STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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 survey was conducted 6/15/21 through 6/17/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No emergency preparedness complaints were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 6/15/2021 through 6/17/2021. Complaints were investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 252 certified bed facility was 182 at the time of the survey. The survey sample consisted of 35 current Resident reviews and 3 closed record reviews.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, clinical record review, and facility document review, the facility staff failed to ensure accommodation of resident needs by failing to provide a method to call for staff assistance for 1 of 36 residents in the survey sample, Resident	F 558	F558 Corrective Action(s): As indicated in CMS-2567, Resident #79 was given a method to call for assistance from staff when needed.	7/28/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		07/16/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 558	Continued From page 1 #79. The findings included: For Resident #79, the facility staff failed to provide a method to call for staff assistance. Resident #79's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease with Late Onset, Cognitive Communication Deficit, Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbance, Chronic Diastolic Congestive Heart Failure, and Type 1 Diabetes Mellitus with Hyperglycemia. The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 4/23/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns. In section G, Functional Status, Resident #79 was coded as requiring extensive assistance with bed mobility and personal hygiene and supervision only in eating. On 6/15/21 at 12:10 pm, surveyor observed Resident #79 in bed without a corded call light or an alternative call method available. At 12:30 pm, surveyor spoke with CNA (certified nursing assistant) #1 and CNA #1 entered the resident's room and verified that there was no call light. Surveyor asked CNA #1 if the resident should have a call light and CNA #1 stated "not really" and that the resident was confused. At 12:43 pm, surveyor spoke with Unit Manager #1 and asked why Resident #79 did not have a call light, Unit Manager #1 stated some of the residents from 2 West did not have call lights for various reasons	F 558	Identification of Deficient Practice(s) & Corrective Action(s): All residents may have potentially been affected. The DON and ADON have completed a 100% audit of all resident rooms to ensure a method to call for assistance is available. Systemic Change(s); The facility policy & procedure for call bell and assistance monitoring has been reviewed and no changes are warranted at this time. The DON and/or designee will in-services licensed nursing staff on the policy and the need for all residents to have an appropriate method to alert staff of needed assistance. Monitoring: The DON is responsible for maintaining compliance. The DON and/or designee will perform daily room and unit rounds to monitor for compliance. Any/all negative findings will be corrected at the time of discovery and disciplinary action will be taken as needed. Finding of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for changes in facility policy, procedure, and/or practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 558	Continued From page 2	F 558		

and this resident does not use a call light. Surveyor asked Unit Manager #1 if it would be care planned and they stated "yes".

Surveyor was unable to locate documentation within Resident #79's care plan concerning the reason for the resident not having a corded call light or an alternate method for calling for assistance. On 6/15/21 at 7:51 pm, surveyor spoke with the nursing supervisor and asked why Resident #79 did not have a call light as the care plan did not include documentation related to the call light. Nursing Supervisor stated "I'm unable to answer that" and stated they would check on it and take care of it. At 8:10 pm, surveyor again spoke with the Nursing Supervisor who stated "I got (him/her) a call light" and stated they did not see the reason for the resident not having a call light on the care plan. Surveyor asked "Do you think (he/she) is safe with a call light"? Nursing Supervisor stated "yes ma'am" and stated they talked to the nurse and the nurse is going to watch the resident.

On 6/16/21 at 7:20 am, surveyor spoke with the DON (director of nursing) who stated they were unaware that the resident did not have a call light and the Nursing Supervisor called them last night and they investigated it and found no reason for Resident #79 not to have a call light even though the resident may not be able to use it.

On 6/16/21 at 7:53 am, surveyor observed Resident #79 in bed with a corded call light within reach. Surveyor asked the resident how they would call for help if needed and they stated "it's easy" and "you just go at it". Surveyor showed the resident the call light and asked if they knew what it was for and the resident shook their head

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 558	Continued From page 3 no. Surveyor requested and received the facility policy entitled, "Call Bell/Assistance Monitoring" which states in part: Policy It is the policy of the facility to provide residents with a means of communicating with staff. A call system is installed in each resident room and toilet/bath areas. The facility responds to resident needs and requests. Procedure F. Alternative methods of calling for assistance may be needed due to Resident-specific needs or repairs to the system. In such cases; a. If a residents needs dictates an alternate method of calling for assistance, this will be care planned appropriately On 6/16/21 at 4:15 pm during a meeting with the administrator and DON, surveyor discussed the concern of Resident #79 not having access to a call light. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/17/21.	F 558		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures	F 607		7/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 607	Continued From page 4 to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to implement facility policy and procedures regarding reporting of all alleged violations involving abuse for 2 of 36 residents in the survey sample, Residents #173 and #131. The findings included: 1. For Resident #173, the facility staff failed to implement facility policy regarding reporting a resident to resident altercation occurring on 4/01/21. Resident #173's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease Unspecified, Unspecified Psychosis not due to Substance or Known Physiological Condition, Chronic Atrial Fibrillation Unspecified, Peripheral Vascular Disease Unspecified, and Major Depressive Disorder Recurrent Unspecified. The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 5/29/21 assigned the resident a BIMS (brief interview for mental status) score of 4 out of 15 in section C, Cognitive Patterns. A review of Resident #173's clinical record revealed the following documentation: A progress note dated 4/01/21 19:55 (7:55 pm)	F 607	F607 Corrective Action(s): The investigation, which occurred on 4/1/21, explained the physical altercation between Resident #173 and Resident #131, but were not reported in the timeframes mandated by regulation. A FRI is not warranted at this time. A facility Incident & Accident form has been completed for this incident. Identification of Deficient Practice(s) and Corrective Action(s): All other residents may have been affected. The DON and/or designee will review facility incident reports and behavior notes from the past 30 days to ensure that all resident to resident altercations 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. Systemic Change(s): The Facility Policy and Procedure has been reviewed and changes are not warranted at this time. The Vice President of Operations will conduct in-services for all staff, including the Administrator and DON, on the reporting guidelines for abuse, neglect and misappropriations including time lines for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 607	Continued From page 5 states "This writer assessed resident after altercation with other resident. No apparent injuries were noted upon assessment. Did state that (he/she) felt (his/her) tooth on (his/her) left side was loose. Assessed mouth and did not see any abnormalities at this time. Will monitor for any changes". On 6/15/21 at approximately 4:15 pm, survey team leader spoke with the administrator and requested all FRIs (facility reported incidents) for the past 6 months. The administrator stated that no FRIs have been sent in during the past 6 months except for COVID-19 reporting. At 4:20 pm, surveyor spoke with the DON (director of nursing) who stated they do not have an FRI because the incident was witnessed and there was no injury. The DON provided surveyor a copy of the facility incident investigation dated 4/01/21 20:30 (8:30 pm) which states in part, "Observed resident on receiving side of an altercation. Other resident had hand over resident's mouth as (he/she) was screaming for (him/her) to stop. As resident was getting agitated (he/she) began to slap this resident in face multiple times" and "(He/she) stated that (he/she) wanted (him/her) to stop. (He/she) felt as if (his/her) tooth on left side of (his/her) mouth was loose and that (he/she) would later have a bruise to (his/her) face." On 6/16/21 at 12:30 pm, surveyor spoke with the DON who stated they submit FRIs for resident to resident altercations if there is an injury. DON further stated the administrator, physician, and herself discussed the incident involving Resident #173 and decided that because the altercation was witnessed and there was no injury they	F 607	reporting incidents. Any future negative findings will result in immediate corrective action. Monitoring: The Administrator and DON are responsible for monitoring compliance. The 24-hour report will be reviewed daily to monitor resident-to-resident altercations. Investigations and reporting of these events will follow reporting guidelines and facility Policy & Procedure. Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 607	Continued From page 6	F 607		

decided not it report it. DON stated if there is no injury they normally do not report it.

Surveyor requested and received the facility policy entitled, "Abuse" which states in part:
Definitions:
"Abuse" is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, can cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
7) Reporting
a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect,
exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 607	Continued From page 7	F 607		

jurisdiction in long-term care facilities) in accordance with State law through established procedures.

On 6/17/21 at 10:00 am, during a meeting with the administrator and DON, surveyor discussed the concern of the facility not implementing facility policy regarding reporting the resident to resident altercation involving Resident #173.

No further information regarding this issue was presented to the survey team prior to the exit conference on 6/17/21.

2. For Resident #131, the facility staff failed to implement facility policy regarding reporting a resident to resident altercation occurring on 4/01/21.

Resident #131's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease with Early Onset, Cognitive Communication Deficit, Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbance, and Adult Failure to Thrive.

The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 5/11/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns.

A review of Resident #131's clinical record revealed the following documentation:

A nursing progress note dated 4/02/21 21:27 (9:27 pm) states "Resident was involved in physical altercation yesterday. No s/s (signs/symptoms) of injury or pain noted at this

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 607	Continued From page 8	F 607		

time".

On 6/15/21 at approximately 4:15 pm, survey team leader spoke with the administrator and requested all FRIs (facility reported incidents) for the past 6 months. The administrator stated that no FRIs have been sent in during the past 6 months except for COVID-19 reporting.

On 6/16/21 at 1:50 pm, surveyor spoke with the DON (director of nursing) and requested the facility's investigation and facility reported incident for the resident to resident altercation involving Resident #131. At approximately 2:00 pm, the DON returned and stated the incident was not reported.

Surveyor was provided with an investigation report dated 4/01/21 17:34 (5:34 pm) stating in part, "Resident was observed grabbing another resident by the hair and L (left) forearm pinning (him/her) to the table for trying to take (his/her) wheeled walker away", "separated residents and assessed for injury", and "no injuries observed at time of incident".

Surveyor requested and received the facility policy entitled, "Abuse" which states in part:
Definitions:
"Abuse" is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, can cause physical harm, pain or mental anguish.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 607	Continued From page 9	F 607		

It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
7) Reporting
a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect,
exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

On 6/17/21 at 10:00 am, during a meeting with the administrator and DON, surveyor discussed the concern of the facility not implementing facility policy regarding reporting the resident to resident altercation involving Resident #131 occurring on 4/01/21. The DON stated the incident was not reported due to the residents' dementia.

No further information regarding this issue was presented to the survey team prior to the exit conference on 6/17/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 609	Continued From page 10	F 609		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility document review, the facility staff failed to ensure that all alleged violations involving abuse were reported for 2 of 36 residents in the survey sample, Residents # 173 and #131.	F 609	F609 Corrective Action(s): The investigation, which occurred on 4/1/21, explained the physical altercation between Resident #173 and Resident #131, but were not reported in the	7/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 609	Continued From page 11 The findings included: 1. For Resident #173, the facility staff failed to report a resident to resident altercation occurring on 4/01/21. Resident #173's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease Unspecified, Unspecified Psychosis not due to Substance or Known Physiological Condition, Chronic Atrial Fibrillation Unspecified, Peripheral Vascular Disease Unspecified, and Major Depressive Disorder Recurrent Unspecified. The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 5/29/21 assigned the resident a BIMS (brief interview for mental status) score of 4 out of 15 in section C, Cognitive Patterns. A review of Resident #173's clinical record revealed the following documentation: A progress note dated 4/01/21 19:55 (7:55 pm) states "This writer assessed resident after altercation with other resident. No apparent injuries were noted upon assessment. Did state that (he/she) felt (his/her) tooth on (his/her) left side was loose. Assessed mouth and did not see any abnormalities at this time. Will monitor for any changes". On 6/15/21 at approximately 4:15 pm, survey team leader spoke with the administrator and requested all FRIs (facility reported incidents) for the past 6 months. The administrator stated that no FRIs have been sent in during the past 6	F 609	timeframes mandated by regulation. A FRI is not warranted at this time. A facility Incident & Accident form has been completed for this incident. Identification of Deficient Practice(s) and Corrective Action(s): All other residents may have been affected. The DON and/or designee will review facility incident reports and behavior notes from the past 30 days to ensure that all resident to resident altercations 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. Systemic Change(s): The Facility Policy and Procedure has been reviewed and changes are not warranted at this time. The Vice President of Operations will conduct in-services for all staff, including the Administrator and DON, on the reporting guidelines for abuse, neglect and misappropriations including time lines for reporting incidents. Any future negative findings will result in immediate corrective action. Monitoring: The Administrator and DON are responsible for monitoring compliance. The 24-hour report will be reviewed daily to monitor resident-to-resident altercations. Investigations and reporting of these events will follow reporting guidelines and facility Policy & Procedure.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 609	Continued From page 12 months except for COVID-19 reporting. At 4:20 pm, surveyor spoke with the DON (director of nursing) who stated they do not have an FRI because the incident was witnessed and there was no injury. The DON provided surveyor a copy of the facility incident investigation dated 4/01/21 20:30 (8:30 pm) which states in part, "Observed resident on receiving side of an altercation. Other resident had hand over resident's mouth as (he/she) was screaming for (him/her) to stop. As resident was getting agitated (he/she) began to slap this resident in face multiple times" and "(He/she) stated that (he/she) wanted (him/her) to stop. (He/she) felt as if (his/her) tooth on left side of (his/her) mouth was loose and that (he/she) would later have a bruise to (his/her) face." On 6/16/21 at 12:30 pm, surveyor spoke with the DON who stated they submit FRIs for resident to resident altercations if there is an injury. DON further stated the administrator, physician, and herself discussed the incident involving Resident #173 and decided that because the altercation was witnessed and there was no injury they decided not it report it. DON stated if there is no injury they normally do not report it. Surveyor requested and received the facility policy entitled, "Abuse" which states in part: Definitions: "Abuse" is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial	F 609	Aggregate findings will be reported to the Quality Assurance Committee monthly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 609	Continued From page 13	F 609		

well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, can cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
7) Reporting
a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect,
exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures.

On 6/17/21 at 10:00 am, during a meeting with the administrator and DON, surveyor discussed the concern of the facility not reporting the resident to resident altercation involving Resident #173.

No further information regarding this issue was presented to the survey team prior to the exit conference on 6/17/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 609	Continued From page 14	F 609		

2. For Resident #131, the facility staff failed to report a resident to resident altercation occurring on 4/01/21.

Resident #131's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease with Early Onset, Cognitive Communication Deficit, Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbance, and Adult Failure to Thrive.

The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 5/11/21 assigned the resident a BIMS (brief interview for mental status) score of 14 out of 15 in section C, Cognitive Patterns.

A review of Resident #131's clinical record revealed the following documentation:

A nursing progress note dated 4/02/21 21:27 (9:27 pm) states "Resident was involved in physical altercation yesterday. No s/s (signs/symptoms) of injury or pain noted at this time".

On 6/15/21 at approximately 4:15 pm, survey team leader spoke with the administrator and requested all FRIs (facility reported incidents) for the past 6 months. The administrator stated that no FRIs have been sent in during the past 6 months except for COVID-19 reporting.

On 6/16/21 at 1:50 pm, surveyor spoke with the DON (director of nursing) and requested the facility's investigation and facility reported incident for the resident to resident altercation involving Resident #131. At approximately 2:00 pm, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 609	Continued From page 15	F 609		

DON returned and stated the incident was not reported.

Surveyor was provided with an investigation report dated 4/01/21 17:34 (5:34 pm) stating in part, "Resident was observed grabbing another resident by the hair and L (left) forearm pinning (him/her) to the table for trying to take (his/her) wheeled walker away", "separated residents and assessed for injury", and "no injuries observed at time of incident".

Surveyor requested and received the facility policy entitled, "Abuse" which states in part:
Definitions:
"Abuse" is the willful infliction of injury, unreasonable confinement, intimidation, or punishment resulting in physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, can cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. Willful, as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.
7) Reporting
a) The organization will maintain systems to ensure that all alleged violations involving abuse, neglect,
exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 609	Continued From page 16 than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility, or his or her designee, and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. On 6/17/21 at 10:00 am, during a meeting with the administrator and DON, surveyor discussed the concern of the facility not reporting the resident to resident altercation involving Resident #131 and the DON stated the incident was not reported due to the residents' dementia. No further information regarding this issue was presented to the survey team prior to the exit conference on 6/17/21.	F 609		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review,	F 684	F684	7/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 684	Continued From page 17 and facility document review, the facility staff failed to ensure the residents receive treatment and care in accordance with the comprehensive person-centered care plan for 1 of 36 residents in the survey sample, Resident #79. The findings included: For Resident #79, the facility staff failed to follow physician's orders for the administration of Hydralazine, a vasodilator used to treat high blood pressure. Resident #79's diagnosis list indicated diagnoses, which included, but not limited to Alzheimer's Disease with Late Onset, Cognitive Communication Deficit, Dementia in Other Diseases Classified Elsewhere with Behavioral Disturbance, Chronic Diastolic Congestive Heart Failure, Hypertensive Heart Disease with Heart Failure, and Type 1 Diabetes Mellitus with Hyperglycemia. The most recent annual MDS (minimum data set) with an ARD (assessment reference date) of 4/23/21 assigned the resident a BIMS (brief interview for mental status) score of 3 out of 15 in section C, Cognitive Patterns. Resident #79's physician's orders included an active order dated 5/25/21 stating "Hydralazine HCl Tablet 10 mg give 1 tablet by mouth every 12 hours as needed for Htn (hypertension) give if SBP (systolic blood pressure) > than 160 or DBP (diastolic blood pressure) > 90". A review of Resident #79's June 2021 MAR (medication administration record) revealed that on two separate occasions the residents SBP was greater than 160 and Hydralazine was not	F 684	Corrective Action(s): Resident #79s attending physician was notified that the facility failed to follow ordered parameters to give 1 Hydralazine tablet every 12 hours for hypertension when Systolic blood pressure is greater than 160 or Diastolic blood pressure is greater than 90. Failures to follow physician orders for Resident #79 include: The facility failed to administer Hydralazine 10mg for a blood pressure of 168/73 on 6/2/21 at 0900 and failed to administer Hydralazine 10mg on 6/3/21 0900 for a blood pressure of 163/70. The facility administered Hydralazine 10mg on 6/8/21 at 0850 for a blood pressure of 134/62. Identification of Deficient Practice(s) and Corrective Action(s): Resident with blood pressure medication orders with specific parameters may have been potentially affected. The facility conducted an audit of resident's physician orders with specific blood pressure medication parameters and MARS over the last 30 days to identify residents at risk for receiving blood pressure medication when not indicated and omissions of blood pressure medications when indicated. No other issues or areas of deficient practice were identified. Systemic Change(s): The facility policy and procedure has been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 684	Continued From page 18 administered. On 6/02/21 at 9:00 am the resident's blood pressure was 168/73 and on 6/03/21 at 9:00 am the resident's blood pressure was 163/70, Hydralazine was not initialed on the MAR as being administered on either occasion. Hydralazine was initialed on the June 2021 MAR as being administered on 6/08/21 at 8:50 am, however the resident's documented blood pressure was 134/62. On 6/16/21 at approximately 7:20 am, surveyor notified the DON (director of nursing) of Resident #79 not receiving Hydralazine on 6/02/21 and 6/03/21 as ordered and the medication being given on 6/08/21 with a documented blood pressure below the ordered parameters. On 6/16/21, the DON provided the surveyor with a copy of a Medication Error Report dated 6/16/21 7:59 am for Resident #79 for errors occurring on 6/03/21, 6/04/21, and 6/08/21. The Medication Error Report states in part, "6/08 Nurse administered prn hydralazine 10 mg for BP of 134/62 when perimeter is SBP > 160 or DBP > 90. On 6/03 and 6/04 Hydralazine not given for BP 168/73 and 163/70 with above perimeters". Surveyor requested and received the facility policy entitled "Medication and Treatment Administration" which states in part, the purpose of the policy is to "ensure all medications and treatments are administered to each resident according to the correct dose, route and times as ordered by the provider." On 6/16/21 at 4:15 pm during a meeting with the administrator and DON, surveyor discussed the concern of Resident #79's medication errors for Hydralazine administration.	F 684	reviewed and revisions have been made. The electronic medication administration record has been updated to prompt licensed nursing staff to answer the question yes/no if blood pressure is within ordered parameters prior to administering medication. Licensed nursing staff were in-serviced by the DON and/or designee on medication administration of medications with specific perimeters. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON, and/or designee will perform daily MAR audits to monitor for compliance. Additionally, all nurses are being observed and audited during a medication administration pass. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. 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.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 684	Continued From page 19 No further information regarding this issue was presented to the survey team prior to the exit conference on 6/17/21.	F 684		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to ensure 1 of 36 Residents was free of an unnecessary medication (Resident #77). The findings included:	F 757	F757 Corrective Action(s): Resident #77s attending physician was notified that the facility failed to follow ordered parameters to give one 25mg Metoprolol tablet every 12 hours for hypertension, hold if Systolic blood	7/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 757	Continued From page 20	F 757		

The facility nursing staff administered the hypertensive medication Metoprolol without adequate indications for use. Resident #77 clinical record included a physician order to hold this medication for a (BP) blood pressure less than 100 systolic (top number) or less than 60 diastolic (bottom number).

The (EHR) electronic health record included the diagnosis, hypertensive chronic kidney disease, vascular dementia, and type 2 diabetes.

Section C (cognitive patterns) of Resident #77's quarterly (MDS) minimum data set assessment with an (ARD) assessment reference date of 04/16/2021 included a (BIMS) brief interview for mental status summary score of 9 out of a possible 15 points.

Resident #77's clinical record included a physicians order for Metoprolol 25 mg give 1 tablet by mouth every 12 hours for hypertension. Hold for systolic BP less than 100 or diastolic blood pressure less than 60.

A review of Resident #77's (EMARs) electronic medication administration records revealed that the nursing staff administered the medication on the following dates when the BP was out of the parameters set by the physician.
06/06/2021 9:00 p.m. BP documented as 122/58.
06/09/2021 9:00 p.m. BP documented as 130/58.
06/14/2021 9:00 a.m. BP documented as 119/58.
06/15/2021 9:00 a.m. BP documented as 109/55.
06/15/2021 9:00 p.m. BP documented as 121/57.

06/16/21 at 3:41 p.m., the administrator and (DON) director of nursing were made aware of the issue regarding Resident #77's BP pressure is less than 100 or Diastolic blood pressure is less than 60.

Failures to follow physician orders for Resident #77 include:

The facility administered Metoprolol 25mg tablet:

On 06/06/21 2100 - BP documented as 122/58

On 06/09/21 2100 - BP documented as 130/58

On 6/12/21 2100 - BP documented as 121/57

On 06/14/21 2100 - BP documented as 119/58

On 6/15/21 2100 - BP documented as 109/55

Identification of Deficient Practice(s) and Corrective Action(s):
Resident with blood pressure medication orders with specific parameters may have been potentially affected. The facility conducted an audit of resident's physician orders with specific blood pressure medication parameters and MARS over the last 30 days to identify residents at risk for receiving blood pressure medication when not indicated and omissions of blood pressure medications when indicated. No other issues or areas of deficient practice were identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 757	Continued From page 21 medication. No further information regarding this issue was provided to the survey team prior to the exit conference.	F 757	Systemic Change(s): The facility policy and procedure has been reviewed and revisions have been made. The electronic medication administration record has been updated to prompt licensed nursing staff to answer the question yes/no if blood pressure is within ordered parameters prior to administering medication. Licensed nursing staff were in-serviced by the DON and/or designee on medication administration of medications with specific perimeters. Monitoring: The DON is responsible for maintaining compliance. The DON, ADON, and/or designee will perform daily MAR audits to monitor for compliance. Additionally, all nurses are being observed and audited during a medication administration pass. Any/all negative findings and or errors will be corrected at time of discovery and disciplinary action will be taken as needed. 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.	
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.	F 761		7/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 761	Continued From page 22 §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility staff failed to dispose of stored expired laboratory tubes on 2 of 6 units, 2 South and 3 Main and failed to dispose of a stored expired medication on 1 of 6 units 2 North. The findings included: 1. The facility staff failed to dispose of stored expired laboratory tubes in the medication room on 2 South. 06/15/2021 at 12:10 p.m., the surveyor checked the medication room on 2 South with (LPN) licensed practical nurse #1. This medication room included 5 expired blue top laboratory tubes with an expiration date of 03/31/2021 and 1 expired purple top laboratory	F 761	F761 Corrective Action(s): The facility immediately discarded the expired lab tubes in the Medication Rooms on 2-South and 3-Main Units, as well as the expired medication located in the Medication room on the 2-North Unit. Identification of Deficient Practice(s) and Corrective Action(s): Additional medication rooms and other clinical areas throughout the facility may have been affected. The DON, ADON, and Unit Managers performed audits of all medication rooms, medication carts and nurses' stations on the same day of the findings presented in this report. There were no other issues or areas of deficiencies identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 761	Continued From page 23 tube with an expiration date of 01/31/2021. LPN #1 stated she would dispose of the laboratory tubes. 06/16/21 at 3:41 p.m., the administrator and (DON) director of nursing were made aware of the expired laboratory tubes. No further information regarding this issue was provided to the survey team prior to the exit conference. 2. For Unit 3 Main, the facility staff failed to discard stored expired lab specimen tubes. On 6/16/21 at 2:55 pm, in the presence of Unit Manager #1, surveyor observed a basket of lab specimen tubes located in an upper cabinet in the locked medication room on Unit 3 Main. Surveyor removed the basket from the cabinet and observed the expiration dates on each lab specimen tube. Surveyor noted the following: four (4) red top specimen tubes with expiration date of 11/30/20, two (2) red top specimen tubes with expiration date of 3/31/20, one (1) green top specimen tube with expiration date of 11/30/20, one (1) yellow top specimen tube with expiration date of 8/31/20, eight (8) blue top specimen tubes with expiration date of 7/31/20, and five (5) blue top specimen tubes with expiration date of 5/31/20. Unit Manager #1 stated these tubes were left over from the COVID-19 unit and they placed them in the cabinet because they did not know what to do with them and the lab would not take them back due to being on the COVID-19 unit. On 6/16/21 at approximately 4:15 pm, surveyor met with the administrator and DON (director of nursing) and notified them of the expired lab	F 761	Systemic Change(s): The facility's policies and procedures were reviewed and no changes are warranted at this time. The DON and/or designee will provide licensed nurses with an in-service regarding monitoring for and disposing of expired items and proper medication storage. Monitoring: The DON is responsible for monitoring compliance. The DON and/or designee, will perform weekly audits for each medication room, medication cart and nurses' station to ensure compliance. These audits will be presented and discussed weekly to the interdisciplinary team. The DON will be responsible for implementing additional education, disciplinary action, and process changes to ensure compliance is maintained. The findings from these audits, along with the corrective action will be presented to the Quality Assurance Committee for review, analysis, and additional recommendations for changes in facility policy, procedure, practice.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 761	Continued From page 24 specimen tubes observed in the medication room on Unit 3 Main. No further information regarding this issue was presented to the survey team prior to the exit conference 6/17/21. 3. The facility staff failed to dispose of stored expired topical gel Ativan from a secure box within a medication refrigerator on the 2 North unit. The surveyor made observations in the 2 North medication storage room on 06/16/21. The 2 North unit's nurse manager, a licensed practical nurse (LPN #1) was present and opened the locked door to the room, the refrigeration and the narcotic box within the refrigerator. There were two clear bags with syringes containing single-dose topical gel Ativan (anti-anxiety) 0.5 mg/0.5cc. There were a total of 12 syringes, all of which were labeled to expire on 06/12/2021. The unit manager acknowledged the syringes had expired and reported that when expired medications were found, the staff member called either the wound care nurse or the infection preventionist to retrieve the medications. Shortly after the expired medication observation, LPN#1 reported the expired Ativan topical gel syringes were removed. The facility's administrator and director of nursing (DON) were notified of the expired Ativan observation on 06/17/21. No further information was provided prior to the exit conference.	F 761		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		7/28/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 812	Continued From page 25 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to maintain refrigerators in a safe and sanitary condition for 1 (one) of 6 (six) units (Unit 2 North). The findings: The facility staff failed to maintain the medication refrigerator and the pantry refrigerator on unit 2 North in a safe and sanitary condition. On 06/15/21 at 1:39 p.m., the medication refrigerator and the pantry refrigerator on unit 2 North was observed. One of the unit's licensed practical nurses (LPN#2) was present for the observations. The unit manager (LPN #1) was present for some of the refrigerator observations.	F 812	F812 Corrective Action(s): As indicated in CMS-2567, refrigerators on Unit 2 in Medication Room and Pantry were cleaned thoroughly, with both refrigerators free from any visible substances, dust or debris. The refrigerators are currently in a safe and sanitary condition. Identification of Deficient Practice(s) & Corrective Action(s): All other refrigerators have the potential to be affected. Facility Dietary Manager and Housekeeping Supervisor have conducted a complete audit of all other refrigerators within the facility. No other issues or areas of concern were identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	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
F 812	Continued From page 26 The medication refrigerator had visible dust and debris throughout the inside. The shelves on the door as well as the bottom shelf and walls of the main refrigerated area had smears and spills of unknown substances. The unit manager (LPN#1) acknowledged the areas inside the refrigerator could be cleaned and reported the outside of the refrigerator was recently wiped down but the discolored areas on the outside could not be removed. The refrigerator in the pantry had numerous unknown substances (brown, red, and orange in color) visible on the inside of the refrigerator. Dust and unknown substances were visible on the shelves on the door, the bottom shelf of the inside of the refrigerated area, and the side and back walls in the inside of the refrigerator. LPN#1 acknowledged there were substances that could be cleaned up within both refrigerators. On 06/16/21 at approximately 12:30 p.m., the refrigerators on unit 2 North were observed again along with LPN#1 (the unit manager - UM). The freezers had been wiped out and the refrigerators had some areas that had been cleaned. However, both refrigerators had visible substances that remained; had not been wiped clean. The medication refrigerator continued to have dust and debris visible on the shelves. The pantry refrigerator still had a brown substance on the side and back wall of the main refrigerated area. LPN#1 acknowledged the refrigerators needed more cleaning. On 06/16/21 at approximately 3:00 p.m., unit 2 North's refrigerators were observed for a third time. Both refrigerators had been cleaned with no visible substances, dust or debris noted.	F 812	Systemic Change(s); The facility policy & procedure for cleanliness of dietary equipment has been reviewed and no changes are warranted at this time. The facility Dietary Manager has in-serviced the dietary staff that refrigerators and freezers should be free from visible substances, dust, or debris. Monitoring: The Dietary Manager is responsible for maintaining compliance. The Dietary Manager has assigned dietary employees to audit for cleanliness daily when restocking the pantries, including the restock of the refrigerator. The Dietary Manager and/or designee will complete a weekly audit, in addition to the daily audits performed by the dietary employees, to monitor for compliance. Any negative findings will be corrected at the time of discovery with disciplinary actions administered as appropriate Finding of these audits will be reported to the Quality Assurance Committee quarterly for review, analysis, and recommendations for changes in facility policy, procedure, and/or practice	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495092	A. BUILDING _____ B. WING _____	C 06/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER	**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
F 812	Continued From page 27 The aforementioned observations were reported to the administrator and director of nursing on 06/17/21. No further information was provided prior to the exit conference.	F 812		