

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

PRINTED: 07/01/2020
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 _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/16/2020
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	
E 000	Initial Comments An unannounced Emergency Preparedness (EP) COVID-19 Focused Survey was conducted onsite on 6/16/2020 and EP informatin was updated offsite on 6/16/2020. Emergency Preparedness information was reviewed off site on 04/21/2020. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000			
F 000	INITIAL COMMENTS An unannounced COVID-19 Focused Infection Control Survey was conducted onsite and information updated off-site on 6/16/2020. Infection Control information was reviewed off site on 04/21/2020. On 04/21/2020, the census in this 293 certified bed facility was 219 . Of the 219 current residents, none were positive and 1 had pending test results. On 06/16/20, the census was 220. Of the 220 residents, none were positive, and 1 had pending test results.	F 000			

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

TITLE

(X6) DATE

Electronically Signed

07/01/2020

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.