STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB N	O. 0938-0:	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
		495421	B. WING_			С	
FRIENDS	PROVIDER OR SUPPLIER SHIP HEALTH AND REH	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE  5647 STARKEY ROAD  CAVE SPRING, VA 24018				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT	II D RE	(X5) COMPLETION	
E 000	Initial Comments		ΕO	00	2002 %		
F 000	The facility was in si	he survey.	Foo	00			
F 550 SS=D (1)	and Complaint surve through 08/02/18. Six investigated during the required for compliant Federal Long Term Council Virginia Rules and Regular of Nursing Facilities, survey/report will follow. The census in this 12 115 at the time of the consisted of 40 current closed record reviews. Resident Rights/Exerc CFR(s): 483.10(a)(1)(6) 483.10(a) Resident Fine resident has a right self-determination, and access to persons and council to the facility, including the facility in the section.	0 certified bed facility was survey. The survey sample of Resident reviews and 5 coise of Rights 2)(b)(1)(2)  Rights. It to a dignified existence, of communication with and of services inside and services in services in services in services in services in services i	F 550	F550 Corrective Action(s): Resident #29 has received proper silverware for her meals since this incident.  Identification of Deficient Practic Corrective Action(s): All residents may have potentially be affected. The Dietary Director has created an audit mechanism that alled dining staff to ensure proper silverw on each resident tray prior to it leaving kitchen. Negative findings identifies be corrected at time of discovery and forwarded to the Administrator for corrective action, if necessary.	een Sows II are is on the law iii	SEP 0 4 2018	
	ECTOR'S OR PROVIDER/SU	PPLIER REPRESENTATIVE'S SIGNATURE	· · · · · · · · · · · · · · · · · · ·	TITLE	(X6)	DATE	
	· · / 1			Director of Operations		1   18	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/24/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495421 B. WING NAME OF PROVIDER OR SUPPLIER 08/02/2018 STREET ADDRESS, CITY, STATE, ZIP CODE FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH 5647 STARKEY ROAD CAVE SPRING, VA 24018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 550 Continued From page 1 F 550 Systemic Change(s): individuality. The facility must protect and The Dietary Director has in-serviced her promote the rights of the resident. staff on Resident Rights and ensuring that residents have a dignified dining §483.10(a)(2) The facility must provide equal experience. In the event of an emergency, access to quality care regardless of diagnosis, whereby plastic cutlery is needed to be severity of condition, or payment source. A facility distributed to residents, the Dietary must establish and maintain identical policies and Director and the RD have in-serviced the practices regarding transfer, discharge, and the dining staff on assisting the residents with provision of services under the State plan for all opening the plastic cutlery package at tray residents regardless of payment source. delivery. The facility's current policy and procedure and Resident Rights list have §483.10(b) Exercise of Rights. been reviewed and no changes are The resident has the right to exercise his or her warranted at this time. rights as a resident of the facility and as a citizen or resident of the United States. Monitoring: The Dietary Director is responsible for §483.10(b)(1) The facility must ensure that the compliance. Results of the audit will be resident can exercise his or her rights without reviewed by the Administrator weekly for interference, coercion, discrimination, or reprisal 3 months. Aggregate findings will be from the facility. reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice. §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 Completion Date: September 16, 2018 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 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

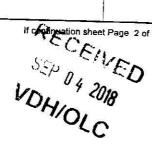
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The findings included.

The Facility staff failed to provide Resident #29 with silverware. The Resident was provided with

Event ID: K4V211

Facility ID: VA0419



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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	8	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING_		C 08/02/2018
	ROVIDER OR SUPPLIER	B CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CO 5647 STARKEY ROAD CAVE SPRING, VA 24018	
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 550	Continued From page	<b>2</b>	F 5	50	
		als. Resident # 29 stated it ne was eating at a fast food			8
	had been admitted to	realed that Resident #29 the facility 08/13/16. but were not limited to,	J	ļ	:
!	essential hypertensio gastroesophageal ref	n, constipation, and	Ĭ		
	quarterly MDS (minimum) with an ARD (assessment)	patterns) of the Residents num data set) assessment ment reference date) of IIMS (brief interview for		Ī	
j L	mental status) summa possible 15 points. Se was coded to indicate	ary score of 15 out of a ection G (functional status)			
ĵ	Resident was coded a	ns not having any functional notion in the upper or lower	1	N.	ì
	focus area is edentulo but were not limited to preferences and obse	sive care plan) included the bus. Interventions included, i, honor my rights rve for changes in daily ght changes and report.	s i	į	
1	held with seven alert a the facility. During this stated she was given	.m., a group interview was and orientated Residents of meeting, Resident #29 plastic cutlery with some of 29 stated no one else has			
		I feel like I am eating fast			
		m., the surveyor manager. The dietary as not aware Resident #29			

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Event ID; K4V211

Facility ID: VA0419

If continuation sheet Page 3 of 123



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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED	
		495421	B. WING			C 08/02/2018
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH		B CENTER - SOUTH		5647 ST	ADDRESS, CITY, STATE, ZIP CODE ARKEY ROAD PRING, VA 24018	1 00/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	20.00	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 550		cutlery.  d DON (director of nursing)	F	550		
	were notified of this is approximately 4:45 p.	.m.				4
		a.m., Resident #29 stated it e plastic cutlery out of the				
	assistant) #1 was ask cutlery CNA #1 stated Resident #29 had rec However, she did not	know why. CNA #1 stated				
20 00 00 00 00 00 00 00 00 00 00 00 00 0	the kitchen.	me out with the trays from				
	about the use of silver Dietary aide #1 stated	, dietary aide #1 was asked rware vs plastic cutlery. I I don't know why someone ery you would need to talk to or the physician		:		Ţ
·	dietician and dietary n explain why the Resid	during an interview with nanager neither staff could lent was receiving plastic not on her tickets (diet istory.	Ĺ			
	The administrative sta during a meeting with 08/02/18 at 8:35 p.m.	iff were notified of the above the survey team on				
	No further information provided to the survey conference.	regarding this issue was team prior to the exit				
F 554		Meds-Clinically Approp	F 5	54		į

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Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 4 of 123

SEP 0 4 2018 VDH/OLC

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIE	PLE CONSTRUCTION	OMB NO. 0938-039
and Plan o	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		(X3) DATE SURVEY COMPLETED
	<u> </u>	495421	B. WING		С
	ROVIDER OR SUPPLIER	3 CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	08/02/2018
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
	this practice is clinicall This REQUIREMENT by: Based on observation interview, clinical record document review it was facility staff failed to as the sample survey for sadministration, Resided: The Findings Included: Resident #67 was a 60 admitted on 6/20/17. As nocluded, but were not is sclerosis, chronic lympics.	nt to self-administer rdisciplinary team, as (2)(ii), has determined that ly appropriate. is not met as evidenced i, resident interview, staff rd review and facility s determined that the lisess 1 of 45 residents in lisefe self-medication int # 67.  year old male who was dmitting diagnoses	F 55-	Corrective Action(s): An assessment for self-administ medications was completed for #67. With no concerns being for Resident #67 is able to keep the medications at bedside. Unit medications at bedside. Unit medication self-administration must be conducted prior to a readministering a medication on a self-administering a medication on the self-administration of medication medication of medication to proper safety assessments are in Any/all negative findings identified to corrected at the time of discontinuation	Resident ound, ese anagers ment that a assessment sident self- their own.  actices & for self- nay have DON on 100% of ensure a place. ified will
F S C C tt A A C irr sp ac	Annual MDS assessme Reference Date (ARD) of taff coded that Resider Summary Score of 15. To oded that Resident #67 or required extensive as activities of Daily Living on July 31, 2018 at 2:45 terviewed Resident #67 pecifically interviewed a dministering Resident #	the clinical record was an ent with an Assessment of 6/28/18. The facility of #67 had a Cognitive of Facility staff also of was independent (0/0) sistance (3/2) with (ADL's).  5 p.m., the surveyor of the facility staff facility staff facility staff facility staff facility staff had too		Systemic Change(s): Current facility policy and prochave been reviewed with no chawarranted at this time. All nurs will be inserviced by the DON designee on the Self-Administra Medications and Treatments Po	anges sing staff or ation of

Event ID: K4V211

Facility ID: VA0419

RECEIVED SEP 0 4 2018 VDH/OLC

If continuation sheet Page 5 of 123

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

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	186 18		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		2004		V			С
		495421	B. WING	B. WING		08	/02/2018
	ROVIDER OR SUPPLIER HIP HEALTH AND REHAE			56	TREET ADDRESS, CITY, STATE, ZIP CODE 647 STARKEY ROAD AVE SPRING, VA 24018		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
	nurses trying to get the Resident #67 stated the Resident #67 stated the emergency everyone that his medications we ordered by the physic that he kept some of the form of the bed. Resident and up his bedside table, and has bedsident #60 form of the clinical record period the clinical record period form of the clinical record form of the clinical review of the produce a safe self-mere record form of the clinical form of the clinical record form	e medications administered.  Inat if there was an area to the emergency and were not administered as ian. Resident #67 stated as medications at the side #67 reached over, opened and retrieved his Flonase abruvica. Resident #67 was for his leukemia and anoth.  2:10 p.m., the surveyor 7's clinical record. Review roduced physician orders, ded, but were not limited to: 50MCG/ACT (Fluticasone in both nostrils one time a pervised self-administration adside. Imbrivica Tablet 140 tablet by mouth one time a SIDENT TO SELF ERVISED, PREFERS TO M. MAY KEEP IN sic)  e clinical record failed to edication assessment for 12:35 p.m., the surveyor Nursing (DON) that ications, Flonase and of his bed that he was surveyor notified the DON is #67's clinical record failed to seessment for Resident #67	F	554	Monitoring: The DON and/or Unit Managers are responsible for maintaining compliant DON and/or Unit Managers will comp weekly audits to monitor that medical self-administration assessments has been conducted for residents wish to self-administer medications. Negative findings will result in disciplinary action as required. Aggregindings will be reported to the QA Committee for review, analysis, and recommendations of change in facility policy, procedure, or practice.  Completion Date: September 16, 201	olete tion ve ing	

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Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 6 of 123

RECEIVED SEP 0 4 2018 VDH/OLC

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 CO A. BUILDING	NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING		C 08/02/2018
	ROVIDER OR SUPPLIER	B CENTER - SOUTH	5647	ET ADDRESS, CITY, STATE, ZIP CODE STARKEY ROAD E SPRING, VA 24018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION
F 554	The DON stated that medication self-admin clinical record. The D Resident #67's clinical could find the assess requested the facility residents to safely self-administration of Treatments." The popart  "Procedure: 1. Reside self-administration of the above assessment of the above assessment by the attending physimust state, May self-Keep at Bedside."  On August 1, 2018 at met with the Administration of the above assessment by the attending physimust state, May self-Keep at Bedside."	Resident #67 should have a nistration assessment on his ON stated she would review at record and see if she ment. The surveyor policy and procedure for If-administer their own  3 p.m., the DON hand policy and procedure titled, of Medications and policy and procedure read in the swho wish to the swho wish to the swho medications must lity to accomplish this task by cognitive, physical, and plan team and attending the each resident by symmetric for and with the written order and with the written order and with the written order administer medications-or  4:38 p.m., the survey team that and with the survey team that and with the side of elf-administrative Team (AT) at medications at the side of elf-administering. The AT that Resident #67 had	F 554		

PRINTED: 08/24/2018 FORM APPROVED

STATEMENT	OF DEFICIENCIES	OVAL PROJECTION			OMB NO. 0938-03	391
AND PLAN C	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495421	B. WNG	<del>-</del>	C 08/02/2049	
6	PROVIDER OR SUPPLIER  HIP HEALTH AND REHAE	3 CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD	08/02/2018	
1 - 102 - 104		Accessorates protesting of the control of the contr		CAVE SPRING, VA 24018		
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETIO	)N
	No additional informat exiting the facility as to to assess Resident #6 administration.  Self-Determination CFR(s): 483.10(f)(1)-(3)  §483.10(f) Self-determ The resident has the ripromote and facilitate through support of resinot limited to the rights (1) through (11) of this §483.10(f)(1) The residactivities, schedules (in waking times), health ocare services consister assessments, and planapplicable provisions of §483.10(f)(2) The residactivities about aspects facility that are significate §483.10(f)(3) The residactivities about aspects facility that are significate §483.10(f)(3) The residactivities and planapplications about aspects facility that are significates	ion was provided prior to be why the facility staff failed in the facility staff failed in the facility must resident self-determination ident choice, including but a specified in paragraphs (f) section.  Ident has a right to choose including sleeping and sare and providers of health in the with his or her interests, in of care and other if this part.  ent has a right to make of his or her life in the lant to the resident.	F 561	4	desires ea  l es & ally their tere it	
	community activities bo facility.  §483.10(f)(8) The reside participate in other activities religious, and communities interfere with the rights facility.  This REQUIREMENT is by:	vities, including social, by activities that do not of other residents in the s not met as evidenced		facility grounds has been created. The Policy identifies safe areas and areas deemed unsafe for residents. All staff residents will be educated on this new policy by the Social Services Directo	Tand	
	IN 100IGON INC	view, staff interview, and				

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 8 of 123

SEP 0 4 2018
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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	2900 140 00		OMB N	10. 0938-039	
AND PLA	N OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		495421	B. WING_		21/52	С	
	OF PROVIDER OR SUPPLIER  DISHIP HEALTH AND REHAL	3 CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIF 5647 STARKEY ROAD CAVE SPRING, VA 24018	CODE	8/02/2018	
(X4) II PREFI TAG	X   (EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN C	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 56	clinical record review, promote and facilitate support of resident's c in the survey sample,  The findings included:  The facility staff failed go outside on the facility a leave of absence for occurred on 6/15/18.  Resident # 61 was a 53 admitted to the facility c included but were not limuscle wasting and attribenign neoplasm of the The clinical record for Freviewed on 8/1/18 at 1 MDS (minimum data se quarterly assessment was reference date) of 6/29/cognitive patterns. In Sestaff documented that R (brief interview for ment of 15, which indicates the cognitively intact.  The current plan of care reviewed and revised or documented a focus are	the facility staff failed to self-determination through hoice for 1 of 45 Residents Resident # 61.  to allow Resident # 61 to ty property without signing m following a fall that  3-year-old female who was on 3/9/17. Diagnoses mited to: anxiety disorder, ophy, depression, and brain.  Resident # 61 was 1:25 am. The most recent the an ARD (assessment was a sith an ARD (assessment 18. Section C assesses ection C0500, the facility resident # 61 had a BIMS all status) score of 15 out that Resident # 61 was  for Resident # 61 was 1:4/16/18. The facility staff a for Resident # 61 as "I chosocial well-being and ons for this focus area mited to: "Encourage me choosing." The facility focus area for Resident as the potential for little	F 5		ector is ing compliance. ector will conduct or for compliance erstand the new dings will result required. be reported to the w, analysis, and nge in facility ctice.		

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		C	(X3) DATE SURVEY COMPLETED	
		495421	B. WNG	300 M	Si .	С	
NAME OF P	ROVIDER OR SUPPLIER		J. Wille	STREET ADDRESS, CITY, STATE, ZIP CODE		08/02/2018	_
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH			5647 STARKEY ROAD CAVE SPRING, VA 24018	•			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR  X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE, DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 561	Continued From page	9	F:	561	s		
	of own customary rou but were not limited to are: Motorcycles, read People, Cosmopolitan tablet/smartphone, ou	tine." Interventions included, b: "My preferred activities ding magazines (Glamour, r), music, TV (television), tdoors, dog visits, socials." s's rights, preferences, and					
	interview with Resider expressed to the surve because she was not facility property withou (leave of absence). The	eyor that she was upset able to go outside on the t signing herself out LOA e surveyor asked Resident					
	actually leaving the factoring to explain that sage and the facility state LOA so they would not	gn out LOA if she was not cility grounds. Resident # 61 she had a fall a few weeks iff wanted her to sign out be held liable if she fell. hat she liked to go outside air on the side of the					
i	building so that she co Resident # 61 explaine fall, she made an arrar	uld see inside of her room.  Id that on the day of the agement with a CNA	Į	į			
i	and that she would cor get her to bring her bac stated that she told the her cell phone to call if	tant) to take her outside ne back in 30 minutes to ck inside. Resident # 61 CNA that she would use she wanted to come in					
) ;	it up off the ground. Re	she dropped her cell to reach her phone to pick sident # 61 stated that she o a window where staff		[			
2 2	attention. Resident # 6 over a rock or somethir	I stated, "I guess I rolled ng," that she thought that chair went off the sidewalk	v.	.2 n			Section 1

TATELACA		WEDICAID SERVICES				
ND PLAN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	1	46 3000
	energy and energy of the	IDENTIFICATION NUMBER:	A. BUILDI		CON	MPLETED
		405404				C
NAME OF	PROVIDER OR SUPPLIER	495421	B. WING_		رم ا	(780)
				STREET ADDRESS, CITY, STATE, ZIP CODE		5/02/2018
FRIEND	SHIP HEALTH AND REHAL	CENTER - SOUTH		5647 STARKEY ROAD		
Z				CAVE SPRING, VA 24018		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL	10	PROVIDER'S PLAN OF CORRECT	TION	<del></del>
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	PREFIX TAG	LEACH CORRECTIVE ACTION SHO	III D RE	
			,,,,,	CROSS-REFERENCED TO THE APPR DEFICIENCY)	OPRIATE	DATE
E 504		\$0				<u> </u>
F 561	Continued From page	10	F 5	61		
	53×5		1.10			
	On 8/2/18 at 2:40 pm,	the surveyor spoke with				
	the administrator regar	rding Resident # 61 having				1
	to sign out LOA to be o	on the facility property. The				ļ
	Surveyor explained to	ne administrator that				
	to sign out LOA to go o	that the facility wanted her	s.li			
	grounds so that the fac	illity would not be to				PRIATE COMPLETION DATE
that h	liable if she fell again	The administrator stated			81	
	that he did not feel that	the area that Resident #	1			
	61 was in had been a s	afe area and this was his				
	way of keeping up with	where she was The				
	surveyor spoke with the	administrator and			1	
	recapped the fall that o	ccurred on 6/15/18. The		1	Ì	
	administrator agreed th	at Resident # 61 had a				
5	facility staff member tak	e her outside therefore	1			
3	someone in the facility I	knew where she was. The	1		j	
	auministrator also agree	ed that Resident # 61 had	i			
	and take her in at a	aff member to come back				
	and take her in at a cert asked the administrator	ain time. The surveyor			ĵ	
1	required to sign out LO	to go out on the facility				
ŀ	grounds prior to the fall	that occurred on 6/15/18	1		Ï	
ĺ	and the administrator re	sponded "No."		1		
la	100					
Ì	On 8/2/18 at 9:25 pm, th	e administrative team			ļ	
	was made aware of the	findings as stated above.				
i			Ì			
	team prior to the and	as provided to the survey				
573	team prior to the exit cor	rerence on 8/2/18.		F573		
- PO 1975 VS 95	Right to Access/Purchas CFR(s): 483.10(g)(2)(i)(ii	e Copies of Records	F 573	Corrective Action(s):		
יט-טי	or (1(a). 400. (U(g)(2)(I)(II	)(3)		Social Services has met with resider	j	
1	§483.10(g)(2) The reside	nt has the right to		and Alven Der the concertunity to	• Court page	
	access personal and me	in nas the right to		inclinedical record Nurse #1 has be		
ı	to him or herself.	acar records pertaining		Serviced on Resident Rights regards	cii ili-	
	(i) The facility must provide	te the resident with		access to incorcal records and st-	16	
a	access to personal and n	nedical records		importance of communicating these		
- 1		1000743		requests to Medical Records, if need	L.	

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/24/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495421 B. WING NAME OF PROVIDER OR SUPPLIER 08/02/2018 STREET ADDRESS, CITY, STATE, ZIP CODE FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH 5647 STARKEY ROAD CAVE SPRING, VA 24018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 573 Continued From page 11 F 573 Identification of Deficient Practices & pertaining to him or herself, upon an oral or Corrective Actions(s): written request, in the form and format requested All other residents may have been by the individual, if it is readily producible in such potentially affected. The Social Services form and format (including in an electronic form Director will inform residents of their or format when such records are maintained rights to access their medical records. electronically), or, if not, in a readable hard copy form or such other form and format as agreed to Systemic Change(s): by the facility and the individual, within 24 hours Facility policy and procedures were (excluding weekends and holidays); and reviewed with no changes warranted at (ii) The facility must allow the resident to obtain a this time. The Social Services Director copy of the records or any portions thereof will in-service the nursing staff on the (including in an electronic form or format when facility policy & procedure regarding such records are maintained electronically) upon resident rights and access to personal and request and 2 working days advance notice to the medical records pertaining to him or facility. The facility may impose a reasonable, herself. cost-based fee on the provision of copies, provided that the fee includes only the cost of: Monitoring: (A) Labor for copying the records requested by Medical Records is responsible for compliance. The Medical Records will the individual, whether in paper or electronic form; perform daily audits to monitor for record (B) Supplies for creating the paper copy or request compliance. Any/all negative electronic media if the individual requests that the findings will be corrected at time of electronic copy be provided on portable media; discovery and disciplinary action will be taken as needed. Aggregate findings of (C)Postage, when the individual has requested the weekly audits will be reported to the the copy be mailed. QA Committee for review, analysis, and recommendations of change in facility §483.10(g)(3) With the exception of information policy, procedure, or practice. described in paragraphs (g)(2) and (g)(11) of this section, the facility must ensure that information Completion Date: September 16, 2018 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

PRINTED: 08/24/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING С 495421 B. WING 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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

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

of own customary routine."

Interventions included but were not limited to: "My preferred activities are: Motorcycles, reading

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 13 of 123

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PRINTED: 08/24/2018 **DEPARTMENT OF HEALTH AND HUMAN SERVICES** FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER COMPLETED A. BUILDING\_ C 495421 B. WING 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (X5)PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETION (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) Continued From page 13 F 573 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

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 A BUILDING	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 573	Continued From page	e 14	F 573		3.0
	the surveyor that she night if "they could give was in my chart." Res	er. Resident # 61 stated to asked a nurse later on that we me a report of the fall that sident # 61 stated to the se replied, "We can't give			
	On 8/1/18 at 11:39 an	n, the surveyor reviewed the			
	progress notes in Res A progress note that v 3:53 pm was documed visibly emotional and unexpected death of h has multiple outburst, at staff. Rsd is reques medical chart regarding she will be contacting protective services) if received within 48 hour medical information care consulting medical reconsulting medical reconsulting that she wou medical records to obt documentation. Rsd st hear about this it will b Administered rsd requestions.	wident # 61's clinical record.  was written on 6/18/18 at inted as "Rsd (Resident) upset this shift over the her father last night. Rsd complaints, and demands ting information from higher recent care stating attorney or APS (adult medical information not hirs of request. Rsd informed hin be released by sords. Rsd replies, "this is how I am treated in this heeds to know." Again, rsd have to go through hain the requested his stes, "the next time you will he from my attourney" hested medication and left			
	the administrator and t regarding Resident # 6 information regarding h	the surveyor spoke with he director of nursing 1 requesting to see			×
	that he was under the i 61 wanted to see a FR that was reported to the	mpression that Resident # I (facility reported incident) e Office of Licensure and histrator explained that he	3 2		

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

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	ROVIDER OR SUPPLIER	3 CENTER - SOUTH	37	STREET ADDRESS, CITY, STATE, ZIP COD 5647 STARKEY ROAD CAVE SPRING, VA 24018	08/02/2018 DE
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F 573	Continued From page	: 15	F 5	573	
į	met with Resident # 6 and explained that the related to fall that occ. The surveyor informed director of nursing that that she requested to related to the fall that surveyor asked the acc of nursing if Resident access to her clinical information that she renursing replied "No." The replied that Resident is records to get the information to the facility storogress note documed clinical record on 6/16	1 and the local ombudsman e facility did not submit a FRI urred with Resident # 61. d the administrator and the t Resident # 61 reported see information in her chart occurred on 6/15/18. The diministrator and the director # 61 had been allowed record to obtain the equested. The director of The director of nursing # 61 never went to medical rmation. The surveyor tt # 61 had made her needs aff as evidenced by the ented in Resident # 61's			
8	obtaining the informati director of nursing stat	ds to assist Resident # 61 in on that was requested. The			
	the administrator and a staff member from me On 8/2/18 at 2:43 pm,	the surveyor spoke with	fi *		) 
z	staff member from med On 8/2/18 at 9:35 pm, was made aware of the	the administrative team e findings as stated above er from medical records	1		n

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F 573	Continued From page	16				
	No further information provided to the survey conference on 8/2/18.	regarding this issue was team prior to the exit	F 570			
F 580 SS=D	Notify of Changes (Inju CFR(s): 483.10(g)(14)	iry/Decline/Room, etc.)	F 580	)		
t t c c c c c c c c c c c c c c c c c c	consistent with his or h representative(s) when (A) An accident involvir results in injury and has physician intervention; (B) A significant changemental, or psychosocial deterioration in health, istatus in either life-threadlinical complications); (C) A need to alter treat a need to discontinue alteratment due to advers commence a new form (D) A decision to transferesident from the facility (483.15(c)(1)(ii).  iii) When making notification; is available and provided hysician.  iii) The facility must also esident and the resident there is- A) A change in room or its specified in §483.10(es) A change in resident in the resident in general to the specified in §483.10(es) A change in resident in the resident in the resident in resi	diately inform the resident; nt's physician; and notify, er authority, the resident there is- ng the resident which is the potential for requiring in the resident's physical, a status (that is, a mental, or psychosocial atening conditions or ment significantly (that is, a existing form of e consequences, or to of treatment); or or or discharge the as specified in attenuate that specified in §483.15(c)(2) the promptly notify the representative, if any, commate assignment		Corrective Action(s): Resident number #54 and # 83's atte physician was notified of the signific weight gain. A facility Incident and Accident form was completed for the incidents.  Identification of Deficient Practices/Corrective Action(s): All other residents with significant we changes or residents with physician ordered weight change notifications in have potentially been affected. The D and/or designee will conduct a 100% audit of all residents with significant weight changes or physician ordered weight change notifications within the 60 days to ensure proper notification to the resident's attending physician. Negative findings will result in a propen notification to the attending physician the completion of a facility Incident & Accident form.	eight last o	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU		IPLE CONSTRUCTION	OMB NO. 0938-0391	
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	(e)(10) of this section (iv) The facility must update the address phone number of the representative(s).  §483.10(g)(15) Admission to a come that is a composite of §483.5) must disclorate its physical configurations that composite of §483.5) must disclorate its physical configuration to the facility of the physical section of the facility of the physical of the facility of the physical of the facility of the physician of the facility of the facility of the facility of the physician of the facility of the physician of the facility of	trecord and periodically (mailing and email) and e resident  posite distinct part. A facility distinct part (as defined in se in its admission agreement ation, including the various rise the composite distinct ify the policies that apply to seen its different locations.  T is not met as evidenced view and clinical record sined that the facility staff residents in the survey 4 and Resident #83.  ad:  the facility staff failed to of a significant weight gain.  63 year old male who was and readmitted on 5/16/18, included, but were not structive pulmonary disease, and chronic kidney disease stage 1 through stage 4 se, diabetes mellitus and imum Data Set (MDS)	F 5	Systemic Change(s): Facility policy and procreviewed with no revisithis time. The DON or service all licensed staff for following physician change notifications are notifying physicians in significant weight change.  Monitoring: The DON is responsible compliance. The DON: will perform an audit domanagement meetings to notifications have occur Any/all negative finding corrected at time of disciplinary action will needed. Aggregate find audits will be reported to Assurance Committee of review, analysis, and refor change in facility por and/or practice.  Completion Date: Septimers.	ons warranted at designee will infon the procedur order weight diproperly the event of a ge.  e for maintaining and/or designee aring weekly risk to ensure proper the diproperly and be taken as lings of these to the Quality quarterly for commendations olicy, procedure,	e
i i	assessment located i	n the clinical record was a	į			1

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

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F 580	Continued From page	e 18	, F 5	80	
	Quarterly MDS asses	ssment with an Assessment			
	Reference Date (ARI	D) of 6/20/18. The facility			
	staff coded that Resid	dent #54 had a Cognitive	İ		
	Summary Score of 15	5. The facility staff also	1		
	coded that Resident	#54 was independent with	9/2		j
	Activities of Daily Livi	ng (ADL's).	į.	10	
	On August 2, 2040 -	7.40			
	reviewed Resident #6	7:40 a.m., the surveyor 54's clinical record. Review	gi		
		produced physician orders.		Ü	ĺ
	Physician orders incli	uded, but were not limited to:		re	
	"Daily weight-gain of	2 pounds in 3 consecutive			
8		) in one week, call physician	ī		
	one time a day for Ro	utine." (sic) The order			ĭi
	originated on 5/16/18		30	3	
					8
		he clinical record produced		j	
		t record. Resident #54's	Ī		#i
	weight was document	ted as:			
	8/2/18 364.6 pc	nunds		I	,
	8/1/18 364 pou				
	7/31/18 358.6 pc				
	7/30/18 360 pounds				
	7/29/18 355 pounds				82
	7/27/18 152 pounds				9:
	7/26/18 349 pounds		ē.	81 50	ł
1	7/25/18 350.6 pound				
8	7/24/18 349.6 pound	s	Ş		3
	Further review of the	clinical record failed to			я
	document that the fac			额	
ii ii		#54 had a 13.4 pound			1
		/18 through 8/1/18, and a 9			
		m 7/24/18 through 7/31/18.			
	August 2 0048 -1 5 5	S. Joseph Brown, and the Company of			
	the Director of Nursing	5 a.m., the surveyor notified g (DON) that Resident #54			
×	had a physician's orde	r to notify the physician if	2	25 15	

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NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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FREEN TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  FS 80  Continued From page 19			B CENTER - SOUTH		5647 STARKEY ROAD	
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, 2016 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 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	PREFIX	EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE COMPLETION BE APPROPRIATE DATE
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pounds in a week on several occasions and the facility staff had not notified the physician of the				ii.		
		pounds in a week on s	several occasions and the			
weight gain.	9		tified the physician of the			
		weight gain.				
No additional information was provided to the		No additional informati	ion was provided to the			
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						

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 20 of 123

SEP 0 4 2018
VDH/OLC

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

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDI	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
- 7		495421	B. WING_		C 08/02/2018
	ROVIDER OR SUPPLIER	AB CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE COMPLETION
F 580	by the physician.	the facility failed to notify the	F 5	80	il .
	#83 had been admitt Diagnoses included, normal pressure hyd hypertensive heart d	isease with heart failure, ons, gastroesophageal reflux			:: ::
1	admission MDS (min with an ARD (assess 06/17/18 included a	patterns) of the Residents nimum data set) assessment ment reference date) of BIMS (brief interview for nary score of 15 out of a			
,	orders for daily weigh		e 		
	administration record nursing staff had doo weighed 173 on 07/2 The surveyor was un documentation to ind	Rs (electronic medication is) revealed that the facility tumented the Resident 1 and 184.8 on 07/22/18. The able to find any icate the facility staff had of the weight change.			a a
	for the 7-day period p 07/14-170.6, 07/15-1	President Landrick Company (Company Company Co			

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-039
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED
	495421	B. WING		С
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAE	PE - 28		STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	08/02/2018
PREFIX   {EACH DEFICIENCY	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RE COURTER
the reviewed the weight clinical record, and the unable to locate any in physician had been no increase.  The facility provided the of a policy titled "NURS This policy read in part substantiate daily care.  All contact with the print	a.m., RN (registered nurse) ts with the surveyor, the doctor's book and was formation indicating the tified of the weight  e survey team with a copy SING DOCUMENTATION." "PURPOSE: 1. ToWHAT TO CHART4. hary care provider"  DON (director of nursing) ve during a meeting with 02/18 at 8:35 p.m.  egarding this issue was eam prior to the exit  se/Neglect Policies )  nust develop and es and procedures that: and prevent abuse, of residents and lent property, policies and procedures sillegations, and	F 58	F607 Corrective Action(s): The Administrator and Director of Nursing who were employed at the tion of Resident #322's injury are no long employed. The investigation, which occurred on 12/12/18, explained how 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 we review facility skin assessments from past 2 months to ensure that all areas of injury and/or bruises were properly investigated and reported per the facility investigated and reported per the facility.	er the

STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	// // / / / / / / / / / / / / / / / / /	The state of the s	OMB NO. 0938-0391
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING		С
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/02/2018
FRIENDS	SHIP HEALTH AND REHA	R CENTED SOUTH		5647 STARKEY ROAD	
		O CENTER + SOUTH		CAVE SPRING, VA 24018	
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		
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F 607	Continued From page	22	i		1
		review, and during the	F 60	Systemic Change(s):	
	COurse of a complaint	investigation, the facility		The Facility Policy and Procedure I	nas
	staff failed to impleme	investigation, the facility	1	been reviewed and changes are not	
	Drocedure for investig	ating and reporting injuries	I	warranted at this time. The Directo	rof
	of unknown origin to the	he appropriate state	<b>!</b>	Operations will conduct in-services	for all
	agencies for 1 of 45 re	esidents, Resident #322.	Ě	staff, including the Administrator at	nd i
		soldents, resident #322.		DON, on the reporting guidelines for	
	The findings included:			abuse, neglect and misappropriation	ts
*	680		la la	including time lines for reporting incidents. Any future negative findi	
	A complaint was filed v	with the Office of Licensure	i	will result in immediate corrective a	ngs
	and Certification on 1/4	4/2018. This complaint was		The result in manediate corrective 2	iction.
	investigated during an	unannounced survey that	i Î	Monitoring:	
1	took place onsite at the	e facility from 7/31/18		The Administrator and DON are	
	through 8/2/18. The co	mplaint was investigated	i I	responsible for monitoring complian	nce.
İ	as a closed record.			The 24-hour report will be reviewed	
ľ	N-Dispun economics of to the			to monitor for injuries or bruises of	
	The complainant was o	contacted on 8/2/18 at 9:00		unknown origin. Investigations and	
	am. The complainant a	lleged that Resident # 322		reporting of these events will follow	
Í	obtained a giant bruise			reporting guidelines and facility Pol Procedure. Aggregate findings will	be
	Resident # 322 was a 9	90-year-old-female that	1	reported to the Quality Assurance	
i	was originally admitted	to the facility on 11/10/17		Committee monthly for review, anal and recommendations for change in	
	with a readmission date	of 11/28/17, Diagnoses		facility policy, procedure, and/or pra	
	included but were not li	mited: chronic obstructive	1	racinty poncy, procedure, and or pre	ictice.
	pulmonary disease, sle	ep disorder, atrial		Completion Date: September 16, 20	018
ļ	fibrillation, and heart fai	lure.		though A total company was suppressed Palaboration 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2 - 2	
-	The closed clinical reco	rd for Resident # 322 was	ļ		
1	reviewed on 8/2/18 at 1	0:52 am. The most recent			F
	MDS (minimum data se	t) was a 14-day			
i a	assessment with an ARI	D (assessment reference	ŀ		
(	date) of 12/12/17. Section	on C of the MDS	1		
8	assesses cognitive patte	erns. In Section C0500,	ĺ		j
t	he facility staff documer	nted that Resident # 322	Ţ		i l
į r	nad a BIMS (brief intervi	iew for mental status)			] [
S	score of 13 out of 15, wh	nich indicated that	. 1		
Į F	Resident # 322 was cog	nitively intact.	ĺ		
1	he plan of care for Res	ident # 322 was reviewed			
1	ne plan of care for Res	ident # 322 was reviewed			

PRINTED: 08/24/2018 FORM APPROVED

STATEMEN	T OF DEFICIENCIES	WAS BROKES	and the same of the			OMB NO. 0938-0391
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495421	B. WING			С
NAME OF	PROVIDER OR SUPPLIER	<del> </del>		STREET ADDRESS, CITY, STATE, ZIP C	<u>_</u>	08/02/2018
			N .	NEW YORK WAS TOTAL WAS CONSTRUCTED TO THE WAS TO STATE OF THE STATE OF	ODE	
FRIEND	SHIP HEALTH AND REH	AB CENTER - SOUTH		5647 STARKEY ROAD		
04015	CURABA ADV	TATELON DE LA CONTRACTION DE L		CAVE SPRING, VA 24018		
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F 607	Continued From pag	ne 23			39	
	151 101/15	-55/40-2 M/GR	F 60	07		
	documented a feeting	2/17. The facility staff		<u> </u>		
	the potential for pro-	area as "Resident # 322 has	3	i		
	related to impaired a	ssure ulcer development nobility and occasional	31			
	incontinence Per Pe	esident # 322, she has a		e		
	history of bruising as	asily and is on Aspirin therapy.		1.0		
	She will attempt to c	omplete tasks on her own				,
	and has muscle wea	kness at this time that	Ĭ.			
	makes her unsteady	." Interventions included but		28		
	were not limited to: "	Provide medications as		3		
		for side effects: such as				
	uncontrolled bleeding	g or discolorations. Consult	E			
	MD (medical doctor)	/ NP (nurse practitioner) if				
	occurs," and "Inform	Resident # 322 and her				
	family of any new are	eas of skin breakdown."	\$8 	×		
			1			
	The physician signed	the orders for Resident #	l i	₩ 20		122
	322 on 12/28/17. Re	sident # 322 had orders for	6.7			8
	"Aspirin EC (enteric	coated) Tablet Delayed				
	Release 81 MG (milli mouth one time a da	igrams) Give 1 tablet by y for heart health."	18			
	On 8/2/18 at 11:15 at	m, the surveyor reviewed the				
	progress notes in the	closed clinical record for				
	Resident # 322. A pro	ogress note documented on	B			
	12/9/17 at 8:36 pm st	tated, "Rsd (resident) has				1
	large bruise on left si	de = 12 cm (centimeters) x		133		
	5cm; smaller bruise 3	3cm x 2.5 cm. Noticed while		652		
	dressing rsd this AM.	Rsd ambulates in room and				
	to the bathroom with	out assistance, Denies pain.				f
	Bed and chair alarms	present and working. RP				
	(responsible party) avail times."	ware. Call bell within reach at				
		, the surveyor spoke with				
	the administrator and					
	regarding the bruised	areas on Resident# 322's				
		or requested to see any				
	reporting and investig	ations that were completed				

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 24 of 123

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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			(X3) DATE SURVEY COMPLETED	
		495421	B. WING			C
NAME OF P	ROVIDER OR SUPPLIER		10	STREE	ET ADDRESS, CITY, STATE, ZIP CODE	1 08/02/2018
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH		B CENTER - SOUTH		5647 \$	STARKEY ROAD SPRING, VA 24018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	•	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 607	Continued From page	24	F	507		
	regarding this issue. director of nursing infinitioning incident occurred prior	The administrator and ormed the surveyor that this or to both of their facility however, they would				
;	On 8/2/18 at 1:10 pm, facility reported incide by the facility and did	the surveyor reviewed the ints that had been submitted not locate a facility reported ises on Resident # 322.	Х	ä		
Î	provided the surveyor	the director of nursing with a progress note from ed clinical record that was /17 at 11:48 am. The				:
,	progress note stated 'discoloration to "stome assessment, I noted a discoloration to right's hip area of the abdom	ach" area, Upon pprox., 2-3 cm ide of abdomen near the	e E			
i	approx. 5-6 cm discolorabdomen near hip are Discolorations are dar with yellowish edges r	oration to the left side of the a of the abdominal fold. k purple and blue in color noted. There are no		8		
	line or several inches area. I noted in the fro around her waist, alon there again were no di she has a colostomy ti	o her back along the waist above or below the waist above or below the waist of her abdomen area g on the abdominal fold iscolorations. I noted that hat is positioned over an en that protrudes out about		9		
	the size of a large orar there was no discolora either. Resident had n assessing the discolor know they were there, knew how they occurre "always bruise easily."			12		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/24/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED C 495421 B. WING 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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: Injuries of unknown origin; 2. Unusual occurrences shall be reported to

and or regulations.

appropriate agencies as required by current law

 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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/24/2018 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED 495421 B. WNG NAME OF PROVIDER OR SUPPLIER 08/02/2018 STREET ADDRESS, CITY, STATE, ZIP CODE FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH 5647 STARKEY ROAD CAVE SPRING, VA 24018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY 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 Reporting of Alleged Violations F 609 SS=D CFR(s): 483.12(c)(1)(4) F609 Corrective Action(s): §483.12(c) In response to allegations of abuse, The Administrator and Director of neglect, exploitation, or mistreatment, the facility Nursing who were employed at the time must: of Resident #322's injury are no longer employed. The investigation, which §483.12(c)(1) Ensure that all alleged violations occurred on 12/12/18, explained how the bruise occurred, albeit not in the involving abuse, neglect, exploitation or timeframes mandated by regulation. A mistreatment, including injuries of unknown FRI is not warranted at this time. A source and misappropriation of resident property, facility Incident & Accident form has are reported immediately, but not later than 2 been completed for this incident. hours after the allegation is made, if the events that cause the allegation involve abuse or result in Identification of Deficient Practice(s) serious bodily injury, or not later than 24 hours if and Corrective Action(s): the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to

accordance with State law through established procedures.

officials (including to the State Survey Agency and

adult protective services where state law provides

the administrator of the facility and to other

for jurisdiction in long-term care facilities) in

§483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in

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	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-039
IND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495421	B. WING		С
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/02/2018
FRIENDSHIP HEALTH AND REI	JAB CENTER COURT		5647 STARKEY ROAD	
	TAB CENTER - SOUTH		CAVE SPRING, VA 24018	
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES	ID ID		600.00 B
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survey Agency, wit incident, and if the appropriate correction. This REQUIREMENT by:  Based on staff interport and injury of unappropriate agencies survey sample, Resurvey samp	ate law, including to the State hin 5 working days of the alleged violation is verified live action must be taken. It is not met as evidenced rview, clinical record review, view, and in the course of a tion, the facility staff failed to riknown source to the is for 1 of 45 Residents in the ident # 322.  Id:  Id:  Id:  Id:  Id:  Id:  Id:  Id	F 609	Systemic Change(s): The Facility Policy and Procedure been reviewed and changes are not warranted at this time. The Directed Operations will conduct in-services staff, including the Administrator and DON, on the reporting guidelines for abuse, neglect and misappropriation including time lines for reporting incidents. Any future negative finding will result in immediate corrective at Monitoring:  The Administrator and DON are responsible for monitoring compliant The 24-hour report will be reviewed 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 reported to the Quality Assurance Committee monthly for review, analyand recommendations for change in facility policy, procedure, and/or pracedure. September 16, 20	or of s for all nd or ns ngs action.  ice. daily  icy & be ysis, ctice.

PRINTED: 08/24/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
	495421	B. WING		С	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAE		5647	ET ADDRESS, CITY, STATE, ZIP CODE STARKEY ROAD E SPRING, VA 24018	08/02/2018	
PREFIX   (EACH DEFICIENC)	NTEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 609 Continued From page	28	F 609		2	
the facility staff documents had a BIMS (brief intescore of 13 out of 15, Resident # 322 was co	ented that Resident # 322 rview for mental status) which indicated that conitively intact.			7 1 1	
The plan of care for Reand revised on 12/12/documented a focus a the potential for pressurelated to impaired mo	esident # 322 was reviewed 17. The facility staff rea as "Resident # 322 has ure ulcer development bility and occasional	1			
incontinence. Per Res history of bruising easi She will attempt to con and has muscle weakr	dent # 322, she has a ly and is on Aspirin therapy. nplete tasks on her own less at this time that	1		a a	
were not limited to: "Pr ordered but monitor for uncontrolled bleeding	side effects: such as or discolorations. Consult IP (nurse practitioner) if esident # 322 and her			e e	
The physician signed the 322 on 12/28/17. Residual Transfer Co. Release 81 MG (milligrouth one time a day for the signal to the	ams) Give 1 tablet by			ti .	
progress notes in the c Resident # 322. There on 12/9/17 at 8:36 pm. "Rsd (resident) has larg cm (centimeters) x 5cm cm. Noticed while dress	was a note documented Documentation states le bruise on left side = 12 ; smaller bruise 3cm x 2.5			9 9	
assistance. Denies pair present and working. R aware. Call belt within r	. Bed and chair alarms P (responsible party				

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 29 of 123

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495421	B. WING		<del>-</del>	C 08/02/2018
	PROVIDER OR SUPPLIER HIP HEALTH AND REH	AB CENTER - SOUTH		5647 9	ET ADDRESS, CITY, STATE, ZIP CODE STARKEY ROAD E SPRING, VA 24018	1 00/02/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 609	Continued From page	ge 29	F	609		
	the administrator an	n, the surveyor spoke with d director of nursing d areas on Resident# 322's		ĺ		
	abdomen. The surve reporting and investi regarding this issue.	eyor requested to see any gations that were completed The administrator and	ì	20)		2
	incident occurred pri employment with the	facility however, they would	ř	9		
	On 8/2/18 at 1:10 pn	e the information.  n, the surveyor reviewed the lents that had been submitted	· 55	is is		,
	by the facility and did	d not locate a facility reported ruises on Resident # 322.	n s	i		E
5	Provided the surveyor Resident # 322's clin documented on 12/1 progress note states	2/17 at 11:48 am. The "Notified regarding	Ē	8 5		
	hip area of the abdor		20.000			
	abdomen near hip ar Discolorations are da with yellowish edges	ea of the abdominal fold. ark purple and blue in color	N.	¥		Ī
	waistline or several in waist area. I noted in area around her wais fold there again were that she has a colost an area of her left ab	nches above or below the the front of her abdomen st, along on the abdominal e no discolorations. I noted omy that is positioned over domen that protrudes out	E			
	about the size of a la					

CTATEMENT		A MICHOAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495421	B. WING_		C 08/02/2018
NAME OF F	PROVIDER OR SUPPLIER		50 50	STREET ADDRESS, CITY, STATE, ZIF	
EDIENDO		VV2		5647 STARKEY ROAD	3322
FRIENDS	HIP HEALTH AND REF	HAB CENTER - SOUTH		CAVE SPRING, VA 24018	
(X4) ID	SIBMMADV	STATEMENT OF DEFICIENCIES		S. S. S. S. S. S. S. S. S. S. S. S. S. S	
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL  OR LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION OF THE APPROPRIATE DATE
F 609	Continued From pa	age 30		200	
			FE	509	25
	discomfort when as	either. Resident had no signs of	1		
	stated did not know	ssessing the discolorations and vithey were there. I asked if			
	she possibly know	how they occurred and she	\$2 S	15 15	
	stated that she "alu	vays bruise easily." She was	SA IS		
	uncertain of how th	ey happened, expressed that		0	,
	she did not feel it w	as on purpose, she "may have		8	
	bumped inti someth	ning." I noted in room that she	1	8	
	has a shelf next to I	left hand rail in the bathroom		8	
	that has her toileting	g and ostomy supplies on it			
	that is waist level. In	n her main living area, there is	E D		
	a stationary chair w	ith padding added to the			
	arms- staff reported	that was added due to risk of	£0	35	
	her "bumping into the	ne arm rests." Her wheelchair		8	
	fits her without muc	h additional room between the	f3 93		
	armrests to her side	es/hip areas. I have contacted	No.		
	therapy to assess to	ensure the wheelchair is the			
	appropriate size for	her. Staff report that resident	ì		
	will get up on her ov	wn related to decreased safety			i i
	awareness due to d	ementia dx (diagnosis). Upon	ST ST	<b>1</b> 90	
	review of her medic	al chart, I noted she is on	83		
ļ	Aspirin daily and ha	d been on Prednisone when		19 10	
į	she was first admitte	ed for three days related to	ii.		<u>j</u>
2.0	respiratory failure, w	which puts her at risk for	100		\$ *
İ	discolorations and fr	ragile skin. Will notify			
	daughters of observ		8	file:	
		ing informed the surveyor that			ű .
į	she was unable to lo	ocate any additional			¥
		g the incident of the bruising			
1	observed on Reside		N.		
į			25	na .	
	The surveyor review	ed the documentation that		IK	
59	was presented by th	e director of nursing and			E 10
	informed the director	r of nursing that while the			2
	documentation in the	e clinical record does have an			
		s conducted on 12/12/17, the		©	
	incident occurred on	12/9/17 which was 3 days		MA	ì
		ntation, therefore if the facility			
		letermine the cause of the			

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	Lygnamu		OMB NO. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILO	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF	Doorwood	495421	B. WING		C 08/02/2040
	PROVIDER OR SUPPLIER SHIP HEALTH AND REHAL	3 CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CO 5647 STARKEY ROAD CAVE SPRING, VA 24018	08/02/2018 DE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 609	bruising at that time the should have been repagencies.  According to the facility Occurrence Reporting documentation that incum" Procedure  1. Our facility will repart the appropriate agencies.	is injury of unknown origin orted to the appropriate  y policy on "Unusual" " the policy contains cludes but is not limited to port the following events to es:	F	609	
	appropriate agencies a and or regulations.  3. A written report de taken by the facility after communicated to the a required by federal and 4. Facility administrative written reports on file."  On 8/2/18 at 9:35 pm, to was made aware of the No further information versus and or regulations.	ces shall be reported to as required by current law stailing the incident actions er the event shall be ppropriate agencies as a state regulations. Sion will keep a copy of the administrative team findings as stated above.			
	team prior to the exit co This is a complaint defic Comprehensive Assess CFR(s): 483.20(b)(2)(ii)	inference on 8/2/18.  ciency.  ment After Signifcant Chg  14 days after the facility ave determined, that cant change in the ental condition. (For a "significant change" or improvement in the	F 63	F637 Corrective Action(s): Resident #13 has improved in performance since 12/16/17 acurrent MDS accurately reflect health status. There is no need significant change assessment completed at this time. A facil & Accident Form was completed incident.	nd her ets her I for a to be

STATEMENT	OF DEFICIENCIES	(X1) PROMPERATURE			OMB NO. 0938-039
AND PLAN (	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING		С
NAME OF I	PROVIDER OR SUPPLIER				08/02/2018
92020270				TREET ADDRESS, CITY, STATE, ZIP CODE	20 4165
FRIENDS	HIP HEALTH AND REH	AB CENTER - SOUTH		47 STARKEY ROAD	
0/ 0 15	2000		C	AVE SPRING, VA 24018	
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	itself without further implementing standa interventions, that had one area of the residerequires interdiscipling care plan, or both.) This REQUIREMEN by: Based on staff interveview, it was determediated to complete a standard to the sample survey, it is sample	intervention by staff or by and disease-related clinical as an impact on more than dent's health status, and mary review or revision of the T is not met as evidenced view and clinical record mined that the facility staff Significant Change Minimum ment for 1 of 45 Residents in desident #13.  d:  102 year old female who was and readmitted on 12/6/17 g diagnoses included, but ypertension, chronic y disease, major depression, of the left femur and an acute ower extremity.  In the clinical record was a twith an Assessment to 51/1/18. The facility staff also in the facility staff also i	F 637	Identification of Deficient Pract & Corrective Action(s): All residents who have discharged hospital and readmitted back to the facility may have been affected. Feather who have discharged and readmit to the facility within the last 60 deshave their charts reviewed to assessignificant change in health status occurred during their time away for facility and, if so, if a proper significant change assessment was completed facility Incident & Accident Form completed for each incident where significant change assessment sho have been completed and wasn't.  Systemic Changes: The facility Policy and Procedure been reviewed and no changes are warranted at this time. The Director Clinical Reimbursement has in-sert the MDS staff on the need to compaignificant change assessment in situations where a patient has disclared from the facility and readmitted an significant change in health has occurred. If so, a significant change hoccurred. If so, a significant change assessment will be completed. Find will be reported to the Quality Assi Committee for review, analysis, an recommendations for change in fact policy, procedure, and/or practice.	d to the ne Patients ted back ays will ss if a  rom the ificant d. A will be a a uld  has  or of viced blete a  harged d a  curred.  ement on eview ccur to as ge dings urance d
!	notes that documented 12/6/17 and was sent	d that Resident #13 fell on to a local hospital. The		Completion Date: September 16,	2018

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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Control to the second s		MEDICAID SERVICES	es establishment of the second	<u> </u>		MB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	10 10 10 10 10 10 10 10 10 10 10 10 10 1	X3) DATE SURVEY COMPLETED	
		495421	B. WING			С	
NAME OF P	ROVIDER OR SUPPLIER	455421	B. WING			08/02/2018	
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH				STREET ADDRESS, CITY, STATE 5647 STARKEY ROAD	, ZIP CODE		
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F 637	Continued From pag	e 33	F	637		200	
	nursing progress not	tes also documented that eing admitted into the hospital				i i	
	two Physician Progres Progress Notes were 12/13/17. The Physi 12/10/17 documente who has been a resid	ician Progress note dated d "This 102-year-old lady	18 18			Ti de la companya de la companya de la companya de la companya de la companya de la companya de la companya de	
	hospital withheld) on 12/09/17, following a fracture. She underw an intramedullary hip	December 6th through fall with acute left femoral rent successful insertion of screw and it was noted that		s .			
81 81	her hospital course wagitation and delirium	vas complicated by anxiety, n." (sic)	0			ti sa	
	Quarterly MDS with a was the last MDS cor #13's fall on 12/6/17, and surgical intervent	clinical record produced a an ARD 10/31/17. This MDS mpleted prior to Resident hospitalization, hip fracture tion to correct the hip arterly MDS with the ARD of		NI			
	10/31/17, the facility s #13 had a Cognitive s facility staff also code independent (0/0) to r (2/2) with ADL's. The	staff coded that Resident Summary Score of 13. The ed that Resident #13 was requiring limited assistance e facility additionally coded s occasionally incontinent of		E.			
	Quarterly MDS with the facility staff coded that Cognitive Summary Stalso coded that Residuals	the clinical record produced a the ARD of 12/16/17. The st Resident #13 had a score of 14. The facility staff lent #13 required extensive that (4/2) with ADI 's The					

facility additionally coded that Resident #13 was

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			And an at Managaria Andreas An	OMB NO. 0938-039
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING	225	_	С
NAME OF F	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE	08/02/2018
	HIP HEALTH AND REHA	per transcaterate		5647	STARKEY ROAD E SPRING, VA 24018	
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F 637	Continued From page	34	j _			80 - 10 - 10 - 10 - 10 - 10 - 10 - 10 -
	frequently incontinent		F	337		
	occasionally incomment	on bladder and	11	B		¥
	occasionally incontine	int of her bowels.				
	On August 2, 2049 at	40-22 200 1100 2000	!	i		
	On August 2, 2018 at	To a.m., the surveyor	i			#
	Practical Nurse // DNI	Nurse, who was a Licensed	ï			10 10
	MDS Nurse that a Size	. The surveyor notified the	İ	İ		^
	MDS Nurse that a Sign	npleted on Resident #13's	II.			ii .
	readmission back into	the facility on 12/9/17. The		i		41 36
1	SUNEVOL TEVIEWED DO	sident #13's clinical record		í		60
	with the MDS Nurse T	he surveyor pointed out	Ū.	1		
1	that Resident #13 had	a fall on 12/6/17 and was		į.		
Ì	sent to the hospital. T	he surveyor reviewed the	į	ĺ		1
!	hospital documentation	that identified that	ij	i		
81	Resident #13 had a lef	t hip fracture and required	G G	Ţ.		8
Ĩ	a surgical procedure to	correct the left his		ļ		
	fracture. The surveyor	then reviewed that	İ	ļ		¥
į	Resident #13 returned	to the facility on 12/9/17.		251		ļ.
	The surveyor reviewed	the Quarterly MDS's with	1			e
	the ARD's of 10/31/17	and 12/16/17 side by side				
	with the MDS Nurse T.	he surveyor pointed out	WI			
	that the Quarterly MDS	with the ARD of 12/16/17	Ĭ	į		į.
2	should have been a Sig	Inificant Change MDS as	I a	ļ		
ļ	Resident #13 had had	a change in all of her	Ú			ii.
4	ADL's and a change in	her bladder and bowet	25	f.		19
į.	continence. The MDS N	Nurse did not verbalize that	9	1		
:	Resident #13's MDS wi	th the ARD of 12/16/17	1	i		
* :	should have been a Sig	Inificant Change MDS	a			
	assessment. However,	the MDS Nurse listened	\$E			
i j	intently to what the surv	eyor was saving and	2	0		
(	occasionally the MDS N	lurse would shake her	5			İ
1	head up and down, indi	cating that she agreed				
<sup>28</sup> <b>∆</b>	with what the surveyor	was saying.	2	ii B		107
(	On August 02, 2018 at 8	3:34 p.m., the survey team	E	1		
- r	net with the Administrat	tor (Adm), DON.		ii		
F	Rehabilitation Director, .	Rehabilitation Assistant.		1		
\$	Staff Coordinator and H	ousekeeping Director.		28		ľ
	The surveyor notified the	e Administrative Team	35			36 St
a and an analysis of the same	02-99) Presious Varaigne Obselet			- E	70 25	

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 35 of 123

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  495421		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	C 08/02/2018		
		IDENTIFICATION NUMBER:	A. BUILDING			
		B. WING				
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	I CACH DELICIENC.	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETIC	
F 657 SS=D t () () () () () () () () () () () () ()	(AT) that Resident #13 with a hip fracture on notified the AT that wh readmitted back into the facility staff should have Change MDS, however completed a Quarterly.  No additional information of the facility staff failed to Change MDS on Reside the facility staff failed to Change MDS on Reside hospitalization with a high intervention to correct to Care Plan Timing and FCFR(s): 483.21(b)(2)(i)-3483.21(b)(2) A compreside to Comprehensive assets in Prepared by an intervention of the comprehensive assets in Prepared by an intervention of the attending physical physica	A had a fall that resulted 12/6/17. The surveyor en Resident #13 was be facility on 12/9/17 the ve completed a Significant or, the facility staff MDS on 12/16/17.  On was provided to the sitting the facility as to why complete a Significant ent #13 after a fall, in fracture and a surgical he hip fracture.  Revision (iii)  sive Care Plans shensive care plan must ent #13 after the plan must ent #15 after completion of essment.  disciplinary team, that do to—sian.  ith responsibility for the do nutrition services staff. The participation of the procession of the resident entative is determined velopment of the	F 657		all  ys e h	

l	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0391	
	AND FLAN (	DF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			(X3) DATE SURVEY COMPLETED	
L			495421	B. WING			C	
60	NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		8/02/2018	
	FRIENDS	HIP HEALTH AND REHA	B CENTER - SOUTH		5647 STARKEY ROAD CAVE SPRING, VA 24018			
	(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES					
	PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE	(XS) COMPLETION DATE	
	F 657	Continued From page	36				i	
	V-0-0-0-0-			F 657				
		or as requested by the	ned by the resident's needs	5 (1) (2)	Systemic Changes:		ľ .	
		(iii)Reviewed and rout	resident.	ł	The facility Policy and Procedure I	ias		
		team after each acces	sed by the interdisciplinary		been reviewed and no changes are			
		comprehensive and qu	sment, including both the	1	warranted at this time. The Director	rof		
		assessments.	darreny review	1	Clinical Reimbursement has in-serv	riced	j	
			is not met as evidenced	I	the MDS department and the IDT o development, revision and	n the		
	1	by:	is not met as evidenced	ļ	implementation process of individu	1993 3	I I	
	ļ		ew, clinical record review,		care plans.	alized	i	
	Ė	and facility document r	eview, the facility staff	9			l.	
		failed to ensure that a	care plan was prepared by		Monitoring:		1	
	L	and interdisciplinary te	am that consisted of the	i	The Director of Clinical Reimburser	nent		
		necessary members ar	nd review and revise the		is responsible for compliance A day	ii.		
	1	plan of care for 1 of 45	residents in the survey		review of falls will occur to commun	ianta .	1	
		sample, Resident # 61.			necessary revisions to care plane and	lon		
					audit will be performed for 3 months	to		
		The findings included:			ensure that all falls have appropriate			
					interventions updated on the plan of Any/all negative findings will be repe	care.		
		The facility staff failed to	o failed to review and		for immediate correction. Findings of	orted	1	
	i	revise the plan of care f	following a fall for Resident	ĺ	interdisciplinary team's audit will be	the	1	
	#	<b>#</b> 61.			reported to the Quality Assurance			
	١.	• NOTES • 10 10 10 10 10 10 10 10 10 10 10 10 10			Committee for review, analysis and			
	11	Resident # 61 was a 53	-year-old female who was	1	recommendations for change in facility	tv		
	5	dimitted to the facility o	n 3/9/17. Diagnoses		policy, procedure, and/or practice.	•	1	
	11	ncluded but were not fir	nited to: anxiety disorder,	1		Ĭ		
	l h	nuscle wasting and atro	phy, depression, and	R P	Completion Date: September 16, 201	.8		
	"	enign neoplasm of the	brain.	ļ		ī	ľ	
	Т	he clinical record for R						
	re	eviewed on 8/1/19 of 14	esident # 61 was			ļ	1	
	I.V	IDS (minimum data set	:25 am. The most recent	8			Ī	
	a	uarterly assessment wi	th an ARD (assessment	ľ		16		
	re	eference date) of 6/20/4	8. Section C of the MDS	Ì		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		
	a	ssesses cognitive patte	rns in Section Cosco				3	
	th	e facility staff documen	ted that Resident # 64			1		
	ha	ad a BIMS (brief interview	PW for montal status	i				
	, sc	core of 15 out of 15, wh	ich indicates that	ļ		Ĵ	ĺ	
	R	esident # 61 was cogni	tively intact. Section	270		2	f	
	, J1	900 of the MDS asses	ses the number of fall	ļ		Ĭ		
-			are maniper of ISII	1		Į.	J	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
				700		c	
2.00		495421	B. WING		9046	08/02/2018	
NAME OF P	ROVIDER OR SUPPLIER		···	STREET	ADDRESS, CITY, STATE, ZIP CODE	1 00/02/2010	
FRIENDSH	IP HEALTH AND REHAM	3 CENTER - SOUTH	0.000	5647 ST	TARKEY ROAD		
			W.W.	CAVE	SPRING, VA 24018		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 657	Continued From page	37	F	657		- M-02	
	since admission, entr		240 1	001			
		ssessment. The facility staff					
		ident #61 had 1 fall with		33			
	injury since her prior a		15	3			
ļ			į	İ			
		the surveyor conducted an					
		eyor that she was upset					
		able to go outside on the				12	
	facility property withou	ut signing herself out LOA					
		ne surveyor asked Resident					
8	— a ser a video a distriction della constitución de la constitució	ign out LOA if she was not					
		cility grounds. Resident # 61					
		she had a fall a few weeks					
		aff wanted her to sign out		ī			
1		t be held liable if she fell.	ř.	¥			
Î		hat she liked to go outside		8			
1	and sit in her wheelch						
		ould see inside of her room.					
	fall, she made an arra	ed that on the day of the					
		stant) to take her outside				i	
		me back in 30 minutes to		×		Ì	
		ick inside. Resident # 61					
		e CNA that she would use	1				
		f she wanted to come in					
		explained that she sat					
	outside for a while but			23			
		to pick her phone up off					
		# 61 stated that she rolled	85				
		indow where staff was				ł	
		e to get anyone's attention.					
	Resident # 61 stated,	"I guess I rolled over a rock				ļ	
	or something," that she	e thought that her wheel on					
	her wheelchair went o	ff the sidewalk and her					
	wheelchair tipped over	T <sub>se</sub>					
	TL	7. 8					
		re for Resident # 61 was on 7/9/18. The facility staff					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495421	B. WING		С
M 	PROVIDER OR SUPPLIER  SHIP HEALTH AND REHA	3 CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP COD 5647 STARKEY ROAD CAVE SPRING, VA 24018	08/02/2018 DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
F 657	"Resident # 61 is a po occurrence related to Resident # 61 has a r (abrasions, bruise)." I revised on 7/9/18 are Resident # 61 to have all times when she wis surveyor reviewed the did not locate any fall were put into place for According to the facility program (Assessment/Docume policy procedure containcluded but was not I resident's care plan w based on incident and interventions are imple On 8/2/18 at 1:45 pm, the director of nursing Coordinator # 1 and R Supervisor # 1 regardi of care for Resident # was appropriate to do fall that occurred on 6/ director of nursing stat.  The administrative tea findings as stated about	area for Resident # 61 as potential risk to have a fall debility and weakness. eccent fall with minor injury interventions documented as documented as "Encourage a staff member with her at shes to go outside." The eplan of care entirely and related interventions that llowing the fall on 6/15/18. By policy for the "Falls intation/Management)" the ains documentation that imited to"13. The fall be updated by MDS as new individualized emented after each fall." the surveyor spoke with in the presence of MDS N (registered nurse) ing the updating of the plan 61. The surveyor asked if it cument interventions for a 15/18 on 7/9/18. The ed "No."		557	
	presented to the surve conference on 8/2/18.	et Professional Standards	F 65	58	

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB	NO. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION  NG	(X3) D.	ATE SURVEY OMPLETED
		495421	B. WING		1	С
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	08/02/2018
FRIENDS	SHIP HEALTH AND REHA	AB CENTER - SOUTH		5647 STARKEY ROAD CAVE SPRING, VA 24018		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	I ID		Office Annual Control	
PREFIX TAG	REGULATORY OR	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	III O BE	(X5) COMPLETION DATE
F 658	§483.21(b)(3) Compr	ehensive Care Plans	F6	F658 Corrective Action(s):		
	The services provide	d or arranged by the facility, mprehensive care plan,		The facility's medication administration program has been adjusted in two areas. The medication block times been altered so there is no overlap	key s have	
	This REQUIREMENT by:	is not met as evidenced iew, clinical record review,		between time-frames. Further, the has worked with the facility's EH provider to eliminate the time frame	e facility R nes	
	facility document revi complaint investigation	ew and in the course of a	Ĭ	before and after each medication thereby reducing the time in which medications can be administered in	h n a	
	facility staff failed to for Professional Practice administration for the	related to medication		compliant manner. Adjustments r the program have been approved to the Medical Director and licensed	y both	
	The Findings Included	<u>t:</u>		Pharmacist, as well as Administra Nursing.	tion and	
	a document provided imedication administra labeled, "(name of fac	p.m., the surveyor reviewed to the survey team about tion. The document was ility withheld) South Med es." The document read:		Identification of Deficient Practices/Corrective Action(s): All residents in the facility are affethe facility's medication administror program. The Administrator and/odesignee will meet with all residen	ation r	
	am to 7 am 2) Mornin	ation administration te following primary ion times: 1) Early from 5 g from 8 am to 11 am 3) 5 pm 4) Evening 6 pm to		discuss the facility's medication administration program, including dialogue regarding their concerns mentioned during survey. All resid expressing concerns during this me will be identified and their medicate administration regime reviewed an	a lents ceting tion	
1	medication administrati	its of the facility. The rns regarding timeliness of on. The residents stated too many agency nurses		altered, as appropriate.		
(	On August 1, 2018 at 3	p.m., a surveyor had a	Ţ			

STATEMENT OF DEFICIENCIES	T OF DEFICIENCIES (X1) PROMPTED AND THE				
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG	OMB NO. 0938-0: (X3) DATE SURVEY COMPLETED	<u>55  </u>
	100404			l c	
NAME OF PROVIDER OR SUPPLIER	495421	B. WING_		08/02/2018	
WINE OF FROMBER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/02/2018	
FRIENDSHIP HEALTH AND REHAI	B CENTER - SOUTH		5647 STARKEY ROAD		
\$70 PC 6235, 1650 PC		14	CAVE SPRING, VA 24018		
(X4) ID SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID		The second secon	
PREFIX (EACH DEFICIENC TAG REGULATORY OR L	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	IDBE COMBIETIO	NC
oriented residents. The facility medication scheresidents stated that is nurse per hall, and the to a staffing with agentated that having the personal part out of the administration, and that have a routine. The resemedication window is to stated that it bothers the many different nurses of facility.  On August 1, 2018 at 4 met with the Administrative Team (A received in the State Ago of medications. The suthat the residents stated were given erratically a were often late being given eviewed the facility documents of the professional standards administration. The DO acknowledge this survey professional standard for administration. The surthat professional standard for administration. The surthat professional standard for administration. The surthat professional standard for administration. The surthat professional standard for administration at the professional standard for administration at the professional standard for administration at the professional standard for administration pass the medication pass the motified the AT that only allow 1 hour before	eting with seven alert and the residents stated that the edule is erratic. The ometimes there is only one facility has recently went by nurses. The residents agency nurses takes the emedication at temporary people do not sidents also stated that the too big. The residents are medications at the sidents also stated that the too big. The residents are that they have so giving medications at the sidents also stated that the factor (Adm) and Director of the factor (Adm) and Director of the factor (Adm) and Director of the factor (Adm) and Director of the factor (Adm) and that their medications are the factor of the survey team notified the AT at that their medications wen. The survey team continuous team and that their medication for asked for the facility's for medication and Adm did not the factor of the	F 65		no further, ility's ation which a ill be gnee ittee with scuss s le east ese ty	

PRINTED: 08/24/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES	MAN PROVIDED ON THE PROVIDED O	20 NO. 100 No. 100 NO.			OMB NO. 0938-0391		
AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	Į (	X3) DATE SURVEY COMPLETED		
	495421	B. WING			C		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E. ZIP CODE	08/02/2018		
FRIENDSHIP HEALTH AND RE	UAD CENTED COURT	į.	5647 STARKEY ROAD	-, 2.0			
THE NEW PARTY AND RE	HAB CENTER - SOUTH		CAVE SPRING, VA 24018				
(X4) ID SUMMARY	STATEMENT OF DEFICIENCIES	ID		11106 000000			
PREFIX (EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCE	LAN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION E DATE		
F 658 Continued From pa	age 41	F 65	2				
21	ne hour before or one hour	1 00.	1				
after, then a medic	ation error was made. The	j					
survey team inform	ned the AT that professional	!					
standards do not a	llow a three or four hour						
window for medica	tion administration. The						
surveyor requested	the facility policy and	Tr.					
procedure for medi	ication administration.	8.					
met with the Adm, Pharmacist. The s about the facility's I administration prog surveyor asked who professional standa administration. The surveyors' question	ard regarding medication EAT did not answer the In the surveyor requested a				e n		
or from the DON re standards related to	nce either from the pharmacy garding professional p medication administration. did not acknowledge the	·	e.				
surveyors' request t related to medication hand delivered a po	for a professional standard on administration. The AT policy and procedure titled, ications." The policy and	B					
safe and timely mar Procedure:6. The medication must che medication, right do	ons shall be administered in a oner, and as prescribed. e individual administering the eck the label to verify the right sage, right time and right dministration before giving the	33 E					
Practices (ISMP) - 2 more frequently than	itute for Safe Medication  . Medications administered  n daily but not more frequently e.g. BID TID 04b, g6b)	a					

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 42 of 123

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STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MULT	IDLE CONTROL	OMB NO. 0938-039
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING		С
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/02/2018
FRIENDS	SHIP HEALTH AND REHAE	CENTED COUTU		5647 STARKEY ROAD	
				CAVE SPRING, VA 24018	
(X4) ID PREFIX	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		
TAG	REGULATORY OR L	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RE COMPLETION
	Administer these medibefore or after the schinformation technology medication use may reaccommodate more that trigger an alert for delabar-coding technology; a medication administratiset different time limits scheduled medications dispensing cabinets. Clhighlighting time-critical on eMARs and different and subsequent scheduthese technologies. ISM	cations within 1 hour eduled time. Current associated with quire vendor updates to: an a single time interval to yed and early doses with change the appearance of delayed doses in electronic on records (eMARs); and for the removal of from automated hallenges also exist with scheduled medications tiating between first doses alled doses when using the encouraging yendors to	F 65	58	
# t t t t t t t t t t t t t t t t t t t	the facility failed to follow standard related to medi. The facility staff were ad their medications outside. The facility was allowing four hour window to admivinch was outside of the of practice related to medically of Life CFR(s): 483.24  483.24 Quality of life to a fundamental to fire the control of t	ing the facility as to why whave a professional cation administration. ministering the residents of the two-hour window. the facility staff a three to inister medications, professional standards dication administration.	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.	

	STATEMENT	OF DEFICIENCIES	(V4) DECLEDED OF THE	2000	<del></del>		DMB NO. 0938-0391
	AND PLAN OF	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
			495421	B. WING			C
ı	NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	<u> </u>	08/02/2018
	FRIENDS	HIP HEALTH AND REHAE	CENTER - SOUTH	5647 STARKEY ROAD CAVE SPRING, VA 24018			
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APP DEFICIENCY)			(XS) COMPLETION E DATE
	t t s a c c g n n n s d d n o o a d d d	residents. Each reside facility must provide the necessary care and set the highest practicable psychosocial well-bein resident's comprehens of care.  This REQUIREMENT by:  Based on Resident intended and staff interview, the promote and enhance in Residents by restricting area dining room(s).  The finding included.  The facility did not providining room on weeken meal.  On 08/01/18 at 3:00 p.m. and the facility. During this meals are dining room on the facility of the facil	ent must receive and the envices to attain or maintain a physical, mental, and g, consistent with the ive assessment and plan is not met as evidenced erview, group interview, facility staff failed to the quality of life of the graph their use of the common ide dining services in the ds or for the breakfast  1., a group meeting was d orientated Residents of meeting, the Residents on was not available for the dining room for the DON (director of or. The administrative ility) did not offer the ends (Saturday/Sunday), om service was not did the evening meal was When asked why the they had lost their dijust employed a new	F6	Systemic Changes: Dining Room A and Diopen for residents who meals in those locations been in-serviced that reright to eat in their privice congregate dining setting discretion. A sign has been inform the residents that available to them.  Monitoring: The Dietary Director is compliance The Dietary designee will conduct which is patients over the ensure that they feel the their meals in the location choosing. Any/all negates be corrected at the time forwarded to the QA confurther review of the direction of the d	wish to eat their s. All staff have sidents have the ate room or in the ag at their been posted om A and B to at this is option is responsible for Director and/or weekly interviews next 3 months to by are able to enjoy on of their tive findings will of discovery and mmittee for hing processes of	y

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
		495421	B. WING	-		C		
	PROVIDER OR SUPPLIER	B CENTER - SOUTH		STREET ADDRESS, CIT 5647 STARKEY ROAD CAVE SPRING, VA		08/02/2018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	DER'S PLAN OF CORRECTION RRECTIVE ACTION SHOULD BI ERENCED TO THE APPROPRIA DEFICIENCY)			
F 675	Continued From page	- 44				* **		
		Residents were showing up.	- JE 1	675		3		
		o.m., nine Residents were				8		
	Interviews-		Ē			i.		
	08/01/18 6:07 p.m., 0 assistant) #2 stated to the dining room on wo 08/01/18 6:11 p.m., in #2. When asked why used on weekends/br staffing issues, some come out for meals, a Residents did not come 08/02/18 7:20 a.m., 0 room was just used M stated I think some petit.  08/02/18 7:25 a.m., 0 asked if she would go she stated "It's a nice 08/02/18 9:00 a.m., 0 she would go to the diweekends. She stated "blah." She then state	ne facility does not serve in eekends. Interview with Dietary person the dining room was not reakfast. He stated maybe times the Residents do not and for breakfast, the ne out that early. INA #3 stated the dining londay-Friday. She then exple would do better using stroup participant #1-When to the dining room to eat						
F 677 SS=D	provided to the survey conference. ADL Care Provided fo CFR(s): 483.24(a)(2) §483.24(a)(2) A reside out activities of daily liv	regarding this issue was team prior to the exit r Dependent Residents ent who is unable to carry ving receives the necessary and nutrition, grooming, and	F 6	77				
						Ť		

	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	Free State of the		OMB N	<u>O. 0938-0391</u>
AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) PROVIDER/SUPPLIER/CLIA (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) AND PLAN OF CORRECTION (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X6) AND PLAN OF CORRECTION (X6) AND PLAN OF CORRECTION (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) MULTIPLE CONSTRUCTION (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/CLIA (X7) PROVIDER/SUPPLIER/SUPP			(X3) DATE SURVEY COMPLETED				
	13.00		495421	B. WING			C
		ROVIDER OR SUPPLIER HIP HEALTH AND REHAB	CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	<u>  08</u>	/02/2018
ľ	(X4) ID	SI MANADY CTA	TEMENT OF OFFICE		57 KING, VA 24018		
	PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE
	to Cook with the cook with the	personal and oral hyginal personal and oral hyginal This REQUIREMENT by:  Based on observation record review it was destaff failed to provide fill Residents in the sample dependent on staff for a (ADL's), Resident #56:  The Findings Included:  1. Resident #56 was a was originally admitted on 7/17/18. Admitting of were not limited to: polytransplant, diabetes methemiparesis following a dysphasia due to cerebigastrostomy tube.  The most current Minimal personal personal fill with an AD ate (ARD) of 6/27/18. hat Resident #56 Cogning 99." The facility staff alse to the following care (4/2) with Activities of Described in the personal personal form of the personal following and the personal f	is not met as evidenced  staff interview and clinical etermined that the facility ingernail care 2 of 45 e survey who were activities of Daily Living and Resident #86.  64 year old female who on 1/6/18 and readmitted diagnoses included, but reystic kidney, kidney llitus, hemiplegia and cerebral infarction, ral infarction and a sessessment Reference. The facility staff coded tive Summary Score was so coded that Resident 3/2) to total nursing care ally Living (ADL's). The resident #56 required with personal care.  7 a.m., the surveyor ying in bed. The Resident #56's fingernails is fingernails also had a	F 677	Corrective Action(s): Resident #56 had her fingernails cleane and cut appropriately on the afternoon 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 designed has completed an audit on all residents to ensure that fingernails are cut and cleane 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 groomin to include fingernail care and facial grooming, to all residents.	of ve	

	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		OMB NO. 0938-0391		
03	AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION G	(X3) DA	TE SURVEY MPLETED
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	NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		8/02/2018
	FRIENDS	HIP HEALTH AND REHAE	CENTER - SOUTH		5647 STARKEY ROAD CAVE SPRING, VA 24018		
Į	(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	1 10			(5)
	PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DC	(X5) COMPLETION DATE
Committee William Committee (Committee Committee tt fi	On August 1, 2018 at 8 observed Resident #56 surveyor observed that were long and had a bit free edge of the finger.  On August 1, 2018 at 1 observed a Registered the hallway. The surve asked the RN is she co surveyor into Resident stated she was headed assigned to provide car on the unit. The RN set accompanied the surveyor poi #56's fingernails were to come at the to Resident #56.  On August 1, 2018 at 2:30 of Resident #56's fingernails were to Resident #56's fingernails were to Resident #56's fingernail The DON stated, "They anow."	8:30 a.m., the surveyor 8 lying in bed. The 12 Resident #56's fingernails 13 rownish debris under the 14 p.m., the surveyor 15 Nurse (RN) walking down 16 yor stopped the RN and 16 accompany the 17 yer som. The RN 18 to lunch and was not 19 to any of the residents 19 ther lunch down and 19 yor into Resident #56's 19 nurse out that Resident 19 and dirty. The RN 19 The RN stated she would 19 provide fingernail care 19 p.m., the surveyor 19 ursing (DON) that 19 yer taking care of that 19 p.m., the survey team 19 provide fingernail care 19 p.m., the survey team 19 provided prior to 19 yer and the AT that Resident 19 yer and the AT that Resident 19 yer and the AT that Resident 19 yer and the AT that Resident 19 yer and the AT that Resident 19 yer and the AT that Resident 19 yer and the AT that Resident 19 yer and the AT that Resident 19 yer and the free edge of 19	F 67	Monitoring: The DON is responsible for maintain compliance. The DON and/or designed will perform grooming audits weekly coinciding with the care plan calendary insure that proper grooming, including fingernail care and facial grooming, hoccurred for specific residents. Any/or negative findings will be reported to the DON for immediate correction. Details findings of these audits will be reported the Quality Assurance Committee for review, analysis, and recommendation for changes in facility policy, procedurand/or practice.  Completion Date: September 16, 201	eee on r to g ass all he iled ed to as re,		

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	UNDER DOS CHARGES			5647 5	STARKEY ROAD			
FRIENDS	HIP HEALTH AND REHA	B CENTER - SOUTH		CAVE	SPRING, VA 24018			
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3050	û			i)				
F 677	Continued From page		. F	677				
	was dependent on sta 2. The facility staff fait fingernails for Reside	led to shave and clean	к	3 <u>U</u>				
	originally admitted to readmission date of 3 but were not limited to	77-year-old-female who was the facility on 10/3/16 with a 6/19/18. Diagnoses included on dysphagia, hypertension, us, and obstructive sleep						
	MDS (minimum data annual assessment was reference date) of 7/3 assesses cognitive paths facility staff document and a BIMS (brief into 15 out of 15, which in was cognitively intact functional status. In Staff documented that	at 11:24 am. The most recent set) assessment was an with an ARD (assessment /18. Section C of the MDS atterns. In Section C0500, mented that Resident # 86 arview for mental status) of dicated that Resident # 86. Section G assesses ection G0110, the facility Resident # 86 requires of two or more persons		2				
	reviewed and revised documented a focus a a self-care deficit in prof daily living) r/t (relathemiplegia, limited mostatus. She requires eall ADL's except meal with set up assistance Resident # 84 prefers time, she does rarely	extensive to total assist with s where she is independent					e L	

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Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 48 of 123

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	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING		C 09/02/2040
NAME OF F	PROVIDER OR SUPPLIER	- W - W		STREET ADDRESS, CITY, STATE, ZIP CO	08/02/2018
FRIENDS	HIP HEALTH AND REHA	D.CENTED DOUTH		5647 STARKEY ROAD	
	III HEALIN AND KENA	D CENTER - SOUTH		CAVE SPRING, VA 24018	
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PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		ON SHOULD BE COMPLETION BE APPROPRIATE DATE
F 677	Continued From page	e 48	F	677	
	the nurse's station. A	t times, she will ask to be up	!	21 · · ·	d.
	in her chair, and then	refuse when staff goes in to			
	get her up." Interventi	ions for this focus area			
	included but were not	limited to: "Personal			
	hygiene/oral care: I re	equire staff extensive	×		
	assistance to complet	te personal hygiene and oral	1		1
	care."		8		11
	Resident # 86 lying in gown. The surveyor of facial hair on Resident asked Resident #86 if bothers her. Resident Resident # 86 then stanot shave her that her comes. The surveyor observed underneath  On 8/1/18 at 8:37 am, Resident # 86 lying in	n, the surveyor observed bed dressed in a hospital bserved grey and black t # 86's chin. The surveyor the facial hair on her chin #86 stated, "Yes it does." ated that the facility does daughter does it when she observed brown debris Resident # 86's fingernails. the surveyor observed bed on dressed in a reveyor observed grey and			76 29
8	black facial hair on Re brown debris undernea	sident # 86's chin and	19		
9	speak with Resident #8 was in to visit. Surveyo hair that was previous! Resident # 86's chin. T Resident # 86 if staff sl stated that she had got staff did not shave her nails, my daughter sha	haved her. Resident # 86  Iten a bath last night but  and, "They didn't do my  ved me." Resident # 86's  he shaved her mom when  e surveyor observed			

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	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	LE CONSTRUCTION	(X3) DATE SUI COMPLET	
NAME OF		495421	B. WING		С	
	(EACH DEFICIEN	AB CENTER - SOUTH  TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	1	STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018  PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO	1 08/02/	(20 OMP
F 684 SS=E	Continued From page The surveyor review checklist and compete certified nursing assist evaluated and check includes but is not limited female), Nail care (Trappropriate)."  On 8/1/18 at 5:35 pm was made aware of the No further information team regarding this is conference on 8/2/18. Quality of Care CFR(s): 483.25  § 483.25 Quality of care Quality of care is a further applies to all treatment facility residents. Based assessment of a resident residents received from the comprehence of the comprehence	the 49  ed the facility new orientation tency evaluation checklist for stants. Tasks that must be ed off by an evaluator nited to" "Shaving (male & imming and cleaning where imming and cleaning where immine findings as stated above.  I was provided to the survey sue prior to the exit  The administrative team the findings as stated above.  I was provided to the survey sue prior to the exit  The addamental principle that the the additional principle that the and care provided to the comprehensive that the facility must ensure the admental principle that the administrative tensure the facility must ensure the administrative tensure the facility must ensure the administrative tensure the facility standards of the ensure the facility standards of the ensure the ensure the facility standards of the ensure the ensure the ensure the facility standards of the ensure the en	F 684	DEFICIENCY)	cian was cation and attending Error dent.  an was d to ordered ce pair y the e left 4th ne and ian. A s	

Event ID. K4V211

Facility ID: VA0419

If continuation sheet Page 50 of 123

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		22 - 35 - 35 - 35 - 35 - 35 - 35 - 35 -	OM	B NO. 0938-0391
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	<del></del>	495421	B. WING	<u> </u>		С
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	1	08/02/2018
FRIENDS	HIP HEALTH AND REHA	R CENTER COUTU		5647 STARKEY ROAD	CODE	
		B CENTER - SOUTH		CAVE SPRING, VA 24018		
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t n F g p s s s s s	hours and to assess f shift.  Resident #36 was an admitted on 5/24/16. included, but were not osteoporosis, hyperter colitis and cerebral informassessment located in Annual MDS assessment Reference Date (ARD) coded that Resident #35 summary Score of 14. coded that Resident #36 assistance (1/1) to exter Activities of Daily Living On July 31, 2018 at 12 or Resident #36 regarding eceived in the State Agreement Resident #36 regarding the medications shysician. Resident #36 taff are bring in her metaff are bring in her metaff are bring in her after upper medications and	acility staff failed to follow ylenol 325 mg every six for pain assessments every 84-year-old female who was Admitting diagnoses Ilmited to: celiac disease, asion, anxiety, ulcerative arct.  The facility staff also 66 fequired set up ensive assistance (3/2) with a facility staff also 166 required set up ensive assistance (3/2) with a facility staff also 167 fequired set up ensive assistance (3/2) with a facility staff also 168 required set up ensive assistance (3/2) with a facility staff also 168 required set up ensive assistance (3/2) with a facility ensity on 5/30/18, and was that she is not as ordered by the 65 stated that the facility ermoon pills with her night time medications	F	Resident #66's attending notified that the facility for bruising Q shift as or physician, failed to apply to the buttocks as ordered physician, failed to obtain shift as ordered by the physician physician physician physician physician physician physician physician physician physician physician physician. A facility failed that the facility failed with the facility failed that the facility failed physician. A facility medication physician. A facility failed physician. A facility failed physician. A facility failed physician. A facility failed physician. A facility failed administer effector effector this form was completed for this form was completed for this physician. A facility failed administer #317's attending physician. A facility failed form was completed for this physician physician. A facility failed form was completed for this physician. A facility failed form was completed for this physician p	g physician was failed to monitor dered by the y Neutral-shield d by the n vital signs Q lysician, and c to the knees ysician. A form was nt.  physician was iled to apply ne physician was led to obtain was led to obtain by the cation Error incident.  lysician was led to dered by the lation Error incident.	
i ati	ii at one time. Residen	t #36 stated that the nedication errors with her				
1 100	legications. Resident #	36 showed the surveyor		İ		
l a	picture taken on 7/23/1	18 at 8:53 p.m. Resident				
# 5	so stated that she had:	Separated the nills into				
tn	ree different sections to	o identify what time they		#		j l
444	ere supposed to be giv ) medications on her ov	en. The picture displayed				

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0391		
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NAME OF F	PROVIDER OR SUPPLIER		<u>-</u>	STREET ADDRESS BIDLET	80	/02/2018	
EDIENDE	UID UE AL TIL AND			STREET ADDRESS, CITY, STATE, ZIP CODE			
INENDS	HIP HEALTH AND REHA	AB CENTER - SOUTH		5647 STARKEY ROAD			
(X4) ID	SUMMARYS	TATEMENT OF DEFICIENCIES		CAVE SPRING, VA 24018			
PREFIX TAG	(EACH DEFICIENCE	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	RE .	(X5) COMPLETION DATE	
To the total control of the to	staff had made a me medications on 7/23/pills were round and brought in 2 oblong Tashe thought the Tyler Resident #36 stated a medications because the physician had ord On July 31, 2018 at 1 entered Resident #36 local Ombudsman sitt bedside. The Ombud had several meeting was Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident #36's concern Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident Resident #36's complaint ad done an investigation resident #36's complaint Resident Resident #36's complaint Resident Resident #36's complaint Resident Resident #36's complaint Resident Resident #36's complaint Resident Resident #36's complaint Resident Resident Resident #36's resident #36's resident Re	that she thought that the dication error with her 18 as her Tylenol 325 mg on 7/23/18 the facility staff Tylenol. Resident #36 stated followere 500mg tablets. She did not take the she knew it was not what ered.  129 p.m., the surveyor 's room and observed the ing at Resident #36's sman stated that she had with the Administration about the about her medications. The Administration about the ings would get better for a fings would get better for a fings would get better for a fings would get better for a find the complaint.  14:38 p.m., the survey team after (Adm) and Director of the resident #36's Complaint, esident #36 had made the facility regarding the fins. The Adm stated that had been involved with ints and that the facility on. The surveyor cility investigation.	F 68-		mely as by eted for was an Error nt. was aintain uring		

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 52 of 123

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ND PLAN C	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	5500-2	OMB NO. 0938-039 (X3) DATE SURVEY	
		- NONTONIBLE	A. BUILDI	NG		MPLETED	
NAME OF F	PROVIDER OR SUPPLIER	495421	B. WING _		1 .	C 8/03/3040	
	HIP HEALTH AND REHA	STATEMENT OF DEFICIENCIES	ID	STREET ADDRESS, CITY, STATE, ZIP COI 5647 STARKEY ROAD CAVE SPRING, VA 24018 PROVIDER'S PLAN OF CO	DE	8/02/2018	
TAG	REGULATORY OF	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
i i i i i i i i i i i i i i i i i i i	mouth every 6 hours assessment q (every (sic)  Continued review of the July 2018 Medica (MAR's). The July20 that the facility staff a pain on 7/5/18 on the On August 2, 2018 at delivered the facility's #36's ongoing concer admiration. Review of documented a medica 7/23/18 Tylenol 500m pharmacy. The invested the Adm and party on 6/5/18, 6/14/7/27/18, 7/28/18, 7/30 On August 2, 2018 at met with the Adm, DO Pharmacist. The survey administrative Team (Administrative Team (Aministrative	the clinical record produced ation Administration Records 18 MAR's failed to document assessed Resident #36 for a day shift.  8:30 a.m., the Adm hand a investigation into Resident as about her medication of the facility investigation ation error related to the grovided by the tigation also included emails Resident #36's responsible 18, 6/15/18, 7/25/18, 1/18, 7/31/18 and 8/1/18.  10:30 a.m., the surveyor N, Medical Director and ey team spoke to the AT) about the facility's administration medication n. During the meeting, the at two medication errors. The Adm stated that the incorrect dosage of that Resident #36 was bl 325 mg and that the enol 500mg tablets. The seen an ongoing issue t with the Ombudsman	F 68	Identification of Deficient Practices/Corrective Act All other residents may hat potentially affected. The I Managers will conduct a lall resident's physician on over the past 30 days to id at risk. Residents identified corrected at time of discovered comprehensive plans of careflect their resident specificattending physicians will be each negative finding and a line ident & Accident Form completed for each negative.  Systemic Change(s):  The facility policy and probeen reviewed and revision made in two areas; the meditimes have been altered so overlap between time-frame the facility has worked with EHR provider to eliminate frames before and after each block, thereby reducing the medications can be administed compliant manner. Licensed in-serviced by the DON and on these changes to the medication program. The designee will also in-service nursing staff on the procedu obtaining, transcribing, and physician medication and treorders.	sion(s):  ave been  OON and Unit  OO% audit of  ders and MAR's  entify resident  d at risk will be  ery and their  re updated to  ic needs. The  e notified of  a facility  will be  e finding.  cedure has  s have been  ication block  there is no  es and, further,  the facility's  the time  n medication  time in which  tered in a  I staff will be  //or designee  ication  c DON and/or  all licensed  re for  completing		

Event ID: K4V211

Facility ID: VA0419

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	/Y2\ \\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	N. C. COLUMNIA	OMB NO. 0938-039
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	PLE CONSTRUCTION  3	(X3) DATE SURVEY COMPLETED
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	PROVIDER OR SUPPLIER SHIP HEALTH AND REHAL	3 CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD	08/02/2018
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PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	RE COMPLETION
F 684	Continued From page	53			
10	the facility staff failed the #36's Tylenol 325mg value administration on 7/23	o ensure that Resident vas available for /18.	F 68-	Monitoring: The DON will be responsible for maintaining compliance. The DON	
	This is a Complaint De	ficiency.		ADON and/or Unit Managers will perform weekly MAR/TAR and chart	
	every day, applying ski lower legs every day, or right 5th toes with norm with dressing or ointme  Resident #54 was a 63-admitted on 7/10/17 and Admitting diagnoses inclimited to: chronic obstri	e Ativan 1 mg every eight ateral lower extremities in repair cream to bilateral leansing the left. 4th and hal saline and treatment ints,  -year-old male who was direadmitted on 5/16/18. Cluded, but were not suctive pulmonary disease, chronic kidney disease age 1 through stage 4		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 a 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	s and
F	The most current Minimassessment located in the Duarterly MDS assessment Reference Date (ARD) of the Coded that Resident Summary Score of 15. Tooded that Resident #54 activities of Daily Living (	ne clinical record was a sent with an Assessment of 6/20/18. The facility t #54 had a Cognitive the facility staff also			
or P "A da	rtne clinical record prod hysician orders included ACE wraps to BLE (bilat aily (2X 3in ea leg) (2 3i	clinical record. Review uced physician orders.			

		MEDICAID SERVICES				OMB NO. 0938-0391		
STATEMENT OF DEFICIENT AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
						С		
NAME OF PROPERTY		495421	B. WING	- 8 <del>- 8</del> -		08/02/2018		
NAME OF PROVIDER OR	SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE			
FRIENDSHIP HEALTI	AND REHA	B CENTER - SOUTH		5647	STARKEY ROAD			
				CAVE	SPRING, VA 24018			
	ACH DEFICIENC	TATEMENT OF DEFICIENCIES DY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION		
F 684 Continue	d From pag	e 54	· -	2041				
		Tubi grips one time a day	г	884		iji		
for dry sk	in Cleanse	d Left 4th toe with NSS		1				
(normal s	aline solution	on), Pat Dry, Apply TAO						
(triple ant	ibiotic ointm	nent), cover with dry dressing						
QD (ever	v day for pr	otection, one time a day for	B			48		
protection	. Cleanse F	R (right) lateral metatarsal						
with NS (	normal salir	ne), pat dry. Apply Aquacel						
AG into w	ound bed,	cover with Metiplex 4 X4.	0	85				
Change D	aily. Every	day shift.	127					
			92 93					
the July 2	018 Treatm	the clinical record produced ent Administration Record				8		
(IAK). Ke	view of the	July 2018 TAR failed to						
abcumen	that the fac	cility staff applied the						
7/30/18	Ordered AU	E wraps on 7/21/18 and on also failed to document that				20		
the physic	ian ordered	skin repair cream was		5				
applied or	7/15/18 7	/21/18 and 7/30/18. The		102				
July 2018	TAR's did r	not document that the facility						
staff clean	sed the left	4th toe and provided the						
physician	ordered tre	atment on 7/17/18, 7/25/18	*					
and 7/26/	18. The Jul	y 2018 also failed to						
document	that the fac	cility staff provided the						
treatment	to the right	5th toe 7/5/18 and 7/16/18	8					
3			C			30		
August 2,	2018 at 8:3	6 a.m., the surveyor notified						
the Directo	or of Nursin	g (DON) that the surveyor						
		nt #54's clinical record. The						
had not or	ovided phys	OON that the facility staff sician ordered treatments on						
the July 20	OVIDED PHYS	The surveyor and DON						
reviewed t	he clinical r	ecord to include the						
physician	orders and	the July 2018 TAR's. The						
surveyor p	ointed out t	hat the facility staff had not				*		
provided the	ne physiciar	ordered treatments.						
On August	02, 2018 a	t 8:34 p.m., the survey team						
met with th Rehabilitat	ie Aaministr ion Director	ator (Adm), DON, , Rehabilitation Assistant,						

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

					OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1	) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		STRUCTION	(X3) DATE SURVEY COMPLETED
	495421	B. WING _			C 08/02/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CE	ENTER - SOUTH		5647 S	FADDRESS, CITY, STATE, ZIP CODE TARKEY ROAD SPRING, VA 24018	1 00/02/2018
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
F 684 Continued From page 55 Staff Coordinator and Hot The surveyor notified the (AT) that the facility staff is physician orders for Resident TAR's failed to document provided physician ordered.  No additional information survey team prior to exiting the facility staff failed to for Resident #54  3. For Resident #55 the fat follow physician orders for for 7 days.  Resident #55 was a 96-yet admitted on 5/29/18. Admitted on	usekeeping Director. Administrative Team had not followed dent #54. The surveyor ent #54's July 2018 that the facility staff ed treatments.  was provided to the gg the facility as to why allow physician orders  acility staff failed to calculate the facility as to why ar-old female who was ar-old female who was atting diagnoses ted to: fall, benign lateral osteoarthritis of unication deficit.  a Data Set (MDS) clinical record was a sessment with an late (ARD) of 6/26/18. It Resident #55 had a of 14. The facility staff equired set up we assistance (3/3) with DL's).  p.m., the surveyor d. Review of the	F 6	84		

Continued review of the clinical record failed to

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495421	B. WING			С	
NAME OF D	ROVIDER OR SUPPLIER	430421	D. Wild_			08/02/2018	
	HIP HEALTH AND REHA	· · · · · · · · · · · · · · · · · · ·		5647 S	T ADDRESS, CITY, STATE, ZIP CODE TARKEY ROAD SPRING, VA 24018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	100	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION	
F 684	Continued From page	e 56	· F6	84	-00		
	Record (MAR's). Rev documented that the	8 Medication Administration view of the July 2018 MAR's facility staff failed to 40mg for 7 days. The July	e				
	2018 MAR's documer	nted that the facility staff Lasix 40mg for one day on	II so				
17 27 28	notified the Director o Resident #55 had a p mg for 7 days. The su	hysician order for Lasix 40 rveyor notified the DON that dministered the Lasix 40 mg					
	met with the Administr surveyor notified the A that Resident #55 had 40 mg for 7 days. The	4:38 p.m., the survey team rator (ADM) and DON. The Administrative Team (AT) I a physician order for Lasix e surveyor notified the AT and only administered the 7/19/18.	į.				
	delivered a medication documented that the fa administered the phys						
	exiting the facility as to	ion was provided prior to why the facility staff failed s' order for Lasix 40 mg for 55.					
;	follow physician orders every shift, apply Neut	e facility staff failed to s to monitor for bruising ral-shield to buttocks and tain vital signs every shift					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTII A. BUİLDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		495421	B. WING		C 02/2048	
	ROVIDER OR SUPPLIER	AB CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP COI 5647 STARKEY ROAD CAVE SPRING, VA 24018	08/02/2018 DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE	
F 684	70 AND AND AND AND AND AND AND AND AND AND	ge 57 c to knees four times a day. n 85-year-old female who was	F 68	34		
	admitted on 2/3/18, included, but were n atherosclerotic hear	Admitting diagnoses ot limited to: atrial fibrillation, t disease, dementia without sion, osteoarthritis and				
	assessment located Quarterly MDS asse Reference Date (AR staff coded that Res Summary Score of 1 that Resident #66 w	nimum Data Set (MDS) in the clinical record was a ssment with an Assessment D) of 6/26/18. The facility ident #66 had a Cognitive 4. The facility staff coded as independent (0/0) to set				
	(ADL's).  On August 1, 2018 a reviewed Resident #	with Activities of Daily Living at 10:20 a.m., the surveyor 66's clinical record. Review produced physician orders.			,	
	Physician orders inc "Monitor/Observe an day) until resolved e every shift Ensure Vi Diclofenac Sodium G	luded, but were not limited to: y/all bruises Q day (every very shift. Vital Signs qshift itals have been documented.	# #		7 7	
	both knees. Neutras & sacrum topically e	hield cream Apply to buttocks very shift for skin integrity. creamto buttocks and	I	a.		
5	the July 2018 Vital S Treatment Administra Review of the July 20 document that the fa	the clinical record produced igns Record (VSR) and ation Records (TAR's).  18 VSR and TAR's failed to cility staff obtained the al signs every shift on 7/5/18	5 5			

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STATEMENT	OF DEFICIENCIES	WAY OBOUTE THE THE				OMB NO. 0938-0391
	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING			C
NAME OF F	PROVIDER OR SUPPLIER	300		STREE	ET ADDRESS, CITY, STATE, ZIP CODE	08/02/2018
FRIENDS	HIP HEALTH AND REHA	B CENTER - SOUTH		5647 5	STARKEY ROAD SPRING, VA 24018	
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	D	1 8	Samuel and the same and the sam	
PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 684	Continued From page	e 58	F	684		
	on the day shift, on 7	/23/18 on the night shift and	20.50			
	on 7/26/18 on the da	y shift.	1			
	The July 2018 TAR's	also failed to document that		22		
	the facility staff applie	ed the physician ordered		Ü		
	Diclofenac to Resider	nt #66's knees on 7/2/18 on	İ	I		
	the am medication pa	ass and the evening	1			Œ
	medication pass, on 1	7/5/18 on the am medication				}
	pass, on 7/24/18 on t time and on 7/26/18 of	he early medication pass on the am medication pass.		0		s.
	The July 2018 TAR's	also failed to document that				E se
	the facility staff monitor	ored Resident #66 for				
6	bruises on 7/2/18 on 1	the evening shift, on 7/5/18				
	on the day shift and o	n 7/26/1 on the day shift.	19			
	The state of the s					
	The July 2018 TAR's	also failed to document that		8		
	the facility staff failed	to apply the physician				1
	ordered Neutra-shield	cream to Resident #66's				
	buttocks and sacrum	on 7/2/18 on the evening				1
	shift, on 7/5/18 on the the day shift.	day shift and on 7/26/18 on				
	On August 1, 2018 at	12 noon, the surveyor				
5	notified a Registered I	Nurse (RN), that Resident	R			1
	#66 had a physician o		÷			
		tra-shield cream to buttock		18		82
	and sacrum, obtaining	the vital signs every shift		8		38
	four times a dev. The	ac to Resident #66's knees				
	that review of the VCD	surveyor notified the RN				
	to document that the fo	and July 2018 TAR's failed acility staff had followed the				
	physician orders for P	acility staπ had followed the esident #66. The surveyor				
	reviewed the clinical re	cord with the DN and				
		orders, July 2018 VSR		9		
	and TAR's.	Pracis, July 2010 VOK				
	On August 1, 2018 at a	4:38 p.m., the survey ream				
	met with the Administra	ator (ADM) and DON. The				

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 59 of 123

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STATEMENT	OF DEFICIENCIES	WEDICAID SERVICES	The same and the same of the s			OMB NO. 0938-0391	
AND PLAN C	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
NAME OF	TROMOS OF SUREY	495421	B. WING	-		C 08/02/2018	
MANNE OF I	PROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
FRIENDS	HIP HEALTH AND REHA	B CENTER - SOUTH		5647 9	STARKEY ROAD		
				CAVE	SPRING, VA 24018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	٠,	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) E COMPLETION ATE DATE	
F 684	Continued From page	÷ 59	F6	84		00 00 0007	
	that the facility staff fa	Administrative Team (AT) hiled to follow physician 66. The facility staff failed to ry shift, failed to apply slofenac and failed to	1			a) (j	
	monitor for bruising.			61			
	No additional information exiting the facility as to follow physician order.	tion was provided prior to o why the facility staff failed ders for Resident #66.		g ps			
	5. For Resident #67 the physician ordered TEI	ne facility staff failed to apply D hose.	80				
	admitted on 6/20/17. A included, but were not sclerosis, chronic lymp	0 year old male who was Admitting diagnoses limited to: multiple phocyte leukemia of B-cell heart failure and benign	u	3 3.		Source (sp)	
	Annual MDS assessm Reference Date (ARD) staff coded that Reside Summary Score of 15. coded that Resident #6 to required extensive a Activities of Daily Living On August 1, 2018 at 2	the clinical record was an ent with an Assessment of 6/28/18. The facility ent #67 had a Cognitive. The facility staff also 67 was independent (0/0) issistance (3/2) with g (ADL's).	N .	2			
	of the clinical record pr Physician orders include "TED hose as resident HS (bedtime) Rinse &d for skin integrity one tin	oduced physician orders. led, but were not limited to: allows. ON in AM, Off at ry and perform skin check ne a day place on in am. allows. ON in AM, Off at					

PRINTED: 08/24/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED **CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING \_ C 495421 B. WING 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH **CAVE SPRING, VA 24018** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 684 Continued From page 60 F 684 HS (bedtime) Rinse &dry and perform skin check for skin integrity one time a day Take off in PM." 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

TED hose on Resident #67.

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

6. For Resident #110 the facility staff failed to

STATEMENT	OF DEFICIENCIES	THE SELLATORS		_	<u> </u>	OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN		(X3) DATE SURVEY COMPLETED	
		495421	B. WING_			C
	PROVIDER OR SUPPLIER	B CENTER - SOUTH		5647 ST	ADDRESS, CITY, STATE, ZIP CODE ARKEY ROAD SPRING, VA 24018	08/02/2018
(X4) ID PREFIX TAG	, (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 684	Continued From page	a 61	í e e			
	100 (GE)	rs to obtain vital signs every	F 6	34		
	Resident #110 was a admitted on 7/13/18, included, but were no hypertension, atrial fit dementia without beh	t limited to: asthma, prillation, depression,				i i
1	No Minimum Data Se available due to Residadmission.	t (MDS) assessment was dent #110's recent		£		1
11 2 2	of the clinical record p Physician orders inclu the following: "Vital Signature:	20 p.m., the surveyor 10's clinical record. Review roduced physician orders. ded, but were not limited to gns QShift (every shift) for ined and verified by Nurse."	10 to 10 to	11		
	the July 2018 Treatmet (TAR's). Review of the document that the faci order to obtain Reside shift. The July 2018 To the vital signs were obtains.	ne clinical record produced ent Administration Records July 2018 TAR's did not lity followed the physician ent #110's vital signs every AR's did not document that tained on: 7/19/18 on the 8 on the day shift and on nift.	er er	4 4		
	#110 had a physician of every shift. The survey review of the July 2018 that the facility staff had ordered vital signs ever	urse (RN) that Resident order to obtain vital signs or notified the RN that TAR's failed to document d obtained the physician	ii.			×

CLIVILLI	STOR WEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED
		495421	B. WING			C 08/02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	
FRIENDS	HIP HEALTH AND REHA	B CENTER ROUTE		5647 STA	RKEY ROAD	
THENDO	TIERETH AND KENA	B CENTER - SOUTH		CAVE SI	PRING, VA 24018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 684	Continued From page	<del>-</del> 62		684		-
		riewed the physician orders	₩.	504		
	and the July 2018 TA	R's. The RN was unable to				
		for the missing time frames				
	listed above.	ior the missing time traines				
				3		
	On August 1, 2018 at	4:38 p.m., the survey team	Į.			1
		rator (ADM) and DON. The		8:		
		Administrative Team (AT)				
	that Resident #110 ha	ad a physician order for the		18		
		vital signs every shift. The				
		AT that review of Resident				
	#110's clinical record					
		e facility staff obtained the				
		al signs on several instances				
	in July 2018.					
	No additional information	tion was provided prior to				
		o why the facility staff failed				
		order to obtain vital signs				
	every shift for Resider	nt #110.				
		facility staff failed to ensure	18			
		n antidepressant medication	3			
9		nt receiving a higher dose				
	than ordered.					
	Resident #12 was adr	mitted to the facility on				İ
		cluded diabetes mellitus				
		in use, hypertensive heart				9
	disease with heart fail	ure, peripheral venous				
	insufficiency, and dep	ression. On the quarterly				
	minimum data set ass	essment with assessment				
		8, the resident scored 13/15				
		for mental status and was				
	assessed as without d		*			
		ners. The resident scored				
		essment (higher scores				
	indicate greater prese	nce of depressive				
	symptoms).					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MUL' IDENTIFICATION NUMBER: A. BUILDI		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING		C
	ROVIDER OR SUPPLIER	B CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CO 5647 STARKEY ROAD CAVE SPRING, VA 24018	J 08/02/2018 DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION E APPROPRIATE DATE
F 684	a physician order dat hour 75 mg (milligran extended release) Gi QD (daily) for 7 days mg PO QD, with star discontinue date 7/5/ (medication administ the medication was a through 7/3, or 19 da dated 6/14/18 with st XR 24 hour 150 mg (hydrochloride extend PO (by mouth) QD (othe resident received through 8/2 (the date	review, the surveyor noted ed 6/14/18 for Effexor XR 24 m) (venlafaxine hydrochloride ve 1 capsule PO (by mouth) then increase dose to 150 to date 6/15/18 0800 and 18 1111. The MAR ration record) documented dministered daily 6/15 ys. Another physician order art date 6/22/18 for Effexor milligram) (venlafaxine ed release) Give 1 capsule laily). The MAR indicated a 150 mg capsule daily 6/22	F	84	
	The surveyor reporte of nursing and admin meeting on 8/2/18.  8. The facility staff fai ordered IV Vancomyo Resident # 317.  Resident # 317 was a admitted to the facility included but were not (Methicillin-resistant satrial fibrillation, hype disease.  The clinical record for reviewed on 8/1/18.	Staphylococcus aureus), rtension, and coronary artery			er er er er er er er er er er er er er e
E		re for Resident # 317 was on 7/27/18. The facility staff	ı	1) 3)	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) BBO ADED/CURRILIER IN	ESECTO ASSESSMENT	Markon to Ale		OMB NO. 0938-0391		
	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	The same and the s		ONSTRUCTION	(X3) DATE SURVEY		
		A.		ING	COMPLETED			
						С		
NAME OF		495421	B. WING			08/02/2018		
INAME OF F	PROVIDER OR SUPPLIER		51 10	STR	EET ADDRESS, CITY, STATE, ZIP CODE	1 00:02/2010		
FRIENDS	HIP HEALTH AND REHA	R CENTED COUTU		5647	7 STARKEY ROAD			
	THE PROPERTY OF THE PARTY OF TH	D CENTER - SOUTH		CAV	/E SPRING, VA 24018			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		1				
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF	ıx	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E	(X5)		
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG		CROSS-REFERENCED TO THE APPROPRI	BE COMPLETION TATE DATE		
	7		<u> </u>		DEFICIENCY)	100-02516/17 T		
F 00.4	0		i					
F 684	Continued From page		F	684		75		
	documented MRSA in	the focus are for infection	<b>1</b> 35 96	!				
	alert. Interventions inc	clude but are not limited to:	i			¥		
	:"(handwritten) Vanc	o. (Vancomycin) IV	į					
	(intravenously)/Labs a	as ordered.	ļ	i		*		
	500V	5,000		ļ				
	Resident # 317 has ci	urrent orders that were						
	signed by the physicia	an on 8/1/18 for	1					
	"Vancomycin HCL Sol	lution Reconstituted	1	1				
	1000mg (milligrams) i	ntravenously every 12						
	hours for MRSA Run i	t over 2 hours in 250 ml	1	1		8		
	bag. Resident # 317 h	į						
	Vancomycin IV since	admission. Upon admission	į	į		20		
	to the facility on 7/20/	18, Resident # 317's orders		ì				
	were "Vancomycin HC	L solution Reconstituted		į				
	750 mg intravenously	every 12 hours for MRSA	i					
8	for 6 weeks 750 mg in	250 ml of Normal Saline to		1		607		
	he administered over	1 hour." The medication	3	I				
15	administration record	reflected that Resident #		Į.				
	317 was to receive his	Wyonermusin at 0.00						
	and 9:00 pm.	IV Vancomycin at 9:00 am	i	E		1		
	and 5.00 pm.					2		
	On 8/1/19 of 2:22 nm	AL ACTION OF THE PARTY OF THE P	i					
	On 8/1/18 at 3:23 pm,	the surveyor observed	ļ	12				
	changed a single li	n his room. The surveyor	1 1					
	317's right upper serve	en PICC line in Resident #	•••	18				
	the current that he he	Resident # 317 informed	1	1				
i.	the surveyor that he ha	as to take antibiotics	i i	13		89 80		
	through his IV every 12	z nours.	į	524		ľ		
	Upon review of the me	dication administration	31					
	the fellowing date	17, the surveyor observed						
	the following dates and	times were out of	53	3		E		
	Compliance for medica	tion administration of IV						
	Vancomycin as ordered	o by the physician	19	8)		1		
	7/20/18 ordered at 9:00	pm, administered at	76 26					
	11:51 pm	TO AN HOUSE PART TO THE						
	7/22/18 ordered at 9:00	am, administered at		1				
	10:11 am	The state of the s				180		
	7/27/18 ordered at 9:00	am, administered at	8					
29	10:08 am	no. Transcribble records and constituted that the first of the first o	el .					

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) MIII	CIOLE COL	OMB NO. 0938-0391	
	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI		ISTRUCTION	(X3) DATE SURVEY COMPLETED
			72 001201		<del></del>	W SHAR
		495421	B. WNG			С
NAME OF F	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE	08/02/2018
					TARKEY ROAD	
FRIENDS	HIP HEALTH AND REHAI	B CENTER - SOUTH			SPRING, VA 24018	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES						
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX	<b>K</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I	BE COMPLETION
N 3000	j n n n n n	3.5.0	TAG		CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE DATE
-	1 × 30 =		0 8	7-1	0.000 (0.000 (0.000)	<del></del>
F 684	Continued From page	65	F	684		ä
		00 pm, administered at				
	10:46 pm					
		00 am, administered at		127		\$5
	10:17 am		8			8/
	11:12 pm	00 pm, administered at	i.			
		00 pm, administered at				n
	10:39 pm	oo piii, administered at				
		pm, administered at 10:35				1
	pm.		额			
	On 9/0/40 -4 40:05			w		
	the administrator direct	n, the survey team met with ctor of nursing, pharmacist,				199
	and the medical direct	tor regarding the issues with	ì			
		stration times. The director				
		e survey team with a typed		5		5
	packet dated 1/4/16, v					ii.
,		dication policy." The packet	## 187			
	contains information th					9
	limited to"Our libera					
		n establishes the following				
	medication administra	tion times;				
	1) Early from 5 am to	p 7 am	Na contract of the contract of			
82	2) Morning from 8 ar					
	3) Mid-day from 2 pr					
(4	4) Evening from 6 pr	n to 10 pm				ie.
	-	**	ii.			
	The survey team expre	essed concerns about				
3		current facility practice				
	and the way medicatio	ested to see a standard of				
	practice that the libera	lized medication pass was				
	based on. The director	of nursing stated that the				
	standard of practice wa	as the liberalized				
1	medication administrat	tion policy. The pharmacist				
	spoke of studies that h	ave been conducted and				
	referenced a research					
	included with the packet	et that was presented to				

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8	THE DIGARD SERVICES	- aprilan			OMB NO. 0938-039 <sup>-</sup>
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ISTRUCTION	(X3) DATE SURVEY COMPLETED
	495421	B. WING_	- 19-18 - S		C 08/02/2018
NAME OF PROVIDER OR SUPPLIER	-	9.00	STREE	T ADDRESS, CITY, STATE, ZIP CODE	1 00/02/2018
FRIENDSHIP HEALTH AND REHA	D CENTED DOUBLE			TARKEY ROAD	
THE RESERVE HEACTH AND REHA	AB CENTER - SOUTH	9	CAVE	SPRING, VA 24018	
(X4) ID SUMMARY S	TATEMENT OF DEFICIENCIES			PROVIDER'S PLAN OF CORRECTION	
PREFIX (EACH DEFICIENCE	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	·	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 684   Continued From pag	e 66		·D.4		
	assured the team that the	F6	84		
way that medications	s were being administered	*			
within the facility is s	afe. The pharmacist stated				
that if there are medi	cations that the physician	¥			
Write specific time na	rameters to be given the		1		
facility can put and a	ctual time into the computer				
program. The directo	r of nursing then stated that		15		
the nurses would be	held to the 1 hour before and				
1 hour afterward star					
administering medica					
Within the packet tha	t was presented to the		Ē		
survey team along wi	th the typed letter with the				
: liberalized medication	n administration times was				
the facility policy on ".	Administering Medications"				
policy date is 1/2017.	Printed on the policy is				
	policies." The "Purpose" of		E E		
the policy states, "Me			r.		
administered in a safe	e and timely manner and as		1		
prescribed." The proc			12		
	icluded but was not limited				
to" 6. The individu	al administering the	88			
medication must ched	k the label to verify the right				
method (route) of ad-	age, right time, and right ninistration before giving the				
medication.	milistration before giving the		11		
On 8/2/18 at 9:35 pm.	, the administrative team		18		
was made aware of the	ne findings as stated above.		ij		
	regarding this issue was team prior to the exit				<del>.</del>
<ol> <li>The facility staff fail medications to Reside ordered times.</li> </ol>	ed to administer ent # 61 during the physician				
Resident # 61 was a 5	i3-vear-old female who was				

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 67 of 123

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				· · · · · · · · · · · · · · · · · · ·	С
	of Decrease of the transport of the second o	495421	B. WING_		08/02/2018
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH			**	STREET ADDRESS, CITY, STATE, ZIP COE 5647 STARKEY ROAD CAVE SPRING, VA 24018	DE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I ID I PREFIX TAG	PROVIDER'S PLAN OF CC ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION DATE
F 684	Continued From page	e 67	F 6	84	
	admitted to the facilit	y on 3/9/17. Diagnoses			
	included but were no	t limited to: anxiety disorder,	12	25	#
		atrophy, depression, and	*	-	
	MDS (minimum data quarterly assessment reference date) of 6/2 assesses cognitive paths facility staff docur had a BIMS score of that Resident # 61 was.  The current plan of care.	t 11:25 am. The most recent set) assessment was a t with an ARD (assessment 29/18. Section C of the MDS atterns. In Section C0500, mented that Resident # 61 15 out of 15, which indicates as cognitively intact.			17 T
	documented a focus the potential for chror spasticity and impairs muscle spasm meds	on 7/30/18. The facility staff area as "Resident # 61 has nic pain r/t (related to) ed mobility. She needs H.S. (hour of sleep) TID (3	e e	H	Ţ
	daily), PRN (as needed She has schedule for 7/30/18." Intervention limited to, "Anticipate pain relief and respon complaint of pain," an	in meds TID (three times ed) pain meds (Oxycodone) baclofen pump to be placed s included but were not Resident # 61's need for id immediately to any d''Administer analgesia as our before treatments or		X MODEL OF THE PROPERTY OF THE	
	interview with Resider Resident # 61 stated, medicines to me in tin Saturday I get medicin I went to the nurse's s need my pills (employ	the surveyor conducted an int # 61. During the interview "They don't get my ine." A few weeks ago on a ines at 9, 1, 5, and bedtime." station at 7:49 and said I isee's name withheld) I said I was after 8 o'clock			

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		495421	B. WING			C 08/02/2018	
NAME OF P	ROVIDER OR SUPPLIER		3.22	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	00/02/2016	
FOIENDA		2 F2122300-V00-			STARKEY ROAD		
FRIENDS	HIP HEALTH AND REHA	B CENTER - SOUTH			E SPRING, VA 24018		
WALE	CUMMANY	ATEMENT OF PECONS AND		CAVE	100 to 10		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x .	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION	
F 684	Continued From page	÷ 68	Fi	584			
	before I got my 5 o'cle		y. 185	JQ-1		88	
	demand them."	ock pins and i fiza to					
	comand mem.						
	The surveyor reviewe	d the progress noted for					
	Resident # 61. The fa	cility staff documented in					
	the progress notes a	late entry on 6/30/18 at 8:15		i.			
	pm. The surveyor rev	iewed a calendar and				91 10	
	6/30/18 was on a Sat						
	documented in Reside						
	stated, " Rsd (residen				99		
	inappropriate behavio		335				
		s station cursing at staff with					
	demands when her ne	eeds are not met					
		requests assistance. Rsd					
	informed calmly via te	lephone after receiving her				8	
	phone call that staff w	as attending to an					
		ith 3 other residents and		1		10	
	she would be assisted	as soon as possible.				201	
1	States, "I don't care, I	have to have my					
	medication for muscle	spasms on a timely basis."		1			
	Again explained to rso	that staff would attend to					
	her needs quickly afte	r attending to emergency					
	needs. Rsd called nur						
		I know someone died, they					
		re not being taken care of."					
0	Rsd then proceeded to						
Î	station and wait at des	sk yelling for staff to help					
101	her. Rsd was propelled	d in w/c (wheelchair) by		KI .			
		sist her in care and nurse					
	provided her requeste	d medication."					
	The surveyor reviewed	the facility medication					
		port for Resident # 61 from				1	
	6/30/18. The following						
	administered at the ap						
	physician's orders:						
	Xarelto Tablet 20 mg (	Rive 1 tablet by mouth					
	every 24 hours for anti						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULI A. BUILDII	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
495421			B. WING		С
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH				STREET ADDRESS, CITY, STATE, ZIP CO 5647 STARKEY ROAD CAVE SPRING, VA 24018	
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF (  (EACH CORRECTIVE ACT)  CROSS-REFERENCED TO TI  DEFICIENC'	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 684	Continued From page	: 69	Fé	584	-
×	scheduled time 5:00 pm	om, time administered 7:45	w.	t.	
ī		20 mg by mouth every 24 cms @ (at) 5pm- scheduled ministered 7:48 pm		î	я.
ē		0 mg Give 1 tablet by mouth pain - scheduled time 6:00 d 7:74 pm		ì	
8	every 24 hours for mu 9pm total dose 30 mg	g Give 1 Tablet by mouth rscle spasms/stiffness @ per neurology-scheduled ministered 7/1/18 at 12:42	ir Š	) 1	
l	am.				ĺ
		20 mg by mouth every 24 cms @ 9pm-scheduled time cd 7/1/18 at 12:42 am.	or N		
		Give 1 tablet by mouth Gives - scheduled time 9:00 17/1/18 at 12:42 am	8		
a de la composição de l		Give 20 mg by mouth at n-scheduled time 9:00pm, /18 at 12:43 am			
	mouth at bedtime for (	150 mg Give 1 tablet by GERD (gastroesophageal uled time 9:00 pm, time t 12:42 am			
		3 mg by mouth at bedtime heduled time 9:00 pm, time t 12:42 am			
	Crestor Tablet 5 mg G	ive 1 tablet by mouth at	(6)		

STATEMENT OF DEI AND PLAN OF CORE		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A DOILDIN		c	
	- water worth a station of the const	495421	B. WING_		08/02/2018
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH				STREET ADDRESS, CITY, STATE, ZIP CO 5647 STARKEY ROAD CAVE SPRING, VA 24018	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE COMPLETION E APPROPRIATE DATE
F 684 Con	tinued From page	70	F 6		
bed pm,	time for high chole time administered	esterol-scheduled time 9:00 d 7/1/18 at 12:42 am		3	
feet	topically at bedtin	ply to bilateral ankles and ne for pain/stiffness-	£8		9
	18 at 12:46 am	m, time administered	ļ		
bedt		e 1 capsule by mouth at nt-scheduled time 9:00 pm, /18 at 12:43 am	15		n
at be	ec allergy tablet 10 edtime for allergie administered 7/1/	0 mg Give 1 tablet by mouth s-scheduled time 9:00 pm /18 at 12:42 am	1		×
Acco	ording to the facilitications," the"F	y policy on "Administering Purpose" of the policy			2
state safe proc	s, "Medications s and timely manne edure contains do	hall be administered in a er and as prescribed." The cumentation that includes "6. The individual			
label right	to verify the right time, and right me		R		a
admi	nistration before g	giving the medication."		•	12
		the administrative team e findings as stated above.		2	
prese	orther information ented to the surve erence on 8/2/18.	regarding this issue was y team prior to the exit			
		led to administer oxygen rate for Resident # 94.		al .	
Resid	lent # 94 was an	38-year-old-male who was		9	

PRINTED: 08/24/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		495421	B. WING_			C	_	
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH				STREET ADDRESS, CITY, 5647 STARKEY ROAD CAVE SPRING, VA 24		08/02/2018 DE		
(X4) ID PREFIX TAG	(EACH DEFICIE	/ STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORF	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)	(X5) E COMPLETION ATE DATE	200,000	
F 684	Continued From p	age 71	; F6	84				
	include but are not	ility on 6/27/18. Diagnoses Ilimited to: chronic obstructive a, atrial fibrillation, type 2 and dysphagia.	N 0. 0.00	# 15 P				
	reviewed on 8/1/18 MDS (minimum da 14-day assessmer reference date) of cognitive patterns. staff documented t (brief interview for which indicated tha cognitively intact.  The current plan of reviewed and revis documented a focu "Resident # 94 has status/dyspnea r/t (	related to) COPD (chronic						
	pneumonitis 2/2 inh Interventions includ "Provide oxygen as Resident # 94 had initiated on 6/27/18 5L/min (liters per m	ary disease), sleep apnea, nalation of food/emesis. led but were not limited to: ordered."  a current order that was for "Oxygen continuous inute). May titrate to keep O2 e 88% every day and night	an N	v n				
	Resident # 94 lying nasal cannula. Upo setting, the surveyo is receiving O2 at 3 time. The surveyor	pm, the surveyor observed in bed receiving oxygen via nobservation of the oxygen robserved that Resident # 94 liters via nasal cannula at this asked Resident # 94 if he was a difficulties and Resident #						

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/24/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING \_ COMPLETED C 495421 B. WING 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH **CAVE SPRING, VA 24018** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ın PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 684 Continued From page 72 F 684 94 replied "No." 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%.

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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

Event ID: K4V211

Facility ID. VA0419

If continuation sheet Page 73 of 123

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#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 08/24/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING\_ COMPLETED C 495421 B. WNG 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 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

cognitively intact.

(brief interview for mental status) of 15 out of 15,

The current plan of care for Resident # 86 was

which indicates that Resident # 86 was

STATEMENT	OF DEFICIENCIES	044 555	- December	- No On		OMB NO: 0938-03
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495421	B. WING			C 08/02/2018
NAME OF F	PROVIDER OR SUPPLIER		30 - 10	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	1 00/02/2010
FRIENDS	HIP HEALTH AND REHA	AD CENTED COUTH		5647	STARKEY ROAD	
TRICHOS	IIIF DEALID AND KED	AB CENTER - SOUTH		CAV	E SPRING, VA 24018	
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	·
PREFIX TAG		CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETIO
F 684	Continued From pag	ne 74	E	694		
	17 191000	d on 7/23/18. The facility staff	F	684		
	has documented a fe	ocus area for Resident # 86,	3	Ĭ		ĵ
	as "Resident #86 ha	s no natural teeth remaining.				
	She wears dentures	and reports no oral				
	discomfort or difficult	ty chewing. She states that	Æ	50		
	her dentures "need s	come work" Por CLD		i		
		tes meals without difficulty as	1	ĺ		
	long as dentures are	in place. Resident # 86 is at		i		
	low risk for developm	nent of dental complications.				Ĭ
	Aspiration precaution	ns. Although patient has been				36 75
	educated and verbal	ized understanding on the				
	importance/risks/of n	not elevating HOB/sitting up	*	į		
	during eating the na	tient still at times refuses to	¥3	ii ii		
		ed or sit up." Interventions		1		Ĩ
93	included but were no	ot limited to: "Keep HOB				
	elevated 45 degrees	while eating drinking.		1		
	Encourage nation to	sit up." The facility staff also	H H	ì		
	documented a focus	area as "Resident # 86 has	50	i		
	diabetes mellitus " In	terventions for this focus	9	ě		61
		re not limited to: "Diabetes		9		
1	medication as ordere					
8		de effects and effectiveness."		1		
3	and the same of th	or enects and enectiveness.		1		189
	The physician signed	the current physician's	f	Ė		
	orders for Resident #	86 on 6/7/18. Orders	1	į.		
1		mited to: "1. Dentures in for				
3		e angle for all meals 3.				e. Si
	C.N.A. to assist with	oral care after each meal		į		1
1		dysphagia," and "Lantus	18			<i>3</i>
		n-Injector 100 unit/ML Inject		10		
		sly at bedtime" which was		10		
	initiated on 6/14/18.			60		
5	On 7/31/18 at 3:34 pr	m, the surveyor observed				
	Resident # 86 in her i	room in bed. Resident # 86				
6		this time was observed				
		ut difficulty. Resident # 86's				
		be at 45 degrees while		95		
	eating. Resident #86	informed the surveyor that		85		
	she eats very slowly					

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/24/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED C 495421 B. WING 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY 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

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

7/28/18 scheduled time 9:00 pm, time administered-7/29/18 at 12:32 am

administered-10:15 pm

administered-10:17 pm

AND PLAN (	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY COMPLETED	
NAME OF	DDO: 40	495421	B. WING			С
FRIENDS	PROVIDER OR SUPPLIER SHIP HEALTH AND REHAR	-91		STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	08	3/02/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	# D DE	(X5) COMPLETIO DATE
686 T	7/30/18 scheduled tim administered-11:27 pn According to the facility Medications," the"P states, "Medications sh safe and timely manne procedure contains do but is not limited to" administering the medilabel to verify the right right time, and right me administration before given on 8/2/18 at 9:35 pm, the was made aware that fadocumented that Reside	e 9:00 pm, time  y policy on "Administering surpose" of the policy nall be administered in a r and as prescribed." The cumentation that includes 6. The individual cation must check the medication, right dosage, thod (route) of iving the medication."  the administrative team right staff had ent #86's HOB was at 90 at the HOB was elevated that insulin had been at #68 outside of the rames.  Ingarding this issue was team prior to the exit	F 684	F686		
§ S B re (i) pr pr uld	483.25(b) Skin Integrity 483.25(b)(1) Pressure ulcers, ased on the comprehensive assessment of a esident, the facility must ensure that- A resident receives care, consistent with refessional standards of practice, to prevent ressure ulcers and does not develop pressure cers unless the individual's clinical condition emonstrates that they were unavoidable; and A resident with pressure ulcers receives			Corrective Action(s): Resident #86's attending physician w notified that the facility staff failed to properly reposition resident per physicorders. Resident #86 has had her order reviewed to reflect current needs. The C.N.A. assigned to care for Resident # on 8/1/18 has been given a disciplinar action for failure to reposition the resident. A facility Incident & Accide form was completed for this incident.	cian crs crs crs crs crs crs crs crs crs crs	

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA					OMB NO. 0938-0391	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) (	(X3) DATE SURVEY COMPLETED	
-		495421	B. WING	B. WING			С	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			08/02/2018	
FRIENDS	SHIP HEALTH AND REHAE	CENTED COUTU		5647 STARKEY				
53		CENTER - SOUTH		CAVE SPRING				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES		- AND 12 - 12 - 12 - 12 - 12 - 12 - 12 - 12				
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	·   (EA	PROVIDER'S PLAN OF CORRECTI CH CORRECTIVE ACTION SHOUL S-REFERENCED TO THE APPRO DEFICIENCY)	DRE	(X5) COMPLETION DATE	
tti h	necessary treatment a with professional stand promote healing, prevenew ulcers from develor This REQUIREMENT by:  Based on observation, record review, it was destaff failed to implement the development of a purn and position 1 of 4 survey, Resident #86  The findings included:  The facility staff failed to Resident #86 every 2 hereadmission date of 3/18 but were not limited to: of the companion of the facility staff document as expenses and a set annual assessment with reference date) of 7/3/18 resident #86 was cognitive patternal and a BIMS (brief interviewed of 15 out of 15, which is the facility staff document and a BIMS (brief interviewed of 15 out of 15, which is the MDS assesses function of the facility staff document and a BIMS (brief interviewed of 15 out of 15, which is the MDS assesses function of MDS assesses function of MDS assesses function of MDS assesses function of MDS assesses function of the facility staff document and a BIMS assesses function of MDS assesses funct	and services, consistent dards of practice, to ent infection and prevent oping.  is not met as evidenced  staff interview and clinical etermined that the facility interventions to prevent ressure ulcer by failing to 5 Residents in the sample  of turn and reposition ours.  -year-old-female who was a facility on 10/3/16 with a 6/18. Diagnoses included by sphagia, hypertension, and obstructive sleep  esident # 86 was  :24 am. The most recent of assessment was an an ARD (assessment an ARD (assessment an ARD (assessment # 86 was an an an an an an an an an an an an an	Fe	and Cor All other breakdow affected. Manager monitor fresidents physician will be ac disciplina facility In be comple  Systemic The facility Wound Car changes ac C.N.A. sta DON and/ wound car preventativ often.  Monitorin The DON The DON two randor high risk of repositioni Any/all neg addressed a additional disciplinary that time. To sent to the monthly for recommence policy, proceedings.	reation of Deficient Practice rective Action(s): residents at high risk for some may have been potential. The DON, ADON and/or will conduct daily audits to proper repositioning of per resident need and/or corders. Any negative find addressed immediately and ary action taken as indicated each negative finding.  Change(s): ty Policy and Procedure for are has been reviewed and rewarranted at this time. The first will be in-serviced by the fordesignee on the facility the program, including the verbenefits of repositioning	skin lly Unit o lings d. A will r no The he 's g nee. lete hts at e . I at ll be ittee		

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
495421	B. WING	<del></del>	C	
D REHAB CENTER - SOUTH	5647	STARKEY ROAD	08/02/2018	
EFICIENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO	ULD BE COMPLETION	
an of care for Resident #86 was revised on 7/23/18. The facility staff in focus area as "Resident # 86 is at the ulcer development related to his essure ulcers, his of MASD ociated skin dermatitis), and limited mobility. Resident # 86 if excoriation to the left gluteal fold, peels. The area then heals, and rent. Not classified as PU r). Currently receiving Calazime ection/prevention to this area and outtocks as well. She is receiving that lateral aspect of right foot/lower by toe for protection." Interventions ere not limited to: "I need tinding/assistance to at least every 2 hours, more often equested."	F 686			
on 6/7/18. The physician's orders ere not limited to: "Turn & position rs as needed for skin integrity," q shift to L (left) gluteal fold and			# *	
ring in bed on her back. The ved an air mattress on her bed. onducted an interview with The surveyor asked if Resident # es or open areas on her body. "I have a sore on my hip." The Resident # 86 if the staff cares for hip. Resident # 86 stated, "They " The surveyor asked if the staff itions her. Resident # 86 stated, urn me."				
	IDENTIFICATION NUMBER:	A BUILDING  495421  B. WING  TREHAB CENTER - SOUTH  IMARY STATEMENT OF DEFICIENCIES EFFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION)  TORY OR LSC IDENTIFYING INFORMATION)  TORY OR LSC IDENTIFYING INFORMATION)  F 686  TO care for Resident #86 was revised on 7/23/18. The facility staff Infocus area as "Resident #86 is at revulcer development related to hx resulcer development related to hx resulcer development related fold, peels. The area then heals, and rent. Not classified as PU ry. Currently receiving Calazime election/prevention to this area and puttocks as well. She is receiving that lateral aspect of right foot/lower y toe for protection." Interventions ere not limited to: "I need iniding/assistance to at least every 2 hours, more often equested."  Signed the current orders for on 6/7/18. The physician's orders ere not limited to: "Turm & position ris as needed for skin integrity," q shift to L (left) gluteal fold and uttocks every shift."  3:05 pm, the surveyor observed ring in bed on her back. The ved an air mattress on her bed. conducted an interview with The surveyor asked if Resident # es or open areas on her body. "Thave a sore on my hip." The Resident # 86 if the staff cares for hip. Resident # 86 stated, "They "The surveyor asked if the staff ittions her. Resident # 86 stated, urn me."	A BUILDING  495421  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 5847 STARKEY ROAD CAVE SPRING, VA 24018  MARY STATEMENT OF DEFICIENCIES EFFICIENCY MUST BE PRECEDED BY FULL TORY OR LSC IDENTIFYING INFORMATION)  TAG  TORY OR LSC IDENTIFYING INFORMATION)  TAG  TAG  TAG  TAG  FROWDERS PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR OFFICIENCY)  F 686  THE PRESIDENT OF THE APPR OFFICIENCY  TAG  TAG  F 686  THE STATE OF THE APPR OFFICIENCY  F 686  THE STATE OF THE APPR OFFICIENCY  TAG  TO USE THE APPR OFFICIENCY  F 686  THE STATE OF THE APPR OFFICIENCY  THE STATE OF THE APPR OFFICIENCY  F 686  THE STATE OF THE APPR OFFICIENCY  TAG  TO USE THE APPR OFFICIENCY  F 686  THE STATE OF THE APPR OFFICIENCY  THE APPR OFFICIENCY  THE APPR OFFICIENCY  F 686  THE STATE OF THE APPR OFFICIENCY  THE APPR OFFICIENCY  THE APPR OFFICIENCY  TAG  TAG  TAG  TAG  TAG  TAG  TAG  TA	

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If continuation sheet Page 79 of 123

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULT	IPLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
740 I LAIT	SI CORRECTION	IDENTIFICATION NUMBER:	A BUILDIN	NG	COMPLETED	
0 9		495421	B. WING_		С	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/02/2018	
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH				5647 STARKEY ROAD CAVE SPRING, VA 24018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION	
F 686	Continued From page	e 79	F6	86		
	On 7/31/18 at 5:15 pt	m, the surveyor observed				
	Resident # 86 lying in	n bed positioned on her back.	额	3		
	On 8/1/18 at 8:37 am	, Resident # 86 was				
	observed lying in bed lying on her back.	l dressed in a hospital gown	II.		ī	
	On 8/1/18 at 10:45 ar	n, Resident # 86 was dressed in a hospital gown	W Co	ĩ	20	
	lying on her back.	uressed in a nospital gown	¥		н Ю Ж	
	On 8/1/18 at 12:13 pr	n, Resident # 86 was	ĭ			
	observed lying in bed Resident # 86 was lyi	dressed in hospital gown. ng on her back. The			00	
	surveyor asked Resid	lent # 86 if facility staff had lesident # 86 stated "No."	I	il n	i	
	Upon review of the fa	cility competency evaluation			a.	
	facility must be evalua	nursing assistants, the ated and checked off on	W			
	tasks that include but	is not limited to: that there d verbal understanding of,		(t)		
	"Checking on resident	ts every 2 hours," and			8	
	"Repositioning resider	nt during check."		8		
	On 8/1/18 at 5:35 pm, was made aware of the	the administrative team e findings as stated above.				
	provided to the survey conference on 8/2/18.			u .		
F 689 SS≃D	Free of Accident Haza CFR(s): 483.25(d)(1)(3	rds/Supervision/Devices 2)	F 68	9		
92 73	§483.25(d) Accidents. The facility must ensur §483.25(d)(1) The resi	re that - ident environment remains				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	1975		OMB NO. 0938-0391	
AND PLAN (	JF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		495421	B. WING		С	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS OF THE	08/02/2018	
FRIENDS	HIP HEALTH AND REHAL	CENTED AND A	f	STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD	15 65	
		S CENTER - SOUTH				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<del></del>	CAVE SPRING, VA 24018		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	DE CONTRACTOR	
F 689	Continued From page	80				
			F 68	9 F689		
	do nee of accident has	zards as is possible; and	1	Corrective Action(s):	<u> </u>	
	\$483.25(d)(2)Each ros	idant '	Ĩ	Resident #55's attending physician l	haa I	
	Supervision and assist	sident receives adequate ance devices to prevent		been notified that facility staff failed	las Lto	
1	accidents.	ance devices to prevent		cnsure a physician ordered chair alar	rm	
		is not met as evidenced	l.	was in place as ordered. A facility		
	by:	to not met as evidenced		incident and accident form has been		
	Based on staff intervie	w and clinical record		completed for this incident.	w.	
l E	review, it was determin	ed that the facility failed to		Pacidons #CC2- + 1		
	ensure an environment	free of accident hazards		Resident #66's attending physician h been notified that facility staff failed	ias	
	for 3 of 45 Residents in	the sample survey	*	check placement of a physician order	to	
1	Resident #55, Residen	t #66 and Resident #110.		wander-guard every shift. A facility	rea	
1			!	Incident and Accident form has been		
Ì	The facility staff failed to interventions.	o implement safety		completed for this incident		
l i -	<b>-</b> 2000 (447 NG 828 N			Resident #110's attending physician I	has	
	The Findings Included:			been notified that facility staff failed	to I	
1.	1 For Death	F25 (27)		ensure a physician ordered chair and i	bed	
1	1. For Resident #55 the	facility staff failed to		alarm was in place as ordered. A facil	lity	
100	mplement a physician o		i	incident and accident form has been completed for this incident.		
F	Resident #55 was a 96-	year-old female who was	,	Tauscon or annual		
i c	admitted on 5/29/18. Ad	mitting diagnoses		Identification of Deficient Practices/Corrective Action(s):		
l n	ncluded, but were not li	mited to: fall, benign		All other residents with physician order		
k	nee and cognitive com	bilateral osteoarthritis of	İ	chair or bed alarms and wander-guard	erea	
8	and cognitive com	nunication deficit.		may have been affected. An audit tool	has	
ī	he most current Minimu	Im Data Set (MDC)		been created that will allow DON and	/or	
а	ssessment located in th	ne clinical record was a	ļ .	designee to review all residents with		
3	0 Day Medicare MDS a	SSESSMent with an		physician ordered bed or chair alarms	and	
A	ssessment Reference [	Date (ARD) of 6/26/18		wander-guards to ensure that they are i	in	
	ne racility staff coded th	at Resident #55 had a		place. A daily review of the treatment		
10	ognitive Summary Scor	e of 14. The facility staff		administration record (TAR) will show the documentation corresponds with the	/u	
C	paed that Resident #55	required set up		visual audit. Negative findings will be	.	
as	ssistance (1/1) to extens	Sive assistance (3/3) with		corrected at the time of discovery with		
L AG	ctivities of Daily Living (	ADL's), In Section 1		disciplinary action given, as appropriat	ie.	
118	900. Falls Since Admiss	ion the facility staff	1		~·	
ac	ocumented that Resider	nt #55 had had one fall				
	thout injury since admis	ssion into the facility.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-039				
A	ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	(X3) DATE SURVEY COMPLETED		
L		<u> </u>	495421	B. WING		С	
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH			65 (M. 1948 - 2011)83 (M. 1948 - 1941)		STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	08/02/2018	3
2	(X4) ID PREFIX TAG	LEACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	)E 20101	TION
	r ta e pa a R # C n R al th	reviewed the clinical recollinical record produce Physician orders include "Chair alarm as resider night shift." (sic)  Continued review of the the August 2018 Treatm Records (TAR's). The standard commented that the chapplied on the August 1  On August 1, 2018 at 3: observed Resident #55  The surveyor did not obplace. The surveyor we informed a Registered Nestoned a physician ord surveyor notified the RN and physician order for the cland RN walked down to entered Resident #55's reconted out that Resident and that a chair alarm content of the content of the cland RN august 1, 2018 at 4:3 otified the Director of Nuesident #55 had a physician order for the cland that a chair alarm content out that Resident and that a chair alarm content of the conte	3:26 p.m., the surveyor cord. Review of the daphysician orders. Hed, but were not limited to: at allows every day and eclinical record produced ment Administration facility staff had air alarm had been, 2018 TAR's.  40 p.m., the surveyor sitting up in her chair. Serve a chair alarm in and to the nurses' desk and durse (RN) that Resident er for a chair alarm. The that the chair alarm was for reviewed the clinical pointed out the specific mair alarm. The surveyor Resident #55's room and doom. The surveyor the surveyor the surveyor that alarm on Resident 4 p.m., the surveyor ursing (DON) that ician order for a chair ir. The surveyor notified arm was not in place	F 68	Systemic Change(s):  The facility policy and procedure for prevention and management and elopement has been reviewed and no revisions are warranted at this time. T DON and/or designee will in-service a nursing staff regarding proper use of a application of fall intervention equipm to include chair and bed alarms and thimportance of the wander-guard check  Monitoring:  The DON is responsible for maintaining compliance. The DON and/or designee will perform daily audits of all resident with physician order chair or bed alarm 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	t.	

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	JUBI			OMB NO. 0938-0	<u>1391</u>	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDIN		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
<u> </u>	<u> </u>	495421	B. WING		<u> </u>	C 08/03/3048		
ATTENDO AND	ROVIDER OR SUPPLIER	B CENTER - SOUTH		5647 S	T ADDRESS, CITY, STATE, ZIP CODE STARKEY ROAD SPRING, VA 24018	08/02/2018		
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F 689	Continued From page	: 82	F 68			* **		
	met with the Administrative surveyor notified the Athat Resident #55 had	rator (ADM) and DON. The Administrative Team (AT) I a physician order for a	F 00	9		1		
i	chair alarm and that the in place.	ne chair alarm had not been		JI <sub>2</sub>		0	11	
	exiting the facility as to ensure an environm	ion was provided prior to o why the facility staff failed nent free of accident #55. The facility staff failed	ż			3 15		
	to implement a physic	ian ordered chair alarm.		ē.				
1	<ol><li>For Resident #66 to follow physician orders a wander-guard every</li></ol>	he facility staff failed to s to check the placement of shift.				p		
	admitted on 2/3/18. Ad included, but were not	limited to: atrial fibrillation,	Ĭ	3		į.		
	atherosclerotic heart d behaviors, hypertensio cognitive communication	isease, dementia without in, osteoarthritis and on deficit.		100			81	
ë i	Quarterly MDS assess Reference Date (ARD) staff coded that Reside Summary Score of 14, that Resident #66 was	num Data Set (MDS) the clinical record was a ment with an Assessment of 6/26/18. The facility ent #66 had a Cognitive The facility staff coded independent (0/0) to set in Activities of Daily Living	5					
G F	eviewed Resident #66 of the clinical record pro Physician orders includ Check for wanderguan	0:20 a.m., the surveyor is clinical record. Review oduced physician orders, ed, but were not limited to: d placement qshift (every ecking Placement." (sic)				te	17	

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 83 of 123

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VDH/OLC

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIED/CLIA		<del>-</del>		OMB NO. 0938-0391	
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		495421	B. WING		С
NAME OF P	ROVIDER OR SUPPLIER		9, 1,	STREET ADDRESS OF THE STREET	08/02/2018
FRIENDS	UID UEALTH AND BELL		ļ	STREET ADDRESS, CITY, STATE, ZIP CO	ODE
FRIENDS	HIP HEALTH AND REHA	B CENTER - SOUTH		5647 STARKEY ROAD	
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES		CAVE SPRING, VA 24018	P
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE COMPLETION HE APPROPRIATE DATE
F 689	689 Continued From page 83		F6	689	
i i	Continued review of	Land Control of the C	W	ė.	
	the July 2018 Treatm	he clinical record produced ent Administration Records	97		
-	(TAR's) Review of the	ne July 2018 TAR's revealed		E .	
	that the facility staff d	id not check for placement			
1	of the wander quard	on July 2, 2018 on the 3-11			
	shift, on July 5, 2018	on the 7-3 shift and on July	JU		
5	26, 2018 on the 7-3 s	hift.		ő	
	notified a Registered a #66 had a physician of and for the staff to che wander-guard every sithe RN that review of to document that the vevery shift as ordered surveyor reviewed Rewith the RN. The surveyor hysician order for the check for placement e then reviewed the July The surveyor pointed of the surveyor pointed	hift. The surveyor notified the July 2018 TAR's failed wander guard was checked by the physician. The sident #66's clinical record reyor pointed out the wander-guard and to very shift. The surveyor 2018 TAR's with the RN. but that the facility staff wander-guard placement	T E		
t t t c r	met with the Administra surveyor notified the Ad hat Resident #66 had wander-guard. The su he physician ordered to thecked every shift for notified the AT that the	4:38 p.m., the survey ream ator (ADM) and DON. The dministrative Team (AT) physician orders for a rveyor notified the AT that for the wander-guard to be placement. The surveyor wander-guard was not on several days in July		Ti and the state of the state o	
. e	lo additional information xiting the facility as to	on was provided prior to why the facility staff failed			

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/24/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 495421 B. WING 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION PRFFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) 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

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

and on 7/31/18 on the 11-7 shift.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X3) MIT	1 TIDLE	CONSTRUCTION	OMB NO. 0938-0391		
AND FLAM	DE CORRECTION	IDENTIFICATION NUMBER:	A. BUILE				(X3) DATE SURVEY COMPLETED	
NAME OF I	DDOMOCD OF THE	495421	B. WING				С	
	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	] 08	/02/2018	
FRIENDS	SHIP HEALTH AND REHAL	3 CENTER - SOUTH			S47 STARKEY ROAD			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	CAVE SPRING, VA 24018				
PREFIX TAG	TEACH DEFICIENCY MUST BE PRECEDED BY CITY		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E ATE	(X5) COMPLETION DATE	
F 690 E SS=D C S	notified a Registered N #110 had physician on alarm for safety. The set that the facility staff had bed alarm and chair al 7/26/18 on the 7-3 shift 11-7 shift. The surveyor record with the RN. The physician orders and the surveyor pointed out the failed to document the surveyor pointed out the failed to document the physician ordered bed surveyor notified the Add that Resident #110 had and chair alarm. The set that the physician ordered were not documented as several days in July 201 No additional information exiting the facility as to vo ensure an environmental and chair alarm was in pluly 2018. Bowel/Bladder Incontine CFR(s): 483.25(e)(1)-(3) 483.25(e) Incontinence. 483.25(e) Incontinence.	Nurse (RN) that Resident ders for a bed and chair surveyor notified the RN d not documented that the arm were applied on t and on 7/31/18 on the or reviewed the clinical ne surveyor reviewed the ne July 2018 TAR's. The at the July 2018 TAR's application of the and chair alarm.  38 p.m., the survey team for (ADM) and DON. The ministrative Team (AT) physician orders for a bed urveyor notified the AT ed bed and chair alarm is being in place on 8.  In was provided prior to why the facility staff failed in the facility staff failed in the face on several days in the control of the control	F 690		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.  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			
a m	esident who is continent dmission receives service laintain continence unlead condition is or becomes so to possible to maintain.	of bladder and bowel on ces and assistance to ss his or her clinical			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	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIDLE	E CONSTRUCTION	OMB	NO. 0938-0391
AND PLAN (	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILE		(X3) D	(X3) DATE SURVEY COMPLETED	
		495421	B. WING			C	
	PROVIDER OR SUPPLIER  HIP HEALTH AND REHA	D. C.F. War			TREET ADDRESS, CITY, STATE, ZIP CODE	](	08/02/2018
	TEACHTAND REHA	B CENTER - SOUTH		33	647 STARKEY ROAD FAVE SPRING, VA 24018		
(X4) ID PREFIX	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.	-	No. 20 The Control of the Control of		
TAG	REGULATORY OR I	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF	2007	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	C .	(X5) COMPLETION DATE
E fa the form re	§483.25(e)(2)For a re incontinence, based or comprehensive assessensure that- (i) A resident who enterindwelling catheter is a resident's clinical condicatheterization was need indwelling catheter or significant who enterindwelling catheter or significant who enterindwelling catheter or significant who enterindwelling catheter or significant who is introduced in the second second in the seco	sident with urinary on the resident's sment, the facility must ers the facility without an not catheterized unless the lition demonstrates that accessary; ers the facility with an subsequently receives one al of the catheter as soon resident's clinical condition reterization is necessary; accontinent of bladder reatment and services to rections and to restore at possible. readed with fecal the resident's ment, the facility must who is incontinent of bowel atment and services to bowel function as a not met as evidenced clinical record review and at was determined that report of the catheter to an size for 1 of 45 survey, Resident #61.	F	590	Systemic Change(s): The facility Policy and Procedure for Foley Catheter usage and Foley Catheter as been reviewed and no change are warranted at this time. The nursing staff will be in-serviced by the DON of the policy and procedures for proper Foley Catheter Orders, to include proposulb and balloon size, and care to include proper anchoring of Foley catheter tubing.  Monitoring: The Director of Nursing is responsible maintaining compliance. The DON and designee will make weekly audits audit of all Foley Catheter's to ensure compliance with anchoring of tubing at to ensure orders are comprehensive. All negative findings will be corrected at ti 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	for d/or ts	

PRINTED: 08/24/2018 FORM APPROVED

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA						OMB NO. 0938-0391		
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED		
		495421	B. WING			С		
NAME OF F	PROVIDER OR SUPPLIER					08/02/2018		
					ET ADDRESS, CITY, STATE, ZIP CODE			
FRIENDS	HIP HEALTH AND REHA	B CENTER - SOUTH			STARKEY ROAD			
-		0N		CAVE	SPRING, VA 24018			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 690	Continued From page	e 87	F6	90				
	The findings included			65		SI .		
	Resident # 61 was a 5	53-year-old female who was						
	admitted to the facility	on 3/9/17. Diagnoses		į				
	included but were not	limited to: anxiety disorder,	99					
	muscle wasting and a benign neoplasm of the	trophy, depression, and ne brain.						
	The clinical record for	Resident # 61 was		8				
	reviewed on 8/1/18 at	11:25 am. The most recent						
	MDS (minimum data s	set) assessment was a	178					
	quarterly assessment	with an ARD (assessment						
	reference date) of 6/29	9/18. Section C of the MDS						
	assesses cognitive pa	tterns. In Section C0500,		İ				
	the facility staff docum	ented that Resident # 61	e E					
	had a BIMS (brief inter	rview for mental status)		28		W.		
,	score of 15 out of 15,	which indicates that	ì					
	Resident # 61 was cog	gnitively intact.	4			¥8		
	Resident # 61 had an the physician on 8/1/18	order that was signed by		2: 83				
	documented as "Foley	Usage for /t Irinany						
	Retention) including Fr	rench size & ml balloon.	II.					
	The surveyor observed	that there is no catheter						
	and bulb size documer	nted with the order.		*		87		
	On 8/01/18 at 9:59 am	, the surveyor was given it # 61 to look at her foley						
	catheter. The surveyor	observed an 1950						
	(French) with 10cc (cut	bic centimeter) bulb. The						
	surveyor observed the	Foley catheter lying across		B B				
	Resident # 61's left leg	unsecured.						
A 3 3	care" The procedure in stated but was not limit catheter into Cath-secu	r policy on "Foley catheter cluded documentation that led to"7. Replace ure device, ensure catheter ladder level and that drain						

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 88 of 123



	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDIN	PLE CONSTRUCTION G	OMB No (X3) DATE COM	
NAME OF	PROVIDER OR SUPPLIER	495421	B. WNG_		3	С
	SHIP HEALTH AND REH	AB CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD	08,	02/201
(X4) ID PREFIX TAG	TEACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPRIED	N D C	(X: COMPL DAT
F 695 SS=D	bag and catheter tut floor." Changing Foldocumentation that sure and reconnect clean date and time cathete and balloon size being the sure conference on 8/2/18. Respiratory/Tracheos CFR(s): 483.25(i) Respiratory care and tracheostomy care plan, the resident and 483.65 of this subpinis REQUIREMENT by: Based on observation, atterview, and clinical retaff failed to ensure the	poing are not touching the ey catheter included stated but was not limited to theter: Assemble items a catheter and catheter kit) are insert catheter, replace drainage bag, document er changed, note catheter and inserted." at the administrative team the findings as stated above. In regarding this issue was ey team prior to the exit at tomy Care and Suctioning to tracheal suctioning. The that a resident who expending tracheostomy ioning, is provided such rofessional standards of ensive person-centered as goals and preferences, part. In the second review, the facility at respiratory care and in a sanitary manner.	F 695	F695 Corrective Action(s) Resident #94's Nebulizer and Bi-Pap masks have been replaced with new on and were dated and stored in a clear plastic bag for storage when not in use 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% revise 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 facility Incident &Accident form will be completed for each negative finding.	e e e e e e e e e e e e e e e e e e e	

STATEMENT	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(V2) 1411		OMB NO	D. 0938-039
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE	
		495421	B. WING_			С
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	08/	02/2018
FRIENDS	HIP HEALTH AND REHAE	CENTER - SOUTH		5647 STARKEY ROAD	E	8
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		CAVE SPRING, VA 24018		
PREFIX TAG	1 (CACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	CHUILDE	(X5) COMPLETION DATE
so op for lini tr no mbo	The facility staff failed and bi-pap masks were manner for Resident # Resident # 94 was an admitted to the facility included but were not lied obstructive pulmonary type 2 diabetes mellitus. The clinical record for Freviewed on 8/1/18 at 1 MDS (minimum data se 14-day assessment with reference date) of 7/11/assesses cognitive pattern facility staff document had a BIMS (brief intervity) as cognitively intact. The current plan of care reviewed and revised on documented a focus are reviewed and revised on documented a focus are resident # 94 has altern tatus/dyspnea r/t (relate obstructive pulmonary displays but the facility staff documented to: "Administer meating to: "Adm	to ensure that the nebulizer e maintained in a sanitary 94.  88-year-old-male who was on 6/27/18. Diagnoses imited to: chronic disease, atrial fibrillation, s, and dysphagia.  Resident # 94 was 1:27 am. The most recent et an ARD (assessment 18. Section C of the MDS erns. In Section C0500, and that Resident # 94 is was 1:27/18. The facility staff a for Resident # 94 was 1:27/18. The facility staff a for Resident # 94 as ed respiratory ed to) COPD (chronic sease), sleep apnea, ary to) inhalation of its included but were not edications/breathing and "Bipap per order. Do eadgear when removing a release mechanism at torders that was on 6/27/18. Orders ted to "DunNeb	F 69		r is mpliance. conduct a mpliance. corrected at ary action negative Quality w, for dure,	

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/24/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING 495421 B. WING 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) **PREFIX** (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 695 Continued From page 90 F 695 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

F 697 Pain Management

SS=D CFR(s): 483.25(k)

conference on 8/2/18.

§483.25(k) Pain Management.

provided to the survey team prior to the exit

F 697

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB NO. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		495421	B. WING_		С
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	08/02/2018
EDIEND	SUID UP ALTH AND DELLA			5647 STARKEY ROAD	
I MEND.	SHIP HEALTH AND REHAE	3 CENTER - SOUTH			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		CAVE SPRING, VA 24018	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIEMENCY)	) RE COMPLETION
F 697	Continued From page	01			
,			F 69		
	The facility must ensu	re that pain management is		Corrective Action(s):	
	provided to residents	who require such services,	1	Resident #12's attending physician w	/as
	the comment with profess	sional standards of practice,	i d	notified that the facility administered	four
	the comprehensive pe	rson-centered care plan,		doses of Oxycodone on 7/8/18. A medication error form has been comp	lared
	and the residents' goa	is and preferences.	i i	for this incident.	pleted
	by:	is not met as evidenced	f	for this theidert.	
	Based on staff intervie		ĺ	Identification of Deficient	į
	review, facility staff fail	ew and clinical record	1	Practices/Corrective Action(s):	
	orders for Pain medica	tion regulting in the	F	All other residents receiving pain	
	resident receiving a hir	ther dose than ordered for		medications may have been potential	ly
	1 of 32 current residen	ts reviewed (Resident	b so	affected. The DON, ADON, and/or I	
	#12).	is is it is the control of the contr		Manager will conduct a 100% audit of	
	• 66 € (3.0) 166 · • • (30)			resident's receiving pain medications	to
	Resident #12 was adm	itted to the facility on		identify residents at risk for having obtained medication errors related to	their
	7/14/17. Diagnoses inc	luded diabetes mellitus		administration. Residents identified a	
	with neuropathy, insulir	use, hypertensive heart	1	will be corrected at time of discovery	
	disease with heart failu	re, peripheral venous	1	their comprehensive plans of care upo	
	insufficiency, and depre	ession. On the quarterly		to reflect their resident specific needs	ni Shaharani
	minimum data set asse	ssment with assessment	1	The attending physicians will be notif	
	reference date 4/30/18,	the resident scored 13/15		of each negative finding and a facility	
	on the brief interview fo	r mental status and was	l	Incident & Accident Form will be	
i	assessed as without de	lirium, psychosis, or		completed for each negative finding.	
	benaviors affecting other	ers. The resident scored		Santamia Changa(a)	
	1/37 on the mood asses	ssment (higher scores		Systemic Change(s): The facility policy and procedures ha	
	indicate greater present	ce of depressive	Ĭ.	been reviewed and revised as such; the	YC
	symptoms).			"bedtime" block for medication	
j	During clinical second			administration has been adjusted so the	nat
	a physician arder detail	view, the surveyor noted		medications given after 12:00am are	
ĺ	hydrochloride tablet 5	2/12/18 for Oxycodone		considered late, thereby resulting in	
	by mouth TID (three fire	g (milligram) Give 5 mg es a day) as needed for		disciplinary actions, as appropriate.	
	pain. The MAR (medical	tion administration		DON and/or designee will in-service	
	record) documented the	medication was	e G	licensed nursing staff on the procedur	
į	administered on 7/8/18	t 00:35 11:34 40:40		obtaining, transcribing, and completing	ng [
	and 22:42. The resident	received four doops on		physician medication and treatment	
	7/8/18.	received four doses ou	j	orders.	
	There was no evidence t	that the physician was			

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STATEME	NT OF DEFICIENCIES	T DENVICES			OMP NO SEES SEE
AND PLAI	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED
		495421	B. WING		C
NAME O	PROVIDER OR SUPPLIER		D. WING _		08/02/2018
FRIEND	SHIP HEALTH AND REHAE	CENTED DAVIS	1	STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD	
-0	——————	S CENTER - SOUTH	ľ	CAVE SPRING, VA 24018	
(X4) ID		ATEMENT OF DEFICIENCIES			207 - 100 - 407
TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION ATE DATE
F 69	7 Continued From page	92	ĺ	Marie	
		se of pain medication.	F 69	Monitoring: The DON will be responsible for	ľ
F 755 SS=0	The surveyor reported of nursing and adminis meeting on 8/2/18, Pharmacy Srvcs/Proce	the concern to the director strator during a summary	F 75	maintaining compliance. The DON, ADON and/or Unit Manager will perfive weekly chart audits coinciding with the care plan calendar to monitor for compliance. Any/all negative findings or errors will be corrected at time of	e and
	N-100- V37/355 -			discovery and disciplinary action will i	be
	§483.45 Pharmacy Ser	vices		taken as needed. Aggregate findings o	f
	The facility must provid	e routine and emergency	Ĭ	these audits will be reported to the Quality Assurance Committee quarterly	
	urugs and biologicals to	its residents, or obtain	1	for review, analysis, and	
	them under an agreeme \$483.70(g). The facility	ent described in may permit unlicensed		recommendations for change in facility	
	personnel to administer	dries if State low		policy, procedure, and/or practice.	
	permits, but only under	the general supervision of		Completion Date: Cont. 1	
	a licensed nurse.	Serie al Supervision of		Completion Date: September 16, 2018	
W. C. Commence	§483.45(a) Procedures. pharmaceutical services that assure the accurate dispensing, and adminis biologicals) to meet the	including procedures acquiring, receiving, stering of all days and		FORE	
	§483.45(b) Service Cons	Sultation. The facility		F755	
	must employ or obtain the pharmacist who-	ne services of a licensed		Corrective Action(s): Residents #36's attending physician was notified that the facility failed to administer Tylenol 325mg medication as	
j	§483.45(b)(1) Provides of	consultation on all		ordered by the attending physician. A	
	aspects of the provision of	of pharmacy services in		facility Medication Error form was	
	the facility.			completed for this incident.	
	§483.45(b)(2) Established receipt and disposition of sufficient detail to enable reconciliation; and	all controlled drugs in an accurate		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.	
	§483.45(b)(3) Determines order and that an account	that drug records are in of all controlled drugs		mordent.	j

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA	6 2-1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	to the state of th	OMB NO. 0938-0391
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	A. BUILDIN	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
495421	B. WING_		С
NAME OF PROVIDER OR SUPPLIER	12: 1::::0	DTD:	08/02/2018
FOIRMOUNT	1	STREET ADDRESS, CITY, STATE, ZIP CODE	27
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH		5647 STARKEY ROAD	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES		CAVE SPRING, VA 24018	
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	SE COMPLETION
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 79		of AR's ent II be ir to hc f

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

Event ID: K4V211

Facility ID. VA0419

If continuation sheet Page 94 of 123



STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			OMB I	NO. 0938-0
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTI A BUILDIN	PLE CONSTRUCTION 3	(X3) DA	TE SURVEY MPLETED
		495421	B. WING			С
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS STREET	0	8/02/2018
FRIENDS	HIP HEALTH AND REHA	AB CENTER - SOUTH	1	STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD		
			į	CAVE SPRING, VA 24018		
(X4) ID PREFIX	SUMMARY S	TATEMENT OF DEFICIENCIES	ID ID		<u> </u>	
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F In the second of the second	staff are bring in her a supper medications a all at one time. Reside facility staff are makin medications. Resider a picture taken on 7/2 #36 stated that she has three different sections were supposed to be gain the staff had made a medications on her Resident #36 stated the staff had made a medications on 7/23/16 bills were round and out or ought in 2 oblong Typeshe thought the Tyleno Resident #36 stated she physician had order the physician had several meeting with the Stated thand she, Resident #36, dministration and thing any or so and then thing the physician had several meeting with the Administration of the physician had she were before she made the physician had she physician had she physician had she physician had she physician had she physician had she physician had she physician had she physician had she physician had she physician had she physician had she physician had order the physician ha	#36 stated that the facility medicines late, the facility afternoon pills with her and night time medications lent #36 stated that the gradication errors with her at #36 showed the surveyor 3/18 at 8:53 p.m. Resident ad separated the pills into so to identify what time they given. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the bed table. The picture displayed over the picture of the picture of the picture of picture of the pictur	F 75		ON, vill audits lendar to negative rrected at ry action ate eported to e d accility	

	OF DEFICIENCIES	MEDICAID SERVICES	<del></del>			OMB NO. 0938-0391
AND PLAN C	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING			С
	PROVIDER OR SUPPLIER	B CENTER - SOUTH		5647 5	ET ADDRESS, CITY, STATE, ZIP CODE STARKEY ROAD	08/02/2018
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	A-6	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	RE COMPLETION
F 755	Continued From page	<del>-</del> 95	-	3 B 10		
	multiple complaints to timeliness of medicat the local Ombudsman	o the facility regarding the ions. The Adm stated that in had been involved with aints and that the facility ation. The surveyor	1	755 1		
	of the clinical record p Physician orders inclu "Tylenol 325mg (Aceta	8 a.m., the surveyor 6's clinical record. Review broduced physician orders. ded, but were not limited to: aminophen) Give 2 tablet by as needed for Pain." (sic)		ā		
	delivered the facility's #36's ongoing concerr admiration. Review of documented a medica 7/23/18 Tylenol 500mg pharmacy. The invest between the Adm and party on 6/5/18, 6/14/1	igation also included emails Resident #36's responsible				e e
i i i i i i i i i i i i i i i i i i i	On August 2, 2018 at 1 met with the Adm, DON Pharmacist. The surve Administrative Team at medication administration program Adm acknowledged that were made on 7/23/18, pharmacy had sent the Tylenol. The Adm states supposed to get Tyleno pharmacy had sent Tyle Adm stated that this has	0:30 a.m., the surveyor N. Medical Director and by team spoke to the bout the facility's liberalized on medication During the meeting, the at two medication errors The Adm stated that the incorrect dosage of d that Resident #36 was		×		

STATEMENT	OF DEFICIENCIES	(X1) PROMPEDICUES INSTITUTE IN				<u>OMB NO. 0938-0</u>	391
AND PLAN O	F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONST	RUCTION	(X3) DATE SURVEY	
			A. BUILDIN	IG		COMPLETED	
		200000000000000000000000000000000000000	Ì			Ċ	
		495421	B. WING _	* *		Cycle	
NAME OF P	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE	08/02/2018	-
EDIENDO	INS 11=41=11 1115				RKEY ROAD		
FRIENDS	HIP HEALTH AND REHA	B CENTER - SOUTH					
(VA) ID	DUBLICUE			CAVE SI	PRING, VA 24018		
(X4) JD PREFIX	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	10	i	PROVIDER'S PLAN OF CORRECTION	(X5)	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE	COMPLETI	ON
i		consistences a semblica existence consistence of	iAd	ř	CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE DATE	
100			<del></del>				
F 755	Continued From page	06	12 versions				
			F 7	55;		Ü	Ī
	and has been trying to	o resolve this issue.					- 1
			İ			2	- 1
	No additional informa	tion was provided to the					ı
	survey team prior to e	exiting the facility as to why	Di Di	1		1	
	the facility staff failed	to ensure that Resident	:			25	
	#36's Tylenol 325mg	was available for	į			44	i
	administration on 7/23	3/18.		i i		3	1
						Í	
1	This is a Complaint De	eficiency.		1			
i	The state of the s	,	8				ı
	2. For Resident #55 t	he facility staff failed to		1		9	
	ensure that physician	ordered Centrum Silver		į			
75	was available for adm	inistration		E		,	
	THE EXEMPTION OF BUILT	moti ation.	il .	*			- 1
3	Resident #55 was a 9	6-year-old female who was				¥	- 1
	admitted on 5/29/18. A	desiting discussion	· ·				- 1
9	included, but were not	limited to fell by	į				
9.3	neonlarm of maniness	infilled to: fall, benign	į				ŀ
	knop and comition and	s, bilateral osteoarthritis of	I				
	knee and cognitive cor	mmunication deficit.	92				
311	Th						
81	The most current Minir	mum Data Set (MDS)	•	3			
	assessment located in	the clinical record was a				17 m	3
	30 Day Medicare MDS	assessment with an					
	Assessment Reference	e Date (ARD) of 6/26/18.		4			
51	The facility staff coded	that Resident #55 had a		% 			
	Cognitive Summary So	core of 14. The facility staff	(% (%)				
	coded that Resident #5	55 required set up		35			
	assistance (1/1) to exte	ensive assistance (3/3) with	в.	8			
S .	Activities of Daily Living	g (ADL's).		8			
			8 8	es.			
* }	On August 1, 2018 at 3	3:26 p.m., the surveyor				2	
i	reviewed the clinical re	cord. Review of the					1
į	clinical record produce:	d a physician orders.	9	b)			1
İ	Physician ordered inclu	ided, but were not limited					
i	to: "Centrum Silver Tab	let (Multiple					1
,	Vitamins-Minerals) Give	e 1 tablet by mouth one					
	time a day for supplem	ent " (sic)					
,		(30)	WI .				ĺ
i	Further review of the at	inical record produced the					d
		mosi record produced the					

STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WING_			C
	ROVIDER OR SUPPLIER	IAB CENTER - SOUTH		5647 9	ET ADDRESS, CITY, STATE, ZIP CODE STARKEY ROAD E SPRING, VA 24018	08/02/2018
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F 755	Continued From pa	ne 97				10 Yi
F (33	July 2018 Medication (MAR's) and the number of the July 2018 MAR notes documented in not available for adri 7/25/18, 7/27/18 and On August 1, 2018 and notified the Director Resident #55 had a Silver and that the number of administration for The surveyor and Didinical record and the specific order for the	on Administration Records rsing progress notes. Review AR's and nursing progress that the Centrum Silver was ministration on 7/22/18,	F 7			
-	documented that the Silver was unavailab	e physician ordered Centrum ple for administration. The the facility policy and				
	met with the Adminis surveyor notified the that Resident #55 ha		N W			
, , , , , , , , , , , , , , , , , , ,	delivered a facility por "After Hours and Em Services." The polic  "Procedures: (name withheld) Serves as to after hours pharmacy withheld). ((Name of	y and procedure read in part of pharmacy vendor the primary emergency and				22 25 25

STATEMEN AND PLAN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI	TIPLE CONSTRUCTION	OMB N (X3) DAT	RM APPROVE NO. 0938-039 TE SURVEY MPLETED
		495421	B. WING			C
	PROVIDER OR SUPPLIER  SHIP HEALTH AND REHAE	CENTER - SOUTH	_ <b> </b>	STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	08	8/02/2018
(X4) ID PREFIX TAG	(CACH DEFICIENCY	STEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE	THE DE	(X5) COMPLETION DATE
F 757 SS=D	resort emergency phair medications that are reproved provided in the provided medications that are reproved are determined to be not before (name of facility next regularly open are back-up pharmacy with vendor) will fill the indicated to provide medicated to provide medicated to provide medication to ensure that physician Centrum Silver, was avait to Resident #55.  Drug Regimen is Free from CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Each resident's drug regunnecessary drugs. Andrug when used-gas. 483.45(d)(1) In excession duplicate drug therapy); as (483.45(d)(2) For excession excession and the provided a	ermacy). Orders for received in the facility after 6 sekends and holidays that eeded by the resident pharmacy withheld) will to be sent to (name of sheld). (Name of pharmacy sated number of doses ication until available from dor)."  In was provided prior to why the facility staff failed ordered medication, sailable for administration from Unnecessary Drugs  In Drugs-General.  Imen must be free from unnecessary drug is any  Inve dose (including for equate monitoring; or equate indications for its  Pence of adverse cate the dose should be adverted to the	F 757	F757 Corrective Action(s):	tially or Unit it of all ons to to their d at risk ery and updated dds. otified ity	

STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	2050 1000	Maron and a second	OMB	NO. 0938-0391
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION  G		ATE SURVEY OMPLETED
		495421	B. WING			С
NAME OF	PROVIDER OR SUPPLIER		<del></del>	STREET ADDRESS OFFICE OFFICE		8/02/2018
EDIENDS	CUID LIFALTH AND ADDRESS			STREET ADDRESS, CITY, STATE, ZIP CODE		
FRIENDS	SHIP HEALTH AND REHA	B CENTER - SOUTH		5647 STARKEY ROAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES		CAVE SPRING, VA 24018		
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FILL	ID PREFIX	PROVIDER'S PLAN OF CORR	ECTION	(X5)
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- 3	<del></del>		<u> </u>	DEFICIENCY)		
F 757	0		[			<del> </del>
F /3/	o ontanaca i rom page		F 75	7		
	§483.45(d)(6) Any cor	mbinations of the reasons		Systemic Change(s):		
	stated in paragraphs (	(d)(1) through (5) of this	22	The facility policy and procedu	ires have	I.
	section.		ì	been reviewed and revised as s	uch; the	p
	This REQUIREMENT	is not met as evidenced	ļ	"bedtime" block for medication administration has been adjuste	1	8
	by:		i.	medications given after 12:00ar	d so that	Î .
	Based on staff interview	ew and clinical record		considered late, thereby resulting	II are now	i
	failed to answer that d	ned that the facility staff		disciplinary actions, as appropri	iate The	
	sample surrouser for	of 45 Residents in the	ļ.	DON and/or designee will in-se	rvice all	
	sample survey was free medications, Resident	e on unnecessary		licensed nursing staff on the pro	cedure for	į [
	medications, Resident	.#12.		obtaining, transcribing, and com	inletino	
	The Findings Included			physician medication and treatm	ient	1
3	THE THIRMINGS MICHAELE	•	İ	orders.		i I
	For Resident #12, facil	lity staff failed to ensure	ŀ	Monitoring:		1
	staff followed physiciar	1 orders for medication	i	The DON will be responsible fo	_	
	resulting in the residen	t receiving a higher dose		maintaining compliance. The Do	DN .	l
	than ordered.	5 - Mg. 0. 0000		ADON and/or Unit Manager will	ll perform	
l i			ř	weekly chart audits coinciding u	vith the	
	Resident #12 was adm	itted to the facility on		care plan calendar to monitor for	ī.	1
1	7/14/17. Diagnoses inc	luded diabetes mellitus	li .	compliance. Any/all negative fin	dings and	
	with neuropathy, insulir	use, hypertensive heart		or errors will be corrected at time	e of	1
	disease with heart failu	re, peripheral venous		discovery and disciplinary action	will be	
1	insufficiency, and depre	ession. On the quarterly		taken as needed. Aggregate find	ings of	
	minimum data set asse	ssment with assessment	7	these audits will be reported to the Quality Assurance Committee quality	iC	
19	reference date 4/30/18,	the resident scored 13/15		for review, analysis, and	arteriy	
	assessed as with	r mental status and was	1	recommendations for change in f	acility	i i
(S)	assessed as without de	Illrium, psychosis, or		policy, procedure, and/or practice	acinty .	
	1/37 on the mood asses	ers. The resident scored		- 100 miles		
Ī	indicate greater present	ssment (higher scores		Completion Date: September 16	, 2018	
	symptoms).	con depressive	25			<b>P</b> a
	,				Ī	
1	During clinical record re	view, the surveyor noted			ļ	
1	a physician order dated	6/14/18 for Effexor XR 24	.!! i		i	
ļ i	nour 75 mg (milligram) (	venlafaxine hydrochloride	] i		į	
	extended release) Give	1 capsule PO (by mouth)				ľ
	리마(daily) for 7 days the	n increase dose to 150	1			Ì
r	ng PO QD, with start da	ite 6/15/18 0800 and	i			
c	discontinue date 7/5/18	1111. The MAR			ì	8

NIC OL ALL	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		2	OMB NO. 0938-0
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
NAME OF		495421	B. WING		С
	PROVIDER OR SUPPLIER SHIP HEALTH AND REH	AB CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	08/02/2018
PREFIX TAG	I LEACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD DE (NO)
F 761 L SS=D C Italian Imag	through 7/3, or 19 day dated 6/14/18 with standard for the resident received through 8/2 (the date administered 225 mg through 7/3. In additional physician order dated hydrochloride tablet 5 by mouth TID (three tippain. The MAR (medital administered on 7/8/1 and 22:42. The reside 7/8/18.  The surveyor reported director of nursing and summary meeting on 8 abel/Store Drugs and CFR(s): 483.45(g)(h)(19/2483.45(g) Labeling of Drugs and biologicals Labelogicals	tration record) documented administered daily 6/15 tys. Another physician order art date 6/22/18 for Effexor imilligram) (venlafaxine ed release) Give 1 capsule laily). The MAR indicated a 150 mg capsule daily 6/22 of the survey). Staff of Effexor ER from 6/22 on, the surveyor noted a 2/12/18 for Oxycodone mg (milligram) Give 5 mg mes a day) as needed for cation administration he medication was 8 at 00:35, 11:24, 16:48, nt received four doses on the concerns to the administrator during a 3/2/18.  Biologicals (2)  Drugs and Biologicals used in the facility must be with currently accepted and include the and cautionary piration date when the conce with State and sance with S	F 761	57	en ed.

TATEMENT OF DEFICIENCIES	(X1) PROVIDED/GLIDDLIED/GLIA	seaso Concer	OMB NO. 0938-039 (X3) DATE SURVEY COMPLETED		
ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN			
495421		B. WING_		С	
NAME OF PROVIDER OR SUPPLIER  FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH			STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD		
(X4) ID SUMMARY STA	TEMENT OF DEFICIENCIES	<u>_</u>	CAVE SPRING, VA 24018		
LUCLIX TEACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION ATE DATE	
§483.45(h)(2) The facili locked, permanently aff storage of controlled drifthe Comprehensive Dru Control Act of 1976 and abuse, except when the package drug distribution quantity stored is minimulate readily detected. This REQUIREMENT is by:  Based on observation, adocument review, the face	impartments under proper and permit only authorized ass to the keys.  Ity must provide separately fixed compartments for ugs listed in Schedule II of ug Abuse Prevention and other drugs subject to a facility uses single unit on systems in which the all and a missing dose can as not met as evidenced staff interview, and facility cility failed to date as when opened, failed to exit on systems in which the all and a missing dose can staff interview, and facility cility failed to date as when opened, failed to exit ons, and failed to exit on two did 300 hall).  It is alled to date multidose acetylcysteine when allely 4:20 p.m., the ed practical nurse) #3 om on 300 hall.  For on this hall included solution and one steine. Both of these thad not been labeled	F 76	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 exist mislabeled, expired or discontinued medications. This audit will also includ review of the refrigerators to ensure the narcotic box is appropriately affixed. Any/all negative findings will be corrected at time of discovery. A Facili 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 drink on the medication carts.	ing le ty	

STATEMENT OF DEFICIENCIES		THE SERVICES	<del></del>			OMB NO. 0938-0391	
AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	PLE CONSTRUCTION	(хз	(X3) DATE SURVEY COMPLETED	
		495421	B. WING	Na	i e	C	
NAME OF P	PROVIDER OR SUPPLIER	* 30. ** *******************************		STREET ADDRESS, CITY, STATE, ZIP COD	<u>l</u>	08/02/2018	
FRIENDS				5647 STARKEY ROAD	<b>/</b> C		
FRIENUS	HIP HEALTH AND REHA	B CENTER - SOUTH		CAVE SPRING, VA 24018			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		T 20 September 1997 September 1997	_		
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 761	Continued From page	e 102	F 70				
	li .		F 761 Monitoring:				
	Medication Vials" rea vials that are opened needle-punctured) ca unless otherwise spe  The administrative tea above findings on 08/  No further information were provided to the conference.  2. The facility staff on on the medication car	y policy titled "Multiuse d in part, "Multiple use or entered (e.g. in only be used for 30 days cified by the manufacturer"  am were notified of the 102/18 at 8:35 p.m.  In regarding these issues survey team prior to the exit wing 1 had a personal drink t, failed to discard expired at to have narcotic box		The DON is responsible for recompliance. The DON or Unwill perform weekly audits of medication rooms and medication rooms and medication rooms and medications are band dated appropriately and the expired or discontinued medibeing removed per protocol, the carts, the DON and/or desalso ensure no personal food items are on the cart. Detail fithis audit will be reported to the Assurance Committee for revanalysis, and recommendation change in facility policy, procand/or practice.  Completion Date: September	it Manager f all ation carts to eing labeled hat all cations are In reviewing signee will or beverage indings of the Quality iew, us for edure,		
	On 8/2/18 at 4:45 pm, medication cart on Wi medication cart the su diet Mt Dew in a draw RN # 2 (registered num Mt. Dew belonged to the trash can. The survey of Lidocaine HCL 1% (milliliters) Single dose Printed on the label or documentation that staportion."  On 8/2/18 at 4:58 pm, medication room on Wobserved Tubersol PP 5/29/18 as the date op Tubersol PPD solution	the surveyor inspected a ng 1. While inspecting the preveyor observed a bottle of er on the medication cart. The confirmed that the diet and discarded it in the per and discarded it in the per observed an opened vial 300mg (milligrams)/30 ml er on the medication cart. The vial Lidocaine is ates, "discard unused the surveyor inspected the fing 1. The surveyor D solution that was dated ened. The box that the was packaged in has on the box that states.					

TATEMENT	OF DEFIGIENCIES F CORRECTION	A MEDICAID SERVICES  IX1) PROVIDER/SUPPLIER/CITA IDENTIFICATION NUMBER	7-440-4002-7-10-0-40-10-0-0-10-0-0	C CONSTRUCTION	(X3) DATE RURVEY
			A. DUILDING		COMPLETED
496421		A. WING		C 08/02/2018	
MANUE OF P	ROVIDER OR SUPPLIER	er people - strateg		TREFT ADDRESS, CITY, STATE, ZIP CODE	00/02/2018
FRIENDS	HIP HEALTH AND REP	AS CENTER - SOUTH	300	1847 STARKEY ROAD CAVE BPRING, VA. 24018	
(X4) ID PREFIK YAG	I (PVCH DISLICIE	Statement of Deficiencies NCY MUST BY PRECEDED BY FULL DR LECTDENT FYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH FORRECTIVE ACTION SHOULD FRORSAUFERENCED TO THE APPROPE DEFICIENCY)	Rh Cobbs areas
F 761	RN# 2 reported to medication inside a containing Aliven withe refrigerator in the According to the fac Medication Visia," if	rved a sec through box on the stor in the medication room.  The surveyor that the fine surveyor that the fine box was Alivan. The box as not permanently affixed to be medication room.  Illily policy on "Multiuse 16 procedure contains."	F 761		
F 776	documentation that" 1. All viels and a stored in accordance directions." On 8/2/16 at 9:35 pt was made aware of Na further information.	includes but is not limited to: impulse are to be used and o with the manufacturer's in, the administrative team the findings as stated above, on regarding this issue was very team prior to the exit s. gnostic Services	F 778	F776 Corrective Action(s): Residents #55's attending physician who their the facility filled to proper and the the facility filled to proper and the the resident's clinical facourd. Results were placed in resident's clinical record on B/2/18. Identification of Deficient	priy
§483.50(b) Radiology and other diagnostic services. §483.50(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 epplicable 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			Practices/Corrective Action(s): All other residents with physician orthinh/tudiology or other diagnostic testir may have been affected. The DON she Unit Managers will conduct a 100% at of all resident's with physician ordered tab/radiology or other diagnostic testin ever the past 30 days to identify resident risk. Residents identified at risk will corrected at time of discovery and their confect timer resident specific needs. The attending physicians will be notified of each negative furding and a facility facidant & Accident Form will be completed for each negative finding.	g f dit s t t be	

		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 00/24/2016 FORM APPROVED OMB NO. 0036-0391
STATEMINT	OF DEFICIENCIES CORRECTION	(X1) PROVIDENIAUPPLIERICHA IDENTIFICATION NUMBER:	(XZ) MOLTIPLE A. BUILDING	CONSTRUCTION	(X3) DATE BURNEY  COMPLETED
		495421	B WING		C
HAME OF P	NOVIDER ON SUPPLIFE			TREET ADDRESS, GRY, STATE, 2IP CODE	DA/02/2018
FRIENDS	MIP HEALTH AND REH	AS CENTER - SOUTH	15 d	847 Starkey Road Ave Spring, va. 24016	
(X4) IO PRICITIK TAG	(LACH DEFICIE)	STATEMENT OF DEFICIENCIES NOV MURT DE INTECCOPO BY FULL R LBC IOPNTIFYME INFORMATIONI	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION IEAUH CORRECTIVE ACS YON SHOULD CROMS-INFERENCED TO 141F APPROPE DEFICIENCY)	ME COMPLETION
	by: Based on etaff Intereview if was dotent failed to ensure that testing were contain of 45, Resident #55. The Findings Included For Resident #55 that the results of a contained in the clin Resident #55 was a admitted on 5/29/18 Included, but were in neoplasm of mening knee and cognitive to the facility staff code Cognitive Summary coded that Resident assistance (1/1) to e Activities of Daily Liv. On August 1, 2016 a reviewed the clinical record production in the facility of the facility	or is not met as evidenced review and clinical record nilhod that the facility staff it the results of diagnostic ned in the clinical record for 1 and in the clinical record for 1 and in the clinical record for 1 and in the clinical record for 1 and in the clinical record.  90-year-old famele who was a call limited to: fall, benigh nea, billateral osteoal thritis of communication deficit.  In the clinical record was a DE assessment with an ance Date (ARD) of 6/26/18, and that Resident #55 had a Score of 14. The facility staff #55 required set up extensive assistance (3/3) with	F 776	Systemic Change(s): The facility policy and procedure for obtaining physician ordered medications been reviewed and no changes are warranted at this three. The hecensed and modical records will be inservice the proper recording of inb/radiology other diagnostic testing results in the resident's clinical record.  Mentoring: The DON will be responsible for maintaining compilance. The DON, ADON and/or Unit Managers will perform weakly chart audits coinciding with the care plan calendar to monito compilance. Any/all negative finding or errors will be corrected at time of discovery and disciplinary action will taken as needed. Aggregate lindings these andits will be reported to the Quality Assurance Committee quarter for review, malysis, and recommendations for change in facility policy, procedure, and/or practice.  Completion Date: September 16, 20	staff cd on or or r for p and be of

074754645			WEDICAID SERVICES			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED	
		F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A BUILDI	TIPLE CONSTRUCTION NG		
			495421	B. WING		С	
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH					STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	08/02/2018 E	
	(X4) ID PREFIX TAG				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION	
	F 842 F SS=E	On August 1, 2018 at 4 notified the Director of Resident #55 had a ph to obtain an EKG. The that the results of the Ethe clinical record. The reviewed the clinical re unable to locate the resordered EKG. The DO the EKG should be located the facility staff was house.  On August 1, 2018 at 4 met with the Administration surveyor notified the Act that Resident #55 had a 7/25/18 to obtain an EK the AT that the results of EKG could not be located to August 2, 2018 at 7: delivered the results of EKG.  No additional information exiting the facility as to resulting the facility as to resulting the facility as to result the resulting the facility as to result the resulting the facility as to result the resulting the facility as to result the resulting the facility as to result the resulting the facility as to result the resulting the facility as to result the resulting the facility as to result the resulting the facility as to result the resulting the facility as to result the resulting the facility as to result the resulting the facility as to result the results of the results o	4:34 p.m., the surveyor Nursing (DON) that rysician order dated 7/25/18 e surveyor notified the DON EKG could not be located in surveyor and DON cord. The DON was sults of the physician N stated that the results of ated in the clinical record able to do the EKG in  :38 p.m., the survey team stor (ADM) and DON. The iministrative Team (AT) a physician order dated if the physician ordered ed on the clinical record.  30 a.m., the DON hand the physician ordered why the facility staff failed so of the physician ordered in was provided prior to why the facility staff failed so of the physician ordered in clinical record for stifiable Information 3.70(i)(1)-(5) dentifiable information. ase information that is the public.	F 7	F842 Corrective Action(s): Residents #56's attending physician wanotified that the facility failed to ensure that the resident's clinical record and P 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 if this incident.	e POS di Por di	
				i	1	!	

PRINTED: 08/24/2018 DEPARTMENT OF HEALTHAND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A BUILDING C 498471 B. WING 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 6847 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 SUMMARY STATEMENT OF DEFICIENCIES. PROVIDER'S PLAN OF CORRECTION ID (X4) ID (X6) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETION PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) F 842 Continued From page 106 F 842 Resident #67's attending physician and pharmacist was notified that the resident's resident-identifiable to an agent only in monthly Drug Regimen Review (DRR) accordance with a contract under which the agent for March 2018 was not in the clinical agrees not to use or disclose the information records. The DRR was obtained via fax except to the extent the facility itself is permitted on \$/1/18 and placed in the resident's to do so. clinical record. §483.70(i) Medical records. Resident #12's attending physician was §483.70(i)(1) In accordance with accepted notified that the facility failed to professional standards and practices, the facility document daily care, medication and must maintain medical records on each resident treatment per the physician orders for that aremultiple clinical interventions. A facility (i) Complete: Medication Error form was completed for (ii) Accurately documented; these incidents. (iii) Readily accessible; and Resident #64's attending physician was (iv) Systematically organized notified that facility failed to document blood pressures associated with §483.70(i)(2) The facility must keep confidential medication hold parameters per physician all information contained in the resident's records. orders and administered BP medications regardless of the form or storage method of the when the BP was below the hold records, except when release isparameters. A facility Medication Error (I) To the individual, or their resident form was completed for this incident. representative where permitted by applicable law; (ii) Required by Law; Resident #51's attending physician was (iii) For treatment, payment, or health care notified that the facility failed to operations, as permitted by and in compliance document the administration of a G-Tube with 45 CFR 164,506: feeding and flush per physician orders. A (tv) For public health activities, reporting of abuse, facility Medication Error form was neglect, or domestic violence, health oversight. completed for this incident. activities, judicial and administrative proceedings, Resident #73's attending physician was law enforcement purposes, organ donation purposes, research purposes, or to coroners. notified that the facility failed to document the administration of the medical examiners, funeral directors, and to avert medication Buspar and Selsun Blue a serious threat to health or safety as permitted Shampoo per physician orders. A facility by and in compliance with 45 CFR 164.512. Mediation Error form was completed for this incident.

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unauthorized use.

§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or

Evant ID; K4V211

Fecility ID: VA0419

if continuation arest Page 107 of 123

SEP 1 8 2018 VDH/OLC

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 Maria and a second	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) OATE SURVEY COMPLETED	
		495421	B WING			C /02/2018	
NAME OF PE	OVIDER OR SUPPLIER	3. Nasid	81	REET ADDRESS, CITY, STATE, ZIP CODE		· ·	
FRIENDSHIP HEALTH AND REHAB GENTER - SOUTH				47 STARKEY ROAD	29		
FRIENDSF	III DEALIN AND KET	AB CENTER - SOUTH	C.	AVĒ SPRING, VA 24018			
(X4) ID PREFIX TAG	FIX (EACH DEPICIENCY MUST BE PRECEDED BY FULL		IQ PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OFFICIENCY)		(x8) COMPLETION DATE	
F 842	§483.70(i)(4) Media for- (i) The period of tin (ii) Flve years from there is no require! (iii) For a minor, 3 legal age under St. §483.70(i)(5) The (ii) Sufficient inform (iii) A record of the (iii) The comprehe provided; (iv) The results of and resident review determinations core (v) Physician's, nu professional's prog (vi) Laboratory, rac services reports at This REQUIREME by:  Based on steff intreview it was determined to ensure a record for 9 of 45 Resident #56, Resident #64, Resident #83, Ret Resident #83, Ret The Findings Including Sheets (POS's) at Medication Admining Including Incl	cal records must be retained the required by State law; or the date of discharge when ment in State law; or years after a resident reaches ate law.  medical record must contain- tation to identify the resident; resident's assessments; nsive plan of care and services any preadmission screening wevaluations and inducted by the State; rse's, and other licensed gress notes; and diology and other diagnostic is required under \$483.50. ENT is not met as evidenced arview and clinical record residents in the sample survey, sident #67. Resident #12, sident #51, Resident #73, reident #99 and Resident #18.  Ideat:  56 the facility staff failed to and accurate Physician Order and July and August 2018 istration Records (MAR's).	F 842	Resident #83's attending phy notified that the facility failed document the administration and duonebs per physician or failed to record the resident's physician orders. A facility is Bror form was completed for incident.  Resident #99's attending physician orders that the facility failed document for the physician or and cheir alarm and neutrashit A facility Medication Error for completed for these incidents.  Resident #118's attending phynotified that the facility failed document for the administration medications Azopt suspension Oxybutin. A facility Medical form was completed for these Identification of Deficient Practices/Corrective Action All other residents may have potentially affected. The DOI Managers will conduct a 100 all resident's physician order MARs/TARs over the past 30 identified at risk will be corrective and their compreplians of care updated to refleresident specific needs. The physicians will be notified of negative finding and a facility Accident Form will be compinegative finding.	I to of diclofence ders and weight per Medication r this sician was to rdered bed eld cream orm was to ion of n and clion Error cincidents.  (a): been N and Unit % audit of s and O days to dents ected at time ethensive cut their attending f each y incident &		
	Desident HEC	a 64 year old female who was			50.00 (50 · · · · · ·	1	
	Mesicent #56 Was	a o4 year old lemale who was					

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

Event ID; K4V211

Facility ID: VA0419

RECEIVAGE Page 108 of 123
SEP 1 8 2018
VDH/OLC

PRINTED: 08/24/2018 **FORMAPPROVED** OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	Lance 100	E CONSTRUCTION		SURVEY
	11 11 11 11 11	SEATH ISM. CITYCHEEK.	A. BUILDING		COMPLETED	
		495421	B. WING			C /02/2018
NAME OF PE	OMDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		PAREDIO
FOIENDS	ID (IPA) VII AND BE	III deliver Adire.	1 0	5647 STARKEY ROAD		
PRIENUSA	IF HEALTH AND RE	HAB CENTER - SOUTH		CAVE SPRING, VA 24018		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES EMCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(<6) CDMPLETIC DATE
F 842	CH-wad Form -	100	I		10.00	
F 042	Continued From p	PALENTANA ENVIRONA	F 842	7.4		1
		on 1/6/18 and readmitted on		Systemic Change(s): The facility policy and procedu	na haa	į.
		g diagnoses included, but were	1529	been reviewed and revisions ha		į
į		cystic kidney, kidney transplant,	ì	made in two greas; the medicati		
İ		nemiplegia and hemiparesis	-	times have been altered so there		Ţ
ļ		al infarction, dysphasia que to	1	overlap between time-frames a		
	cerebral infarction	and a gastrostomy tube.		the facility has worked with the		
			t <sup>©</sup>	EHR provider to eliminate the t		
		Minimum Data Set (MDS)		frames before and after each me		31
j		ed in the clinical record was a		block, thereby reducing the tim		
Quarterly MDS with an Assessment Reference			medications can be administere		3	
		7/18. The facility staff coded		compliant manner. Licensed sta		
		Cognitive Summary Score was	;	in-serviced by the DON and/or		
18	The second secon	taff also coded that Residen:	i I	on these changes to the medical		
		nsive (3/2) to total nursing care	į	administration program. The De		
į		s of Daily Living (ADL's). In	ì	designee will also in-service all nursing staff on the procedure t		
ļ		wing and Nutritional Status, the	i .	obtaining, transcribing, and cor		!
		that Resident #56 had a	l l	physician medication and treatr		1
		was recalving 51% or more of		orders Lastly, the DON and/or		
	her nutrition by the	e reeding tube.	į	has in-serviced the staff on the		6
	0 4	0 -1 4 10 - 1 - 1	Į	Documentation Policy and Proc		Î
		8 at 1 p.m., the surveyor		including the timelines and reg		
į		t #56 clinical record. Review of		regarding correcting an oversig		
		produced physician orders.	1	documention.		Ĺ
		ncluded, but were not limited to				
		rs: "NPO (nothing by mouth), All				100 100 100
		beding via J-tube, Asptrin Tablet Give 1 tablet by mouth one time				
		ory) of stroke." (slc) The	1			
				i d		
		at all other medications were ninistered by the feeding tube				
		ennennendelistenist⊯ moost attitut I⊯ 15660				
	in the contraction of the contra	the clinical record produced the	ļ.			1
		1018 Medication Administration		8		1
		The July and August 2018	1	1		
		ad that the facility staff were	No.	Ĭ		1
	administering the	Asp rin by mouth				}
	The curveyor wer	A to the Discover of Discovers	L			1
		nt to the Director of Nursing's		2	Association and the second	

ADHIOFC SEb 1 & 5018

PRINTED: 08/24/2018 DEPARTMENT OF HEALTH AND SUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING \_ C 496421 **B WING** 98/02/2018 NAME OF PROMOTER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFIC: ENCIES (X6) COMPLETION (X4) ID (FACH DEFICIENCY MUST BE PRECEDED BY FULL FACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX REGULATORY OR USC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) F 842 Continued From page 109 F 842 Monitoring: The DON will be responsible for DON and surveyor walked over into the maintaining compliance. The DON, conference room. The surveyor notified the DON that Resident #56's Aspirin 81 mg was ordered to ADON and/or Unit Managers will perform weekly MAR/I'AR and chart be administered by mouth. However, the physician orders also documented that Resident audits coinciding with the care plan #56 was NPO. The surveyor pointed out that all calendar to monitor for compliance. other medications were ordered to be given by Any/all negative findings and or errors will be corrected at time of discovery and the feeding tube. The surveyor reviewed disciplinary action will be taken as Resident #56's clinical record with the DON. The needed. Aggregate findings of these surveyor reviewed the physician orders and the July and August 2018 MAR's with the DON. The audits will be reported to the Quality Assurance Committee quarterly for surveyor notified the DON that Resident #56's review, analysis, and recommendations POS's and July and August 2018 MAR's were for change in facility policy, procedure, inaccurate as Resident #56 was NPO and the and/or practice. Aspirin was being given by the feeding tube and not by mouth. Completion Date: September 16, 2018 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 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

FORM CMS-2587(02-99) Previous Virialina Obsolele

clinical record.

August 2018 MAR's.

For Resident #67 the facility staff failed to ensure that the March 2018 monthly Drug Regimen Review (DRR) was contained in the

Event ID: K4V211

Feelity ID; VA0419

RECEIPPEND Page 110 of 123
SEP 1 8 2018
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**CENTERS FOR MEDICARE & MEDICAID SERVICES** 

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED	
		<b>495421</b> B. W			C 08/02/2018	
	PROVIDER OR SUPPLIER	B CENTER - SOUTH		STREET ADDRESS, CITY, STATE, ZIP CO 5647 STARKEY ROAD CAVE SPRING, VA 24018		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IN SHOULD BE COMPLETION E APPROPRIATE DATE	
F 842	Continued From page Resident #67 was a 6 admitted on 6/20/17. included, but were no	60 year old male who was Admitting diagnoses	F 84	12		
		nphocyte leukemia of B-cell c heart failure and benign			=	
	assessment located in Annual MDS assessing Reference Date (ARI staff coded that Resident in Coded that Resident in the required extensive Activities of Daily Livi On August 1, 2018 at				M M M M	
	of the clinical record f 2018 DRR.	ailed to produce the March			9	
	notified the Director of Resident #67's record March 2018 DRR. The reviewed Resident #6 surveyor pointed out to was not in the clinical that the DRR should the	2:35 p.m., the surveyor f Nursing (DON) that review I failed to produce the surveyor and DON (7's clinical record. The chat the March 2018 DRR record. The DON stated be in the clinical record, but could locate the March 2018				
	delivered the March 2	3:30 p.m., the DON hand 018 DRR. The DON stated I faxed the March 2018	il a			
	On August 1, 2018 at	4:38 p.m., the survey team				

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

	A second second	I WEDICAID SERVICES				OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		495421	B. WING			C 08/02/2018
	PROVIDER OR SUPPLIER SHIP HEALTH AND REH	AB CENTER - SOUTH	2	STREET ADDRESS, CITY 5647 STARKEY ROAD CAVE SPRING, VA 2	and the state of t	0.000.2010
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG	X (EACH COR	ER'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPRIA DEFICIENCY)	E COMPLETION ATE DATE
F 842	surveyor notified the that Resident #67's the March 2018 DRI No additional inform exiting the facility as to ensure a complet for Resident #67. The ensure that Resident contained the March 3. For Resident #12	strator (ADM) and DON. The Administrative Team (AT) clinical record did not include R. ation was provided prior to to why the facility staff failed and accurate clinical record the facility staff failed to t #67's clinical record	F	842		
	Resident #12 was ac 7/14/17. Diagnoses i with neuropathy, insi disease with heart fa insufficiency, and de minimum data set as reference date 4/30/ on the brief interview assessed as without behaviors affecting o	dmitted to the facility on included diabetes mellitus alin use, hypertensive heart ilure, peripheral venous pression. On the quarterly sessment with assessment 18, the resident scored 13/15 for mental status and was delirium, psychosis, or thers. The resident scored sessment (higher scores ence of depressive	*	40 9 9		T T
	blanks in the medicat 7/20 and 7/30/18 for a Levothyroxine Sodiur time a day for hypoth hydralazine hydrochlo mouth every 8 hours 06:00 Tylenol Extra S	n Tablet 200 microgram one yroidism, the 06:00 dose of oride tablet 100 milligram by for hypertension, and for the trength 500 milligram give 2 for pain. There were blanks				

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

OCCUPANTION OF MEDICARE & MEDICAID SERVICES				OMB NO. 0938-0391			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUC	CTION	(X3) DA	TE SURVEY MPLETED
		495421	B. WING	3 to 10 to 1	<u> </u>		C 8/02/2018
	PROVIDER OR SUPPLIER SHIP HEALTH AND REHAI	3 CENTER - SOUTH		5647 STARKE	RESS, CITY, STATE, ZIP CODE EY ROAD NG, VA 24018		0/02/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (I	PROVIDER'S PLAN OF CORRI EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 842	Vital signs every day on July 4, 5, 7, and 8; buttocks/sacrum/ peri 29; skin prep to bilate 29; Vaseline to both fe Bed alarm as resident 29; bed in low position encourage cough and 7, and 8.  The surveyor reported	der every other day on 7/8; shift to be verified by nurse	F	342			
	disease with heart failution, and chronic disease. On the minim with assessment refere	ures associated with arameters.  sitted to the facility on cluded hypertensive heart are, respiratory failure, atrial obstructive pulmonary aum data set assessment ence date 6/21/18, the on the brief interview for assessed as exhibiting osychosis, and verbal					
	a physician order dated Tablet 3.125 mg(milligra day for HTN (hypertens Hold for systolic BP equ (scheduled AM and EVI dated 7/16/18 for Lasix	am) give 1 tablet 2 times a ion)- parameters in place val to or less than 120 ENING) and an order 20 mg Give 1 tablet by or edema Lasix 20 mg at 2					

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/24/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING C 495421 B. WING 08/02/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH CAVE SPRING, VA 24018 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 842 Continued From page 113 F 842 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

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feeding and flush.

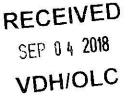
on 7/26/18.

5. For Resident #51, the facility failed to document for the administration of a g-tube

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 114 of 123



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

STATEMENT OF DEFICIENCIES (X1) PROVID IDENTIFI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		495421	B. WING_		C
	ROVIDER OR SUPPLIER HIP HEALTH AND REH			STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018	08/02/2018
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
F 842	Continued From pa	ge 114	F 8	342	
	had been admitted Diagnoses included dysphagia, aphasia	revealed that Resident #51 to the facility 05/26/18. I, but were not limited to, I, hypertensive heart disease, eflux disease, and cerebral	XX 00 00 00 00 00 00 00 00 00 00 00 00 0	и	8
88 194 194	admission MDS (mi with an ARD (asses 06/02/18 had been Resident had proble	e patterns) of the Resident nimum data set) assessment sment reference date) of coded 1/1/3 to indicate the ems with long and short term everely impaired in cognitive on making.	n š		j 
î	medication administ revealed that the nu documented that the Residents osmolite	idents eMARs (electronic ration records) for 07/2018 rsing staff had not ey had administered the feeding or that they had dents peg tube flush on	į.		
i	The surveyor requesthe eMARs.	sted that the facility staff print		b.	
	the surveyor again re unable to find any "h	ere provided to the surveyor eviewed the eMARs and was oles" where the nursing staff ent for the osmolite tube			
	surveyor asked the E she knew why the eM present. The DON ve	oximately 9:33 a.m., the DON (director of nursing) if MARs provided had no holes erbalized to the surveyor that was just printing them.			

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		INSTRUCTION	(X3) DATE SURVEY COMPLETED
		1				С
		495421	8. WING		3 T T	08/02/2018
NAME OF P	ROVIDER OR SUPPLIER	,	-97	STRE	ET ADDRESS, CITY, STATE, ZIP CODE	
FRIENDS	HIP HEALTH AND REHA	AR CENTED COUTH		5647	STARKEY ROAD	
	THE TENENT HATE IN THE IN	CO CENTER - SOOTH		CAVI	E SPRING, VA 24018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	. !	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 842	Ca-6: J F	10000 <b>4.4 F</b>	- 1	3. "		
1 042	Continued From pag		F 8	342		
	On 08/02/18 at 9:35	a.m., the surveyor asked				Vol.
	LPN (licensed practi	cal nurse) #4 if she had any	81	V		
	idea why the "holes"	on the eMARs provided to				
	the surveyor were no	ow filled in with nurse's				
	initials. LPN #4 replie	ed, "No." However, the				
	surveyor spoke with	LPN #4 again at 9:45 a.m.				
	and LPN #4 stated s	he did not understand what	ix			
i	was being asked ear	lier and that she had filled in				
	the holes for Resider	nt #4. She stated she knew				3
	sne had worked with	the Resident that day				
	(U//20) and saw she	had missed signing so she	2	1		
	filled them in. When	asked to explain that LPN #4		i		
	stated she had edited	d the eMARs. LPN #4 was	N	19		
	able to show the sun	eyor on the medication audit				
1	report where she had	signed on 08/02/18 at 8:46				
J	for 07/20.	mpleted both of these tasks		2		
	The surveyor intervie	wed the DON on 08/02/18 at		H		
	11:30 a.m., when ask	ed about the holes on the				
į,	eMARs the DON stat	ed the nurses were allowed	67	i		
i.	to go back up to two	weeks and fill in eMARs.				
Î.	The DON then added	they had a lot of agency				
	staff working and the and document.	supervisor would go back				
	On 08/02/18 at 2:50 r	o.m., LPN #4 stated to the		9		ł
	surveyor that they we	re told last night they had 30				8
	days to go back and f	ill in holes on the eMARs.				
	LPN #4 stated she fel	t very uncomfortable when				
i ,	she was asked about	it this am. She then stated				
3	she would not do that	again (fill in the holes).				j
t s	The facility provided to of a policy titled "NUR this policy read in part substantiate daily care resident's needs and o	e, communicate the				

# DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICARD SERVICES

		MEDICAID SERVICES	<del></del>	_	100s	OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
		495421	B. WNG			С
NAME OF F	PROVIDER OR SUPPLIER		J. Millo	etor	TARRESON OF THE PARTY OF THE PA	08/02/2018
					ET ADDRESS, CITY, STATE, ZIP CODE	
FRIENDS	HIP HEALTH AND REHA	B CENTER - SOUTH			STARKEY ROAD	
/Y4) ID	CUMMARY CT	ATENENT OF DEFICIENCES		CAVE	SPRING, VA 24018	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	<b>x</b>	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 842	Continued From page	116	F {	342	* * * * * * * * * * * * * * * * * * *	9
		am were notified of the	8 978	J-72		18
		ng with the survey team on		88		в
			1	!		
	No further information	regarding this issue was				
	conference.	team prior to the exit	İ			
	6. For Resident #73, t failed to document for for selsun blue shamp	he facility nursing staff the medication buspar and loo.	Ħ			
	The record review rev had been admitted to	ealed that Resident #73		3 1		
	Diagnoses included, b	ut were not limited to, eoplasm, hypertension,				8
	Section C (cognitive padmission MDS (minin with an ARD (assessm 06/29/18 included a Bi mental status) summa possible 15 points.	MS (brief interview for		ŀ		
	the nursing staff had fa administration of the R	nts eMARs (electronic ion records) revealed that illed to document for the esidents buspar (07/16) of the Residents selsun		Ŷ		*
	The surveyor requeste	d copies of the eMARs.				
0	the surveyor again revi	e provided to the surveyor ewed the eMARs and was es" where the nursing staff for buspar.				

PRINTED: 08/24/2018 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING\_ COMPLETED C 495421 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 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION **PREFIX** PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 842 Continued From page 117 F 842 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

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weights.

document for the administration of the medication diclofenac, duonebs, and record the Residents

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

Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 118 of 123



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

		T SERVICES			<del></del>	OMB NO. 0938-0391
STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		NSTRUCTION	(X3) DATE SURVEY COMPLETED
	-	495421	B. WING			C 08/02/2018
	PROVIDER OR SUPPLIER HIP HEALTH AND REHA	B CENTER - SOUTH	STREET ADDRESS, CITY, STATE, ZIP CODE 5647 STARKEY ROAD CAVE SPRING, VA 24018			00/02/2016
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
	normal pressure hydromy hypertensive heart distributed in the provided in the	cout were not limited to, occephalus, ataxia, sease with heart failure, ins., gastroesophageal reflux sorder.  Sease with heart failure, ins., gastroesophageal reflux sorder.  Seatterns) of the Residents mum data set) assessment ment reference date) of IMS (brief interview for any score of 15 out of a sents eMARs (electronic tion records) revealed that if had failed to document for ac (07/16, 07/23, 07/25) 17/25) and failed to its weights on 07/01, 07/04, and copies of the eMARs.  See provided to the surveyor fewed the eMARs and was est where the nursing staff of diclofenac and ghts had been recorded.	F	842		
76 <b>2</b> 168	08/01/18 at 2:35 p.m.,	Resident #83 stated there len she did not receive her				
j	A review of the medical revealed that RN (regis documented for the additional for the additions and for the	ministration of the				

PRINTED: 08/24/2018

CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED
	77 - V	495421	B. WING			C 08/02/2018
	ROVIDER OR SUPPLIER HIP HEALTH AND REHAL	3 CENTER - SOUTH		12	ET ADDRESS, CITY, STATE, ZIP CODE STARKEY ROAD	
	9494, 941545-0444-0455-0455-0455-0455-0455-0455	Application and the second second second second second second second second second second second second second		CAVE	SPRING, VA 24018	
(X4) ID PREFIX TAG			ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 842	Continued From page	119	F	842		*
	she had filled in the his she was at the facility. When asked if she act medications she state nurses." When asked been documented she with the weights listed made a late entry regathe medications/weighthe medications/weighthe medications/weighthe medications/weighthe medications/weighthe medications/weighthe medications/weighthe medications/weighthe surveyor interview nursing) on 08/02/18 about the holes on the the nurses were allow weeks and fill in eMAF they had a lot of agency supervisor would go be a policy titled "NURS this policy read in part substantiate daily care resident's needs and compared the administrative teal above during a meeting 08/02/18 at 8:35 p.m.	the eMARs. RN #1 stated bles on the eMARs and that on the days in question. It to the days in question. It to the days in question. It to the days in question. It to the days in question. It to the days in question days the days assisting my about the weights that had a stated she had a paper. When asked if she had a strding the documentation of the she stated "No, not yet."  I wed the DON (director of the days and document asked to go back up to two the days the DON stated ed to go back up to two the days taff working and the the days and document.  I we survey team with a copy SING DOCUMENTATION"  "PURPOSE: 1. To good the great of the great in the survey team on the great in the survey team on the great in the survey team on the great in the survey team on the great in the survey team on the great in the survey team on the great in the survey team on the great in the survey team on the great in the survey team on the great in the survey team on the great in the survey team on the great in the survey team on the great in the gre		A MARKET STREET, IN THE		
	8. For Resident #99, th failed to document for t	e facility nursing staff he Residents bed alarm,				

chair alarm and neutrashield cream.

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

CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					С	
NAME OF D	DOMEST OF SUPERIES	495421	B. WING		08/02/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
FRIENDS	HIP HEALTH AND REH	AB CENTER - SOUTH		5647 STARKEY ROAD		
				CAVE SPRING, VA 24018		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE COMPLETION HE APPROPRIATE DATE	
F 842	Continued From pa	sge 120	Fi	842	5	
		review reveled that Resident	9,30, 10			
		itted to the facility 07/06/18.				
	Diagnoses included	d, but were not limited to.				
		muscle weakness, anxiety				
	hypertension.	falls, and essential				
	0-404					
	Section C (cognitive	e patterns) of the Residents				
	with an APD (accord	inimum data set) assessment ssment reference date) of				
	07/13/18 included a	BIMS (brief interview for	1			
22	mental status) sumi	mary score of 15 out of a	<b>6</b> 3			
	possible 15 points.				~	
	A review of the Res	idents eTARs (electronic		v.	8	
	treatment administr	ation records) revealed that	19		e e	
	the nursing staff had	d failed to document for the			Ü	
	Residents bed alarr	n, chair alarm, and				
*	neutrashield cream shift.	on 07/17/18 on the evening				
3	The facility provided	the survey team with a copy				
	of a policy titled "NU	JRSING DOCUMENTATION"				
	this policy read in pa	art "PURPOSE: 1. To	38			
	Substantiate daily ca	are, communicate the				
	resident's needs and	d care received"	5			
	The administrative to	eam were notified of the				
9		ting with the survey team on			ж	
	08/02/18 at 8:35 р.п				×	
	No further information	on regarding this issue was				
	provided to the survi conference.	ey team prior to the exit				
	9. For Resident #118	B, the facility staff failed to ministration of medications				
	azopt suspension ar					

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Event ID: K4V211

Facility ID: VA0419

If continuation sheet Page 121 of 123

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	CENTERS FOR MEDICARE & MEDICAID SERVICES					OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
			¥.			С
		495421	B. WING			08/02/2018
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
FRIENDS	HIP HEALTH AND REHA	B CENTER - SOUTH		5647 STARKEY ROAD		
				CAVE SPRING, VA 24018		0
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	IN OF CORRECTION E ACTION SHOULD BE D TO THE APPROPRIA CIENCY)	
F 842	Continued From pag	o 101			\$ <del>.</del>	
		view revealed the Resident	F {	342		8
		tted to the facility 07/19/18.				
	Diagnosis included b	out were not limited to,				
	cerebral infarction, d	vsnhagia diabetes				j
	glaucoma, and depre	yspiragia, diabetes, essive disorder				
	J =======	district.				
	Section C (cognitive)	pattems) of the Residents				Ì
)	admission MDS (min	imum data set) assessment				
	with an ARD (assess)	ment reference date) of				
0	07/26/18 had been co	oded to indicate the Resident				
j	had problems with loa	ng and short term memory				
i	and was severely imp	paired in cognitive skills for				
: 	daily decision making	. However, the surveyor				
		118 was able to answer				
i i	questions appropriate	ely at the time of the survey.				
i c	A review of the Resid	ents eMARs (electronic	£			
	medication administra	ation records) revealed that				
ì	the facility nursing sta	iff had failed to document for	į.	1		
	the Residents azopt a	and oxbutynin on 07/23 and				
	07/25.	0 To 0 To 0 To 0 To 0 To 0 To 0 To 0 To				
1	_		Ĭ,			o o
	The surveyor request	ed copies of the eMARs.				
į	When the eMARs wer	re provided to the surveyor	50	8		
		viewed the eMARs and was				
	unable to find any "ho	les" where the nursing staff		#		
	had failed to documer	nt for these medications.				
	A mandania agrica		ii.			
	revealed that DN (====	ation administration report				1
	revealed that RN (regi	stered nurse) #1 had				
	documented for the administration of the medications on 08/02/18					}
		NO.				
	During an interview wi	th Resident #118 on				
	08/01/18 at 2:35 p.m.,	Resident #118 stated there				1
	has not been a time w	hen she did not receive her				
	medication(s).	THE STATE OF THE S		额		

CENTERS FOR MEDICARE & MEDICAID SERVICES						OMB NO. 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL' A. BUILDI		NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		495421	B. WING			С	
NAME OF P	ROVIDER OR SUPPLIER	455421	D. WING	200		08/02/2018	
want of f	NO FIDER ON SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE		
FRIENDS	HIP HEALTH AND REHAL	B CENTER - SOUTH			STARKEY ROAD		
Alleganismis tila			-12	CAVE	SPRING, VA 24018		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 842	Continued From page	: 122	, 	342	· · · · · · · · · · · · · · · · · · ·	3	
	On 08/02/18 at 11:45		г	142			
		the eMARs. RN #1 stated					
	she had filled in the hi	oles on the eMARs and that	Ĭ			El	
	she was at the facility	on the days in question.	88				
	When asked if she ac	tually administered the	i i				
	medications she state	d, "Yes, I was assisting my	Ì				
	nurses." When asked	if she had a made a late	İ	3			
	entry regarding the do	cumentation of the	Ž.				
	medications she state	d "No, not yet."	120			3	
	The surveyor intention	ved the DON (director of	15	Ü			
	nursing) on 08/02/18 a	at 11:30 a.m., when asked					
	about the holes on the	eMARs the DON stated		18			
	the nurses were allow	ed to go back up to two	N.				
	weeks and fill in eMAF	Rs. The DON then added	ï	23		İ	
	they had a lot of agend	cy staff working and the				2	
	supervisor would go be	ack and document	ì	1		İ	
	1 51	:	7				
	The facility provided th	e survey team with a copy	i	1		Ì	
	of a policy titled "NUR!	SING DOCUMENTATION"				28	
	this policy read in part	"PURPOSE: 1. To		1			
	substantiate daily care	, communicate the		4		ł ·	
	resident's needs and c	are received"		1			
	TL	_	10				
	The administrative tear above during a meeting 08/02/18 at 8:35 p.m.	g with the survey team on		×			
	No further information of provided to the survey conference.	regarding this issue was team prior to the exit					