STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495127	A. BUILDING _____ B. WING _____	C 04/14/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTMINSTER CANTERBURY CHESAP	3100 SHORE DRIVE VIRGINIA BEACH, VA 23451

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		

An unannounced Medicare/Medicaid standard survey was conducted 4/12/16 through 4/14/16. One complaint was investigated during the survey. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care requirement.

The Life Safety Code survey/report will follow.

The census in this 95 certified bed facility was 84 at the time of the survey. The survey sample consisted of 17 resident reviews, 14 current residents (Residents #s 1 through 14) and 3 closed record reviews (Residents #s 15 through 17).

RECEIVED
VDH/OLC

F 332 SS=D 483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE

F 332

The facility must ensure that it is free of medication error rates of five percent or greater.

This REQUIREMENT is not met as evidenced by:
Based on a medication pour and pass observation, 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 25 observed medication opportunities with 2 errors, resulting in a 8% medication error rate. The residents involved in the medication errors were Residents #11 (*Morphine Sulfate oral solution) and Resident #5 (*Cyanocobalamin B-12 injection).

The findings include:

1. LPN #2 was provided with 1:1 reeducation, completed training on "Avoiding common medication errors", and a med pass observation completed by the Staff Development Coordinator prior to the nurse assuming her duties. Resident #11 was assessed for pain with no complaints of pain noted. Physician was made aware of med error with no new orders. Resident #5 was monitored for adverse reaction. Physician was made aware of med error with no new orders.

2. While all residents have the potential to be affected by this deficient practice no resident was negatively affected.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jessica Whitehead
TITLE: ADMINISTRATOR
(X6) DATE: 4.27.16

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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1. On 4/13/16 at 10:00 a.m., Licensed Practical Nurse (LPN) #2 with trainee, Registered Nurse (RN) #1 failed to draw up in a syringe an accurate amount of Morphine Sulfate solution. Instead of 0.25 milliliters (ml), RN #1 drew up 0.20 ml, which was verified as correct by LPN #2, and administered to Resident #11.

*Morphine sulfate oral solution (10 mg per 5 mL and 20 mg per 5 mL) are formulations of morphine, an opioid agonist, indicated for the relief of moderate to severe acute and chronic pain where use of an opioid analgesic is appropriate. Morphine sulfate is a mu-agonist opioid and is a Schedule II controlled substance. Morphine sulfate, like other opioids used in analgesia, can be abused and is subject to criminal diversion (https://dailymed.nlm.nih.gov/dailymed/druginfo.cfm?setid=3b3146e9-17bc-4b2e-b84b-25f85e055a35).

Resident #11 had physician's orders dated 11/25/15 for Morphine Sulfate 100/milligram (mg)/5 mg (20 mg/ml) (0.25 ml) solution, administer 0.25
(5 mg) PO (by mouth) of SL (sublingual) for mild pain/distress.

Resident #11 was admitted to the nursing facility on 12/15/09 with diagnoses that included Hospice related to cerebrovascular disease, decline in physical condition, osteoarthritis, weight loss and chronic pain syndrome.

The resident's care plan dated 3/2016 identified the resident had chronic pain affecting knees and hips, neuropathic pain and was on Hospice. The

3. Nursing staff will be inserviced on safe medication pass practices including properly drawing up liquid medication in a syringe and verifying all injection amounts prior to administration.

4. Random observation of medication pass will be conducted by SDC and/or designee. The DON or Staff Development Coordinator or their designees will monitor through direct observation of nursing staff during med pass to assure staff are properly drawing up liquid medication into syringe to ensure they are free of air bubbles, and to verify all injection amounts prior to administration.

5. Observation Audits to be conducted weekly for 4 weeks then Biweekly for 4 weeks and monthly thereafter. The results of these audits will be reviewed and analyzed monthly for three months and a subsequent plan of action developed as indicated at the monthly QAPI Meeting. The Administrator is responsible for overall compliance.

Date of completion 5/1/16

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F 332	Continued From page 2	F 332		

goal the staff set for the resident was that the resident would be comfortable on a daily basis. Some of the approaches the staff would implement to accomplish this goal included administer pain medications as ordered by the physician.

The Minimum Data Set (MDS) assessment dated 2/29/16 coded Resident #11 with a score of 10 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was moderately impaired in the cognitive skills for daily decision making.

On 4/13/16 at 5:25 p.m., the facility's Clinical Coordinator and LPN #2 were made aware of the aforementioned medication error. The LPN did remember that the RN #1 trainee mentioned there may have been an air bubble in the syringe, but neither she or the trainee removed it before administering the Morphine Sulfate.

On 4/14/16 at approximately 1:30 p.m., the Administrator and the Director of Nursing (DON) were made aware of the aforementioned observations regarding medication pass error. The DON stated she was told by the Clinical Coordinator and LPN #2 about the medication error involving Resident #11.

The facility's policy and procedures entitled Administering Medications dated 12/2012 indicated medications should be administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis. The licensed nurse is responsible to select and verify medications 3 times prior to administration to include right dosage.

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2. On 4/13/16 at 2:49 p.m., Licensed Practical Nurse (LPN) #2 failed to draw up in a syringe an accurate amount of Cyanocobalamin/B-12. Instead of 1.0 milliliters (ml), the LPN drew up 1.4 ml. When she got to the resident's bedside, she adjusted the dose to 1.3 ml. after which she proceeded to administer the injection to Resident #5.

*Cyanocobalamin injection is used to treat and prevent a lack of vitamin B 12 that may be caused by any of the following: pernicious anemia (lack of a natural substance needed to absorb vitamin B 12 from the intestine); certain diseases, infections, or medications that decrease the amount of vitamin B 12 absorbed from food (https://www.nlm.nih.gov/medlineplus/druginfo/meds/a605007.html).

Resident #5 had physician's orders dated 10/13/15 for Cyanocobalamin/B-12 injection 1,000 mcg (microgram)/ml (1 ml) intramuscular one time monthly.

Resident #5 was admitted to the nursing facility on 1/27/15 with diagnosis of generalized weakness and pernicious anemia (B-12 deficiency).

The Minimum Data Set (MDS) assessment dated 2/17/16 coded Resident #5 with a score of 7 out of a possible 15 on the Brief Interview for Mental Status (BIMS) which indicated the resident was severely impaired in the cognitive skills for daily decision making.

The resident's care plan dated 2/2016 identified

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F 332	Continued From page 4	F 332		

the resident had generalized weakness, anti-platelet alteration. The goal the staff set for the resident was that she would not develop any significant changes in condition. Some of the approaches the staff would implement to accomplish this goal included administration of medications as ordered by the physician.

On 4/13/16 at 5:25 p.m., the facility's Clinical Coordinator and LPN #2 were made aware of the aforementioned medication error. The LPN did remember taking a second look and readjusting the dosage at the resident's bedside. The LPN verified, through demonstration with a 3 ml syringe, that she miscalculated the dose.

On 4/14/16 at approximately 1:30 p.m., the Administrator and the Director of Nursing (DON) were made aware of the aforementioned observations regarding medication pass error. The DON stated she was told by the Clinical Coordinator and LPN #2 about the medication error involving Resident #5.