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F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, clinical record review, and facility policy review the facility staff failed to follow professional standards of practice for the administration of medications for 1 of 2 residents, Resident #1. The finding included: For Resident #1 the facility staff failed compare the medication label to the physician's order, resulting in the resident receiving multiple incorrect doses of the medication morphine sulfate. Resident #1's face sheet listed diagnoses which included but not limited to multiple sclerosis, epilepsy, long term use of opiate analgesic, and personal history of traumatic brain injury. Resident #1's most recent minimum data set with an assessment reference date of 11/18/24 assigned the resident a brief interview for mental status score of 3 out of 15. This indicates that the resident is severely cognitively impaired. Resident #1's comprehensive care plan was reviewed and contained a plan for "... has dx (diagnosis) of MS (multiple sclerosis) with chronic pain..." Interventions for this care plan included "Administer medications as per orders. See MAR	F 658	Past noncompliance: no plan of correction required.	

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

Electronically Signed

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(medication administration record) for details."

Resident #1's clinical record was reviewed and contained a physician's order summary which read in part, "Morphine Sulfate Oral Solution 10 mg/5 ml (Morphine Sulfate). Give 2.5 ml via G-Tube every hour as needed for Pain/SOB (shortness of breath)-start date 01/27/25", "Morphine Sulfate Oral Solution 10 mg/ 5 ml (Morphine Sulfate). Give 2.5 ml via G-Tube every 4 hours for pain/SOB-start date 01/27/25", "Morphine Sulfate Oral Solution 10 mg/5ml (Morphine Sulfate). Place and dissolve 2.5 ml buccally every 4 hours for pain/SOB-start date 01/28/25", "Morphine Sulfate Oral Solution 10 mg/5ml. Place and dissolve 2.5 ml buccally every 2 hours for pain/SOB-start date 01/29/25", and "Morphine Sulfate Oral Solution 10 mg/5 ml. Place and dissolve 2 ml buccally every 6 hours for pain/SOB-start date 01/29/25"

Resident #1's electronic medication administration record for the month of January 2025 was reviewed and contained entries as above. The entry for Morphine via G-Tube every 4 hours had been initialed as being administered ordered at 10 pm on 01/27/25, 2 am, 6 am and 10 am on 01/28/25. The entry for Morphine buccally every 4 hours had been initialed as being administered at 2 pm and 6 pm on 01/28/25. The entry for Morphine every 6 hours buccally was initialed as being administered at 12 am and 6 am on 01/29/25. The entry for Morphine every hour as needed via G-Tube was initialed as being administered on 01/29/25 at 8:07 am. The entry for Morphine every 2 hours buccally was initialed as being administered on 01/29/25 at 12 pm.

Resident #1's "Individual Resident's Controlled

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Substance Record" for morphine was reviewed and contained a pharmacy label which read in part, "Morphine 100 mg/5ml Conc-3 30 ml. Give 2.5 ml VGT (via G-Tube) every hour as needed for pain/SOB"

Surveyor spoke with the facility administrator on 06/16/25 regarding Resident #1's morphine order and subsequent medication errors. Administrator stated that pharmacy sent a different concentration of the morphine, labeled the dosage incorrectly, and the nurses that administered the morphine failed to compare the label to the physician's order.

Surveyor requested and was provided with a facility policy entitled "Administering Medications" which read in part, "Medications shall be administered in a safe and timely manner, and as prescribed...7. The individual administering the medication must check the label to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication."

Administrator provided surveyor with a copy of the facility's investigation which read in part, "... (Resident #1) readmitted to ... (facility omitted) on 01/27/2025 ...Resident was readmitted...for hospice, end of life care with a prognosis of days to weeks. Discharge orders from ... (name omitted) included: Morphine 10 mg/5 ml, give 2.5 ml every 1 hour as needed. Orders were entered correctly into ... (electronic record) and prescriptions sent to ... (omitted) pharmacy. On January 27, 2025, at 2043 ... received the Morphine Sulfate from pharmacy. The bottle and narcotic control sheet were both labeled "Morphine 100 mg/5 ml concentrate give 2.5 ml

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every 1 hours as needed for pain/sob. Pharmacy failed to notify ... (facility omitted) of a concentration change from original order sent to pharmacy. Additionally, with change in concentration, pharmacy made an error instructing to give 2.5 ml (50 mg) every hour as needed for pain/sob."

The facility administrator provided the surveyor with a copy of the facility's Plan of Correction which read as follows:
On January 31, 2025, RCA (root cause analysis) completed for ... (facility omitted) nursing department. Findings from the RCA identified 2 root causes for the error. First, the MAR (medication administration record) dosing did not match the concentration or instructions on the narcotic control sheet nor on the actual medication bottle that was provided by pharmacy. Second, nurses failed to administer the medication based on the facility policy and procedure. Based on the findings, the facility's plan of correction is as follows:

1. Upon discovery of the error on January 29, 2025, an immediate audit was completed on all remaining residents receiving liquid narcotics to ensure no system wide failure occurred. There were no findings from this audit.
2. Review of our current policy and procedure for medication administration was completed. No changes indicated during this review.
3. Created a 2-step verification on all liquid controlled narcotics received from pharmacy to ensure that concentration and instructions match concentration and instructions on the MAR.
4. ... (name omitted), Administrator and ... (name omitted), DON (director of nursing) met with all 4 nurses and provided education in regards to

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medication error. All 4 nurses were placed on disciplinary action to include a Performance Improvement Plan and all 4 nurses were reported to the Board of Nursing.
5. All nursing staff at ... (facility omitted) were assigned education in ... (name omitted) with a mandatory completion date of February 28, 2025. Additional training to be provided on drug calculations by February 28, 2025.
6. A review with attestation to be completed with all nursing staff on medication administration policy and procedure.
7. Medication administration observation to be completed on all nursing staff by February 28, 2025.
8. To assist with compliance, ... (name omitted), DON will present findings of the above to our quarterly QAPI (quality assurance and performance improvement) meeting and a determination will be made on future audits/actions.

All credible evidence was reviewed and verified on 06/16/25. Nursing staff were interviewed on policy and procedure for medication administration. A review of new hire nurses was completed to ensure that all new hires have received training in medication administration and dosage calculations. Medication storage rooms and medication carts were observed for correct labeling of medications with no discrepancies found.

The concern of nursing staff failing to follow professional standards of practice for the administration of medications was discussed with the administrator, DON, assistant director of nursing and vice-president of operations on 06/16/25 at 4:00 pm.

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F 658	Continued From page 5 No further information was provided prior to exit. This is a past non-compliance deficiency.	F 658		
F 761 SS=J	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. §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 staff interview, clinical record review and facility document review the facility staff failed to accurately label medications for 1 of 2 residents, Resident #1.	F 761	Past noncompliance: no plan of correction required.	

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The findings included:

For Resident #1 the facility staff failed to ensure the medication Morphine Sulfate was labeled with the correct dosage, resulting in the resident receiving multiple incorrect doses.

Resident #1's face sheet listed diagnoses which included but not limited to multiple sclerosis, epilepsy, long term use of opiate analgesic, and personal history of traumatic brain injury.

Resident #1's most recent minimum data set with an assessment reference date of 11/18/24 assigned the resident a brief interview for mental status score of 3 out of 15. This indicates that the resident is severely cognitively impaired.

Resident #1's comprehensive care plan was reviewed and contained a plan for "... has dx (diagnosis) of MS (multiple sclerosis) with chronic pain..." Interventions for this care plan included "Administer medications as per orders. See MAR (medication administration record) for details."

Resident #1's clinical record was reviewed and contained a physician's order summary which read in part, "Morphine Sulfate Oral Solution 10 mg/5 ml (Morphine Sulfate). Give 2.5 ml via G-Tube every hour as needed for Pain/SOB (shortness of breath)-start date 01/27/25", "Morphine Sulfate Oral Solution 10 mg/ 5 ml (Morphine Sulfate). Give 2.5 ml via G-Tube every 4 hours for pain/SOB-start date 01/27/25", "Morphine Sulfate Oral Solution 10 mg/5ml (Morphine Sulfate). Place and dissolve 2.5 ml buccally every 4 hours for pain/SOB-start date 01/28/25", "Morphine Sulfate Oral Solution 10

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mg/5ml. Place and dissolve 2.5 ml buccally every 2 hours for pain/SOB-start date 01/29/25", and "Morphine Sulfate Oral Solution 10 mg/5 ml. Place and dissolve 2 ml buccally every 6 hours for pain/SOB-start date 01/29/25"

Resident #1's electronic medication administration record for the month of January 2025 was reviewed and contained entries as above. The entry for Morphine via G-Tube every 4 hours had been initialed as being administered ordered at 10 pm on 01/27/25, 2 am, 6 am and 10 am on 01/28/25. The entry for Morphine buccally every 4 hours had been initialed as being administered at 2 pm and 6 pm on 01/28/25. The entry for Morphine every 6 hours buccally was initialed as being administered at 12 am and 6 am on 01/29/25. The entry for Morphine every hour as needed via G-Tube was initialed as being administered on 01/29/25 at 8:07 am. The entry for Morphine every 2 hours buccally was initialed as being administered on 01/29/25 at 12 pm.

Resident #1's "Individual Resident's Controlled Substance Record" for morphine was reviewed and contained a pharmacy label which read in part, "Morphine 100 mg/5ml Conc-3 30 ml. Give 2.5 ml VGT (via G-Tube) every hour as needed for pain/SOB."

Surveyor spoke with the facility administrator on 06/16/25 regarding Resident #1's morphine order and subsequent medication errors. Administrator stated that pharmacy sent a different concentration of the morphine, labeled the dosage incorrectly, and the nurses that administered the morphine failed to compare the label to the physician's order.

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Surveyor requested and was provided with a facility policy entitled "Administering Medications" which read in part, "Medications shall be administered in a safe and timely manner, and as prescribed...7. The individual administering the medication must check the label to verify the right medication, right dosage, right time, and right method (route) of administration before giving the medication."

Administrator provided surveyor with a copy of the facility's investigation which read in part, "... (Resident #1) readmitted to ... (facility omitted) on 01/27/2025 ...Resident was readmitted...for hospice, end of life care with a prognosis of days to weeks. Discharge orders from ... (name omitted) included: Morphine 10 mg/5 ml, give 2.5 ml every 1 hour as needed. Orders were entered correctly into ... (electronic record) and prescriptions sent to ... (omitted) pharmacy. On January 27, 2025, at 2043 ... received the Morphine Sulfate from pharmacy. The bottle and narcotic control sheet were both labeled "Morphine 100 mg/5 ml concentrate give 2.5 ml every 1 hours as needed for pain/sob. Pharmacy failed to notify ... (facility omitted) of a concentration change from original order sent to pharmacy. Additionally, with change in concentration, pharmacy made an error instructing to give 2.5 ml (50 mg) every hour as needed for pain/sob."

The facility administrator provided the surveyor with a copy of the facility's Plan of Correction which read as follows:
"On January 31, 2025, RCA (root cause analysis) completed for ... (facility omitted) nursing department. Findings from the RCA identified 2 root causes for the error. First, the MAR

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(medication administration record) dosing did not match the concentration or instructions on the narcotic control sheet nor on the actual medication bottle that was provided by pharmacy. Second, nurses failed to administer the medication based on the facility policy and procedure. Based on the findings, the facility's plan of correction is as follows:

1. Upon discovery of the error on January 29, 2025, an immediate audit was completed on all remaining residents receiving liquid narcotics to ensure no system wide failure occurred. There were no findings from this audit.
2. Review of our current policy and procedure for medication administration was completed. No changes indicated during this review.
3. Created a 2-step verification on all liquid controlled narcotics received from pharmacy to ensure that concentration and instructions match concentration and instructions on the MAR.
4. ... (name omitted), Administrator and ... (name omitted), DON (director of nursing) met with all 4 nurses and provided education in regards to medication error. All 4 nurses were placed on disciplinary action to include a Performance Improvement Plan and all 4 nurses were reported to the Board of Nursing.
5. All nursing staff at ... (facility omitted) were assigned education in ... (name omitted) with a mandatory completion date of February 28, 2025. Additional training to be provided on drug calculations by February 28, 2025.
6. A review with attestation to be completed with all nursing staff on medication administration policy and procedure.
7. Medication administration observation to be completed on all nursing staff by February 28, 2025.

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8. To assist with compliance, ... (name omitted), DON will present findings of the above to our quarterly QAPI (quality assurance and performance improvement) meeting and a determination will be made on future audits/actions."

All credible evidence was reviewed and verified on 06/16/25. Nursing staff were interviewed on policy and procedure for medication administration. A review of new hire nurses was completed to ensure that all new hires have received training in medication administration and dosage calculations. Medication storage rooms and medication carts were observed for correct labeling of medications with no discrepancies found.

The administrator also provided the surveyor with an RCA and Plan of Correction from the pharmacy which read as follows:
"On January 31, 2025 a Root Cause Analysis (RCA) was completed with ... (pharmacy name omitted). Members of the RCA included ... (name omitted) VP (vice-president) of Operations, ... (name omitted), Administrator, ... (name omitted), DON (director of nursing), ... (name omitted) Pharmacist, and ... (name omitted), Director of Pharmacy. ... (pharmacy name omitted) to submit to ... (facility omitted) an action plan to include notifying nursing staff of any variations to the original orders that involve concentration changes and supplying a warning label on all medications to check concentration of any liquid narcotics.

Medication Administration Error Correction Process Report
Purpose:
To ensure residents remain free from medication

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errors.
Incident Overview:
Resident ... (name omitted) at ... (facility name omitted) was prescribed Morphine 10 mg/5 ml with the following instructions:
2.5ml every 4 hours via PEG (percutaneous endoscopic gastrostomy tube) for 14 days
2.5ml every hour as needed for pain via PEG tube
The prescription was issued by the hospitalist upon the resident's discharge from the hospital to the nursing home. However, due to a pharmacy dispensing error, the pharmacist provided a 30ml bottle of Morphine 100mg/5ml instead of the prescribed 10mg/5ml. This resulted in a different concentration that what was prescribed and recorded on the Medication Administration Record (MAR).
At ... (facility omitted), 2.5ml (50mg) of the incorrect concentration was administered to ... (Resident #1) by the nursing staff. Upon discovering the error, ... (pharmacy name omitted) was immediately notified. The pharmacy staff corrected the issue and promptly re-educated the pharmacy staff. A Quality Assurance (QA) report was completed as required, and the physician was informed. The correct medication was then delivered to the facility.
Corrective Actions Taken:
1. Staff Education and Re-Education
The pharmacist and certified pharmacy technician responsible for the error were re-educated on proper dispensing procedures.
Both employees received verbal notices regarding the importance of following correct processes.
The Pharmacist-in-Charge met with the employees to reinforce adherence to dispensing

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protocols.
2. Process Improvements to Prevent Future Errors:
Highlighting Concentrations in the Docu-Trak System:
The morphine concentration to be dispensed will now be highlighted in the system to ensure visibility and accuracy.
Enhanced Prescription Entry in QS1 Pharmacy System
When entering liquid morphine prescriptions, the quantity to be administered will now include the dose in milligrams (mg) in parentheses. Example: 0.25 ml (5 mg) instead of pulling directions directly from ... (electronic record system).
Improved Storage and Labeling of Morphine Concentrations:
Different morphine concentrations will be stored in separate areas of the narcotic cabinet to prevent mix-ups.
Warning stickers will be placed on bottles to emphasize concentration differences.
The 10mg/5ml bottles come in 100ml calibrated bottles, whereas the 100mg/5ml bottles come in 30ml calibrated bottles. Staff will be required to verify concentration during final checks before dispensing.
These measures aim to enhance patient safety and eliminate the risk of similar medication errors in the future."

The concern of not ensuring the medication Morphine sulfate was labeled with the correct dosage information was discussed with the administrator, director of nursing, assistant director of nursing, and vice-president of operations on 06/16/25 at 4:00 pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495421	A. BUILDING _____ B. WING _____	C 06/18/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTH AND REHAB CENTER - SOUTH	**5647 STARKEY ROAD ROANOKE, VA 24018**

(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 13 No further information was provided prior to exit. This is a past non-compliance deficiency.	F 761		