

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 34730 Description of Structure: This is a four story noncombustible structure, steel frame with spray on fireproofing, metal decking and concrete floors. The interior walls are steel studs with gypsum wallboard. The south renovation was constructed with flame retardant wood framing for the walls and partitions with gypsum wallboard.</p> <p>Construction Type: II (222)</p> <p>Sprinkler status: Fully Sprinklered</p> <p>An unannounced recertification Life Safety Code survey was conducted 11/27/2018 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid.</p> <p>The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)</p>	K 000		
K 161	<p>Building Construction Type and Height CFR(s): NFPA 101</p> <p>Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5</p> <p>Construction Type 1 I (442), I (332), II (222) Any number of stories</p>	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Mike Shepoto</i>	Administrator	11-6-18

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

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 1 non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based upon observations and interviews the facility construction type does not meet the requirements of the Life Safety Code. This has the ability to affect all occupants in the building. Findings include:	K 161		

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 2 On 11/26//2018 at approximately 10:35 AM it was observed that spray on fire proofing material was missing from the structural steel beam, above the drop-in ceiling in the elevator lobby of the 4th floor. On 11/26//2018 at approximately 10:53 AM it was observed that spray on fire proofing material was missing from the structural steel beam, above the drop-in ceiling outside of Room 4007. On 11/26//2018 at approximately 11:22 AM it was observed that there is combustible foam used above the ceiling on the 2nd floor outside of the Dayroom. The Facility Maintenance Manager witnessed this evidence through observation and interview.	K 161	Identified areas where the fireproofing is missing will be repaired A facility audit did not reveal similar fireproofing issues. The appropriate staff members will be educated regarding the importance of compliance with this matter. These areas will be inspected semi-annually to determine if the structural steel beams are missing fireproofing. Documentation will be kept on file in the Maintenance Manager office. These monitoring efforts will be ongoing.	01/01/19
K 324	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the	K 324		

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 324	Continued From page 3 corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2 This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based upon observations and interviews the facilities cooking area does not meet the requirements of the Life Safety Code. This has the ability to affect all occupants in the building. Findings include: On 11/26//2018 at approximately 12:20 PM it was observed that there is an accumulation of grease on the hood vents in the Cafe'. The Facility Maintenance Manager witnessed this evidence through observation and interview.	K 324	Hood vents properly cleaned A facility audit did not reveal similar issues. The appropriate staff members will be educated regarding the importance of compliance with this matter. These hood vents will be cleaned every two months. Documentation will be kept on file in the Maintenance Manager office. These efforts will be ongoing.	11/30/18
K 345	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based upon observations and interviews the facility failed to maintain the fire alarm system	K 345	Carts were removed Area to be properly marked A facility audit did not reveal similar issues. The appropriate staff members will be educated regarding the importance of compliance with this matter.	11/26/18

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 345	Continued From page 4 requirements of the Life Safety Code. This has the ability to affect all occupants in the building. Findings include: On 11/26//2018 at approximately 12:07 PM it was observed that a pull station in the Kitchen by the Office is obstructed. The Facility Maintenance Manager witnessed this evidence through observation and interview.	K 345	A quarterly audit will be preformed throughout the building to monitor randomly selected pull stations for proper clearance Documentation will be kept on file in the Maintenance Manager office. These monitoring efforts will be ongoing	
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based upon observations and interviews the facility sprinkler system does not meet the requirements of the Life Safety Code. This has	K 353	Date sprinkler system last checked September 28, 2018 Tested by Magic City Sprinkler Water system supply Source Western Virginia Water Authority	

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 5 the ability to affect all occupants in the building. Findings include: On 11/26//2018 at approximately 10:46 AM it was observed that wires are being supported from sprinkler piping above the ceiling in the corridor outside of Room 412. On 11/26//2018 at approximately 11:03 AM it was observed that wires are being supported from sprinkler piping above the ceiling in the elevator lobby on the 3rd floor. On 11/26//2018 at approximately 10:56 AM it was observed that a sprinkler escutcheon is missing in the HVAC shaft hall on the 4th floor. The Facility Maintenance Manager witnessed this evidence through observation and interview.	K 353	Wires were removed from sprinkler pipes in identified areas. Escutcheon was replaced. A facility audit did not reveal similar issues The appropriate staff members and outside contractors will be educated regarding the importance of compliance with this matter. A quarterly sprinkler pipe audit will be preformed in each area of facility. Random areas will be audited. Documentation will be kept on file in the Maintenance Manager office. These monitoring efforts will be ongoing	11/29/18 11/26/18
K 372	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Surveyor: 34730	K 372		

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 6 Based upon observations and interviews the facility smoke barrier construction does not meet the requirements of the Life Safety Code. This has the ability to affect all occupants in the building. Findings include: On 11/26//2018 at approximately 11:11 AM it was observed that there is an unprotected through penetration to the smoke barrier wall on the 3rd floor by the smoke doors. The Facility Maintenance Manager witnessed this evidence through observation and interview.	K 372	Identified penetrations have been enclosed/repaired. A facility audit did not reveal similar penetrations. Appropriate staff will be educated regarding the prohibition of above ceiling penetrations. Agreements with 3rd parties will include provisions regarding penetrations. Work preformed by 3rd parties will be monitored by staff during renovations/repairs and upon completion. A quarterly penetration audit will be preformed in each area of facility Random areas will be audited. Documentation will be kept on file in the Maintenance Manager office. These monitoring efforts will be ongoing	11/29/18
K 923	Gas Equipment - Cylinder and Container Storage CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be	K 923		

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	<p>Continued From page 7</p> <p>stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather.</p> <p>11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Surveyor: 34730</p> <p>Based upon observations and interviews the facilities oxygen storage does not meet the requirements of the Life Safety Code. This has the ability to affect all occupants in the building.</p> <p>Findings include:</p> <p>On 11/26//2018 at approximately 10:38 AM it was observed that the Oxygen storage area on the 4th floor does not have a precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING."</p> <p>On 11/26//2018 at approximately 12:13 PM it was observed that multiple oxygen cylinders in the Main storage area are not secured to prevent falling over.</p> <p>The Facility Maintenance Manager witnessed</p>	K 923	<p>Sign installed as required</p> <p>A facility audit did not reveal similar issues.</p> <p>The appropriate staff members will be educated regarding the importance of compliance with this matter.</p> <p>These areas will be inspected semi-annually to insure compliance is being maintained.</p> <p>Documentation will be kept on file in the Maintenance Manager office.</p> <p>These monitoring efforts will be ongoing</p>	12/07/18

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 923	Continued From page 8 this evidence through observation and interview.	K 923	<p>Cylinders properly secured in racks</p> <p>A facility audit did not reveal similar issues.</p> <p>The appropriate staff members will be educated regarding the importance of compliance with this matter.</p> <p>This areas will be inspected quarterly to insure compliance is being maintained. Documentation will be kept on file in the Maintenance Manager office.</p> <p>These monitoring efforts will be ongoing</p>	12/07/18

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - FRIENDSHIP MANOR WEST B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
--	---	--	---

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

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

K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 34730 Description of Structure: This is a one story non-combustible structure, steel frame, metal decking and concrete floors. The interior walls are steel studs with gypsum wallboard. The is a roof overbuild of combustible construction that required a FSES under the 2000 Life Safety Code. The FSES for compliance with the 2012 Life Safety Code had not been completed at time of survey.</p> <p>Construction Type: II (222)</p> <p>Sprinkler status: Fully Sprinklered</p> <p>An unannounced recertification Life Safety Code survey was conducted 11/26/2018 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was not in compliance with the Requirements for Participation Medicare and Medicaid.</p> <p>The findings that follow demonstrate non-compliance with Title 42 Code of Regulations, 483.70(a) et seq (Life Safety from Fire.)</p>	K 000		
K 161	<p>Building Construction Type and Height CFR(s): NFPA 101</p> <p>Building Construction Type and Height 2012 EXISTING Building construction type and stories meets Table 19.1.6.1, unless otherwise permitted by 19.1.6.2 through 19.1.6.7 19.1.6.4, 19.1.6.5</p> <p>Construction Type</p>	K 161		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>M. De Bequatos</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11-6-18</i>
--	-------------------------------	-----------------------------

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

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - FRIENDSHIP MANOR WEST B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 1 1 I (442), I (332), II (222) Any number of stories non-sprinklered and sprinklered 2 II (111) One story non-sprinklered Maximum 3 stories sprinklered 3 II (000) Not allowed 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH) 6 V (111) 7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered Sprinklered stories must be sprinklered throughout by an approved, supervised automatic system in accordance with section 9.7. (See 19.3.5) Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate. This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based upon observations and interviews the facility construction type does not meet the requirements of the Life Safety Code. This has the ability to affect all occupants in the building. Findings include:	K 161	All identified areas of missing fireproofing will be repaired A facility audit did not reveal similar fireproofing issues. The appropriate staff members will be educated regarding the importance of compliance with this matter.	01/01/19

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - FRIENDSHIP MANOR WEST B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 161	Continued From page 2	K 161	These areas will be inspected semi-annually to determine if the structural steel beams are missing fireproofing. Documentation will be kept on file in the Maintenance Manager office. These monitoring efforts will be ongoing.	
K 353	<p>Sprinkler System - Maintenance and Testing CFR(s): NFPA 101</p> <p>Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available.</p> <p>a) Date sprinkler system last checked _____</p> <p>b) Who provided system test _____</p> <p>c) Water system supply source _____</p> <p>Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Surveyor: 34730 Based upon observations and interviews the facility sprinkler system does not meet the requirements of the Life Safety Code. This has the ability to affect all occupants in the building.</p> <p>Findings include:</p>	K 353	<p>Date sprinkler system last checked September 28, 2018</p> <p>Tested by Magic City Sprinkler</p> <p>Water system supply Source Western Virginia Water Authority</p>	

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - FRIENDSHIP MANOR WEST B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 353	Continued From page 3 On 11/26//2018 at approximately 10:35 AM it was observed that there is storage within 18 inches of the sprinkler head in the 2 West Linen Closet. The Facility Maintenance Manager witnessed this evidence through observation and interview.	K 353	Items were removed as needed to maintain proper height distance from sprinkler head. These areas will be clearly marked with a red line at 18" below sprinkler heads with instructions not to exceed. A facility audit did not reveal similar issues. The appropriate staff members will be educated regarding the importance of compliance with this matter. A quarterly audit will be preformed throughout the building to monitor randomly selected storage areas for compliance. Documentation will be kept on file in the Maintenance Manager office.	11/27/18

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

Printed: 11/28/2018
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495092	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 - RENOVATED WING B. WING _____	(X3) DATE SURVEY COMPLETED 11/26/2018
NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW ROANOKE, VA 24012		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 34730 Description of Structure: This is a four story non-combustible structure, steel frame with spray on fireproofing, metal decking and concrete floors. The interior walls are steel studs with gypsum wallboard. This building is the two north day room and therapy rooms, renovated in 2013.</p> <p>Construction Type: II (222)</p> <p>Sprinkler status: Fully Sprinklered</p> <p>An unannounced recertification Life Safety Code survey was conducted 11/26/2018 in accordance with 42 Code of Federal Regulation, Part 483: Requirements for Long Term Care Facilities. The facility was surveyed for compliance using the LSC 2012 Existing regulations. The facility was in compliance with the Requirements for Participation Medicare and Medicaid.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE
Mike Shepotes *Administrator* *11-6-18*

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