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 09/20/2019

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 000	INITIAL COMMENTS An unannounced abbreviated Medicare/Medicaid survey was conducted 9/19/19 through 9/20/19. A complaint was investigated during the survey. Corrections are required for compliance with the following Federal Long Term Care requirements. The census in this 252 certified bed facility was 233 at the time of the survey. The survey sample consisted of 6 current Resident reviews (Residents 1 through 6).	F 000		
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 resident interview, staff interview, clinical record review, and in the course of a complaint investigation, facility staff failed to ensure the resident received treatment and care by giving a a medication as ordered for 1 of 6 residents in the survey sample (Resident #1). Resident #1 was admitted to the facility on 11/15/18. Diagnoses included type 1 diabetes mellitus with 1-diabetic autonomic polyneuropathy 2-chronic kidney disease 3- ketoacidosis 4-peripheral angiopathydysphagia, nausea with vomiting, difficulty walking, acquired absence of	F 684	F684 Corrective Action(s): As indicated on CMS-2567, Resident #1□s attending physician was notified that the nurse misread her insulin order and, thus, administered the wrong dose. A facility Medication Error form was completed for this incident. Identification of Deficient Practices/Corrective Action(s): All other residents with insulin orders may have been potentially affected. As	11/1/19

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

Electronically Signed | 10/16/2019

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F 684	Continued From page 1 right lower leg, and end stage renal disease with dependence on hemodialysis. On the 14-Day Minimum Data Set assessment with assessment reference date 9/4/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. During an interview on 9/20/19, the resident reported being unaware that a complaint had been made. Resident #1 expressed displeasure that the complaint was filed. Resident #1 reported that on 8/28/19, the nurse who gave her insulin stated that she would need 2 injections because the pen would not let the nurse give the whole dose. After giving the second injection, the nurse said that the second injection contained the last 20 units. The resident stated she learned then that the total dose was 20 units. The resident and nurse agreed that the resident should go as scheduled to hemodialyis as scheduled (with the hemodialysis center on campus and physicially connected to the facility) because they routinely monitor blood sugar during hemodialysis and were equipped to give dextrose as needed. The resident stated that dialysis center staff sent her to the emergency department for assessment after hemodialysis because blood glucose readings were still low. The resident reported not feeling ill or losing consciousness. Clinical record review revealed a nursing note dated 8/28/19 at 7:52 AM documenting that the nurse had misread the order and administered 100 units rather than the 6 units ordered, that the dialysis center had called about the error, and the physician had been called and the information from the dialysis center relayed to the physician's	F 684	indicated on CMS-2567, the facility conducted an audit of all those resident□s physician orders and MAR□s over the past 30 days to identify residents at risk for receiving the wrong insulin dosage. As indicated on CMS-2567, no other anomalies associated with insulin administration were discovered. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. Per CMS-2567, no systemic failure contributed to this isolated error. As referenced in CMS-2567, licensed nursing staff were in-serviced by the DON and/or designee on insulin administration. Monitoring: The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers 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. Aggregate 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.	

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F 684	Continued From page 2	F 684		

office. The nurse notified the unit manager of the situation. A second note dated 8/28/19 at 10:44 AM documented that the dialysis center had notified nursing staff that the resident had been sent to the hospital emergency department. The note also documented that Resident #1 was her own responsible party and agreed to the transfer.

The resident's medication orders included an order dated 8/21/19 for "Admelog SoloStar Solution Pen-injector 100 UNIT/ML (milliliter) (insulin Lispro) inject 6 unit subcutaneously with meals for DM (diabetes mellitus)".

The facility policy titled Administering Medications included under PROCEDURE 6. The individual administering the medication must check the label to verify the right medication, the right dosage, right time and right method (route) of administration before giving the medication.

Surveyors interviewed 4 medication nurses on 9/20/19.

During an interview on 9/20/19 at 9:34 AM, RN #1 reported the routine for insulin administration would be to read the order, check the medication administration record (MAR), and look for the ordered dose. When asked if anything would cause the nurse to question the dose, the nurse replied that if a dose seemed to be huge, she would call the doctor. RN #1 stated she was an agency nurse who usually worked in hospitals. RN #1 stated she did dual signoffs for insulin and found another nurse to check insulin doses. RN #1 reported having received insulin administration training at the facility.

During an interview on 9/20/19 at 9:50 AM, RN #2

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F 684	Continued From page 3	F 684		

reported the routine for insulin administration would be to check order on the screen, find the insulin, dial 2 and push to assure needle patency, check the order, wipe the pen with alcohol, dial the insulin dose, then administer the insulin to the resident. When asked if anything would cause the nurse to question the dose, the nurse replied that if the blood sugar was too low, she would contact the doctor. When asked about using a second syringe, the nurse replied that the dose would be split between the old and new when the current pen did not have the full dose left. RN #2 reported receiving annual training on medication administration as well as insulin adminstration training the prior day.

During an interview on 9/20/19 at 9:40 am with LPN #1, the nurse stated that prior to administering insulin she verifies the insulin order and if it is an unusual dose, she would double check the order or call the doctor. LPN #1 stated an inservice was given on insulin administration in "the last couple months" and again yesterday.

During an interview on 9/20/19 at 9:50 am with LPN #2, the nurse stated that prior to administering insulin she reviews the MAR for the correct medication, time, dose and route three times. LPN #2 stated she has been inserviced on insulin administration.

During an interview on 9/19/19, the director of nursing and administrator reported that, as a result of the error, the nurse who made the error no longer worked at the facility. The nurse had reported and documented the error. The nurse reported to management in an interview after the incident that she had simply misread the order, mistaking the medication description for the

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F 684	Continued From page 4 prescribed dose. Surveyors interviewed and reviewed the records of 5 additional residents in the facility. None of the residents reported insulin administration errors. None of the records documented anomalies associated with insulin administration. Surveyors discussed the findings with the administrator and director of nursing during a summary meeting on 9/20/19. Surveyors concluded that the nurse followed facility policy but simply misread the order. No systemic failure contributed to the error. Staff followed procedures to address the error after it occurred. This is a complaint deficiency.	F 684		
F 760 SS=D	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on resident interview, staff interview, clinical record review, and in the course of a complaint investigation, facility staff failed to ensure the resident was free of significant medication errors for 1 of 6 residents in the survey sample (Resident #1). Resident #1 was admitted to the facility on 11/15/18. Diagnoses included type 1 diabetes mellitus with 1-diabetic autonomic polyneuropathy 2-chronic kidney disease 3- ketoacidosis 4-	F 760	F760 Corrective Action(s): As indicated on form CMS-2567, Resident #1's attending physician was notified that the nurse misread her insulin order and, thus, administered the wrong dose. A facility Medication Error form was completed for this incident. The nurse responsible for the administration error was terminated from employment.	11/1/19

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F 760	Continued From page 5 peripheral angiopathydysphagia, nausea with vomiting, difficulty walking, acquired absence of right lower leg, and end stage renal disease with dependence on hemodialysis. On the 14-Day Minimum Data Set assessment with assessment reference date 9/4/19, the resident scored 15/15 on the brief interview for mental status and was assessed as without signs of delirium, psychosis, or behaviors affecting care. During an interview on 9/20/19 Resident #1 reported that on 8/28/19,the nurse who gave her insulin stated that she would need 2 injections because the pen would not let the nurse give the whole dose. After giving the second injection, the nurse said that the second injection contained the last 20 units. The resident stated she learned then that the total dose was 20 units. The resident and nurse agreed that the resident should go as scheduled to hemodialyis as scheduled (with the hemodialysis center on campus and physicially connected to the facility) because they routinely monitor blood sugar during hemodialysis and were equipped to give dextrose as needed. The resident stated that dialysis center staff sent her to the emergency department for assessment after hemodialysis because blood glucose readings were still low. The resident reported not feeling ill or losing consciousness. Clinical record review revealed a nursing note dated 8/28/19 at 7:52 AM documenting that the nurse had misread the order and administered 100 units rather than the 6 units ordered, that the dialysis center had called about the error, and the physician had been called and the information from the dialysis center relayed to the physician's office. The nurse notified the unit manager of the	F 760	Identification of Deficient Practices/Corrective Action(s): All other residents with insulin orders may have been potentially affected. As indicated on form CMS-2567, the facility conducted an audit of all those resident's physician orders and MAR's over the past 30 days to identify residents at risk for receiving the wrong insulin dosage. As indicated on form CMS-2567, no other anomalies associated with insulin administration were discovered. Systemic Change(s): The facility policy and procedure has been reviewed and no changes are warranted at this time. Per form CMS-2567, no systemic failure contributed to this isolated error. As referenced on form CMS-2567, licensed nursing staff were in-serviced by the DON and/or designee on insulin administration. Monitoring: The DON will be responsible for maintaining compliance. The DON, ADON and/or Unit Managers 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. Aggregate 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.	

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F 760	Continued From page 6	F 760		

situation. A second note dated 8/28/19 at 10:44 AM documented that the dialysis center had notified nursing staff that the resident had been sent to the hospital emergency department. The note also documented that Resident #1 was her own responsible party and agreed to the transfer.

The resident's medication orders included an order dated 8/21/19 for "Admelog SoloStar Solution Pen-injector 100 UNIT/ML (milliliter) (insulin Lispro) inject 6 unit subcutaneously with meals for DM (diabetes mellitus)".

The facility policy titled Administering Medications included under PROCEDURE 6. The individual administering the medication must check the label to verify the right medication, the right dosage, right time and right method (route) of administration before giving the medication.

This is a complaint deficiency.