WestminsterCanterbury
SHENANDOAH VALLEY

To: Wietske G. Weigel-Delano	**Fax:** (804) 527-4502
From: Michael C Williams	**Date:** 10/26/17
Phone: 540 665-5913	**Pages:** 18
Re: POC from 10/11-12/17 Survey	**CC:**

HARD copy to follow: Plan of Correction for VDH-ETC survey 10/11-12/17

IF THERE IS A PROBLEM WITH THIS TRANSMISSION, PLEASE CALL (540) 665-0156

CONFIDENTIALITY NOTICE:

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

PRINTED: 10/17/2017
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
	495165	A. BUILDING _____ B. WING _____	C 10/12/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SHENANDOAH VLY WESTMINSTER-CANTERBURY	300 WESTMINSTER CANTERBURY DR WINCHESTER, VA 22603

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F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 10/11/17 through 10/12/17. One complaint was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 51 certified bed facility was 43 at the time of the survey. The survey sample consisted of 12 current Resident reviews (Residents # 1 through #10 and #15 and #16) and four closed record reviews (Residents # 11 through # 14).	F 000	**The submission of the Plan of Correction does not constitute agreement on the part of Shenandoah Valley Westminster-Canterbury that the deficiencies cited within the report represent deficient practices on the part of Shenandoah Valley Westminster Canterbury. This plan represents our on-going pledge to provide quality care that is rendered in accordance with all regulatory requirements.**	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly-	F 278	F-Tag 278 **1. Corrective Action** Nurse (LPN) #1 will complete a modification for Resident #5 significant change MDS with an assessment reference date of 9/9/17 regarding the use of hypnotic medications. **2. Other Potential Residents** All residents with a MDS assessment are potentially affected. A complete audit on active residents with a current MDS, section N will be reviewed to insure proper coding for the assessment reference date.	

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

Administrator | 10/26/17

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 278	Continued From page 1 (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on staff interview and clinical record review, it was determined that the facility staff failed to maintain a complete and accurate MDS (minimum data set) assessment for one of 16 residents in the survey sample, Resident #5. The facility staff failed to accurately code Resident #5's significant change MDS, with an assessment reference date of 9/9/17 regarding the use of hypnotic medications (sleeping pills). The findings include: Resident #5 was admitted to the facility on 5/19/15 with diagnoses that included but were not limited to: chronic obstructive pulmonary disease, depression, malnutrition, macular degeneration, hearing loss and insomnia. The most recent MDS assessment, a significant change assessment, with an assessment reference date (ARD) of 9/9/17, coded Resident #5 as scoring a 13 on the BIMS (brief interview for mental status) score, indicating she was	F 278	**3. Systems Change** All disciplines entering data on the MDS will be re-educated on the instructions of the RAI manual for section N by 11/17/17. The RN who signs the completion of the MDS will insure the coding of section N is accurate for the assessment based on the assessment reference date. **4. Monitoring** The night shift nurse will run a daily report of residents using anti-psychoactive medications. The results will be reported at the Interdisciplinary Team meetings every month for three months, then quarterly for one year. Report of findings will be submitted to the QAPI committee. **5. Date** This corrective action will be completed by 11/17/17.	

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cognitively intact to make daily decisions. In Section N - Medications, the resident was coded as having received no hypnotic medications during the seven - day look back period.

The physician orders dated, 8/8/17 documented, "Ambien (used for insomnia (1)) 5 mg (milligrams); give 0.5 tablet (half a tablet) by mouth every 23 hours as needed for insomnia. Target behaviors include: c/o (complaint of) not sleeping well and increased tiredness."

The September 2017 MAR (medication administration record) documented, "Ambien Tablet 5 mg; give 0.5 tablet by mouth every 23 hours as needed for insomnia. Target behaviors include: c/o not sleeping well and increased tiredness." The Ambien was documented as given on 9/7/17 and 9/8/17, both days within the lookback period of Resident #5's significant change MDS assessment, with an ARD of 9/9/17.

An interview was conducted with LPN (licensed practical nurse) #1, the unit coordinator, on 10/12/17 at 11:20 a.m. LPN #1 was asked to review Resident #5's MAR for September 2017 and the significant change MDS assessment with an ARD of 9/9/17. After review, when asked if the MDS was completed correctly, LPN #1 stated, "No, that is a coding error." When asked which resource was used to complete the MDS assessment, LPN #1 stated, "The RAI (resident assessment instrument) manual."

The RAI manual October 2017 documented, "N0410D - Hypnotic: Record the number of days a hypnotic medication was received by the resident at any time during the 7-day look-back period."

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F 278	Continued From page 3 The administrator ASM (administrative staff member) #1, LPN #1 and RN (registered nurse) #1, the assistant director of nursing, were made aware of the above concern on 10/12/17 at 2:10 p.m. No further information was presented prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0012721/?report=details	F 278		
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 administration observation, staff interview, facility document review, and clinical record review, the facility staff failed to ensure the facility was free of a less than 5% (five percent) medication error rate. Of 32 opportunities for error, two medication errors were observed involving two of four residents involved in the medication administration observation. Residents #15 and #16. This resulted in a medication error rate of 6.5%. 1. On 10/12/17 at 8:50 a.m., LPN (licensed practical nurse) #2 nurse administered TUMS to Resident #15during the meal when it was ordered for before meals and the medication was	F 332	**F-Tag 332** **1. Corrective Action** Nurse (LPN) #2 was counseled on 10/25/17 on the proper medication administration policy. A medication audited completed on 10/26/17. **2. Other Potential Residents** All residents who are prescribed medications with parameters (before meals/with meals, etc.) are at risk for receiving medications outside of the one-hour window for administration. An audit for medications with parameters will be performed by 10/27/17.	

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administered outside of the one-hour window for administration.

2. On 10/12/17 at 8:57 a.m. LPN #2 administered Omeprazole to Resident #16 with the meal when it was ordered before meals and the medication was administered outside of the one-hour window for administration.

The findings include:

1. Resident #15 was admitted to the facility on 12/26/13 with diagnoses that included but were not limited to: dementia, stroke, depression, high blood pressure, and gastroesophageal reflux disease (gastroesophageal reflux disease (GERD) is a condition in which the stomach contents (food or liquid) leak backwards from the stomach into the esophagus [the tube from the mouth to the stomach]. This action can irritate the esophagus, causing heartburn and other symptoms. (1)).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/12/17, coded Resident #15 as scoring a three on the BIMS (brief interview for mental status) score, indicating that she was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance to being totally dependent upon one or more staff members for all of her activities of daily living.

Observation was made on 10/12/17 at 8:50 a.m. of LPN (licensed practical nurse) #2 preparing medications for Resident #15. LPN #2 took two TUMS out of the container, and proceeded to crush the medication. Resident #15 was in the

3. Systems Change

Nurses who administer prescribed medications will be re-educated on medication administration and the prevention of medication errors including the six rights of medication of administration. 1. The right medication; 2. The right dose; 3. The right client/resident; 4. The right route; 5. The right time; 6. The right documentation.

4. Monitoring

The Director of Health Services, Unit Coordinator or designee will run a daily report of medication administration concerns for the last 24 hours. Any findings of will be addressed at the daily Interdisciplinary team meeting. Timely and appropriate follow up will be conducted for licensed nurses.

5. Date

The corrective action will be completed by 11/17/17.

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dining room eating her bacon. LPN #2 asked Resident #15 if she could administer her medications and Resident #15 shook her head yes. LPN #2 proceeded to administer Resident #15 the crushed TUMS between bites of bacon.

The physician orders dated, 2/8/17 documented, "Tums tablet Chewable (calcium carbonate antacid); Give 2 tablet by mouth before meals related to Gastro-esophageal reflux disease without esophagitis, fruit flavored, may crush." TUMS relieves heartburn, acid indigestion, sour stomach, and upset stomach associated with these symptoms. (2)

Resident #15's MAR (medication administration record) documented, "Tums tablet Chewable (calcium carbonate antacid); Give 2 tablet by mouth before meals related to Gastro-esophageal reflux disease without esophagitis, fruit flavored, may crush." The scheduled time of administration for this medication was 7:30 a.m., 11:00 a.m. and 4:00 p.m.

An interview was conducted with LPN #2 on 10/12/17 at 1:11 p.m. When asked why TUMS are given, LPN #2 stated, "They are given for indigestion or calcium replacement." When asked if TUMS should be administered during a meal, LPN #2 stated, "I was behind this morning."

The facility policy, "Medication Administration - General Guidelines" documented in part, "2. Medications are administered in accordance with written orders of attending physician, manufacturer's specifications, and professional standards of practice....11.

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Medications are administered within one hour before and one hour after the scheduled time, except for orders relating to before, after and during meal orders, which are administered according to the established medication administration schedule."

According to "Fundamentals of Nursing", Seventh Edition, 2009: by Perry and Potter Chapter 35 "Medication Administration" Chapter 35, pg. 707 read: "Professional standards, such as the American Nurses Association's Nursing: Scope and Standards of Nursing Practice (2004), apply to the activity of medication administration. To prevent medication errors, follow the six rights medication administration consistently every time you administer medications. Many medication errors can be linked, in some way, to an inconsistency in adhering to the six rights of medication administration. The six rights of medication administration include the following: 1. The right medication, 2. The right dose, 3. The right client, 4. The right route, 5. The right time, and 6. The right documentation."

The administrator, ASM (administrative staff member) #1, LPN #1 and RN (registered nurse) #1, the assistant director of nursing, were made aware of the above concern on 10/12/17 at 2:10 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://wwwqa.nlm.nih.gov/medlineplus/275/ency/article/000265.htm
(2) This information was obtained from the following website:

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https://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=35f79dcf-1743-4d9f-aba5-5ead6b056309.

2. On 10/12/17 at 8:57 a.m. LPN #2 administered Omeprazole to Resident #16 with the meal when it was ordered before meals and the medication was administered outside of the one-hour window for administration.

Resident #16 was admitted to the facility on 2/5/15 with diagnoses that included, but were not limited to: dementia, depression, high blood pressure, and gastroesophageal reflux disease (GERD).

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 8/5/17, coded Resident #16 as scoring a five on the BIMS (brief interview for mental status) score, indicating she is severely impaired to make daily cognitive decisions. Resident #16 was coded as requiring limited or supervision for all of her activities of daily living.

Observation was made on 10/12/17 at 8:57 a.m. of LPN (licensed practical nurse) #2 preparing and administering medications to Resident #16. LPN #2 dispensed Omeprazole (used to treat GERD (1)) 20 mg (milligrams), one tablet. Resident #16 was in the dining room eating her breakfast. LPN #2 asked Resident #16 if she could administer the medications during the meal and Resident #16 agreed. LPN #2 administered Omeprazole 20 mg to Resident #16, between bites of her toast.

The physician order dated, 2/9/17, documented,

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"Prilosec capsule delayed release 20 mg (Omeprazole); Give 1 capsule by mouth one time a day related to gastroesophageal reflux disease." The scheduled time for the medication was for 7:30 a.m.

An interview was conducted with other staff member (OSM) #8, the facility consulting pharmacist, on 10/12/17 at 12:05 p.m. When asked if there were any special considerations a nurse should follow in the administration of Omeprazole, OSM #8 stated, "It should be given 30 minutes to an hour prior to a meal. This is not a contraindication but a recommendation by the manufacturer."

The pharmacist provided this surveyor with documentation from his computer from the following website: Clinical Pharmacology - ip.com, that documented in part, "Omeprazole - Route Specific Administration: Oral Administration - Administer on an empty stomach, 60 minutes before meals. If given once daily, administer before the first meal of the day."

The facility reference drug book found in the medication room, titled: Nursing 2018 Drug Handbook; Wolters Kluwer, documented in part, "Administration: P.O. (by mouth) - give drug at least 1 hour before meals."

An interview was conducted with LPN #2 on 10/12/17 at 1:11 p.m. When asked what is Omeprazole given for, LPN #2 stated, "GERD." When asked if there were any special considerations when giving this medication, LPN #2 stated, "Most likely it should be given a half hour before meals." When asked if she did that this morning for Resident #16, LPN #2 stated,

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F 332	Continued From page 9 "No, I was behind this morning. It showed in pink (on the computer screen - indicating that is was out of time range)." The administrator, ASM (administrative staff member) #1, LPN #1, the unit coordinator, and RN (registered nurse) #1, the assistant director of nursing, were made aware of the above concern on 10/12/17 at 2:10 p.m. No further information was provided prior to exit. (1) Nursing 2018 Drug Handbook, Walters Kluwer, page 1117.	F 332		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to:	F 441	**F-Tag 441** **1. Corrective Action** Nurse (LPN) #4 was counseled on the practices of infection control and the spread of infection during medication administration on 10/12/17. No ill effects to Resident #10 **2. Other Potential Residents** All residents prescribed medications are potentially affected.	

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F 441	Continued From page 10 (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.	F 441	**3. Systems Change** All licensed staff will be re-educated on medication administration protocols including the insurance of that medications do not come into contact with potentially contaminated objects/services, infection control practices and the prevention of spreading infection. Education will include a return demonstration of disinfecting the medication cart, equipment on the cart before, during and after medication administration every shift and as needed. **4. Monitoring** Random medication cart audits will be done weekly for four weeks, then quarterly by Nurse Educator for one year. Any findings will be reported to the Quality Assurance Committee. **5. Date** Corrective action will be completed by 11/17/17.	

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	495165	A. BUILDING _____ B. WING _____	C 10/12/2017

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(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 observation, facility document review, staff interview and clinical record review, it was determined that the facility staff failed to maintain infection control practices, for one of four residents in the medication administration observation, Resident #10.

LPN (licensed practical nurse) #4 failed to maintain infection control practices while preparing mediations for administration for Resident #10.

The findings include:

Resident #10 was admitted to the facility on 9/17/17 with diagnoses that included, but were not limited to: high blood pressure, high cholesterol levels and history of a hip fracture.

The most recent MDS (minimum data set) assessment, a Medicare 14-day assessment, with an assessment reference date of 10/1/17, coded the resident as being cognitively intact to make daily decisions.

Observation was made on 10/12/17 at 8:40 a.m. of LPN (licensed practical nurse) #4 administering medications to Resident #10. LPN #4 pushed Amlodipine (used to treat high blood pressure (1)), 10 mg (milligrams) out of the pill package. The pill popped out onto the surface of the medication cart. LPN #4 put on a pair of gloves and picked the pill up and placed it in the

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medication cup with the other medications. LPN #4 proceeded to administer the mediation to Resident #10. The surface of the medication cart was observed. There was a white powdery substance visible on the top of the cart. When this surveyor touched the surface of the cart, there was a sticky substance also on the cart. The computer was above the cart and there was visible dust on the brackets and arm that held the computer, this surveyor could draw a line in the dust. An interview was conducted with LPN #4. When asked how often she cleaned her medication cart, LPN #4 stated, "Frequently." When asked when she last cleaned her cart, LPN #4 stated, "Seven a.m." When asked what process she should follow when a pill touches the surface of the medication cart, LPN #4 stated, "I should have thrown the pill away and gotten a new one."

An interview was conducted with LPN #1, the unit coordinator, on 10/12/17 at 11:27 a.m. When asked what happens if nurse administering medications drops a pill on the top of the medication cart, LPN #1 stated, "You throw it away and pull a new one." LPN #1 was informed of the above observation.

The facility policy, "Medication Administration - General Guidelines" did not address dropping pills on the medication cart.

According to "Potter, Patricia A., and Anne Griffin Perry. Fundamentals of Nursing: Concepts, Process, and Practice", 4th ed. St Louis: Mosby-Year Book, Inc., 1997: "All medications should be handled to ensure that they do not come into contact with potentially contaminated objects or surfaces.

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F 441	Continued From page 13 The administrator, ASM (administrative staff member) #1, LPN #1 and RN (registered nurse) #1, the assistant director of nursing, were made aware of the above concern on 10/12/17 at 2:10 p.m. No further information was provided prior to exit. (1) This information was obtained from the following website: https://www.ncbi.nlm.nih.gov/pubmedhealth/PMHT0008948/?report=details	F 441		
F 507 SS=D	483.50(a)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS (a) Laboratory Services (2) The facility must- (iv) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to maintain laboratory test results in the clinical record for one of 16 residents in the survey sample, Resident #6. The facility staff failed to file the results of a thyroid test in the clinical record for Resident #6. The findings include: Resident #6 was admitted to the facility on 2/14/17 with diagnoses that included but were not	F 507	F-Tag 507 **1. Corrective Action** The TSH lab results were obtained and placed on the clinical record for Resident #6 on 10/12/17. **2. Other Potential Residents** All residents who are ordered lab work are potentially affected. An audit for all active residents who have ordered lab work will be conducted by night shift nurses on 10/25/17 to ensure results are on the medical record. **3. Systems Change** The night shift nurse will run a report for lab/diagnostic orders weekly to see what was ordered for labs. The report will be crossed reference with the medical record to insure the results are on the chart.	

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limited to: Parkinson's disease (a progressive disorder of the nervous system marked by muscle tremors, muscle rigidity, decreased mobility, stooped posture, slow voluntary movements and a mask-like facial expression (1)), dementia, high blood pressure, asthma and hypothyroidism (Your thyroid is a butterfly-shaped gland in your neck, just above your collarbone. It is one of your endocrine glands, which make hormones. Thyroid hormones control the rate of many activities in your body. These include how fast you burn calories and how fast your heart beats. All of these activities are your body's metabolism. If your thyroid gland is not active enough, it does not make enough thyroid hormone to meet your body's needs. This condition is hypothyroidism (2)).

The physician order dated, 6/10/17 documented, "TSH (thyroid stimulating hormone - a hormone secreted by the anterior pituitary gland that controls the release of thyroid hormone from the thyroid. (3)) every day shift every six months starting on the 17th for 7 days related to subclinical iodine-deficiency hypothyroidism. Start 8/17/17."

Review of the clinical record did not evidence any laboratory test results for August 2017 for a TSH level.

An interview was conducted with LPN (licensed practical nurse) #4 on 10/12/17 at 12:50 p.m. The order was reviewed with LPN #4. LPN #4 could not locate any TSH laboratory test results for Resident #6 in the clinical record. LPN #4 then called the laboratory. LPN #4 stated the test was done on 8/15/17 and she confirmed the test results were not in the clinical record.

F 507

4. Monitoring

The Director of Health Services, Unit Coordinator or designee will conduct a monthly audit for three months, then quarterly to ensure all lab results are on the medical record. Any findings will be reported to the QAPI Committee.

5. Date

Corrective action will be accomplished by 11/17/17.

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On 10/12/17 at 1:05 p.m. LPN #4 returned to this surveyor and presented the results of Resident #6's TSH laboratory (lab) test done on 8/15/17. When asked where these results were located, LPN #4 stated she had someone pull up the labs on the system (laboratory portal) and further stated, "It (the TSH lab test result) wasn't in the chart."

On 10/12/17 at approximately 2:10 p.m. LPN #1, the unit coordinator, was asked the process for laboratory test results to get on the clinical record, LPN #1 stated, The DON (director of nursing), ADON (assistant director of nursing) or their designee drop the results off to each unit. Any critical lab results they call the doctor and RP (responsible party). All other labs are put in a folder for the doctor's review. Once reviewed by the physician, the nurse files them in the clinical record."

The facility policy, "Laboratory and Diagnostic Testing Results, Notification of Physician," documented in part, "4. All results of laboratory and diagnostic testing are placed in the resident's clinical record."

The administrator, ASM (administrative staff member) #1, LPN #1 and RN (registered nurse) #1, the assistant director of nursing, were made aware of the above concern on 10/12/17 at 2:10 p.m.

No further information was provided prior to exit.

(1) This information was obtained from the following website:
https://www.ncbi.nlm.nih.gov/pubmedhealth/PMH

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F 507	Continued From page 16 T0024544/ (2) This information was obtained from the following website: https://medlineplus.gov/hypothyroidism.html (3) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman; page 571.	F 507		