State of Virginia

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | VA0089 | A. BUILDING: _____ B. WING _____ | 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 |

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| F 000 | Initial Comments<br><br>An unannounced biennial licensure survey was conducted on 6/15/2021 through 6/17/2021. The facility was found not to be in substantial compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities.<br><br>The census in this 252 bed facility was 182 at the time of the survey. | F 000 | | |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities.<br><br>12 VAC 5-371-140 (E) (3) Cross reference to F-607.<br>12 VAC 5-371-210 Cross reference to F-609.<br>12 VAC 5-371-220 (B) Cross reference to F-684.<br>12 VAC 5-371-220 (A) Cross reference to F-757.<br>12 VAC 5-371-300 (L) Cross reference to F-761.<br>12 VAC 5-371-340(A) Cross reference to F-812. | F 001 | 12 VAC 5-371-140 (E) (3)<br><br>Corrective Action(s):<br>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.<br><br>Identification of Deficient Practice(s) and Corrective Action(s):<br>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 | 7/28/21 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 07/16/21

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| F 001 | Continued From page 1 | F 001 | reporting at that time.<br><br>Systemic Change(s):<br>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.<br><br>Monitoring:<br>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.<br><br>12 VAC 5-371-210<br><br>Corrective Action(s):<br>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. | |

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| F 001 | Continued From page 2 | F 001 | Identification of Deficient Practice(s) and Corrective Action(s):<br>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.<br><br>Systemic Change(s):<br>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.<br><br>Monitoring:<br>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. | |

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| F 001 | Continued From page 3 | F 001 | 12 VAC 5-371-220 (B)<br><br>Corrective Action(s):<br>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.<br><br>Failures to follow physician orders for Resident #79 include:<br><br>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.<br><br>The facility administered Hydralazine 10mg on 6/8/21 at 0850 for a blood pressure of 134/62.<br><br>Identification of Deficient Practice(s) and Corrective Action(s):<br>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.<br><br>Systemic Change(s): | |

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| F 001 | Continued From page 4 | F 001 | 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.<br><br>Monitoring:<br>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.<br><br>12 VAC 5-371-220 (A)<br><br>Corrective Action(s):<br>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 pressure is less than 100 or Diastolic blood pressure is less than 60.<br><br>Failures to follow physician orders for | |

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| F 001 | Continued From page 5 | F 001 | Resident #77 include:<br><br>The facility administered Metoprolol 25mg tablet:<br><br>On 06/06/21 2100 - BP documented as 122/58<br><br>On 06/09/21 2100 - BP documented as 130/58<br><br>On 6/12/21 2100 - BP documented as 121/57<br><br>On 06/14/21 2100 - BP documented as 119/58<br><br>On 6/15/21 2100 - BP documented as 109/55<br><br>Identification of Deficient Practice(s) and Corrective Action(s):<br>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.<br><br>Systemic Change(s):<br>The facility policy and procedure has been reviewed and revisions have been made. The electronic medication administration record has been updated to prompt | |

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| F 001 | Continued From page 6 | F 001 | 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.<br><br>Monitoring:<br>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.<br><br>12 VAC 5-371-300 (L)<br><br>Corrective Action(s):<br>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.<br><br>Identification of Deficient Practice(s) and Corrective Action(s):<br>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 | |

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| F 001 | Continued From page 7 | F 001 | nurses' stations on the same day of the findings presented in this report. There were no other issues or areas of deficiencies identified.<br><br>Systemic Change(s):<br>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.<br><br>Monitoring:<br>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.<br><br>12 VAC 5-371-340(A)<br><br>Corrective Action(s):<br>As indicated in CMS-2567, refrigerators on Unit 2 in Medication Room and Pantry were cleaned thoroughly, with both refrigerators free from any visible | |

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| F 001 | Continued From page 8 | F 001 | substances, dust or debris. The refrigerators are currently in a safe and sanitary condition.<br><br>Identification of Deficient Practice(s) & Corrective Action(s):<br>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.<br><br>Systemic Change(s);<br>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.<br><br>Monitoring:<br>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, | |

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| F 001 | Continued From page 9 | F 001 | and/or practice | |