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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1.	PLE CONSTRUCTION G 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED	
	495092				B. WING 11/		
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	(EACH DEFICIENCY MUS	TATEMENT OF DEFICIENC! T BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	TS		K 000			
	noncombustible str on fireproofing, me floors. The interior gypsum wallboard. constructed with fla	cture: This is a four structure, steel frame vertal decking and concer walls are steel stude. The south renovations with gypsum wattons with gypsum wa	vith spray crete s with on was framing for				
	Construction Type:	: II (222)					
	Sprinkler status: Fi	ully Sprinklered					
	survey was conduct with 42 Code of Fe Requirements for I facility was surveyed LSC 2012 Existing	ecertification Life Satcted 11/27/2018 in accederal Regulation, Patong Term Care Faciled for compliance us regulations. The factwith the Requirementare and Medicaid.	cordance rt 483: lities. The ing the ility was				
		ollow demonstrate ith Title 42 Code of 70(a) et seq (Life Saf	ety from				
K 161	Building Construct CFR(s): NFPA 101	ion Type and Height		K 161			
	2012 EXISTING Building construction	ion Type and Height on type and stories n less otherwise permit 9.1.6.7					
	Constructi 1 I (442), I (3	ion Type 332), II (222) Any ni	umber of				

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.

If continuation sheet Page  $\,$  1 of 9

(X6) DATE

TITLE

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I(A)) FROVIDER/SUFFLIER/CLIA		1 ' '	) MULTIPLE CONSTRUCTION BUILDING 01 - MAIN BUILDING 01 (X3) DATE SI COMPLE		
495092			B. WING 11/26/2018				
					STATE, ZIP CODE		
				RSHBERC KE, VA 2	GER RD NW 4012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE I BE PRECEDED BY FULL I ENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETIO	N
K 161	Continued From pa	~	_	K 161			
	sprinklered	non-sprinklered and	d				
	Sprinklered						
	2 II (111) non-sprinklered	One story					
	·	Maximum 3 stories					
	sprinklered						
	3 II (000) non-sprinklered	Not allowed					
	4 III (211)	Maximum 2 sto	ories				
	sprinklered						
	5 IV (2HH) 6 V (111)						
	7 III (200)	Not allowed					
	non-sprinklered 8 V (000)	Maximum 1 sto	rv				
	sprinklered		,				
		must be sprinklered oproved, supervised	automatic				
	system in accordan	ice with section 9.7.					
	19.3.5) Give a brief descrip	otion, in REMARKS, o	of the				
	construction, the nu	umber of stories, incl	uding				
		on which patients are					
	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						
			denced				
Based upon observations and interviews the facility construction type does not meet the requirements of the Life Safety Code. This has							
		all occupants in the b					
	Findings include:						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

495092

B. WING \_\_

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

	NOAN	OKE, VA 2	4012	
(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	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.		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	01/01/19
K 324	The Facility Maintenance Manager witnessed this evidence through observation and interview.  Cooking Facilities  CFR(s): NFPA 101	K 324	Maintenance Manager office. These monitoring efforts will be ongoing.	
	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			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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A. BUILDING 01 - MAIN BUILDING 01

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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

	ROAN	OKE, VA 2	4012	
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	OR LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIATE	11/30/18
K 345	The Facility Maintenance Manager witnessed this evidence through observation and interview.	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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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A. BUILDING 01 - MAIN BUILDING 01

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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.	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	
I/ 050	The Facility Maintenance Manager witnessed this evidence through observation and interview.	V 050		
K 353	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101	K 353	Date sprinkler system last checked September 28, 2018	
	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		Tested by Magic City Sprinkler  Water system supply Source  Western Virginia Water Authority	
	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			

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

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(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01

(X3) DATE SURVEY COMPLETED

495092

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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

	ROANG	OKE, VA 2	4012	
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K 353	Continued From page 5	K 353		
,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	the ability to affect all occupants in the building.		Wires were removed from sprinkler pipes in identified areas.	11/29/1
	Findings include:		in identified dreds.	
	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		Escutcheon was replaced.	11/26/1
	outside of Room 412.		A facility audit did not reveal similar issues	
	On 11/00//0010 at annuaring state 11/02 ANAit was		The appropriate staff members and outside	
	On 11/26//2018 at approximately 11:03 AM it was observed that wires are being supported from		contractors will be educated regarding the	
	sprinkler piping above the ceiling in the elevator lobby on the 3rd floor.		importance of compliance with this matter.	
	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.		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	
	The Facility Maintenance Manager witnessed this evidence through observation and interview.		Manager office. These monitoring efforts will be ongoing	
K 372	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101	K 372		
	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			

Printed: 11/28/2018 FORM APPROVED

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA X3) DATE SURVEY A. BUILDING 01 - MAIN BUILDING 01 COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** 495092 B. WING 11/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 327 HERSHBERGER RD NW FRIENDSHIP HEALTH AND REHAB CENTER **ROANOKE, VA 24012** (X5) COMPLETION DATE PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 372 K 372 Continued From page 6 11/29/18 Identified penetrations have been enclosed/repaired. Based upon observations and interviews the facility smoke barrier construction does not meet A facility audit did not reveal similar the requirements of the Life Safety Code. This has the ability to affect all occupants in the penetrations. building. Appropriate staff will be educated Findings include: regarding the prohibition of above ceiling penetrations. Agreements with 3rd parties On 11/26//2018 at approximately 11:11 AM it was will include provisions regarding observed that there is an unprotected through penetrations. Work preformed by 3rd penetration to the smoke barrier wall on the 3rd floor by the smoke doors. parties will be monitored by staff during renovations/repairs and upon completion. The Facility Maintenance Manager witnessed this A quarterly penetration audit will be evidence through observation and interview. preformed in each area of facility Random K 923 K 923 Gas Equipment - Cylinder and Container Storag areas will be audited. Documentation will CFR(s): NFPA 101 be kept on file in the Maintenance Manager office. These monitoring efforts Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet will be ongoing 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

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

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

Printed: 11/28/2018 **FORM APPROVED** 

CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING 01 - MAIN BUILDING 01 COMPLETED 495092 B. WING 11/26/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER 327 HERSHBERGER RD NW **ROANOKE, VA 24012** (X5) COMPLETION DATE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY **PREFIX** OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 923 Continued From page 8 K 923 this evidence through observation and interview. Cylinders properly secured in racks 12/07/18 A facility audit did not reveal similar issues. The appropriate staff members will be educated regarding the importance of compliance with this matter. This areas will be inspected quarterly to insure compliance is being maintained. Documentation will be kept on file in the Maintenance Manager office. These monitoring efforts will be ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IIATI PROVIDEN/SUPPLIEN/CLIA I		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - FRIENDSHIP MANOR WEST		(X3) DATE SURVEY COMPLETED	
	495092			B. WING		11/26/2018	
	FRIENDSHIP HEALTH AND REHAB CENTER 327 I				STATE, ZIP CODE GER RD NW 4012		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCI I BE PRECEDED BY FULL ENTIFYING INFORMATION)	REGULATORY	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
K 000	Surveyor: 34730 Description of Struction-combustible stidecking and concreare steel studs with roof overbuild of corequired a FSES ur Code. The FSES fulfe Safety Code had of survey.  Construction Type: Sprinkler status: Full An unannounced resurvey was conduct with 42 Code of Fer Requirements for Lacility was surveye LSC 2012 Existing not in compliance with regulations, 483.70 Fire.) Building Construction CFR(s): NFPA 101  Building Construction Building Construction Construction CFR(s): NFPA 101	cture: This is a one structure, steel frame, ete floors. The interior gypsum wallboard. In the steel the s	metal or walls The is a on that afety ne 2012 ed at time  ety Code cordance rt 483: lities. The ng the lity was s for	K 000			
LABORATO	RY DIRECTOR'S OR PROV	• •	NITATIVE'S SIGN	JATURE	A TITLE		(X6) DATE

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

Admistration

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

(X2) MULTIPLE CONSTRUCTION

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY COMPLETED

FRIENDSHIP HEALTH AND REHAB CENTER

327 HERSHBERGER RD NW ROANOKE, VA 24012

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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 non-sprinklered 4 III (211) Maximum 2 stories sprinklered 5 IV (2HH)	K 161		
	7 III (200) Not allowed non-sprinklered 8 V (000) Maximum 1 story sprinklered 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.		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

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**CENTERS FOR MEDICARE & MEDICAID SERVICES** OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - FRIENDSHIP MANOR WEST COMPLETED 495092 11/26/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE FRIENDSHIP HEALTH AND REHAB CENTER 327 HERSHBERGER RD NW **ROANOKE, VA 24012** (X5) COMPLETION DATE (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY (EACH CORRECTIVE ACTION SHOULD BE OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) Continued From page 2 K 161 K 161 These areas will be inspected semi-annually to determine if the structural On 11/26//2018 at approximately 12:27 AM it was steel beams are missing fireproofing. observed that spray on fire proofing material was Documentation will be kept on file in the missing from the structural steel beams in the 1 North Mechanical Room. Maintenance Manager office. These monitoring efforts will be ongoing. The Facility Maintenance Manager witnessed this evidence through observation and interview. K 353 Sprinkler System - Maintenance and Testing K 353 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. Date sprinkler system last checked a) Date sprinkler system last checked September 28, 2018 b) Who provided system test Tested by Magic City Sprinkler c) Water system supply source Water system supply Source Provide in REMARKS information on coverage Western Virginia Water Authority 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

Findings include:

requirements of the Life Safety Code. This has the ability to affect all occupants in the building.

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

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

NAME OF PROVIDER OR SUPPLIER FRIENDSHIP HEALTH AND REHAB CENTER  SUMMARY STATEMENT OF DEFICIENCE STATE ADRESS, CITY. STATE. ZIP CODE  327 HERSHBERGER RD NW ROANOKE, VA 24012  SUMMARY STATEMENT OF DEFICIENCE STATE  (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY PREFIX TAG  INITIAL COMMENTS  Surveyor: 34730  Description of Structure: This is a four story non-combustible structure, sited 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.  Construction Type: II (222)  Sprinkler status: Fully Sprinklered  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 Torm Care Facilities. The facility was surveyed for compliance with the Requirements for Participation Medicare and Medicaid.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING 03 - RENOVATED WING			(X3) DATE SURVEY COMPLETED	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE	LAROPATO		//IDER/SLIPPI IED BEDDES!	ENTATIVE'S SIG	NATURE	TITLE		(X6) DATE	

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.