STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495262	A. BUILDING ______ B. WING ______	03/29/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH NURSING HOME	**339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939**

(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
E 000	Initial Comments An unannounced Medicare/Medicaid standard survey was conducted 3/27/18 through 3/29/18. The facility's Emergency Preparedness Plan was reviewed and found to be in compliance with CFR 483.73, the Federal requirements for Emergency Preparedness in Long Term Care facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 3/27/18 through 3/29/18. No complaints were investigated. Corrections are required for compliance with 42 CFR Part 483, the Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 60 certified bed facility was 55 at the time of the survey. The survey sample consisted of 15 current Resident reviews and two closed record reviews.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		4/18/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 04/13/2018

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 550	Continued From page 1 §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review the facility failed to ensure dignity for three of 17 residents in the survey sample. The facility had care instructions posted on the closet doors and wall of Resident #13, Resident #7 and Resident #8. The instructions were visible to anyone entering the room. 1. Care instructions regarding eating/drinking and mouth care were posted on the closet door in Resident #13's room. The instructions referenced "Bed B" and were visible to anyone entering the room.	F 550	1.) At the time of the survey the signs were removed from the room of Resident #13, #7 and #8 to ensure resident's dignity is maintained. 2.) A 100% audit of all resident rooms was conducted and any signs with specific care instructions were removed. 3.) All staff will be in-serviced by the DON and the ADON that signs with resident specific care instructions should not be hung in any resident room so that is visible to all that enters to maintain resident's dignity. Any sign observed to be	

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F 550	Continued From page 2 2. Care instructions regarding swallowing was posted on the closet door in Resident #7's room. The instructions were visible to anyone entering the room. 3. Instructions regarding personal hair care were posted on the wall in Resident #8's room. The instructions included the resident's name and were visible to anyone entering the room. The findings include: 1. Care instructions regarding eating/drinking and mouth care were posted on the closet door in Resident #13's room. The instructions referenced "Bed B" and were visible to anyone entering the room. Resident #13 was admitted to the facility on 9/14/15 with a re-admission on 6/15/17. Diagnoses for Resident #13 included dementia, anemia, muscle weakness, anxiety disorder, GERD (gastro-esophageal reflux disease), bipolar disorder, and COPD (chronic obstructive pulmonary disease). The minimum data set (MDS) dated 3/25/18 assessed Resident #13 with impaired cognitive skills. On 3/27/18 at 9:36 a.m., Resident #13 was observed in her room. Posted on the closet door was a note, which was titled "Bed B" and included eating/swallowing and mouth care instructions. The note stated the following: 1. Have pt. take 1-2 sips between food bites. 2. After every meal and/or snack, clean patient's mouth with toothette!!!	F 550	hung will be removed and taken to the Administrator or Director of Nursing for further direction and education to whomever posted the sign. 4.) Weekly audits will be conducted by the management team for three months to ensure that signs with resident specific care instructions are not hung in resident rooms. Results will be discussed at monthly QAPI meetings for three months. 5.) Completion Date: 4-18-2018	

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On 3/27/18 at 9:38 a.m., the certified nursing assistant (CNA) #1 caring for Resident #13 was interviewed about the posted care instructions. CNA #1 stated the resident was being monitored for aspiration for about a month, but now she was getting better. CNA #1 said she thought the note remained up just in case as a reminder.

On 3/28/18 at 4:26 p.m., the director of nursing (DON) was interviewed about the posted care instructions for Resident #13. The DON stated the facility has a new speech therapist who has only been with the facility about 2-3 weeks and the instructions were left up by the previous speech therapist. The DON stated she met with one of the other therapists and reviewed documentation that noted the speech therapy had ended and the instructions were mistakenly left up in Resident #13's room.

On 3/29/18 at 9:01 a.m., the speech therapist (ST) was interviewed about the posted care instructions. The ST stated she personally does not use posted personal care instructions and she chooses to educate staff on care instructions by including them in therapy sessions for residents.

These findings were reviewed with the administrator, director of nursing and assistant director of nursing during a meeting on 3/28/2018 at 4:05pm.

2. Care instructions regarding swallowing was posted on the closet door in Resident's #7's room. The instructions were visible to anyone entering the room.

Resident #7 was admitted to the facility on

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10/29/2017 with a re-admission on 11/22/17. Diagnoses for Resident #7 included heart disease, respiratory disease, chronic kidney disease, dementia, hyperlipidemia, GERD (gastro-esophageal reflux disease), major depressive disorder and hypertension. The minimum data set (MDS) dated 3/5/18 assessed Resident #7 with impaired cognitive skills.

On 3/27/18 at 3:09 p.m., Resident #7 was observed in her room. Posted on the wall near Resident #7's closet door was a sign titled "Safe Swallowing Techniques." Posted on the wall near Resident #7's closet door was a second sign with swallowing instructions and a third sign was posted on the wall at the head of resident 7's bed. The first sign stated the following:

SAFE SWALLOWING TECHNIQUES
1. Small bite of food
2. Follow bite with small sip of liquid
3. Clear throat
4. Dry Swallow
5. Repeat starting at #1 again for each new bite.

The second and third signs stated the following: "chin tuck swallow, small sip."

On 3/28/18 at 4:26 p.m., the director of nursing (DON) was interviewed about the posted care instructions for Resident #7. The DON stated the facility has a new speech therapist who has only been with the facility about 2-3 weeks and the instructions were left up by the previous speech therapist. The DON stated she met with one of the other therapists and reviewed documentation that noted the speech therapy had ended and the instructions were mistakenly left up in Resident #7's room.

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On 3/29/18 at 9:01 a.m., the speech therapist (ST) was interviewed about the posted care instructions. The ST stated she personally does not use posted personal care instructions and she chooses to educate staff on care instructions by including them in therapy sessions for residents.

These findings were reviewed with the administrator, director of nursing and assistant director of nursing during a meeting on 3/28/2018 at 4:05 p.m.

3. Instructions regarding personal hair care were posted on the wall in Resident #8's room. The instructions included the resident's name and were visible to anyone entering the room.

Resident #8 was admitted to the facility on 8/22/13 with a re-admission on 9/2/15. Diagnoses for Resident #8 included high blood pressure, anemia, dementia, depression and anxiety. The minimum data set (MDS) dated 12/15/17 assessed Resident #8 with severely impaired cognitive skills and requiring the extensive assistance of one person for daily hygiene.

On 3/27/18 at 9:00 a.m., Resident #8's room was inspected. A handwritten note was posted on the wall behind the resident's bed stating, "Reminder!!! Take the pony-tail out of [Resident 8's] hair at Bedtime!!! (it is so tangled in the morning + hurts her to comb it out.)." The note was undated, included the resident's name and was visible to anyone entering the room.

On 3/29/18 at 9:26 a.m., the licensed practical nurse (LPN #1) caring for Resident #8 was

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F 550	Continued From page 6 interviewed about the posted care instructions. LPN #1 stated she was not sure who posted the instructions or when they were posted. On 3/29/18 at 9:30 a.m., the registered nurse unit manager (RN #1) was interviewed about the posted instructions in Resident #8's room. RN #1 stated she thought the family might have posted the instructions. RN #1 stated care instructions were not typically posted on the walls. RN #1 stated certified nurses' aides had reference guides in the computer system regarding care instructions for each resident. These findings were reviewed with the administrator and director of nursing during a meeting on 3/28/18 at 4:00 p.m.	F 550		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights	F 656		4/18/18

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F 656	Continued From page 7 under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, the facility staff failed to develop a comprehensive plan of care for one of 17 residents in the survey sample. Resident #48 had no care plan developed regarding anxiety and the use of an anti-anxiety medication at bedtime. The findings include: Resident #48 was admitted to the facility on 1/31/18 with a re-admission on 2/23/18. Diagnoses for Resident #48 included heart failure, peripheral vascular disease, anxiety, atrial fibrillation, protein-calorie malnutrition and	F 656	1.) Resident #48 discharged prior to the facility being notified of the failure to develop a comprehensive plan of care. 2.) A 100% audit was completed on all residents with Anti-Anxiety medications to ensure they have a comprehensive plan of care. 3.) An in-service was conducted by the DON for nursing staff to ensure that all residents on Anti-Anxiety medications have a comprehensive plan of care related to the medication. An in-service was conducted by the DON with the MDS Coordinator and the facility Social Worker to ensure that all residents on Anti-Anxiety	

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gastroesophageal reflux disease. The minimum data set (MDS) dated 3/2/18 assessed Resident #48 as cognitively intact.

Resident #48's clinical record documented a physician's order dated 3/1/18 for Ativan (lorazepam) 0.5 mg (milligrams) to be administered at each bedtime for treatment of anxiety. The resident's medication administration record documented the resident was administered the Ativan at bedtime from 3/1/18 through 3/28/18.

A physician's progress noted dated 3/5/18 documented, "...Patient states that she felt better this morning because last night she was given Ativan to help her sleep. She states that she has been having difficulty sleeping since she arrived here..."

Resident #48's plan of care (revised 3/8/18) included no problems, goals and/or interventions regarding the resident's use of Ativan or anxiety at bedtime. The plan of care made no mention of any non-drug interventions to reduce anxiety or interventions to enhance sleep.

On 3/29/18 at 8:24 a.m., the registered nurse (RN #2) responsible for MDS and care plan development was interviewed about Resident #48. RN #2 stated she would review the care plan and advise.

On 3/29/18 at 8:41 a.m., the director of nursing (DON) was interviewed about Resident#48's care plan. The DON stated the Ativan use was not on the care plan. The DON stated Resident #48's Ativan use at bedtime was not added to the care plan when the order was placed. The DON

medications have a comprehensive plan of care related to the medication.
4.) The Social Worker will audit all new orders for Anti-Anxiety medications for monthly for three months to ensure that the resident has a comprehensive plan of care to address the Anti-Anxiety medication. Audit results will be discussed at monthly QAPI meetings for three months.
5.) Date of Completion: 4-18-18

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F 656	Continued From page 9 stated the only related item on the care plan was about issues with mood. The Nursing 2017 Drug Handbook on page 902 describes Ativan as an anxiolytic benzodiazepine used for the treatment of anxiety and insomnia due to anxiety. (1) These findings were reviewed with the administrator and DON during a meeting on 3/29/18 at 2:00 p.m. (1) Rader, Janet, Dorothy Terry and Leigh Ann Trujillo. Nursing 2017 Drug Handbook. Philadelphia: Wolters Kluwer, 2017.	F 656		
F 684 SS=E	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 observation, resident interview, staff interview, facility document review and clinical record review, the facility staff failed to follow professional standards of practice for two of 17 residents in the survey sample. 1a) Resident #33 was administered the medication Advair that had been opened beyond the recommended 30 days. 1b) The Advair was	F 684	1.) The Advair for Resident #33 was disposed of and reordered during the time of survey. The order cream for Resident #159 was corrected to reflect the appropriate range for administration as well as appearing on the TAR instead of the MAR. 2.) A 100% audit was completed of physician orders to ensure that treatment	4/18/18

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administered to Resident #33 without prompts or instructions for administration. 1c) As a result, the resident inhaled the medication three times instead of once as ordered by the physician. 1d) The resident did not rinse and spit after inhaling the Advair as recommended by the manufacturer.

2a) Resident #159 was administered another resident's medications in error. 2b) In addition, Resident #159 was not administered a prescribed topical cream in a timely manner. This medication was entered on the medication administration record (MAR) as given when the medication had not been administered.

The findings include:

1. Resident #33 was administered the medication Advair that had been opened beyond the recommended 30 days. The Advair was administered to Resident #33 without prompts or instructions for administration. As a result, the resident inhaled the medication three times instead of once as ordered by the physician. The resident did not rinse and spit after inhaling the Advair as recommended by the manufacturer.

Resident #33 was admitted to the facility on 1/22/18 with diagnoses that included tibia fracture, COPD (chronic obstructive pulmonary disease), chronic kidney disease, heart failure and diabetes. The minimum data set (MDS) dated 2/19/18 assessed Resident #33 as cognitively intact.

On 3/28/18 at 7:50 a.m., a medication pass observation was conducted with licensed practical nurse (LPN) #2 administering medications to Resident #33. During this

orders were entered correctly on the TAR with an assigned shift.
3.) The nurse that administered resident #159 medication in error was given individual education by the DON. All licensed nursing staff will be in-serviced by the DON on standards of practice for the administration of Adviar and the expiration period of this medication. All licensed nursing staff will be in-serviced by the DON on entering treatments onto the TAR.
4.) The ADON will conduct random weekly medication pass observations for three months of licensed nurses to ensure that professional standards of practice are observed. Audit results will be discussed at monthly QAPI meetings for three months.
5.) Date of completion: 4-18-18

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F 684	Continued From page 11 observation, LPN #2 administered the orally inhaled medication Advair to Resident #33. After activating the inhaler device, LPN #2 administered the Advair to Resident #33 without any prompts or instructions. The resident orally inhaled Advair three times from the device. The resident did not rinse and spit after inhaling the Advair. LPN #2 provided no prompts or instructions to rinse and spit or regarding the proper times to inhale. The Advair administered to Resident #33 was labeled as opened on 2/21/18 indicating the medication had been opened for over one month when administered. Resident #33's clinical record documented a physician's order dated 2/6/18 for Advair Diskus Aerosol Powder Breath Activated 250-50 mcg (micrograms) per dose with instructions stating, "1 puff inhale orally one time a day" for treatment of COPD. The Advair Diskus manufacturer's package insert (prescribing information 10000000146189) stated concerning dosage and administration, "Advair Diskus should be administered as 1 inhalation twice daily by the orally inhaled route only. After inhalation, the patient should rinse his/her mouth with water without swallowing to help reduce the risk of oropharyngeal candidiasis. More frequent administration or a greater number of inhalations (more than 1 inhalation twice daily) of the prescribed strength of Advair Diskus is not recommended as some patients are more likely to experience adverse effects..." This package insert stated concerning storage of Advair Diskus, "Safely throw away Advair Diskus in the trash 1 month after you open the foil pouch or when the counter reads 0, whichever comes first."	F 684		

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(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
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On 3/28/18 at 8:30 a.m., LPN #2 that administered the Advair to Resident #33 was interviewed about the out of date medication, three inhalations and lack of rinsing and spitting. LPN #2 stated she did not think Advair was one of the medications that required a rinse and spit after inhaling. LPN #2 stated she did not know there was a discard date for the Advair after it was opened. LPN #2 stated she did not think the three inhalations of the Advair were a problem because the inhale device was activated with only one dose. LPN #2 stated she thought the resident inhaled several times to make sure she got the entire dose.

These findings were reviewed with the administrator and director of nursing during a meeting on 3/28/18 at 4:00 p.m.

2. Resident #159 was administered another resident's medications in error. In addition, Resident #159 was not administered a prescribed topical cream in a timely manner. This medication was entered on the medication administration record (MAR) as given when the medication had not been administered.

Resident #159 was admitted to the facility on 3/3/18 with diagnoses that included femur fracture, high blood pressure, anxiety, depression, dysphagia and dry eye syndrome. The minimum data set (MDS) dated 3/10/18 assessed Resident #159 as cognitively intact.

A) Resident #159 was administered another resident's medications in error.

Resident #159's clinical record documented a

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nursing note dated 3/7/18 at 11:02 p.m. stating, "...resident was given the wrong medication during HS [bedtime] medication pass...Resident has no s/s [signs/symptoms] of adverse reaction...[Physician] notified and stated to monitor vital signs every 4 hours over night and hold her scheduled Ativan at HS..." (sic) A note dated 3/7/18 at 11:16 p.m. documented, "Resident was given the wrong medication during HS med pass...MD stated to monitor vitals every 4 hours x 2 cycles and push fluids..."

The facility's investigation of Resident #159's medication error dated 3/7/18 documented, "Nursing was in the middle of bedtime medication pass and CNA's [certified nurses' aides] were coming up and stating that two other resident [s] were requesting to see me. Nurse walked in the wrong room after the medication [s] were being pulled." (sic) This statement listed the medications given to Resident #159 in error as Remeron 15 mg (milligrams), Ranitidine 75 mg, aspirin 81 mg and Colace 100 mg.

A care plan meeting note dated 3/8/18 stated, "Nurse administered wrong medications to this resident last PM 3/7/18 at 2000 [8:00 p.m.]. Nurse was distracted due to staff notifying her of other resident needs and she went into wrong room after pulling meds [medications]. She did have pictures up to identify correct resident per the nurse. Administering nurse new [knew] of error as soon as she went to sign off the meds and returned to her cart..." (sic)

On 3/27/18 at 3:31 p.m., the director of nursing (DON) was interviewed about the documented medication error with Resident #159. The DON stated the nurse was distracted, went into the

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wrong room and gave Resident #159 another resident's medications.

These findings were reviewed with the administrator and director of nursing during a meeting on 3/29/18 at 2:00 p.m.

B) Resident #159 was not administered a prescribed topical cream in a timely manner. This medication was entered on the medication administration record (MAR) as given when the medication had not been administered.

On 3/27/18 at 8:50 a.m., Resident #159 was interviewed about any concerns with her care. Resident #159 stated she was not always getting cream applied to her back as the physician ordered. Resident #159 stated she had a rash on her back and the cream was supposed to be applied twice per day. Resident #159 stated the cream had not been applied this morning (3/27/18). On 3/27/18 at 11:45 a.m., the resident stated the prescribed cream had not been applied yet to her back.

Resident #159's clinical record documented a physician's order dated 3/14/18 for Fluocinonide-E Cream 0.05% to be applied to the mid-lower back topically two times per day for treatment of a rash. The resident's medication administration record (MAR) for March 2018 listed the cream was scheduled for administration at 8:00 a.m. and 8:00 p.m. each day.

On 3/27/18 at 11:46 a.m., the registered nurse (RN #4) administering medications to Resident #159, was interviewed about the back cream scheduled for 8:00 a.m. RN #4 stated, "I haven't

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put it [cream] on yet." RN #4 stated she thought the resident was getting a bath/shower. RN #4 stated she would apply the cream "now."

On 3/27/18 at 11:50 a.m., Resident #159's MAR was reviewed. The MAR documented the Fluocinonide-E Cream 0.05% had been administered to Resident #159 on 3/27/18 at 8:00 a.m.

On 3/27/18 at 11:57, RN #4 was interviewed about why the MAR indicated the cream was applied at 8:00 a.m. when the cream was not applied until approximately 11:50 a.m. RN #4 stated, "I accidentally clicked it off [MAR]. I just gave it to her [Resident #159] a few minutes ago." RN #4 stated she had signed the cream as given at 8:00 a.m. because she knew she was going to give it. RN #4 stated she had not applied the cream at 8:00 a.m. because the resident was busy getting ready for the day.

On 3/28/18 at 12:31 p.m., the director of nursing (DON) was interviewed about Resident #159's cream not applied when scheduled and the MAR inaccurately listing the cream as administered. The DON stated nurses were supposed to sign off the MAR at the time the medications were administered. The DON stated medications were supposed to be administered within an hour before or an hour after the scheduled administration time listed on the MAR.

The facility's policy titled Medication Administration Times (revised 5/1/10) stated, "Facility should ensure that authorized personnel, as determined by Applicable Law, administer medications according to times of administration as determined by Facility's pharmacy committee

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and/or Physician/Prescriber...Facility should commence medication administration with sixty (60) minutes before the designated times of administration and should be completed by sixty (60) minutes after the designated times of administration..."

The Lippincott Manual of Nursing Practice 10th edition on page 17 includes the following as common departures from standards of care, "Failure to implement a physician's, advanced practice nurse's, or physician assistant's order properly or in a timely fashion...Failure to administer medications properly and in a timely fashion or to report and administer omitted doses appropriately...Failure to make prompt, accurate entries in a patient's medical record..." (1)

These findings were reviewed with the administrator and director of nursing during a meeting on 3/28/18 at 4:00 p.m.

(1) Nettina, Sandra M. Lippincott Manual of Nursing Practice. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2014.

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F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		4/18/18

§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

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F 761	Continued From page 17 §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 observation, staff interview, facility document review and clinical record review, the facility staff failed to discard out of date medications on one of two medication carts and failed to accurately label a prescribed medication for one of 17 residents in the survey sample. Three vials of Lantus insulin opened beyond the recommended 28 days were available for use on the right hall medication cart. Advair Diskus opened longer than the recommended 30 days was also available for use in the right hall medication cart. A supply of the medication Metoprolol Succinate for Resident #48 had an inaccurate dosage printed on the pharmacy label. The findings include: 1. Three vials of Lantus insulin opened beyond the recommended 28 days were available for use on the right hall medication cart. Advair Diskus opened longer than the recommended 30 days was also available for use in the right hall	F 761	1.) The three vials of expired insulin were disposed of and reordered at the time of the survey. The Advair Diskus was disposed of and reordered at the time of the survey. The medication for Resident #48 was returned to the pharmacy due to resident had been discharged prior to the notification of the incorrect label. 2.) A 100% audit of the medication cart was completed to ensure that all medication were in current date range. A 100% audit was completed of the medication cart to ensure that medication labels match the physician order. If different, the medication a sticker will be applied that states "Directions Changed Refer to Chart". 3.) All licensed nursing staff were in-serviced by the DON on the policy and procedure for changes in medication orders for appropriate labeling of the	

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F 761	Continued From page 18 medication cart. On 3/28/18 at 8:07 a.m., the right hall medication cart was inspected accompanied by licensed practical nurse (LPN) #2. Stored and available for use was a vial of Lantus insulin opened on 2/18/18; a vial of Lantus insulin opened on 2/19/18 and a vial of Lantus insulin opened on 2/27/18. Also stored in the cart was Advair diskus for a current resident opened on 2/21/18. On 3/28/18 at 8:07 a.m., LPN #2 was interviewed about the Advair and insulin stored that were opened in February 2018. LPN #2 stated the insulins were "way past the date" as they were supposed to be discarded 28 days after opening. LPN #2 stated she did not know the Advair had a discard date. LPN #2 stated she checked insulin dates before she administered them but was not sure who was responsible for monitoring carts for out of date medicines. On 3/28/18 at 9:06 a.m., the director of nursing (DON) was interviewed about the out of date medicines on the right hall cart. The DON stated the Lantus insulin was good for 28 days after opening and should have been discarded. The DON stated nurses were responsible for monitoring the carts and discarding medications as needed. The facility's policy titled Insulin Storage Recommendations (revised 9/29/16) documented opened Lantus insulin was to be discarded after 28 days. The Advair Diskus manufacturer's package insert (prescribing information 10000000146189) stated concerning storage of Advair Diskus, "Safely	F 761	medication. All licensed nursing staff were in-serviced by the DON on the policy and procedure on insulin and inhaler storage recommendations. 4.) The medication carts will be audited weekly for three months by the Unit Manager and/or ADON for proper medication storage and labeling. Audits will be discussed for three months at monthly QAPI meetings. 5.) Date of completion: 4-18-18	

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throw away Advair Diskus in the trash 1 month after you open the foil pouch or when the counter reads 0, whichever comes first."

These findings were reviewed with the administrator and director of nursing during a meeting on 3/28/18 at 4:00 p.m.

2. A supply of the medication Metoprolol Succinate for Resident #48 had inaccurate dosage on the pharmacy label.

Resident #48 was admitted to the facility on 1/31/18 with a re-admission on 2/23/18. Diagnoses for Resident #48 included heart failure, peripheral vascular disease, anxiety, atrial fibrillation, protein-calorie malnutrition and gastroesophageal reflux disease. The minimum data set (MDS) dated 3/2/18 assessed Resident #48 as cognitively intact.

Resident #48's clinical record documented a physician's order dated 2/26/18 for the medication Metoprolol Succinate 150 mg (milligrams) to be given two times per day for treatment of congestive heart failure.

On 3/28/18 at 7:40 a.m., a medication pass observation was conducted with licensed practical nurse (LPN) #2 administering medicines to Resident #48. LPN #2 administered the medication Metoprolol Succinate 150 mg (milligrams) as ordered by the physician. The pharmacy label on Resident #48's Metoprolol Succinate supply did not match the physician's order. The pharmacy labeled documented, "Give 3 tablets (300 mg) by mouth one time per day" instead of the ordered 150 mg two times per day.

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On 3/28/18 at 8:38 a.m., LPN #2 was interviewed about the inaccurate dosage on Resident #48's Metoprolol Succinate pharmacy label. LPN #2 stated the 300 mg label could have been from a previous order. LPN #2 stated she thought a new supply card of medicine was sent to the facility when a new order was entered.

On 3/28/18 at 8:56 a.m., the director of nursing (DON) was interviewed about the inaccurate pharmacy label. The DON stated the 300 mg dose was from a previous order that had been discontinued. The DON stated pharmacy did not send a new card or label if the older dose could be used. The DON stated she was not aware of any re-labeling done by the pharmacy when dosages were changed.

The facility's pharmacy procedure titled Reordering, Changing, and Discontinuing Orders (revised 1/1/13) stated concerning dose changes, "Pharmacy should receive a discontinuation order BEFORE a new order (that reflects a change) is filled...If pharmacy receives a new order that changes the strength or dose of a medication previously ordered, and there is adequate supply on hand...Pharmacy should discontinue the original order...Facility should enter the new order on the appropriate Medication Record Forms...If permitted by Applicable Law, Facility should notify Pharmacy not to send the medication by attaching a 'Change in Directions' sticker to the existing quantity of medications until Pharmacy permanently affixes the new label to the medication package or container. Facility may order from Pharmacy bulk rolls of 'Change in Directions' stickers."

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F 761	Continued From page 21 These findings were reviewed with the administrator and director of nursing during a meeting on 3/28/18 at 4:00 p.m. The DON stated at this time they had not been using the "Change in Directions" stickers for dose changes as referenced in the pharmacy procedure.	F 761		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other	F 880		4/23/18

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F 880	Continued From page 22 persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, review of facility documents, and staff interview, the facility failed to develop an all encompassing infection control	F 880	1.) C.N.A. #2 was in-serviced by the DON on infection control practices during the time of the survey. Infection Control	

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program based on accepted national standards that included, but was not limited to, the prevention, identification, and control of the spread of infection; the surveillance of communicable disease and infectious outbreaks; employee health; all of which was reviewed, and revised as necessary, at least annually. The facility staff also failed to follow infection control practices during the service and preparation of resident meal trays in the Dining Room.

The findings include:

1. The facility failed to develop an all encompassing infection control program based on accepted national standards that included, but was not limited to, the prevention, identification, and control of the spread of infection; the surveillance of communicable disease and infectious outbreaks; employee health; all of which was reviewed, and revised as necessary, at least annually.

At approximately 10:00 a.m. on 3/29/18, the surveyor met with the Assistant Director of Nursing (ADON) who was identified as being the contact person for the Infection Prevention and Control Program (IPCP). Asked to see the facility's IPCP, the ADON gave the surveyor a policy titled "Antibiotic Stewardship Program Policy." The policy section was titled, "Infection Prevention and Control Program." The policy effective date was April 28, 2017, and the most recent review and revision date was February 12, 2018.

The Policy statement was as follows:
"The Infection Prevention and Control Committee (IPCC) will meet monthly to oversee the

F 880 (Provider's Plan of Correction)

Policy and Procedure was updated to reflect required regulations and standards and to include employee surveillance.
2.) All residents that eat meals in the dining room are at risk for this practice. An individual in-service was conducted by the DONR for C.N.A. #2 regarding infection control practices during meal service. The facility has updated their Infection Control Policy to be based on National Standards and to meet regulatory requirements to include employee surveillance.
3.) The Regional Director of Clinical Services in-serviced the Administrator and DON on the updated Infection Control Policy which includes National Standards and employee surveillance. All nursing staff were in serviced by the DON and/or ADON on infection control practices during meal services. All staff were in-serviced by the DON and/or ADON on the updated facility policy for Infection Control which includes employee surveillance.
4.) The Unit Manager and/or ADON will randomly monitor the dining room weekly for three months to ensure that staff are following infection control practices during meal service. Audits will be discussed for three months at facility QAPI meetings. Infection Control Plan will be discussed at monthly QAPI meetings for three months.
5.) Date 4/23/18

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surveillance, investigating, reporting, control, and prevention of infections within the facility; as well as monitoring/tracking of antibiotic prescribing, use, and resistance in order to promote a culture of optimal antibiotic use within the facility. Antibiotic stewardship will focus on improving antibiotic use by avoiding unnecessary or inappropriate antibiotics. The antibiotic stewardship program will be reviewed on an annual basis and as needed."

The Procedure portion of the policy provided for the naming of a committee chairman; designated the individual to keep minutes of the meetings and to whom the minutes were to be shared; established the membership of the committee; and set forth the agenda for the meetings.

Asked if the policy presented to the surveyor was the entire IPCP, the ADON indicated that it was. When asked what accepted national standards were used in the development of the policy, the ADON said, "I use McGeer." The ADON than added "I also use CDC (Centers for Disease Control and Prevention)." Asked where the CDC, or any other source was referenced in the policy, the ADON admitted there was no reference to the CDC or any other entity.

(NOTE: McGeer is a diagnostic tool for infections, including Respiratory Tract Infections, Urinary Tract Infections, Gastrointestinal Tract Infections, and Skin, Soft Tissue and Mucosal Infections.)

The ADON was then asked how often the policy was updated. "If there is an update that comes out, then we update it," the ADON said. Continuing, the ADON said, "There is no regular schedule (for updating) that I am aware of."

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SHENANDOAH NURSING HOME	339 WESTMINISTER DRIVE FISHERSVILLE, VA 22939

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As the discussion of the IPCP progressed, the ADON said the policy was made up of "...bits and pieces..." and that there was no one policy that contained all the individual parts. The ADON then gave the surveyor five separate policies that she indicated were a part of the IPCP. Following are the policies, including the review/revision dates, provided by the ADON:

Policy: Contact Precautions - Effective date: June 2013, Reviewed/Revised: May 27, 2015.
Policy: Standard Precautions - Effective date: January 2008, Reviewed/Revised: April 2015.
Policy: Infection Control - Tuberculosis Screening - Residents - Effective date: September 2008, Reviewed/Revised: August 2017.
Policy: Tuberculosis, Employee Screening for - Effective date: October 2013, Last reviewed; April 2015.
Policy: Employee Health - Effective date: July 22, 2016, No review or revision dates listed.

Asked specifically how the policy addressed employee health, such as employees who have a respiratory illness, the ADON said, "That's addressed in the new employee handbook. It isn't in the infection control plan."

The questioning then turned to the surveillance plan. At that point, the Director of Nursing (DON) joined the discussion. The surveyor asked to see the surveillance plan used to identify, track, and monitor, and including the analysis of surveillance data. The ADON provided the surveyor with three forms, a Resident TB (Tuberculosis) Screening and Immunization Audit, a floor plan of the facility for tracking infections by room, and an Antibiotic Use Tracking Sheet. The surveyor told the ADON

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and the DON that the forms presented appeared to be some of the tools for surveillance, but what was needed was the plan that laid out the what, when, why, and how of surveillance.

The DON placed a telephone call the the Corporate Nurse Consultant and, via speaker phone, explained to the consultant the surveyor's request. The surveyor also spoke to the consultant regarding the request for the surveillance plan. After approximately 10 minutes of searching the corporate computer data base, the consultant said, "I'm not finding any, I will keep looking."

At approximately 1:30 p.m. on 3/29/18, the survey team met with the Administrator, the DON, and the ADON. Among the issues discussed was the IPCP. At that time the DON advised they had no additional information regarding either the IPCP or the surveillance portion of the plan.

2. A certified nursing assistant failed to follow infection control practices during meal service.

A meal service observation was observed on 03/27/2018 at 7:50 a.m. Certified Nursing Assistant (CNA) #2 was observed assisting with the meal service during this time to three residents without performing hand hygiene between assisting each resident.

During this observation, CNA #2 was observed taking off and replacing the first resident's glasses. Without performing hand hygiene, CNA #2 assisted the second resident with meal service by handling the second resident's silverware, prepared the biscuit with butter, and assisted with the resident's coffee cup. CNA #2 touched the

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F 880	Continued From page 27 biscuit without using gloves. Without performing hand hygiene, CNA #2 assisted the third resident with meal service by handling the silverware and feeding the resident. On 3/28/18 at 10:23 a.m., the director of nursing (DON) was interviewed about the hand hygiene policy. The DON stated the staff was supposed to use the proper hand hygiene between caring for each resident. The facility's policy titled Hand Washing (revised August 2015) states staff are to perform hand hygiene before and after having direct contact with residents. These findings were reviewed with the administrator, director of nursing and assistant director of nursing during a meeting on 3/28/2018 at 4:05 p.m.	F 880		
F 881 SS=E	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on review of facility documents and staff interview, the facility failed to develop an effective Antibiotic Stewardship Program that included written protocols for antibiotic use in the facility,	F 881	1.) Antibiotic Stewardship Policy and Procedure was updated to reflect required regulations and National Standards. 2.) The facility has updated their Antibiotic	4/23/18

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F 881	Continued From page 28 including, but not limited to, prescribing, documentation of the indication, dosage, and duration of antibiotic use. The stewardship program also failed to address periodic review of antibiotic use by prescribing physicians, the optimization of treatment of infections, and a system of feedback on antibiotic use. The findings were: At approximately 11:00 a.m. on 3/29/18, during a discussion with the Assistant Director of Nursing (ADON), who was identified as being the contact person for the Infection Prevention and Control Program (IPCP), the Antibiotic Stewardship Program was discussed. The surveyor asked the ADON for the Antibiotic Stewardship Program, including the written protocols on antibiotic prescribing, documentation of the indication, dosage, and duration of use; the protocols for the review of clinical signs and symptoms, and laboratory reports; the mechanism for the periodic review of antibiotic use by prescribing physicians; protocols to optimize treatment of infections; and, a system for feedback on antibiotic use. The ADON and the Director of Nursing (DON), who was also present, referred the surveyor to the Antibiotic Stewardship Program Policy, which included the policy section, "Infection Prevention and Control Program." The policy had an effective date of April 28, 2017, and a review/revision date of February 12, 2018. The ADON and DON further referred the surveyor to items K and L under "Section D - The IPCC (Infection Prevention and Control Committee)	F 881	Stewardship Policy to be based on National Standards and to meet regulatory requirements. 3.) The DON was in-serviced by the Regional Director of Clinical Services on the new Antibiotic Stewardship Policy & Procedure. The assigned Facility Infection Control Coordinator was in-serviced by the DON on the updated facility policy for Antibiotic Stewardship. 4.) The Antibiotic Stewardship Policy and Procedure will be discussed at monthly QAPI meetings for three months. 5.) Date 4/23/18	

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meeting agenda will include":

Item K. "Facility will monitor/review for antibiotic usage when the resident is new to the facility; when a prior resident returns or is transferred from a hospital or other facility during each monthly medication regimen review when the resident has been prescribed or is taking an antibiotic, or any antibiotic regimen review is requested by the QAA committee."

Item L, "Facility antibiotic use protocol(s) will address antibiotic prescribing practices (i.e., documentation of the indication, dose, and duration of the antibiotic; review of laboratory reports to determine if the antibiotic is indicated of needs to be adjusted; and infection assessment is completed prior to prescribing) and the monitoring of antibiotic use (i.e., antibiotic use reports, antibiotic resistance reports)."

When requested by the surveyor, the ADON and the DON were unable to produce either the written Antibiotic Stewardship Program, or the written protocols used as a basis for the program.

At approximately 1:30 p.m. on 3/29/18, the survey team met with the Administrator, the DON, and the ADON. Among the issues discussed was the lack of a written Antibiotic Stewardship Program.