DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495234	A. BUILDING _____ B. WING _____	C 12/07/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE HALL VIRGINIA BEACH	5580 DANIEL SMITH ROAD VIRGINIA BEACH, VA 23462

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 12/6/16 through 12/7/16. Two complaints were investigated. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 90 certified bed facility was 82 at the time of the survey. The survey sample consisted of 18 residents, 14 current Resident reviews (Resident #1 through 14) and 4 closed record reviews (Resident #15 through 18).	F 000		
F 332 SS=D	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on medication pour and pass observations, staff interview, facility document review and clinical record review the facility staff failed to ensure they were free of medication error rates less than 5%. There were 26 observed medication opportunities with 3 errors, resulting in a 11.5% medication error rate. The residents involved in the medication errors were Residents #13 (Fluticasone nasal spray and Gabapentin by mouth) and Resident #11 (Vitamin D). The findings include:	F 332	F332 Corrective Action(s): The Residents involved in Medication Pass Observation #11 & #13 have had their attending physicians notified of the medication errors. LPN #1 and RN#1 involved in the medication pass observation have received disciplinary action and a one-on-one inservice training on medication administration and the 5 rights of medication administration. A facility Incident & Accident form was completed for each medication error.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle B. Jackson, LNHA | TITLE: Administrator | (X6) DATE: 12/19/16

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 332	Continued From page 1 1. Resident #13 was admitted to the nursing facility on 11/29/16 with diagnoses that included allergic rhinitis and diabetes with nerve pain. The resident was too newly admitted for a completed Minimum Data Set (MDS) assessment, thus a Nursing Admission Assessment was used to ascertain information about the resident. Resident #13 was assessed to be alert and oriented. On 12/6/16 at 5:00 p.m., Resident #13 received one spray of Fluticasone nasal spray to each nostril. The resident had physician's order dated 12/6/16 for *Fluticasone 50 micrograms (mcg)-give 2 sprays to each nostril twice a day for allergy, rhinitis. *Fluticasone Propionate Nasal Spray, 50 mcg is an aqueous suspension of micro-fine Fluticasone propionate for topical administration to the nasal mucosa by means of a metering, atomizing spray pump. Fluticasone propionate is a synthetic, trifluorinated corticosteroid with anti-inflammatory activity (https://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archived=5767). On 12/6/16 at 5:40 p.m., Licensed Practical Nurse (LPN) #1 stated Resident #13 took the Fluticasone nasal spray out of her hands and self administered one spray to each nostril. The LPN did not instruct or attempt to administer the second spray to each nostril per physician's order. The LPN stated the resident took the nasal spray out of her hands so quickly, she was not able to deliver the nasal spray herself, but should have ensured the correct amount of sprays were given. The resident was assessed to self	F 332	**Identification of Deficient Practices & Corrective Actions(s):** All residents may have potentially been affected. A 100% medication pass audit of all licensed nurses within the facility will be conducted to identify those nurses at risk for Medication Administration and/or technique errors. A facility Incident & Accident form will be completed for each negative finding as well as one-on-one inservice training and appropriate disciplinary action if warranted for nursing staff observed. **Systemic Change(s):** The facility Policy and Procedure for medication administration and has been reviewed and no changes are warranted at this time. All Licensed nursing staff will be inserviced by the DON and/or Nurse consultant on the facility policy & procedure for medication administration. Inservices will include administering medication per physician order and the 5 rights of medication administration.	

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F 332	Continued From page 2 administer the Fluticasone in the presence of the nurse. On 12/7/16 at 10:30 a.m., during an interview with the Director of Nursing (DON), she stated LPN #1 should have administered the nasal spray. It was determined the resident was assessed for self administration, but that it would be in the presence of the nurse with the nurse providing the necessary instructions. The DON created a medication error report. On 12/6/16 at 5:00 p.m., LPN #1 administered Gabapentin 100 milligram (mg) capsule to Resident #13. The resident had physician's orders dated 11/29/16 for Gabapentin 100 mg three times a day (6:30 a.m., 2:30 p.m. and 10:30 p.m.) for nerve pain. *Neurontin (Gabapentin) capsules, tablets, and oral solution are used to help control certain types of seizures in people who have epilepsy (https://medlineplus.gov/druginfo/meds/a694007.html). On 12/7/16 at 10:30 a.m., during an interview with the DON, she stated the nurse who entered the order in the system did not code the order correctly. She stated the way the order was coded, it caused the order to highlight at 5:00 p.m. instead of 10:30 p.m. The DON stated LPN #1 was educated to follow the written physician orders instead of the highlights on the computer. The DON generated a medication error report. The facility's policy and procedures titled "Administering Medications" dated 12/2012 indicated medications should be administered in accordance with physician's orders.	F 332	**Monitoring:** The Director of Nursing is responsible for maintaining compliance. The DON and/or designee will conduct two random weekly medication pass observations of licensed nurses to monitor for compliance. The pharmacy consultant will conduct two medication pass observations of licensed nursing staff during the facility visit. Any negatives findings will be addressed at the time of discovery and appropriate disciplinary action will be taken. All discrepancies found in these audits will be reported to the Quality Assurance Committee for review, analysis, and recommendations for change in facility policy, procedure, and/or practice. **Completion Date: January 13, 2017**	

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F 332	Continued From page 3 2. During a medication pass and pour observation, the facility staff failed to administer the correct dose of Vitamin D3 medication for Resident #11. Resident #11 was originally admitted to the nursing facility on 01/15/14 with the diagnosis that included but not limited to vitamin D deficiency. The annual Minimum Data Set (MDS) with an Assessment Reference Date (ARD) of 09/14/16 with a Brief Interview for Mental Status (BIMS) coded 99, as the resident was unable to complete the interview indicating short and long term memory problems and moderately impaired for daily decision making. During the medication pass and pour observation on 12/07/16 at approximately 9:30 a.m., RN #1 gave Resident # 11 Vitamin D3 50,000 units. On 12/07/16 at 11:30 a.m., this surveyor reconciled the medication given to Resident #11 by the physicians current orders for December 2016 indicating that Vitamin D3 50,000 units was scheduled to be given on Thursday, 12/08/16. *Vitamin D3 helps your body absorb calcium. Calcium is one of the main building blocks of bone. A lack of vitamin D can lead to bone diseases such as *osteoporosis. Vitamin D also has a role in your nerve, muscle, and immune systems. http://www.nlm.nih.gov/medlineplus/druginfo/meds/a682053.html. *Osteoporosis is a disease that thins and weakens the bones. Your bones become fragile and break easily, especially the bones in the hip, spine, and wrist. https://medlineplus.gov/vitamind.html.	F 332		

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F 332	Continued From page 4 On 12/7/16 at 2:15 p.m., the Director of Nursing (DON) was made aware of the error that was made during the medication administration observation. The DON agreed that this was a medication error and she would be speaking with RN #1. The Administrator was informed of the finding during a briefing on 12/07/16 at approximately 3:55 p.m. The facility did not present any further information about the findings. The facility's policy: "Administering Medications" revised on December 2012. Under section #7: "The individual administering medications must check the label THREE (3) times to verify the right resident, right medication, right dose, right time and right method (route) of administration before giving the medication".	F 332		