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	10/29/2024

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. 34307 Based on observation, staff interview and family interview the facility staff failed to maintain essential equipment for one of 35 residents, Resident #201. The findings included: For Resident #201 the facility staff failed to ensure the toilet was in proper working order. Resident #201's face sheet listed diagnoses which included but not limited to Alzheimer's disease and chronic kidney disease. Resident #201's most recent minimum data set with an assessment reference date of 08/14/24 coded the resident as having both and long- and short-term memory problems with severely impaired cognitive skills for daily decision making. Surveyor spoke with Resident #201's family member on 10/23/24 at 1:20 pm. Resident's family member stated to surveyor, Have you looked in her bathroom, there is sh** (word omitted) on the wall and everything. Surveyor observed Resident #201's bathroom on 10/23/24 at 4:10 pm. Surveyor observed a brownish substance on the toilet seat, front of toilet stool and wall in front of toilet. Surveyor pointed out brownish substance to unit manager, who stated they would have someone clean the bathroom. The concern of not providing a clean, comfortable and homelike environment was discussed with the administrator, director of nursing, and vice-president of operations on 10/29/24 at 1:30 pm. No further information was provided prior to exit.

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

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. 34307 Based on observation, staff interview, and family interview the facility staff failed to provide an activities program designed to meet the needs of the residents for one of 5 units, memory care unit. The findings included: For the memory care unit, the facility staff failed to provide meaningful and engaging activities. Surveyor spoke with a family member on 10/23/24 at 1:20 pm. Resident's family member stated, They need more activities for these people, they just have them sitting in a room, waiting to die. They all just sit there and sleep. Surveyor made the following observations on the memory care unit: 10/23/24 at 2:05 pm-Residents seated in dining room, eating lunch. Staff stated lunch trays don't arrive on unit until around 1:00 pm. 10/23/24 at 4:10 pm-Residents sitting in dining room, music playing. No staff members observed in area. No activities observed. 10/24/24 at 9:50 am-Residents sitting in dining room, music playing. No activities observed and no staff members in area. 10/24/24 at 11:15 am-18 residents seated in dining room, around table or against the wall. Music playing, no activities. No staff in attendance. No activities observed. 10/24/24 at 2:15 pm-27 residents seated in dining room with 2 staff in attendance. Six residents being assisted with eating lunch, others just sitting. No engaging activities observed. 10/24/24 at 3:50-17 residents seated in dining room, with one staff person in attendance, not engaging with the residents. Residents seated at table and around the wall. 14 residents seated outside on patio, with activity staff in attendance, talking and engaging with residents. 10/25/24 at 8:20 am-15 residents and 2 staff in dining room. Residents eating breakfast. 10/25/24 at 10:10 am-14 residents seated in dining room. No staff in attendance. No activities observed. 10/28/24 at 11:05 am-17 residents in dining room, 16 seated at table/around wall. One wandering through area. PT (physical therapy) staff in area working with one resident, no other staff in area. No activities observed. 10/28/24 at 3:20 pm-19 residents seated in dining room, one wandering in room. 5 residents seated in hallway outside nurse's station, one resident seated at end of hallway, one resident seated in doorway to bedroom. No staff in attendance. No activities observed. Surveyor spoke with activities assistant on 10/28/24 at 3:40 pm. Activities assistant stated they provide activities daily, according to what is on the activities calendar. Surveyor asked activities assistant how many residents participate in activities, and they stated almost all enjoy balloon play and bingo. Surveyor asked activities assistant what activities they provide the residents, and they stated, parachute play, balloon volleyball, bingo, patio time, coloring and 1:1 activity for some residents. Surveyor asked activities assistant how long they are on the unit providing activities, and they stated, 30-40 minutes a day. Activities assistant stated they are currently providing activities for 2 units, and that the memory care unit has an active open position at this time. Surveyor reviewed the monthly activities calendars for the months of August, September and October 2024. For August there were 16 days with activities specifically for the memory care unit, for September there were 14 days with activities for memory care unit, and for October there were 12 days with activities for memory care unit. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Surveyor spoke with the facility administrator on 10/29/24 at 9:15 am. Administrator stated that they have now moved a nurse's aide with prior activities experience onto that unit to help provide activities until a permanent replacement can be hired. Administrator also provided surveyor with a copy of the employment posting advertising for a full-time activity person. Surveyor observed residents on the memory care unit on 10/29/24 at 10:35 am. Surveyor observed 15 residents seated in dining room involved in an arts and crafts activity. Surveyor observed one staff person assisting the residents and engaging residents in conversation. The concern of not providing an activities program was discussed with the administrator, director of nursing, and vice-president of operations on 10/29/24 at 1:25 pm. No further information was provided prior to exit.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. 21227 Based on staff interviews and clinical record review, the facility staff failed to follow medical provider orders for one (1) of 35 sampled residents (Resident #88). The findings include: The facility staff failed to administer Resident #88's Sevelamer as ordered by the medical provider. The medication had been scheduled to be administered during a time the resident was also scheduled to receive dialysis outside of the facility. (Sevelamer is medication given to individuals with chronic kidney disease. Sevelamer is used to manage an individual's phosphorus and/or calcium levels.) Resident #88's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/2/24, was signed as completed on 10/8/24. Resident #88 was assessed as usually being able to make self understood and as being able to understand others. Resident #88's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. Resident #88's medical record included a medical provider order for the resident to receive Sevelamer 800 mg one (1) tablet by mouth with meals. Resident #88's care planned focused areas included end-stage renal disease and hemodialysis. Resident #88's care planned goals included: .will maintain lab values within therapeutic range . Resident #88's care plan included the following intervention: Give medications as ordered. Resident #88's clinical documentation indicated the following doses of sevelamer had not been administered as ordered by the medical provider: - On 10/18/24, the morning dose of Sevelamer was documented as not being given due to the resident being at dialysis. - On 10/21/24, the morning dose of Sevelamer was documented as not being given due to the resident being at dialysis. - On 10/23/24, the morning dose of Sevelamer was documented as not being given due to the resident being at dialysis. - On 10/25/24, the morning dose of Sevelamer was documented as not being given due to the resident being at dialysis. - On 10/28/24, the morning dose of Sevelamer was documented as not being given due to the resident being at dialysis. (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/29/24 at 11:12 a.m., the surveyor discussed the facility's staff failure to administer Resident #88's aforementioned doses of Sevelamer with the facility's Director of Nursing (DON). The DON reported the morning dose of Sevelamer had been scheduled to be administered at 7:30 a.m., the DON stated the time for which Resident #88's Sevelamer is scheduled to be administered has been adjusted to allow for the resident to receive the medication prior to going to dialysis.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. 21227 Based on observations, staff interviews, clinical record review, and facility document review, the facility staff failed to ensure complete and/or accurate clinical records for three (3) of 35 sampled residents (Resident #5, Resident #29, and Resident #88). The findings include: 1. The facility staff failed to document complete and/or accurate information related to Resident #88's wound care. Resident #88's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/2/24, was signed as completed on 10/8/24. Resident #88 was assessed as usually able to make self understood and as able to understand others. Resident #88's Brief Interview for Mental Status (BIMS) summary score was documented as a 15 out of 15; this indicated intact and/or borderline cognition. The following information was found in a facility policy titled Documentation Policy (with a date of March 2016): - Licensed Nurses and CNAs will document all pertinent nursing assessments, care interventions and follow up [sic] actions in the medical record. - Entries will be made as soon as possible after an event or observation is made. - Document all the facts and pertinent information related to an event . Resident #88's clinical record included provider orders for left lower extremity (LLE) wound care to be provided daily with a medication named Santyl applied to the wounds. Resident #88's treatment administration record (TAR) indicated the resident did not receive this LLE wound care on the following dates: 9/28/24, 9/29/24, and 9/30/24. Resident #88 was documented as refusing wound care on 9/28/24. On 9/29/24 and 9/30/24, nursing staff documented they were waiting on the medication Santyl to provide the wound care. On 10/24/24, the surveyor discussed, with the Administrator and the Director of Nursing (DON) the aforementioned three (3) days where documentation failed to provide evidence Resident #88's wound care had been provided. On 10/25/24 at 10:05 a.m., the DON provided late entry notes to indicate the wound care in question had been completed. A late entry note, dated 10/24/24 at 5:15 p.m., documented the wound care for 9/28/24 and 9/29/24 had been provided. A late entry note, dated 10/25/24 at 10:02 a.m., documented the wound care for 9/30/24 had been provided. 2. The facility staff failed to document what specific information was provided to the medical provider during a notification related to Resident #29. (continued on next page)

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #29's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 10/16/24, was signed as completed on 10/23/24. Resident #29 was assessed as able to make self understood and as able to understand others. Resident #29's Brief Interview for Mental Status (BIMS) summary score was documented as a 12 out of 15; this indicated moderate cognitive impairment. Resident #29's clinical record included the following note dated 10/22/24 at 1:06 p.m.: This nurse notified MD (provider name omitted) and he gave no new orders at this time. This note did not detail what information had been shared with Resident #29's medical provider. The surveyor asked the administrative staff about what information was shared with the medical provider. The following clarification note was created on 10/23/24 at 10:39: Hemoglobin A 1 C was called in by this nurse. 3. Resident #5's clinical record included documentation that incorrectly indicated Resident #5 was on contact isolation precaution when the resident was on enhanced barrier precautions. Resident #5's Minimum Data Set (MDS) assessment, with an Assessment Reference Date (ARD) of 8/23/24, was signed as completed on 8/30/24. Resident #5 was assessed as able to make self understood and as able to understand others. Resident #5's Brief Interview for Mental Status (BIMS) summary score was documented as a nine (9) out of 15; this indicated moderate cognitive impairment. The following information was found in a facility policy titled Isolation Precautions: Implementation of Standard Precautions / Transmission-Based Precautions (dated 10/11/23): - Signage should be placed on the resident door or inside the clear pouch on the hanging caddy indicating the type of precautions. - Isolation caddy should be placed either as hanging caddy on the resident door or as stand-alone caddy outside the resident room. - All supplies should be gathered prior to entering room for care. Resident #5's clinical record included documentation, occurring every shift, that indicated Resident #5 was on contact isolation precautions from 10/19/24 through the day shift of 10/29/24. Observations on 10/23/24 and 10/29/24 failed to indicate Resident #5 was on contact isolation precautions; Resident #5 was noted to have a sign on their door indicating enhanced barrier precautions. On 10/29/24 at approximately 9:55 a.m., Registered Nurse (RN) #5 confirmed they were providing care for Resident #5. RN #5 denied being aware of Resident #5 being on contact isolation precautions. RN #5 directed the surveyor to the enhanced barrier precautions sign that had been posted on the frame of the door leading to Resident #5's room. On 10/29/24, interviews with the facility's Infection Preventionist and Resident #5's medical provider indicated contact isolation precautions were not needed for Resident #5 and that enhanced barrier precautions met the needs of Resident #5.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. 28567 Based on staff interview, clinical record review, and facility document review the facility staff failed to collaborate care with the contract Hospice company for 1 of 2 residents, Resident #331. The findings included: The facility staff failed to coordinate care with the contract Hospice company. The clinical record did not include Hospice visit notes. Resident #331's clinical record included the following diagnosis, malignant neoplasm of upper lobe, left bronchus or lung. There was no completed minimum data set (MDS) assessment for this resident. Resident #331's clinical record included provider orders to admit to Hospice 10/18/24. During the entrance conference the survey team requested information regarding the Hospice contracts. The facility staff provided the survey team with a copy of a Hospice contract that provided Resident 331's Hospice services. This document read in part, .Compliance of Records .Nursing facility and Hospice shall each prepare and maintain complete and detailed clinical records concerning each Residential Hospice Patient receiving Nursing Facility Services and Hospice Services .Each clinical record shall completely, promptly and accurately document all services provided to, and events concerning, each Residential Hospice Patient (including evaluations, treatments, progress notes . During a review of the electronic clinical record the surveyor was unable to locate any documentation from the Hospice provider. The facility nursing staff had documented that Hospice had been in to see this Resident on 10/19/24, 10/20/24, and 10/23/24. On 10/25/24 at 10:15 a.m., the surveyor and Licensed Practical Nurse (LPN) #3 reviewed Resident #331's hard chart and was unable to find documentation regarding Hospice visits. LPN #3 stated Hospice patients usually have 2 separate books, and the Hospice nurse should make a note when they visit. On 10/28/24 at 1:08 p.m., the surveyor and LPN #3 again checked Resident #331's hard chart for Hospice documentation. The hard chart did not include progress notes. On 10/28/24 at 4:30 p.m., during an end of the day meeting with the [NAME] President of Operations, Administrator, and Director of Nursing the issue with the missing Hospice documentation was reviewed. On 10/29/24 at approximately 9:30 a.m., the Administrator provided the surveyor with a copy of the Hospice notes that included a fax time/date/time stamp of 10/29/24 at 7:52 a.m. and included copies of Hospice visits from 10/19/24-10/25/24 (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	No further information regarding this issue was provided to the survey team prior to the exit conference.