	OF DEFICIENCIES OF CORRECTION		/SUPPLIER/CLIA TION NUMBER:	A. BUILDING:	,	(X3) DATE SURVEY COMPLETED	
		VA0089		B. WING		06/17/202 <u>1</u>	
AME OF PF	ROVIDER OR SUPPLIER		STREET	ADDRESS, CITY, ST	ATE, ZIP CODE		
			327 HEF	RSHBERGER RD	NW		
RIENDSF	IIP HEALTH AND REF	IAB CENTER	ROANO	KE, VA 24012			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEF NCY MUST BE PREC DR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
F 000	Initial Comments			F 000			
	An unannounced b conducted on 6/15 The facility was fou compliance with th Regulations for the Facilities. The census in this	/2021 through 6/ Ind not to be in s e Virginia Rules Licensure of Nu	17/2021. substantial and ırsing				
F 001	time of the survey. Non Compliance			F 001		7/28/21	
	The facility was ou following state lice This RULE: is not The facility was no	nsure requireme met as evidence t in compliance v	nts: ed by: vith the		12 VAC 5-371-140 (E) (3)		
	following Virginia F Licensure of Nursin 12 VAC 5-371-140	ng Facilities. (E) (3)	Cross		Corrective Action(s): The investigation, which occurred on 4/1/21, explained the physical altercatio	n	
	reference to F-607 12 VAC 5-371-210 to F-609.		Cross reference		between Resident #173 and Resident #131, but were not reported in the timeframes mandated by regulation. A F	RI	
	12 VAC 5-371-220 to F-684. 12 VAC 5-371-220	. ,	Cross reference Cross reference		is not warranted at this time. A facility Incident & Accident form has been completed for this incident.		
	to F-757. 12 VAC 5-371-300 to F-761.		Cross reference		Identification of Deficient Practice(s) and Corrective Action(s):	1	
	12 VAC 5-371-340 to F-812.	(A)	Cross reference		All other residents may have been affected. The DON and/or designee wil 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		

Electronically Signed

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED
		VA0089	B. WING		06/17/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, ST	ATE, ZIP CODE	
RIENDSI	HIP HEALTH AND REH	AB CENTER	ERSHBERGER RD IOKE, VA 24012	NW	
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F 001	Continued From pa	ge 1	F 001	reporting at that time.	
				 reporting at that time. Systemic Change(s): The Facility Policy and Procedure h been reviewed and changes are no warranted at this time. The Vice Pr of Operations will conduct in-service all staff, including the Administrator DON, on the reporting guidelines for abuse, neglect and misappropriatio including time lines for reporting inc Any future negative findings will res immediate corrective action. Monitoring: The Administrator and DON are responsible for monitoring compliar The 24-hour report will be reviewed to monitor resident-to-resident altercations. Investigations and rep of these events will follow reporting guidelines and facility Policy & Proc Aggregate findings will be reported Quality Assurance Committee mont review, analysis, and recommendat for change in facility policy, procedu and/or practice. 12 VAC 5-371-210 Corrective Action(s): The investigation, which occurred of 4/1/21, explained the physical altered between Resident #173 and Reside #131, but were not reported in the timeframes mandated by regulation is not warranted at this time. A facil Incident & Accident form has been completed for this incident. 	t esident esident es for and r ns idents. uit in nce. daily porting eedure. to the thy for ions ure, an cation ent

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE SURVEY COMPLETED
		VA0089	B. WING		06/17/202 <u>1</u>
AME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	ATE, ZIP CODE	
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F 001	Continued From pa	age 2	F 001	Identification of Deficient Practic Corrective Action(s): All other residents may have bee affected. The DON and/or desig review facility incident reports ar behavior notes from the past 30 ensure that all resident to reside altercations were properly invest and reported per the facility Polic Procedure. Any/all negative findi result in a proper investigation at reporting at that time. Systemic Change(s): The Facility Policy and Procedur been reviewed and changes are warranted at this time. The Vice of Operations will conduct in-ser all staff, including the Administra DON, on the reporting guidelines abuse, neglect and misappropria including time lines for reporting Any future negative findings will immediate corrective action. Monitoring: The Administrator and DON are responsible for monitoring comp The 24-hour report will be review to monitor resident-to-resident altercations. Investigations and of these events will follow report guidelines and facility Policy & P Aggregate findings will be report Quality Assurance Committee m review, analysis, and recommen for change in facility policy, proc	en gnee will nd days to nt tigated cy & ings will nd re has not President vices for tor and s for ations incidents. result in liance. ved daily reporting ing Procedure. ted to the onthly for dations

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		(X3) DATE SURVEY COMPLETED
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F 001	Continued From pa	age 3	F 001		
	·			12 VAC 5-371-220 (B)	
				Corrective Action(s): Resident #79s attending physician w notified that the facility failed to follo ordered parameters to give 1 Hydra tablet every 12 hours for hypertension when Systolic blood pressure is great than 160 or Diastolic blood pressure greater than 90.	w lazine on ater
				Failures to follow physician orders for Resident #79 include:	or
				The facility failed to administer Hydralazine 10mg for a blood press 168/73 on 6/2/21 at 0900 and failed administer Hydralazine 10mg on 6/3 0900 for a blood pressure of 163/70	to 3/21
				The facility administered Hydralazin 10mg on 6/8/21 at 0850 for a blood pressure of 134/62.	e
				Identification of Deficient Practice(s) Corrective Action(s): Resident with blood pressure medic orders with specific parameters may been potentially affected. The facility conducted an audit of resident's phy orders with specific blood pressure medication parameters and MARS of the last 30 days to identify residents for receiving blood pressure medicat when not indicated and omissions of pressure medications when indicate other issues or areas of deficient pra- were identified.	ation / have y /sician over at risk tion f blood ed. No
				Systemic Change(s):	

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		VA0089	B. WING	-FTN/	06/17/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
FRIENDSI	IIP HEALTH AND REF	HAB CENTER	RSHBERGER RE DKE, VA 24012	NW	
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	DN (X5)
PREFIX TAG	(EACH DEFICIE	NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETI
F 001	Continued From pa	age 4	F 001		
		aye +		The facility policy and procedure has reviewed and revisions have been in The electronic medication administra- record has been updated to prompt licensed nursing staff to answer the question yes/no if blood pressure is y ordered parameters prior to administ medication. Licensed nursing staff y in-serviced by the DON and/or desig on medication administration of medications with specific perimeters Monitoring: The DON is responsible for maintain compliance. The DON, ADON, and/or designee will perform daily MAR aud monitor for compliance. Additionally, nurses are being observed and audit during a medication administration p Any/all negative findings and or error be corrected at time of discovery and disciplinary action will be taken as ne Findings of these audits will be repor the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facil policy, procedure, and/or practice. 12 VAC 5-371-220 (A) Corrective Action(s): Resident #77s attending physician w notified that the facility failed to follow ordered parameters to give one 25m Metoprolol tablet every 12 hours for hypertension, hold if Systolic blood pressure is less than 100 or Diastolic blood pressure is less than 60.	ade. ation within ering vere nee ing or lits to all ted ass. rs will d beded. ted to ity yas v g
				•	

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(3) DATE SURVEY COMPLETED
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NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	NTE, ZIP CODE	
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F 001	Continued From pag	ge 5	F 001		
				Resident #77 include:	
				The facility administered Metoprolol 25n tablet:	ng
				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 physicial orders with specific blood pressure medication parameters and MARS over the last 30 days to identify residents at rr for receiving blood pressure medication when not indicated and omissions of blood pressure medications when indicated. If other issues or areas of deficient practico were identified.	n ve an isk vod No
				Systemic Change(s): The facility policy and procedure has be reviewed and revisions have been made The electronic medication administration record has been updated to prompt	e.

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	,	X3) DATE SURVEY COMPLETED
		VA0089	B. WING		06/17/202 <u>1</u>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
FRIENDS	HIP HEALTH AND REH	AB CENTER	RSHBERGER RD DKE, VA 24012) NW	
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F 001	Continued From pa	ge 6	F 001	licensed nursing staff to answer the question yes/no if blood pressure is with ordered parameters prior to administerin medication. Licensed nursing staff were in-serviced by the DON and/or designed 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 monitor for compliance. Additionally, all nurses are being observed and audited during a medication administration pass Any/all negative findings and or errors w be corrected at time of discovery and disciplinary action will be taken as need Findings of these audits will be reported the Quality Assurance Committee quarterly for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. 12 VAC 5-371-300 (L) Corrective Action(s): The facility immediately discarded the expired lab tubes in the Medication Roo 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 medication rooms, medication carts and	ng e e e to to vill ed. to to ms e d d

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IAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, ST	ATE, ZIP CODE	
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F 001	Continued From pa	age 7	F 001	nurses' stations on the same day of findings presented in this report. T were no other issues or areas of deficiencies identified. Systemic Change(s): The facility's policies and procedur reviewed and no changes are warr at this time. The DON and/or desi will provide licensed nurses with ar in-service regarding monitoring for disposing of expired items and pro medication storage. Monitoring: The DON is responsible for monito compliance. The DON and/or desi will perform weekly audits for each medication room, medication cart a nurses' station to ensure compliance These audits will be presented and discussed weekly to the interdiscip team. The DON will be responsible implementing additional education, disciplinary action, and process ch to ensure compliance is maintained findings from these audits, along w corrective action will be presented Quality Assurance Committee for r analysis, and additional recomment for changes in facility policy, proce practice. 12 VAC 5-371-340(A) Corrective Action(s): As indicated in CMS-2567, refriger Unit 2 in Medication Room and Pat were cleaned thoroughly, with both refrigerators free from any visible	There The There The The The The The The The The The Th

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:		3) DATE SURVEY COMPLETED
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TAG F 001	Continued From page 8		F 001	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 t be affected. Facility Dietary Manager an Housekeeping Supervisor have conducte a complete audit of all other refrigerators within the facility. No other issues or area of concern were identified. Systemic Change(s); The facility policy & procedure for cleanliness of dietary equipment has bee 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.	d ed as
				Monitoring: The Dietary Manager is responsible for maintaining compliance. The Dietary Manager has assigned dietary employee 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 audit 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 Qualit Assurance Committee quarterly for review, analysis, and recommendations for changes in facility policy, procedure,	a ts

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPF IDENTIFICATION		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPL	
		VA0089		B. WING		06/*	17/202 <u>1</u>
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F 001	Continued From pag			F 001	and/or practice		