knee and cognitive communication deficit. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 6/26/18. The facility staff coded that Resident #55 had a Cognitive Summary Score of 14. The facility staff coded that Resident #55 required set up assistance (1/1) to extensive assistance (3/3) with Activities of Daily Living (ADL's). On August 1, 2018 at 3:26 p.m., the surveyor reviewed the clinical record. Review of the clinical record produced a physician orders. Physician ordered included, but were not limited to: "Centrum Silver Tablet (Multiple Vitamins-Minerals) Give 1 tablet by mouth one time a day for supplement." (sic) Further review of the clinical record produced the	F 755		

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F 755	Continued From page 97 July 2018 Medication Administration Records (MAR's) and the nursing progress notes. Review of the July 2018 MAR's and nursing progress notes documented that the Centrum Silver was not available for administration on 7/22/18, 7/25/18, 7/27/18 and 7/31/18. On August 1, 2018 at 4:34 p.m., the surveyor notified the Director of Nursing (DON) that Resident #55 had a physician order for Centrum Silver and that the medication was not available for administration for several days in July 2018. The surveyor and DON reviewed Resident #55's clinical record and the surveyor pointed out the specific order for the Centrum Silver, the July 2018 MAR's and the nursing progress notes that documented that the physician ordered Centrum Silver was unavailable for administration. The surveyor requested the facility policy and procedure for ordering medications. On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #55 had a physician order for Centrum Silver. The surveyor notified the AT that the Centrum Silver was not available for administration on several occasions. On August 2, 2018 at 3:45 p.m., the DON hand delivered a facility policy and procedure titled, "After Hours and Emergency Pharmacy Services." The policy and procedure read in part ... "Procedures: (name of pharmacy vendor withheld) Serves as the primary emergency and after hours pharmacy for (name of facility withheld). ((Name of another pharmacy vendor withheld) pharmacy will serve as back-up/last	F 755		

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F 755	Continued From page 98 resort emergency pharmacy). Orders for medications that are received in the facility after 6 pm weekdays or on weekends and holidays that are determined to be needed by the resident before (name of facility pharmacy withheld) will next regularly open are to be sent to (name of back-up pharmacy withheld). (Name of pharmacy vendor) will fill the indicated number of doses needed to provide medication until available from (Facility pharmacy vendor)." No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that physician ordered medication, Centrum Silver, was available for administration to Resident #55.	F 755		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or	F 757	**F757** **Corrective Action(s):** Resident #12's attending physician was notified that the facility administered four doses of Oxycodone on 7/8/18. A medication error form has been completed for this incident. **Identification of Deficient Practices/Corrective Action(s):** All other residents receiving pain medications may have been potentially affected. The DON, ADON, and/or Unit Manager will conduct a 100% audit of all resident's receiving pain medications to identify residents at risk for having obtained medication errors related to their administration. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 757	Continued From page 99 §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure that 1 of 45 Residents in the sample survey was free on unnecessary medications, Resident #12. The Findings Included: For Resident #12, facility staff failed to ensure staff followed physician orders for medication resulting in the resident receiving a higher dose than ordered. Resident #12 was admitted to the facility on 7/14/17. Diagnoses included diabetes mellitus with neuropathy, insulin use, hypertensive heart disease with heart failure, peripheral venous insufficiency, and depression. On the quarterly minimum data set assessment with assessment reference date 4/30/18, the resident scored 13/15 on the brief interview for mental status and was assessed as without delirium, psychosis, or behaviors affecting others. The resident scored 1/37 on the mood assessment (higher scores indicate greater presence of depressive symptoms). During clinical record review, the surveyor noted a physician order dated 6/14/18 for Effexor XR 24 hour 75 mg (milligram) (venlafaxine hydrochloride extended release) Give 1 capsule PO (by mouth) QD (daily) for 7 days then increase dose to 150 mg PO QD. with start date 6/15/18 0800 and discontinue date 7/5/18 1111. The MAR	F 757	**Systemic Change(s):** The facility policy and procedures have been reviewed and revised as such; the "bedtime" block for medication administration has been adjusted so that medications given after 12:00am are now considered late, thereby resulting in disciplinary actions, as appropriate. The DON and/or designee will in-service all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Manager will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

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F 757	Continued From page 100 (medication administration record) documented the medication was administered daily 6/15 through 7/3, or 19 days. Another physician order dated 6/14/18 with start date 6/22/18 for Effexor XR 24 hour 150 mg (milligram) (venlafaxine hydrochloride extended release) Give 1 capsule PO (by mouth) QD (daily). The MAR indicated the resident received a 150 mg capsule daily 6/22 through 8/2 (the date of the survey). Staff administered 225 mg of Effexor ER from 6/22 through 7/3. In addition, the surveyor noted a physician order dated 2/12/18 for Oxycodone hydrochloride tablet 5 mg (milligram) Give 5 mg by mouth TID (three times a day) as needed for pain. The MAR (medication administration record) documented the medication was administered on 7/8/18 at 00:35, 11:24, 16:48, and 22:42. The resident received four doses on 7/8/18. The surveyor reported the concerns to the director of nursing and administrator during a summary meeting on 8/2/18.	F 757		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and	F 761	**F761** **Corrective Action(s):** The multidose vial of PPD solution and acetylcysteine on 300-hall have been discarded with new products obtained. RN #2 has been disciplined regarding her beverage on the medication cart. The Tubersol PPD solution on Wing 1 was discarded and new product obtained. The box containing Ativan was has been permanently affixed to the refrigerator in the medication room on Wing 1.	

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F 761	Continued From page 101 biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and facility document review, the facility failed to date multidose vial medications when opened, failed to dispose of expired medications, and failed to ensure the narcotic box was firmly affixed on two of four halls (100 hall and 300 hall). The findings included: 1. For the 300 hall-Staff failed to date multidose vials of PPD solution and acetylcysteine when opened. On 08/02/18 at approximately 4:20 p.m., the surveyor and LPN (licensed practical nurse) #3 entered the medication room on 300 hall. The medication refrigerator on this hall included one multidose vial of PPD solution and one multidose vial of acetylcysteine. Both of these vials had been opened but had not been labeled with the date opened. The box that contained the PPD solution read	F 761	**Identification of Deficient Practices & Corrective Action(s):** All other Medications may have potentially been affected. The DON and/or designee will conduct a 100% review of all medication carts and medication rooms to identify any existing mislabeled, expired or discontinued medications. This audit will also include review of the refrigerators to ensure the narcotic box is appropriately affixed. Any/all negative findings will be corrected at time of discovery. A Facility Incident and Accident form will be completed for each incident identified. **Systemic Change(s):** The facility policy and procedure has been reviewed and no changes are warranted at this time. The licensed nursing staff will be in-serviced by the pharmacy consultant and/or DON on the policy for monitoring medications to ensure proper labeling, dating and removal of all expired or discontinued medications and supplies from the medication carts and medication room. Additionally, all licensed nursing staff will be in-serviced on the infection control hazards of having personal drinks on the medication carts.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 102 discard-opened product after 30 days. A review of the facility policy titled "Multiuse Medication Vials" read in part, "...Multiple use vials that are opened or entered (e.g. needle-punctured) can only be used for 30 days unless otherwise specified by the manufacturer..." The administrative team were notified of the above findings on 08/02/18 at 8:35 p.m. No further information regarding these issues were provided to the survey team prior to the exit conference. 2. The facility staff on wing 1 had a personal drink on the medication cart, failed to discard expired medications, and failed to have narcotic box secured to the refrigerator. On 8/2/18 at 4:45 pm, the surveyor inspected a medication cart on Wing 1. While inspecting the medication cart the surveyor observed a bottle of diet Mt Dew in a drawer on the medication cart. RN # 2 (registered nurse) confirmed that the diet Mt. Dew belonged to her and discarded it in the trash can. The surveyor observed an opened vial of Lidocaine HCL 1% 300mg (milligrams)/30 ml (milliliters) Single dose on the medication cart. Printed on the label on the vial Lidocaine is documentation that states, "discard unused portion." On 8/2/18 at 4:58 pm, the surveyor inspected the medication room on Wing 1. The surveyor observed Tubersol PPD solution that was dated 5/29/18 as the date opened. The box that the Tubersol PPD solution was packaged in has documentation printed on the box that states, "discard opened product after 30 days." The	F 761	**Monitoring:** The DON is responsible for maintaining compliance. The DON or Unit Manager will perform weekly audits of all medication rooms and medication carts to ensure that medications are being labeled and dated appropriately and that all expired or discontinued medications are being removed per protocol. In reviewing the carts, the DON and/or designee will also ensure no personal food or beverage items are on the cart. Detail findings of this audit will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 496421	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 08/02/2018
NAME OF PROVIDER OR SUPPLIER: FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE: 5847 STARKEY ROAD, CAVE SPRING, VA 24018	

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F 761	Continued From page 103 surveyor also observed a see through box on the door of the refrigerator in the medication room. RN # 2 reported to the surveyor that the medication inside of the box was Ativan. The box containing Ativan was not permanently affixed to the refrigerator in the medication room. According to the facility policy on "Multiuse Medication Vials," the procedure contains documentation that includes but is not limited to: .. " 1. All vials and ampules are to be used and stored in accordance with the manufacturer's directions." ... On 8/2/18 at 9:35 pm, the administrative team was made aware of the findings as stated above. No further information regarding this issue was presented to the survey team prior to the exit conference on 8/2/18.	F 761	F776 **Corrective Action(s):** Residents #55's attending physician was notified that the facility failed to properly assure that the results of a physician ordered EKG were in the resident's clinical record. Results were placed in the resident's clinical record on 8/2/18.	
F 776 SS=D	Radiology/Other Diagnostic Services CFR(s): 483.50(b)(1)(i)(ii) §483.60(b) Radiology and other diagnostic services. §483.60(b)(1) The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in §482.26 of this subchapter. (ii) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under	F 776	**Identification of Deficient Practices/Corrective Action(s):** All other residents with physician ordered lab/radiology or other diagnostic testing may have been affected. The DON and Unit Managers will conduct a 100% audit of all resident's with physician ordered lab/radiology or other diagnostic testing over the past 30 days to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 776	Continued From page 104 Medicare. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure that the results of diagnostic testing were contained in the clinical record for 1 of 45, Resident #55 The Findings Included: For Resident #55 the facility staff failed to ensure that the results of a physicians ordered EKG was contained in the clinical record. Resident #55 was a 80-year-old female who was admitted on 5/29/18. Admitting diagnoses included, but were not limited to: fall, benign neoplasm of meninges, bilateral osteoarthritis of knee and cognitive communication deficit. The most current Minimum Data Set (MDS) assessment located in the clinical record was a 30 Day Medicare MDS assessment with an Assessment Reference Date (ARD) of 6/26/18. The facility staff coded that Resident #55 had a Cognitive Summary Score of 14. The facility staff coded that Resident #55 required set up assistance (1/1) to extensive assistance (3/3) with Activities of Daily Living (ADL's). On August 1, 2018 at 3:26 p.m., the surveyor reviewed the clinical record. Review of the clinical record produced a physician order dated 7/25/18 for the facility staff to obtain an EKG. Continued review of the clinical record failed to produce the results of the physician ordered EKG.	F 776	**Systemic Change(s):** The facility policy and procedure for obtaining physician ordered medication has been reviewed and no changes are warranted at this time. The licensed staff and medical records will be in-serviced on the proper recording of lab/radiology or other diagnostic testing results in the resident's clinical record. **Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: September 16, 2018**	

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	495421		C 08/02/2018

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F 776	Continued From page 105	F 776		
	On August 1, 2018 at 4:34 p.m., the surveyor notified the Director of Nursing (DON) that Resident #55 had a physician order dated 7/25/18 to obtain an EKG. The surveyor notified the DON that the results of the EKG could not be located in the clinical record. The surveyor and DON reviewed the clinical record. The DON was unable to locate the results of the physician ordered EKG. The DON stated that the results of the EKG should be located in the clinical record as the facility staff was able to do the EKG in house.			
	On August 1, 2018 at 4:38 p.m., the survey team met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #55 had a physician order dated 7/25/18 to obtain an EKG. The surveyor notified the AT that the results of the physician ordered EKG could not be located on the clinical record.		**F842** **Corrective Action(s):** Residents #56's attending physician was notified that the facility failed to ensure that the resident's clinical record and POS was complete and accurate for July and August of 2018, resulting in an order for PO aspirin when all other medications were to be given via G-tube. A facility Medication Error form was completed for this incident.	
	On August 2, 2018 at 7:30 a.m., the DON hand delivered the results of the physician ordered EKG.			
	No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure that the results of the physician ordered EKG was contained in the clinical record for Resident #55.			
F 842 SS=E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5)	F 842	Resident #67's attending physician and pharmacist was notified that the resident's monthly Drug Regimen Review (DRR) for March 2018 was not in the clinical records. The DRR was obtained via fax on 8/1/18 and placed in the resident's clinical record.	
	§483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is			

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 842	Continued From page 106 resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.	F 842	Resident #67's attending physician and pharmacist was notified that the resident's monthly Drug Regimen Review (DRR) for March 2018 was not in the clinical records. The DRR was obtained via fax on 8/1/18 and placed in the resident's clinical record. Resident #12's attending physician was notified that the facility failed to document daily care, medication and treatment per the physician orders for multiple clinical interventions. A facility Medication Error form was completed for these incidents. Resident #64's attending physician was notified that facility failed to document blood pressures associated with medication hold parameters per physician orders and administered BP medications when the BP was below the hold parameters. A facility Medication Error form was completed for this incident. Resident #51's attending physician was notified that the facility failed to document the administration of a G-Tube feeding and flush per physician orders. A facility Medication Error form was completed for this incident. Resident #73's attending physician was notified that the facility failed to document the administration of the medication Buspar and Selsun Blue Shampoo per physician orders. A facility Mediation Error form was completed for this incident.	

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	495421		C 08/02/2018

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F 842	Continued From page 107 §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review it was determined that the facility staff failed to ensure a complete and accurate clinical record for 9 of 45 residents in the sample survey, Resident #56, Resident #67, Resident #12, Resident #64, Resident #51, Resident #73, Resident #83, Resident #99 and Resident #118. The Findings Included: 1. For Resident #56 the facility staff failed to ensure complete and accurate Physician Order Sheets (POS's) and July and August 2018 Medication Administration Records (MAR's). Resident #56 was a 64 year old female who was	F 842	Resident #83's attending physician was notified that the facility failed to document the administration of diclofenac and duonebs per physician orders and failed to record the resident's weight per physician orders. A facility Medication Error form was completed for this incident. Resident #99's attending physician was notified that the facility failed to document for the physician ordered bed and chair alarm and neutrashield cream. A facility Medication Error form was completed for these incidents. Resident #118's attending physician was notified that the facility failed to document for the administration of medications Azopt suspension and Oxybutin. A facility Medication Error form was completed for these incidents. **Identification of Deficient Practices/Corrective Action(s):** All other residents may have been potentially affected. The DON and Unit Managers will conduct a 100% audit of all resident's physician orders and MARs/TARs over the past 30 days to identify resident at risk. Residents identified at risk will be corrected at time of discovery and their comprehensive plans of care updated to reflect their resident specific needs. The attending physicians will be notified of each negative finding and a facility Incident & Accident Form will be completed for each negative finding.	

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F 842	Continued From page 108	F 842	Systemic Change(s):	

originally admitted on 1/6/18 and readmitted on 7/17/18. Admitting diagnoses included, but were not limited to: polycystic kidney, kidney transplant, diabetes mellitus, hemiplegia and hemiparesis following a cerebral infarction, dysphasia due to cerebral infarction and a gastrostomy tube.

The most current Minimum Data Set (MDS) assessment located in the clinical record was a Quarterly MDS with an Assessment Reference Date (ARD) of 6/27/18. The facility staff coded that Resident #56 Cognitive Summary Score was "99." The facility staff also coded that Resident #56 required extensive (3/2) to total nursing care (4/2) with Activities of Daily Living (ADL's). In Section K Swallowing and Nutritional Status, the facility staff coded that Resident #56 had a feeding tube and was receiving 51% or more of her nutrition by the feeding tube.

On August 1, 2018 at 1 p.m., the surveyor reviewed Resident #56 clinical record. Review of the clinical record produced physician orders. Physician orders included, but were not limited to the following orders: "NPO (nothing by mouth), All meds via G-tube feeding via J-tube, Aspirin Tablet Chewable 81MG Give 1 tablet by mouth one time a day for Hx (history) of stroke." (sic) The surveyor noted that all other medications were ordered to be administered by the feeding tube.

Further review of the clinical record produced the July and August 2018 Medication Administration Records (MAR's). The July and August 2018 MAR's documented that the facility staff were administering the Aspirin by mouth.

The surveyor went to the Director of Nursing's (DON's) office and asked to speak with her. The

The facility policy and procedure has been reviewed and revisions have been made in two areas; the medication block times have been altered so there is no overlap between time-frames and, further, the facility has worked with the facility's EHR provider to eliminate the time frames before and after each medication block, thereby reducing the time in which medications can be administered in a compliant manner. Licensed staff will be in-serviced by the DON and/or designee on these changes to the medication administration program. The DON and/or designee will also in-service all licensed nursing staff on the procedure for obtaining, transcribing, and completing physician medication and treatment orders. Lastly, the DON and/or designee has in-serviced the staff on the Nursing Documentation Policy and Procedure, including the timelines and regulations regarding correcting an oversight in documention.

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F 842	Continued From page 109 DON and surveyor walked over into the conference room. The surveyor notified the DON that Resident #56's Aspirin 81 mg was ordered to be administered by mouth. However, the physician orders also documented that Resident #56 was NPO. The surveyor pointed out that all other medications were ordered to be given by the feeding tube. The surveyor reviewed Resident #56's clinical record with the DON. The surveyor reviewed the physician orders and the July and August 2018 MAR's with the DON. The surveyor notified the DON that Resident #56's POS's and July and August 2018 MAR's were inaccurate as Resident #56 was NPO and the Aspirin was being given by the feeding tube and not by mouth. On August 1, 2018 at 4:36 p.m., the survey team met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #56's clinical record was inaccurate. The surveyor notified the AT that Resident #56 received all of her medications by feeding tube. Yet the physician orders and July and August 2018 MAR's documented that the Aspirin was ordered and being given by mouth. No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #56. The facility staff failed to ensure complete and accurate POS's and July and August 2018 MAR's. 2. For Resident #67 the facility staff failed to ensure that the March 2018 monthly Drug Regimen Review (DRR) was contained in the clinical record.	F 842	**Monitoring:** The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers will perform weekly MAR/TAR and chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. Aggregate findings of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date:** September 16, 2018	

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F 842	Continued From page 110	F 842		

Resident #67 was a 60 year old male who was admitted on 6/20/17. Admitting diagnoses included, but were not limited to: multiple sclerosis, chronic lymphocyte leukemia of B-cell type, chronic diastolic heart failure and benign prostatic hyperplasia.

The most current Minimum Data Set (MDS) assessment located in the clinical record was an Annual MDS assessment with an Assessment Reference Date (ARD) of 6/28/18. The facility staff coded that Resident #67 had a Cognitive Summary Score of 15. The facility staff also coded that Resident #67 was independent (0/0) to required extensive assistance (3/2) with Activities of Daily Living (ADL's).

On August 1, 2018 at 2:10 p.m., the surveyor reviewed Resident #67's clinical record. Review of the clinical record failed to produce the March 2018 DRR.

On August 1, 2018 at 2:35 p.m., the surveyor notified the Director of Nursing (DON) that review Resident #67's record failed to produce the March 2018 DRR. The surveyor and DON reviewed Resident #67's clinical record. The surveyor pointed out that the March 2018 DRR was not in the clinical record. The DON stated that the DRR should be in the clinical record, but she would see if she could locate the March 2018 DRR.

On August 1, 2018 at 3:30 p.m., the DON hand delivered the March 2018 DRR. The DON stated that the pharmacy had faxed the March 2018 DRR to her.

On August 1, 2018 at 4:38 p.m., the survey team

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F 842 Continued From page 111

F 842

met with the Administrator (ADM) and DON. The surveyor notified the Administrative Team (AT) that Resident #67's clinical record did not include the March 2018 DRR.

No additional information was provided prior to exiting the facility as to why the facility staff failed to ensure a complete and accurate clinical record for Resident #67. The facility staff failed to ensure that Resident #67's clinical record contained the March 2018 DRR.

3. For Resident #12, facility staff failed to document daily care and treatment in the clinical record.

Resident #12 was admitted to the facility on 7/14/17. Diagnoses included diabetes mellitus with neuropathy, insulin use, hypertensive heart disease with heart failure, peripheral venous insufficiency, and depression. On the quarterly minimum data set assessment with assessment reference date 4/30/18, the resident scored 13/15 on the brief interview for mental status and was assessed as without delirium, psychosis, or behaviors affecting others. The resident scored 1/37 on the mood assessment (higher scores indicate greater presence of depressive symptoms).

During clinical record review, the surveyor noted blanks in the medication administration record on 7/20 and 7/30/18 for administration of Levothyroxine Sodium Tablet 200 microgram one time a day for hypothyroidism, the 06:00 dose of hydralazine hydrochloride tablet 100 milligram by mouth every 8 hours for hypertension, and for the 06:00 Tylenol Extra Strength 500 milligram give 2 tablets every 8 hours for pain. There were blanks on the treatment administration record for

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F 842 Continued From page 112

F 842

Mepilex to right shoulder every other day on 7/8; Vital signs every day shift to be verified by nurse on July 4, 5, 7, and 8; Miracle Cream to buttocks/sacrum/ peri area on July 5, 7, 8, and 29; skin prep to bilateral heels on July 5, 7, 8, and 29; Vaseline to both feet on July 5, 7, 8, and 29; Bed alarm as resident allows on July 5, 7, 8, and 29; bed in low position on July 5, 7, and 8; and encourage cough and deep breathing on July 5, 7, and 8.
The surveyor reported the concern to the director of nursing and administrator during a summary meeting on 8/2/18.

4. For Resident #64, facility staff failed to document blood pressures associated with medication with hold parameters.

Resident #64 was admitted to the facility on 1/16/18. Diagnoses included hypertensive heart disease with heart failure, respiratory failure, atrial fibrillation, and chronic obstructive pulmonary disease. On the minimum data set assessment with assessment reference date 6/21/18, the resident scored 13/15 on the brief interview for mental status and was assessed as exhibiting symptoms of delirium, psychosis, and verbal aggression on 1-3 days of the 7 day lookback period.

During clinical record review, the surveyor noted a physician order dated 5/24/2018 for Coreg Tablet 3.125 mg(milligram) give 1 tablet 2 times a day for HTN (hypertension)- parameters in place Hold for systolic BP equal to or less than 120 (scheduled AM and EVENING) and an order dated 7/16/18 for Lasix 20 mg Give 1 tablet by mouth one time a day for edema Lasix 20 mg at 2 PM **hold for Systolic BP<100** and an order

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 113 dated 7/16/18 for Lasix Tablet 40 mg Give 1 tablet by mouth one time a day for edema **hold for Systolic BP <100** (scheduled EARLY). These orders would require staff to check blood pressure 3 times per day if EARLY and AM medications were administered together or 4 times per day if EARLY and AM medications were administered separately. The surveyor was unable to locate documentation of blood pressures as often as daily during July 2018. The Blood Pressure Summary documented Blood pressures on 7/29/18 at 09:21 was 131/81; on 7/17/18 at 10:05 was 121/88; on 7/12/18 at 17:13 was 135/91; and on 7/10/18 at 10:10 was 112/79. Staff documented administering the Coreg 3.125 mg on 7/10/18 in the AM when the blood pressure was below the hold parameter. The Treatment Administration Record included an order dated 6/20/18 for Vital Signs Qweek every day shift every Wednesday for Vital signs were obtained and verified by nurse. This was checked on 7/4, 7/11, 7/18, and 7/25. Those blood pressures were not documented. The surveyor interviewed the resident's medication nurse on 7/26/18. The nurse stated that CNAs obtained vital signs daily and the nurse entered them into the clinical record and the software would tell the nurse to hold the medication if the vital signs met hold parameters. The nurse was unable to retrieve the blood pressures for that day. The administrator and director of nursing were notified of the concern during a summary meeting on 7/26/18. 5. For Resident #51, the facility failed to document for the administration of a g-tube feeding and flush.	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 842 Continued From page 114

F 842

The record review revealed that Resident #51 had been admitted to the facility 05/26/18. Diagnoses included, but were not limited to, dysphagia, aphasia, hypertensive heart disease, gastroesophageal reflux disease, and cerebral infarction.

Section C (cognitive patterns) of the Resident admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/02/18 had been coded 1/1/3 to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making.

A review of the Residents eMARs (electronic medication administration records) for 07/2018 revealed that the nursing staff had not documented that they had administered the Residents osmolite feeding or that they had completed the Residents peg tube flush on 07/20/18.

The surveyor requested that the facility staff print the eMARs.

When the eMARs were provided to the surveyor the surveyor again reviewed the eMARs and was unable to find any "holes" where the nursing staff had failed to document for the osmolite tube feeding and flush.

On 08/02/18 at approximately 9:33 a.m., the surveyor asked the DON (director of nursing) if she knew why the eMARs provided had no holes present. The DON verbalized to the surveyor that she did not know she was just printing them.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 115 On 08/02/18 at 9:35 a.m., the surveyor asked LPN (licensed practical nurse) #4 if she had any idea why the "holes" on the eMARs provided to the surveyor were now filled in with nurse's initials. LPN #4 replied, "No." However, the surveyor spoke with LPN #4 again at 9:45 a.m. and LPN #4 stated she did not understand what was being asked earlier and that she had filled in the holes for Resident #4. She stated she knew she had worked with the Resident that day (07/20) and saw she had missed signing so she filled them in. When asked to explain that LPN #4 stated she had edited the eMARs. LPN #4 was able to show the surveyor on the medication audit report where she had signed on 08/02/18 at 8:46 a.m. that she had completed both of these tasks for 07/20. The surveyor interviewed the DON on 08/02/18 at 11:30 a.m., when asked about the holes on the eMARs the DON stated the nurses were allowed to go back up to two weeks and fill in eMARs. The DON then added they had a lot of agency staff working and the supervisor would go back and document. On 08/02/18 at 2:50 p.m., LPN #4 stated to the surveyor that they were told last night they had 30 days to go back and fill in holes on the eMARs. LPN #4 stated she felt very uncomfortable when she was asked about it this am. She then stated she would not do that again (fill in the holes). The facility provided the survey team with a copy of a policy titled "NURSING DOCUMENTATION" this policy read in part "PURPOSE: 1. To substantiate daily care, communicate the resident's needs and care received..."	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 842 Continued From page 116

F 842

The administrative team were notified of the above during a meeting with the survey team on 08/02/18 at 8:35 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

6. For Resident #73, the facility nursing staff failed to document for the medication buspar and for selsun blue shampoo.

The record review revealed that Resident #73 had been admitted to the facility 06/22/18. Diagnoses included, but were not limited to, diabetes, malignant neoplasm, hypertension, urinary rendition, and anxiety disorder.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/29/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

A review of the Residents eMARs (electronic medication administration records) revealed that the nursing staff had failed to document for the administration of the Residents buspar (07/16) and for the application of the Residents selsun blue shampoo (07/27).

The surveyor requested copies of the eMARs.

When the eMARs were provided to the surveyor the surveyor again reviewed the eMARs and was unable to find any "holes" where the nursing staff had failed to document for buspar.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 842 Continued From page 117

A review of the medication audit report revealed that the nursing staff had documented for the administration of the buspar for 07/16 on 08/02 at 8:34 a.m.

During an interview with Resident #73 on 08/01/18 at 2:35 p.m., Resident #73 stated there has not been a time when she did not receive her medication.

The surveyor interviewed the DON (director of nursing) on 08/02/18 at 11:30 a.m., when asked about the holes on the eMARs the DON stated the nurses were allowed to go back up to two weeks and fill in eMARs. The DON then added they had a lot of agency staff working and the supervisor would go back and document.

The facility provided the survey team with a copy of a policy titled "NURSING DOCUMENTATION" this policy read in part "PURPOSE: 1. To substantiate daily care, communicate the resident's needs and care received..."

The administrative team were notified of the above during a meeting with the survey team on 08/02/18 at 8:35 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

7. For Resident #83, the facility nursing failed to document for the administration of the medication diclofenac, duonebs, and record the Residents weights.

The clinical record review revealed the Resident #83 had been admitted to the facility 06/10/18.

F 842

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 842 Continued From page 118

F 842

Diagnoses included, but were not limited to, normal pressure hydrocephalus, ataxia, hypertensive heart disease with heart failure, unspecified convulsions, gastroesophageal reflux disease, and sleep disorder.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 06/17/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

A review of the Residents eMARs (electronic medication administration records) revealed that the facility nursing staff had failed to document for the Residents diclofenac (07/16, 07/23, 07/25) and duonebs (07/23, 07/25) and failed to document the Residents weights on 07/01, 07/04, 07/07, and 07/28.

The surveyor requested copies of the eMARs.

When the eMARs were provided to the surveyor the surveyor again reviewed the eMARs and was unable to find any "holes" where the nursing staff had failed to document for diclofenac and duonebs. All of the weights had been recorded except for 07/01.

During an interview with Resident #83 on 08/01/18 at 2:35 p.m., Resident #83 stated there has not been a time when she did not receive her medication(s).

A review of the medication administration report revealed that RN (registered nurse) #1 had documented for the administration of the medications and for the weights on 08/02/18.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 842 Continued From page 119

F 842

On 08/02/18 at 11:45 a.m., RN #1 was interviewed regarding the eMARs. RN #1 stated she had filled in the holes on the eMARs and that she was at the facility on the days in question. When asked if she actually administered the medications she stated, "Yes, I was assisting my nurses." When asked about the weights that had been documented she stated she had a paper with the weights listed. When asked if she had a made a late entry regarding the documentation of the medications/weights she stated "No, not yet."

The surveyor interviewed the DON (director of nursing) on 08/02/18 at 11:30 a.m., when asked about the holes on the eMARs the DON stated the nurses were allowed to go back up to two weeks and fill in eMARs. The DON then added they had a lot of agency staff working and the supervisor would go back and document.

The facility provided the survey team with a copy of a policy titled "NURSING DOCUMENTATION" this policy read in part "PURPOSE: 1. To substantiate daily care, communicate the resident's needs and care received..."

The administrative team were notified of the above during a meeting with the survey team on 08/02/18 at 8:35 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

8. For Resident #99, the facility nursing staff failed to document for the Residents bed alarm, chair alarm and neutrashield cream.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 120	F 842		

The clinical record review reveled that Resident #99 had been admitted to the facility 07/06/18. Diagnoses included, but were not limited to, Parkinson disease, muscle weakness, anxiety disorder, repeated falls, and essential hypertension.

Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/13/18 included a BIMS (brief interview for mental status) summary score of 15 out of a possible 15 points.

A review of the Residents eTARs (electronic treatment administration records) revealed that the nursing staff had failed to document for the Residents bed alarm, chair alarm, and neutrashield cream on 07/17/18 on the evening shift.

The facility provided the survey team with a copy of a policy titled "NURSING DOCUMENTATION" this policy read in part "PURPOSE: 1. To substantiate daily care, communicate the resident's needs and care received..."

The administrative team were notified of the above during a meeting with the survey team on 08/02/18 at 8:35 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

9. For Resident #118, the facility staff failed to document for the administration of medications azopt suspension and oxbutynin.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 842	Continued From page 121 The clinical record review revealed the Resident #118 had been admitted to the facility 07/19/18. Diagnosis included, but were not limited to, cerebral infarction, dysphagia, diabetes, glaucoma, and depressive disorder. Section C (cognitive patterns) of the Residents admission MDS (minimum data set) assessment with an ARD (assessment reference date) of 07/26/18 had been coded to indicate the Resident had problems with long and short term memory and was severely impaired in cognitive skills for daily decision making. However, the surveyor found that Resident #118 was able to answer questions appropriately at the time of the survey. A review of the Residents eMARs (electronic medication administration records) revealed that the facility nursing staff had failed to document for the Residents azopt and oxbutynin on 07/23 and 07/25. The surveyor requested copies of the eMARs. When the eMARs were provided to the surveyor the surveyor again reviewed the eMARs and was unable to find any "holes" where the nursing staff had failed to document for these medications. A review of the medication administration report revealed that RN (registered nurse) #1 had documented for the administration of the medications on 08/02/18. During an interview with Resident #118 on 08/01/18 at 2:35 p.m., Resident #118 stated there has not been a time when she did not receive her medication(s).	F 842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	495421		C 08/02/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 842 Continued From page 122

On 08/02/18 at 11:45 a.m., RN #1 was interviewed regarding the eMARs. RN #1 stated she had filled in the holes on the eMARs and that she was at the facility on the days in question. When asked if she actually administered the medications she stated, "Yes, I was assisting my nurses." When asked if she had a made a late entry regarding the documentation of the medications she stated "No, not yet."

The surveyor interviewed the DON (director of nursing) on 08/02/18 at 11:30 a.m., when asked about the holes on the eMARs the DON stated the nurses were allowed to go back up to two weeks and fill in eMARs. The DON then added they had a lot of agency staff working and the supervisor would go back and document.

The facility provided the survey team with a copy of a policy titled "NURSING DOCUMENTATION" this policy read in part "PURPOSE: 1. To substantiate daily care, communicate the resident's needs and care received..."

The administrative team were notified of the above during a meeting with the survey team on 08/02/18 at 8:35 p.m.

No further information regarding this issue was provided to the survey team prior to the exit conference.

F 842