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 _____	02/21/2020

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

(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 Emergency Preparedness survey was conducted 2/19/20 through 2/21/20. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities. No complaint(s) were investigated during the survey.	E 000		
F 000	INITIAL COMMENTS An unannounced standard and licensure survey was conducted 2/19/20 through 2/21/20. The facility had nine citations cited, in the Requirement for Long-Term Care Facilities. Zero complaint(s) were investigated during the survey.	F 000		
F 574 SS=C	Required Notices and Contact Information CFR(s): 483.10(g)(4)(i)-(vi) §483.10(g)(4) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including: (i) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes - (A) A description of the manner of protecting personal funds, under paragraph (f)(10) of this section; (B) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under section 1924(c) of the Social Security Act. (C) A list of names, addresses (mailing and email), and telephone numbers of all pertinent State regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State licensure office, the State Long-Term Care Ombudsman program, the	F 574		4/3/20

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

Electronically Signed | 03/26/2020

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F 574	Continued From page 1	F 574		

protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community and the Medicaid Fraud Control Unit; and

(D) A statement that the resident may file a complaint with the State Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community.

(ii) Information and contact information for State and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman program (established under section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. 3001 et seq) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15001 et seq.)

(iii) Information regarding Medicare and Medicaid eligibility and coverage;

(iv) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act); or other No Wrong Door Program;

(v) Contact information for the Medicaid Fraud Control Unit; and

(vi) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to

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F 574	Continued From page 2 resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives requirements and requests for information regarding returning to the community. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, it was determined the facility staff failed to accurately post the State Agency contact information. The findings include: A group interview was conducted with five residents, (Resident #21 with a BIMS (brief interview mental), of 15, of a score of 0-15 with 15 being cognitively intact, Resident 20 with a BIMS of 9, indicating moderate cognitive impairment, Resident #35 with a BIMS of 13, indicating cognitively intact, Group Resident (GR) #17 with a BIMS of 14, indicating cognitively intact and GR Resident #9 with BIMS of 9) on 2/20/2020 at 11:00 a.m. When asked if they were aware of the location for the state survey inspection the results, all of the five residents stated they did not know where the results were posted. A tour was conducted immediately after the group meeting and four facility bulletin boards posted in the three units were checked for any postings containing the State Agency contact information. An admission folder used for residents upon admission was reviewed. The folder contained a document titled, "Resident's Right Poster: Resident Assistance Agencies." The facility documented the state agency as "Virginia Health	F 574	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-tag 574 1. Corrective Action Proper agency information was updated on 2/21/2020 and given to the social work team to put into the new resident folder packets as well as posted on all appropriate bulletin boards 2. Other Potential Residents All new resident packets were updated and specific sections designated for regulatory information on bulletin boards. 3. Systems Change Medical records will be educated on the required information and proper height of postings as well as to check the bulletin boards monthly ensuring postings are correct and at the proper height. The social worker for healthcare will review agency contact information routinely for accuracy and update folders accordingly.	

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F 574	Continued From page 3 Quality Center," without the correct name, address or contact number for the state agency. Further observation of the facility revealed a copy of the Form was located on one of five bulletin boards observed throughout the facility. The form on the fifth bulletin board contained the incorrect information as documented above regarding the contact information for the state agency. An interview was conducted with administrative staff member (ASM) #1, the administrator, on 2/20/2020 at 4:54 p.m., regarding the location of the information to contact the state agency, for the residents residing in the facility. ASM #1 stated it was in their admissions folder. The above form was reviewed with ASM #1. ASM #1 contacted his admission staff member who came to the conference room with the current admission folders. The folders were reviewed and revealed they contained same information as documented above. A copy of the policy regarding the state agency information posting was requested from ASM #1 at this time. ASM #1, the administrator and ASM #2, the director of health services, were made aware of the above information on 2/20/2020 at 5:49 p.m. No further information was obtained prior to exit.	F 574	4. Monitoring The Directors of Health Services and Resident Services along with the Administrator will monitor the bulletin boards for proper information, postings and proper height. The Social Worker for Healthcare will review regulatory postings located throughout the community□s bulletin boards on a quarterly basis with residents at healthcare council meetings. 5. Date Corrective action will be completed by 4/3/2020	
F 577 SS=C	Right to Survey Results/Advocate Agency Info CFR(s): 483.10(g)(10)(11) §483.10(g)(10) The resident has the right to- (i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and	F 577		4/3/20

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F 577	Continued From page 4 (ii) Receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies. §483.10(g)(11) The facility must-- (i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility. (ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and (iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public. (iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview and staff interview, it was determined the facility staff failed to post the most recent survey results in a place readily accessible to the residents and/or families. The findings included; A group interview was conducted with five residents, (Resident #21 with a BIMS (brief interview mental), of 15, of a score of 0-15 with 15 being cognitively intact, Resident 20 with a BIMS of 9, indicating moderate cognitive impairment, Resident #35 with a BIMS of 13, indicating cognitively intact, Group Resident (GR) #17 with a BIMS of 14, indicating cognitively intact and GR Resident #9 with BIMS of 9) on	F 577	F-tag 577 1. Correct Action All survey information was moved to the proper height and additional required survey information added to the appropriate bulletin boards on 2/21/2020 2. Other Potential Residents All bulletin boards were checked for proper survey postings and incorrect information added as well as all postings moved to the proper height. 3. Systems Change Medical records will be educated on the required information and proper height of postings as well as to check the bulletin boards monthly ensuring postings are correct and at the proper height. Following	

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F 577	Continued From page 5 2/20/2020 at 11:00 a.m. When asked if they were aware of the location for the state survey inspection the results, all of the five residents stated they did not know where the results were posted. A tour was conducted on the three units of the health care center. On the Dogwood unit, a notice regarding the posting of the results was located on a bulletin board. The posting documented, "Survey reports and respective plans of correction for the preceding three years may be found in either the director of health services office (located on Redbud court) or administrators office (main floor admin [administration] area). Appointments may be necessary to best accommodate schedules." This notice was posted at the very top of the bulletin board above this surveyors head. Attached below this notice in a plastic sleeve was the survey results for 2018. The survey results were behind several other documents in plastic sleeves and was not visibly available. The results were posted at the top of the bulletin board, out of the reach of any resident in a wheelchair. On the Redbud unit, the survey results were located at the beginning of the hall. The results and the above notice were located behind a glass cabinet and not within the reach of the residents. On The Laurels unit, the notice was found at the top of the bulletin board, again, out of the reach of any resident in a wheelchair. The plastic sleeve containing the results were the results of the 10/12/2017 survey. An interview was conducted with administrative	F 577	any type of survey by the Office of Licensure and Certification, the Administrator or designee will add completed surveys to the bulletin boards. 4. Monitoring The Director of Health Services, Healthcare Coordinator and Administrator will monitor the bulletin boards for proper information, postings and proper height. 5. Date Corrective action will be completed by 4/3/2020	

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F 577	Continued From page 6 staff member (ASM) #1, the administrator, on 2/20/2020 at 4:54 p.m., regarding the location and posting for the most recent survey results. ASM #1 stated they should be on the bulletin boards on each unit. When asked if the residents can access them, ASM #1 stated, "Yes, they are thumbtacked up." The above observations were shared with ASM #1. When asked why the residents had to ask for the past three years for survey results, ASM #1 stated, "So they didn't junk up the bulletin board". When asked how a resident could reach the most recent survey results behind the glass on the Redbud unit, ASM #1 stated that a resident normally sits there. When asked if the residents are expected to slide the glass doors to the cabinet and reach up into the cabinet to obtain the most recent survey results, ASM #1, I guess not. A copy of the facility policy on posting the survey results was requested at this time of ASM #1. ASM #1, the administrator and ASM #2, the director of health services, were made aware of the above information on 2/20/2020 at 5:49 p.m. No further information was obtained prior to exit.	F 577		
F 622 SS=D	Transfer and Discharge Requirements CFR(s): 483.15(c)(1)(i)(ii)(2)(i)-(iii) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- (i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B) The transfer or discharge is appropriate	F 622		4/4/20

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F 622	Continued From page 7	F 622		

because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
(C) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident;
(D) The health of individuals in the facility would otherwise be endangered;
(E) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or
(F) The facility ceases to operate.
(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

§483.15(c)(2) Documentation.
When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's

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F 622	Continued From page 8 medical record and appropriate information is communicated to the receiving health care institution or provider. (i) Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii) The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. (iii) Information provided to the receiving provider must include a minimum of the following: (A) Contact information of the practitioner responsible for the care of the resident. (B) Resident representative information including contact information (C) Advance Directive information (D) All special instructions or precautions for ongoing care, as appropriate. (E) Comprehensive care plan goals; (F) All other necessary information, including a copy of the resident's discharge summary, consistent with §483.21(c)(2) as applicable, and any other documentation, as applicable, to ensure a safe and effective transition of care. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that	F 622	F-tag 622 1. Corrective Action	

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F 622	Continued From page 9 the facility staff failed to provide required information to hospital staff upon facility initiated transfers of two of 27 residents in the survey sample, Residents #43 and #36. The facility staff failed to evidence that comprehensive care plan goals were provided to hospital staff when Resident #43 was transferred to the hospital on 1/6/2020. The facility staff failed to evidence that comprehensive care plan goals were provided to hospital staff when Resident #36 was transferred to the hospital on 12/28/19. The findings include: 1. Resident #43 was admitted to the facility on 2/18/19. Resident #43's diagnoses included but were not limited to pneumonia, muscle weakness and difficulty swallowing. Resident #43's quarterly MDS (minimum data set) assessment, with an ARD (assessment reference date) of 1/27/2020, coded the resident as being cognitively intact. Review of Resident #43's clinical record revealed the resident was transferred to the hospital on 1/6/20 for an elevated temperature and abnormal lung sounds. Further review of Resident #43's clinical record, including nurses' notes and an eInteract hospital transfer form dated 1/6/20, failed to reveal evidence that the resident's comprehensive care plan goals were provided to the hospital staff when Resident #43 was transferred to the hospital on 1/6/2020 On 2/20/20 at 4:27 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated nurses send eInteract transfer forms and an orange folder containing a face sheet, physician orders, medication administration	F 622	Resident #36 and resident #43 have not had any hospital transfers since 12/28/19 and 1/6/20 respectfully, therefore no comprehensive care plan goals can be provided to hospital staff. 2. Other Potential Residents All residents who may have been transferred to hospital will have a copy of the comprehensive care plan goals included in packet of documents sent to the hospital. 3. Systems Change The hospital transfer checklist has been updated with the comprehensive care plan as part of the packet of documents sent to the hospital. The licensed nurse will sign off on the checklist that includes all documents to be sent. The checklist will remain in the hard medical record. 4. Monitoring The night shift nurse will review the hospital transfer checklist for accuracy during the daily chart checks. If the comprehensive care plan was noted to not have been sent, the licensed nurse should fax the care plan to the hospital and document a progress note in the electronic medical record. The results will be reported to the Interdisciplinary Team weekly for three months, then quarterly for one year. Report of findings will be submitted to the QAPI committee. 5. Date Corrective action will be completed by 4/4/2020	

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F 622	Continued From page 10	F 622		

records and treatment administration records to hospital staff when residents are transferred to the hospital. RN #1 stated the nurses do not provide hospital staff with residents' comprehensive care plan goals when residents are transferred.

On 2/20/20 at 5:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of health services) were made aware of the above concern.

The facility policy titled, "(Name of facility) Initiated Transfer and Discharge" documented, "4) The medical record:
a) Will clearly identify the basis or reason for transfer or discharge
b) Identify Information provided to the receiving provider which at a minimum will include...
vii) The resident's comprehensive care plan goals..."

No further information was presented prior to exit.

2. Resident #36 was admitted to the facility on 1/18/17. Resident #36's diagnoses included but were not limited to major depressive disorder, muscle weakness and heart failure. Resident #36's five day Medicare MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/7/20, coded the resident as being cognitively intact.

Review of Resident #36's clinical record revealed the resident was transferred to the hospital on 12/28/19 for shortness of breath and a chest sensation. Further review of Resident #36's clinical record, including nurses' notes and an eInteract hospital transfer form dated 12/28/19,

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F 622	Continued From page 11 failed to reveal evidence that the resident's comprehensive care plan goals were provided to the hospital staff when Resident #36 was transferred to the hospital on 12/28/19. On 2/20/20 at 4:27 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 stated nurses send eInteract transfer forms and an orange folder containing a face sheet, physician orders, medication administration records and treatment administration records to hospital staff when residents are transferred to the hospital. RN #1 stated the nurses do not provide hospital staff with residents' comprehensive care plan goals when residents are transferred. On 2/20/20 at 5:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of health services) were made aware of the above concern. No further information was presented prior to exit.	F 622		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information	F 655		4/4/20

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	495165	A. BUILDING _____ B. WING _____	02/21/2020

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

(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 655	Continued From page 12 necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services. (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, resident interview, staff interview, facility document review and clinical record review, it was determined the facility staff failed to develop a complete baseline care plan for one of 27 residents in the survey sample, Resident #100. The facility staff failed to develop a baseline care plan to address Resident #100's	F 655	F-tag 655 1. Corrective Action Resident #100 was no longer using the spirometer, the device was placed in her wardrobe in a plastic bag and resident educated on why. 2. Other Potential Residents	

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F 655	Continued From page 13 use of a spirometer on admission and to address the resident's functional status and care requirements. The findings included: Resident #100 was admitted to the facility on 2/8/2020 with diagnoses that included but were not limited to: knee replacement, high blood pressure, and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/15/2020 coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions. On 2/29/2020, at approximately 4:05 p.m., Resident #100 was observed sitting in her recliner. An incentive spirometer (2), was observed sitting on the nightstand uncovered. When asked if she uses the incentive spirometer, Resident #100 said she used when she first got to the facility but since she's up more, she hasn't used it as much. The baseline care plan dated 2/8/2020 failed to evidence any documentation for the use of a spirometer and failed to evidence any documentation for Resident #100's "Functional Status". There were no check marks documented under the Self Care: Admission Performance for eating, personal hygiene, toilet use, dressing, or bathing. There were no check marks documented under functional Abilities and	F 655	All current residents who were admitted from the hospital as of 2/21/2020 have had equipment orders reviewed to reflect the ongoing need. In addition, residents were interviewed to determine other equipment needed but not ordered, its medical need, and if so, proper orders obtained or family will be asked to remove. An audit was performed of all hospital admissions on 2/21/2020 and found all with proper orders. 3. Systems Change The Baseline Care Plan, Respiratory conditions- Section J/Health Conditions, has been modified to include the notation of equipment, verification of its use and proper physician orders. All Licensed nurses will be educated on the revisions to the baseline care plan in addition to educating the direct care staff on communicating resident use or access to medical equipment. 4. Monitoring The MDS coordinator will review completion of all baseline care plans within 24 hours reconciling noted equipment with proper orders. Any variances will be addressed daily at the nursing Interdisciplinary team meeting with further education or appropriate and timely action taken. 5. Date The corrective action will be completed by 4/4/2020.	

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F 655	Continued From page 14	F 655		

Goals - Mobility: bed mobility, transfer, walk in room, and walk in corridor, location on unit or mobility devices used. A walker was observed in Resident #100's room throughout the survey.

An interview was conducted with RN (registered nurse) #1 on 2/20/2020 at 4:25 p.m. When asked who develops the baseline care plan RN #1 stated it's done as a group. RN #1 stated upon admission the floor nurses start one but after that, the MDS nurse and unit managers work on the care plans. When asked the purpose of the care plan, RN #1 stated it has measureable goals to work toward for each resident.

An interview was conducted with ASM #2 on 2/20/2020 at 5:45 p.m. When asked if the baseline care plan should include the use of the spirometer, ASM #2 stated yes. When asked if the baseline care plan should have the resident's functional status documented, ASM #2 stated, yes, that should be filled in.

ASM #1, the administrator and ASM #2, the director of health services, were made aware of the above information on 2/20/2020 at 5:49 p.m. A request was made for a policy on the use of incentive spirometers was requested.

No further information was obtained prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
(2) Incentive spirometer is a device used to help you keep your lungs healthy after surgery or when you have a lung illness, such as pneumonia. Using the incentive spirometer teaches you how

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F 655	Continued From page 15 to take slow deep breaths. Deep breathing keeps your lungs well-inflated and healthy while you heal and helps prevent lung problems, like pneumonia. This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000451.htm	F 655		
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 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)-	F 656		4/4/20

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F 656	Continued From page 16 (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 observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to implement the comprehensive care plan for one of 27 residents in the survey sample, Resident #14. The facility staff failed to implement Resident #14's comprehensive care plan to administer oxygen at 4 LPM (liters per minute0 as precede by the physician. Resident #14 was observed on separate occasion receiving oxygen at rates below 4LPM. The finding include: Resident #14 was admitted to the facility on 1/15/19 with diagnoses that included but were not limited to: myasthenia gravis (a disease characterized by chronic fatigability and weakness especially in the face and neck region, but also affecting the muscles of the trunk and limbs) (1), diabetes, dementia, and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an	F 656	F-tag 656 1. Corrective Action Resident #14□s administration of oxygen was immediately corrected to 4LPM via nasal cannula on 2/20/20 by the licensed nurse. Oxygen saturation records per physicians order, were reviewed from 2/19 -21/2020 averaging 97%. 2. Other Potential Residents All residents prescribed oxygen are potentially affected. An audit was completed on 2/20/20 for all residents with oxygen therapy to assess if the care plan agrees with current physician orders. Findings noted that all prescribed orders agreed with current care plans. 3. Systems Change All licensed staff will be educated on SWVC□s oxygen administration policy. Education will include a return demonstration for correctly reading liters of oxygen flow on a concentrator. The treatment administration record (TAR) will include checking all residents receiving continuous oxygen twice/shift to insure	

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F 656	Continued From page 17 assessment reference date of 11/28/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. Resident #14 was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he required supervision after set up assistance was provided. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen therapy. The comprehensive care plan, dated 1/15/19 and revised on 8/13/19, documented in part, "Focus: (Resident #14) has oxygen therapy r/t (related to) myasthenia gravis." The "Interventions" documented in part, "OXYGEN SETTING: O2 [oxygen] at 4 LPM [liter per minute] via NC [nasal cannula] with humidification unless using an E-tank (portable oxygen tank) when is away from his room, at all times." Observation was made of Resident #14 on 2/19/2020 at 4:00 p.m. The resident was in bed with his oxygen on via the nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator flowmeter revealed the oxygen flowrate was set at 3.5 LPM with the ball sitting on the 3.5 line and the top of the ball resting under the 4.0 line. A second observation was made on 2/20/2020 at 1:59 p.m., Resident #14 was in his recliner with his oxygen on via the nasal cannula, connected to an oxygen concentrator that was running. The oxygen concentrator flowrate was set with the bottom of the ball sitting on the 2.5 line and the top of the ball resting under the 3.0 line.	F 656	oxygen rate observed is in compliance with physician orders. Documentation will be reflected on the TAR. 4. Monitoring Random oxygen administration audits will be done weekly for four weeks, then quarterly by Nurse Educator for one year. Any findings will be reported to the QAPI Committee. 5. Date The corrective action will be completed by 4/4/2020.	

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F 656	Continued From page 18	F 656		

The physician order dated, 1/19/19, documented, "Oxygen @ (at) 4 lpm (liters per minute) via NC (nasal cannula - a plastic tube with two prongs that insert in the nose) via concentrator or portable O2 (oxygen).

On 2/20/2020 at 2:02 p.m. RN (registered nurse) #3 was asked to observe the oxygen concentrator for Resident #14. When asked how to read the oxygen flowrate being delivered to the resident, RN #3 stated you have to get down to eye level with the machine and read it. The line must go through the center of the ball. When asked to read the flowrate of oxygen that Resident #14 was currently receiving, RN #3 stated, it's just below 3 Liters. When asked about the physician orders for Resident #14's oxyegn, RN #3 stated she would have to check the orders. The physician orders documented above for 4 liters of oxygen per minute were reviewed with RN #3.

An interview was conducted with RN #4 on 2/20/2020 at 3:10 p.m. When asked if staff are implementing the comprehensive care plan if the physician ordered 4 LPM of oxygen and the resident is receiving less oxygen per minute than the prescribed rate, RN #4 stated no.

An interview was conducted with administrative staff member (ASM) #2, the director of health services, on 2/20/2020 at 3:42 p.m. When asked if the staff are implementing the comprehensive care plan if the care plan documents to give oxygen per the physician order and the oxygen is not set according to the physician order, ASM #2 stated, no.

The facility policy, Care Plan, Comprehensive,

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F 656	Continued From page 19 documented in part, "All services provided or arranged by the facility to meet the needs identified in the written plan of care meet professional standards of quality and are provided by qualified persons in accordance with each resident's written plan of care." ASM #1, the administrator and ASM #2, the director of health services, were made aware of the above information on 2/20/2020 at 5:49 p.m. No further information was obtained prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 384.	F 656		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review and clinical record review, it was determined that the facility staff failed to follow professional standards of practice for one of 27 residents in the survey sample, Resident #36. On 2/1/20, a nurse placed a dressing over open areas on Resident #36's right buttock. The facility staff failed to transcribe a physician's order for the dressing. The findings include:	F 658	F-tag 658 1. Corrective Action Resident #36 was assessed by the Nurse Practitioner on 2/14/20 prescribing treatment orders for the observed open area. Care Plan was updated to reflect the proper diagnosis on 2/20/2020 2. Other Potential Residents All residents who have a current pressure injury are potentially affected. An audit was conducted on 2/20/20 to insure	4/4/20

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F 658	Continued From page 20 Resident #36 was admitted to the facility on 1/18/17. Resident #36's diagnoses included but were not limited to major depressive disorder, muscle weakness and heart failure. Resident #36's five day Medicare MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/7/20, coded the resident as being cognitively intact. A nurse's note dated 2/1/20 documented, "Resident has two 0.3 cm (centimeter) long minimally split areas of skin on right inner buttock. Placed extra thin duoderm (dressing) over the area. Will notify NP (nurse practitioner) of area." Review of Resident #36's clinical record failed to reveal a physician's order for the duoderm dressing that was placed on Resident #36's right buttock on 2/1/20. Resident #36's comprehensive care plan initiated on 2/10/20 documented, "(Name of Resident #36) has impairment to skin integrity of right inner buttock. Pressure injury...Treatment per orders..." On 2/20/20 at 3:27 p.m., an interview was conducted with ASM (administrative staff member) #3 (the nurse practitioner). ASM #3 stated she was made aware of the open area on Resident #36's right buttock and the dressing that was applied on 2/1/20. ASM #3 stated she should confirm telephone orders are put into the computer system when a nurse calls her but she does not always do this. On 2/20/20 at 4:27 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked if a resident should have a physician's	F 658	residents with a pressure injury had matching physician□s orders and documentation on their care plans. Findings noted no variances. 3. Systems Change All licensed nurses will be educated on SWVC□s policy and procedures for Pressure Ulcer Risk Assessment and Pressure Ulcer Prevention & Care Protocol. The Nurse Practitioner (NP) and MDS coordinator will conduct weekly wound rounds as well as review any resident with a pressure injury at the daily nursing Interdisciplinary team meeting. Any new orders/treatments will be noted and documented in the electronic medical record and respective care plan updated. 4. Monitoring The Director of Health Services, Healthcare Coordinator or designee will conduct a monthly audit for three months, then quarterly for 1 year to ensure all pressure injuries have orders along with appropriate documentation and that the Care Plan is reflective of the orders. All findings will be reported to the QAPI Committee. 5. Date The corrective action will be completed by 4/4/2020.	

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F 658	Continued From page 21 order for a dressing placed on his body. RN #1 stated, "Yes, because all of their treatments should have orders and when they are due to be changed so that you have specifics on what you are putting a treatment to." On 2/20/20 at 5:29 p.m., ASM (administrative staff member) #2 (the director of health services) stated the facility employees follow the facility policies as their standard of practice. On 2/20/20 at 5:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 were made aware of the above concern. The facility policy titled, "Physician Orders" documented, "A physician's order is required for all evaluations and treatment. Orders may be written directly by the physician or obtained verbally when the physician is not in the facility. All telephone/verbal orders must be followed up in writing with a signature from the physician giving the order."	F 658		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to	F 686		4/4/20

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F 686	Continued From page 22 promote healing, prevent infection and prevent new ulcers from developing. 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 provide care and services for the treatment of a pressure injury (1) for one of 27 residents in the survey sample, Resident #36. The facility staff failed to obtain a physician's order for a dressing observed on Resident #36's right buttock on 2/14/20 and the nurse practitioner concluded the dressing that was applied on the resident's right buttock may have contributed to the pressure injuries on the right buttock. The findings include: Resident #36 was admitted to the facility on 1/18/17. Resident #36's diagnoses included but were not limited to major depressive disorder, muscle weakness and heart failure. Resident #36's five day Medicare MDS (minimum data set) assessment with an ARD (assessment reference date) of 1/7/20, coded the resident as being cognitively intact. Section M documented Resident #36 did not have any pressure injuries. A Braden scale for predicting pressure sore (injury) risk dated 12/31/19 documented Resident #36 was not at risk for the development of pressure injuries. A nurse's note dated 2/1/20 documented, "Resident has two 0.3 cm (centimeter) long minimally split areas of skin on right inner buttock. Placed extra thin duoderm (dressing) over the area. Will notify NP (nurse practitioner) of area." Review of Resident #36's clinical record	F 686	F-tag 686 1. Corrective Action Resident #36 was assessed by the Nurse Practitioner (NP) on 2/14/20 prescribing treatment orders for the observed open area. 2. Other Potential Residents All residents who have a pressure area are potentially affected. On 2/20/2020, an audit was conducted for all residents with pressure areas reviewing the treatment orders for application of dressings (including cleansing, ointments, etc.) to agree with the physician□s order. No variances were found. 3. Systems Change All licensed nurses will be educated on SWVC□s policy and procedures for Pressure Ulcer Risk Assessment and Pressure Ulcer Prevention & Care Protocol. The NP and MDS coordinator will conduct weekly wound rounds as well as review any resident with a pressure injury at the daily nursing Interdisciplinary team meeting. Any new orders/treatments will be noted and documented in the electronic medical record. 4. Monitoring The Director of Health Services, Healthcare Coordinator or designee will conduct a monthly audit for three months, then quarterly for 1 year to ensure all pressure injuries have orders and weekly documentation is completed. Any findings will be reported to the QAPI Committee.	

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SHENANDOAH VLY WESTMINSTER-CANTERBURY	300 WESTMINSTER CANTERBURY DR WINCHESTER, VA 22603

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F 686	Continued From page 23 failed to reveal a physician's order for the duoderm dressing that was placed on Resident #36's right buttock on 2/1/20. A weekly non pressure skin assessment dated 2/3/20 documented, "Skin warm and dry. Two 0.3 cm areas noted open on right buttock. TX (Treatment) in place." (Note- there was no physician's order or evidence of the treatment that was in place in Resident #36's clinical record). A weekly non pressure skin assessment dated 2/10/20 documented, "No new skin issues noted. Skin warm, dry and intact." Further review of Resident #36's clinical record failed to reveal any treatment orders until 2/14/20. Resident #36's comprehensive care plan initiated on 2/10/20 documented, "(Name of Resident #36) has impairment to skin integrity of right inner buttock. Pressure injury...Treatment per orders..." A note signed by the nurse practitioner on 2/14/20 documented, "HPI (History of present illness): (Name of Resident #36) is seen this morning prior to getting out of bed for the day in his apartment on Dogwood neighborhood. He is able to comment that his buttock hurts. O (Observation): Right buttock: Thin Duoderm is removed. It has partially rolled. There were two areas of concern. First, higher up on his buttock more lateral was a healing fissure. This was approximately 0.3 cms [centimeter] in length and nearly healed. No drainage, flesh colored, no odor and about 0.1 cm in depth. No surrounding erythema (red skin). The second area was a	F 686	5. Date The corrective action will be completed by 4/4/2020.	

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 _____	02/21/2020

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 686	Continued From page 24	F 686		

pressure area with a fissure that may have been caused by the thin Duoderm. There was a developing area of tenderness as well. The fissure measures approximately 0.7 cm in length and 0.3 cm in width. It was about 0.2 cm in depth. There was a developing area of erythema that was tender to touch adjacent to this. It was blanchable.
A (Assessment):
1. Right buttock stage 2 pressure ulcers (injuries) (1).
P (Plan):
1. Both areas were covered with one half piece of thin Duoderm. This will need to be monitored carefully to make sure that it does not roll, as he tends to move in his chair such that this could roll. The area is too close to his anus for use of a Mepilex (dressing). Apply weekly and PRN (as needed) to clean dry skin."

On 2/20/20 at 3:27 p.m., an interview was conducted with ASM (administrative staff member) #3 (the nurse practitioner). ASM #3 stated she was made aware of the open area on Resident #36's right buttock and the dressing that was applied on 2/1/20. ASM #3 stated she should confirm telephone orders are put into the computer system when a nurse calls her but she does not always do this. ASM #3 stated she observed Resident #36's right buttock on 2/14/20. ASM #3 stated on this date, Resident #36 was in bed and a duoderm dressing was on the resident's buttock. ASM #3 stated the duoderm had wrinkled and rolled and she questioned if a contributing factor of the pressure injury was due to the rolled duoderm dressing. ASM #3 was made aware that there was no evidence of a physician's order for the duoderm on Resident #36's right buttock until 2/14/20. ASM #3 stated

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 _____	02/21/2020

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 686	Continued From page 25	F 686		

she did not know why the duoderm was on Resident #36's right buttock and if the duoderm should have been on the resident's right buttock when she observed the area on 2/14/20. ASM #3 stated the duoderm was a possible contributing factor to the pressure injuries.

On 2/20/20 at 4:27 p.m., an interview was conducted with RN (registered nurse) #1. RN #1 was asked if a resident should have a physician's order for a dressing placed on his body. RN #1 stated, "Yes, because all of their treatments should have orders and when they are due to be changed so that you have specifics on what you are putting a treatment to."

On 2/20/20 at 5:56 p.m., ASM (administrative staff member) #1 (the administrator) and ASM #2 (the director of health services) were made aware of the above concern.

The facility policy titled, "Physician Orders" documented, "A physician's order is required for all evaluations and treatment. Orders may be written directly by the physician or obtained verbally when the physician is not in the facility. All telephone/verbal orders must be followed up in writing with a signature from the physician giving the order."

The facility policy titled, "Pressure Ulcer Prevention and Care Protocol" documented, "A program of prevention, care, and treatment of pressure ulcers is carried out for all Health Care residents to prevent skin breakdown and promote healing. The responsibility of all caregivers is to prevent, care for, and provide treatment for pressure ulcers..."

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 _____	02/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 686	Continued From page 26 No further information was presented prior to exit. Reference: 1. "A pressure injury is localized damage to the skin and underlying soft tissue usually over a bony prominence or related to a medical or other device. The injury can present as intact skin or an open ulcer and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. The tolerance of soft tissue for pressure and shear may also be affected by microclimate, nutrition, perfusion, co-morbidities and condition of the soft tissue. Stage 2 Pressure Injury: Partial-thickness skin loss with exposed dermis Partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister. Adipose (fat) is not visible and deeper tissues are not visible..." This information was obtained from the website: https://cdn.ymaws.com/npuap.site-ym.com/resource/resmgr/npuap_pressure_injury_stages.pdf	F 686		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by:	F 695		4/4/20

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 _____	02/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 27 Based on observation, resident interview, staff interview and facility document review, it was determined the facility staff failed to provide respiratory care and services consistent with professional standards of practice, and the comprehensive person-centered care plan for three of 27 residents in the survey sample, (Residents #14, #35 and #100). The facility staff failed to administer oxygen per the physician order for Resident #14. The facility staff failed to store Resident #35's CPAP (continuous positive airway pressure) mask in a sanitary manner. During separate observations Resident #35's CPAP machine with mask and tubing resting on the nightstand. The facility failed to obtain physician orders for the use of an Incentive Spirometer for Resident #100. The findings include: 1. Resident #14 was admitted to the facility on 1/15/19 with diagnoses that included but were not limited to: myasthenia gravis (a disease characterized by chronic fatigability and weakness especially in the face and neck region, but also affecting the muscles of the trunk and limbs) (1), diabetes, dementia, and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 11/28/19, coded the resident as scoring a "3" on the BIMS (brief interview for mental status) score, indicating the resident was severely impaired to make daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of his activities of daily living except eating in which he required supervision	F 695	F-tag 695 1. Corrective Action On 2/20/2020, Resident #14□s administration of oxygen was immediately corrected to 4LPM via nasal cannula by the licensed nurse; the CPAP mask and tubing for Resident #35 was properly stored in a plastic bag and the incentive spirometer for Resident #100 was placed in her wardrobe in a plastic bag and resident educated on why. 2. Other Potential Residents All residents prescribed oxygen therapy or the use of a respiratory devices/equipment are potentially affected. An audit was conducted on 2/20/2020 for residents with oxygen orders, CPAP or other respiratory equipment revealed all orders matched observed equipment settings in addition to orders for other devices which were also stored properly. 3. Systems Change All licensed staff will be educated on the SVWC policy and procedure for Oxygen Therapy including a return demonstration with various devices. Treatment plans will include checking all residents on continuous oxygen twice a shift for proper settings and saturation levels with appropriate documentation in the electronic medical record. Additional education for licensed staff will include a review of the following SVWC policies: Oxygen Therapy-Mask, Nasal Cannula and Humidification; Continuous Positive Airway Pressure (CPAP) and Incentive Spirometer emphasizing the proper storage of respiratory equipment and	

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 _____	02/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 695	Continued From page 28 after set up assistance was provided. In Section O - Special Treatments, Procedures and Programs, the resident was coded as using oxygen therapy. Observation was made of Resident #14 on 2/19/2020 at 4:00 p.m. The resident was in bed with his oxygen on via the nasal cannula connected to an oxygen concentrator. Observation of the oxygen concentrator flowmeter revealed the oxygen flowrate was set at 3.5 LPM with the ball sitting on the 3.5 line and the top of the ball resting under the 4.0 line. A second observation was made on 2/20/2020 at 1:59 p.m., Resident #14 was in his recliner with his oxygen on via the nasal cannula, connected to an oxygen concentrator that was running. The oxygen concentrator flowrate was set with the bottom of the ball sitting on the 2.5 line and the top of the ball resting under the 3.0 line. The physician order dated, 1/19/19, documented, "Oxygen @ (at) 4 lpm (liters per minute) via NC (nasal cannula - a plastic tube with two prongs that insert in the nose) via concentrator or portable O2 (oxygen). The comprehensive care plan, dated 1/15/19 and revised on 8/13/19, documented in part, "Focus: (Resident #14) has oxygen therapy r/t (related to) myasthenia gravis." The "Interventions" documented in part, "OXYGEN SETTING: O2 [oxygen] at 4 LPM [liter per minute] via NC [nasal cannula] with humidification unless using an E-tank (portable oxygen tank) when is away from his room, at all times." Review of the nurse's notes failed to evidence	F 695	accounting of ordered respiratory equipment. 4. Monitoring Random oxygen administration/CPAP audits by the nurse educator will be done weekly for four weeks, then quarterly for one year. All findings will be reported to the QAPI Committee. 5. Date Correction Action will be completed by 4/4/2020.	

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 _____	02/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 695	Continued From page 29	F 695		

documentation of the oxygen setting for the month of February.

On 2/20/2020 at 2:02 p.m. RN (registered nurse) #3 was asked to observe the oxygen concentrator for Resident #14. When asked how to read the oxygen flowrate being delivered to the resident, RN #3 stated you have to get down to eye level with the machine and read it. The line must go through the center of the ball. When asked to read the flowrate of oxygen that Resident #14 was currently receiving, RN #3 stated, it's just below 3 Liters. When asked about the physician orders for Resident #14's oxygen, RN #3 stated she would have to check the orders. The physician orders documented above for 4 liters of oxygen per minute were reviewed with RN #3, and it was confirmed Resident #14 was to receive oxygen at 4 LPM.

An interview was conducted with administrative staff member (ASM) #2, the director of health services, on 2/20/2020 at 3:42 p.m. When asked how to read an oxygen concentrator, ASM #2 stated you need to get down to eye level. You read the line of the prescribed rate and the ball must be centered with the line going through the center of the ball. When asked if the staff were following the physician orders if Resident #14's oxygen was not set at the prescribed flow rate, ASM #2 stated, no.

The facility policy, "Oxygen Therapy - Mask, Nasal Cannula and Humidification" documented in part, "d. Turn on the oxygen source to the prescribed liter flow. The center of the float ball must be on the line of the ordered level of oxygen. The center of the float ball must be observed at eye level. The licensed nurse should

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 _____	02/21/2020

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

(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 695	Continued From page 30	F 695		

check the level at least twice a shift."

ASM #1, the administrator and ASM #2, the director of health services, were made aware of the above information on 2/20/2020 at 5:49 p.m.

No further information was obtained prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 384.

2. Resident #35 was admitted to the facility on 4/2/19 with diagnoses that included but were not limited to: sleep apnea - (condition in which the patient has transient periods of apnea [not breathing] during sleep) (1), diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/4/2020, coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for his activities of daily living except eating in which he was independent after set up assistance was provided.

Observation was made of Resident #35's room during the initial screening of the facility on 2/19/2020 at approximately 4:45 p.m. A CPAP (Continuous Positive Airway Pressure) (2) machine was observed sitting on the night stand. The tubing and mask were uncovered resting on the surface of the nightstand. A second observation was made of the CPAP machine with

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 _____	02/21/2020

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

(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 695	Continued From page 31	F 695		

mask and tubing resting on the nightstand on 2/19/2020 at 5:42 p.m. and on 2/20/2020 at 2:25 p.m.

The physician orders dated 4/2/19 documented, "Assist resident each night with applying CPAP. Setting #9/ Remove in am (morning) Fill with distilled H2O (water) at bedtime for CPAP application."

The comprehensive care plan dated, 4/2/19 documented in part, "Focus: (Resident #35) has altered respiratory status requiring the use of CPAP machine QHS (every bedtime) r/t (related to) sleep apnea." The "Interventions" failed to evidence any documentation related to the storage of the CPAP mask and tubing.

An interview was conducted with RN (registered nurse) #3 on 2/20/2020 at 2:32 p.m. When asked how a CPAP tubing and mask are stored when not in use, RN #3 stated they should be covered.

An interview was conducted with administrative staff member (ASM) #2, the director of health services, on 2/20/2020 at 3:42 p.m. When asked how a CPAP mask and tubing should be stored when not in use, ASM #2 sated they should be cleaned, dried, placed on a clean surface such as a towel. When asked if they should be just sitting directly on the surface of the resident's nightstand, ASM #2 stated, no.

The facility policy, "Continuous Positive Airway Pressure (CPAP)" documented in part, "Cleaning of Equipment: All circuits (tubing, mask, head gear) are disposable and should be discarded upon discontinuation of therapy. If using a resident's own machine, wash the water tube and

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 _____	02/21/2020

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

(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 695	Continued From page 32	F 695		

air tubing in warm water using a mild detergent. Rinse tubing thoroughly and allow to air dry. Clean the external surfaces of the devices with appropriate Sani-Cloth. Allow to air dry before using again."

ASM #1, the administrator and ASM #2, the director of health services, were made aware of the above information on 2/20/2020 at 5:49 p.m. When asked what standard of practice they follow, ASM #2 stated they follow their policies.

No further information was obtained prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 534.
(2) CPAP- Continuous Positive Airway Pressure a non-ventilator technique that recruits lung volume and often improves the Pao2/Flo2 ratio, is most likely to help patients with modest ventilatory requirements and acute atelectasis or lung edema.) The Merck Manual, 16th Edition, 1992 page 639.

3. Resident #100 was admitted to the facility on 2/8/2020 with diagnoses that included but were not limited to: knee replacement, high blood pressure, and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/15/2020 coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she

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 _____	02/21/2020

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

(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 695	Continued From page 33	F 695		

was capable of making daily cognitive decisions.

On 2/29/2020, at approximately 4:05 p.m., Resident #100 was observed sitting in her recliner. An incentive spirometer (2), was observed sitting on the nightstand uncovered. When asked if she uses the incentive spirometer, Resident #100 said she used when she first got to the facility but since she's up more, she hasn't used it as much.

Review of the clinical record failed to reveal a physician's order for the use of a spirometer.

The baseline care plan dated 2/8/2020 failed to evidence any documentation of the use of a spirometer.

An interview was conducted with RN (registered nurse) #3 on 2/20/2020 at 2:07 p.m. When asked if there needs to be an order for a resident to use an incentive spirometer, RN #3 stated she's didn't know and would have to ask someone. When asked if she was aware of how often Resident #100 uses the incentive spirometer, or if the resident uses it, RN #3 stated, "No, I have to talk to the nurse practitioner." When asked how a piece of respiratory equipment should be stored, RN #3 stated, it should be covered. When asked why is should be covered, RN #3 stated to keep it clean.

An interview was conducted with administrative staff member (ASM) #2, the director of health care services, on 2/20/2020 at 3:42 p.m. When asked if there should be a physician's order for the use of a spirometer, ASM #2 sated, yes. When asked how the incentive spirometer should be stored when not in use, ASM #2 sated it

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 _____	02/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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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
F 695	Continued From page 34 should be in a plastic bag. ASM #1, the administrator and ASM #2, the director of health services, were made aware of the above information on 2/20/2020 at 5:49 p.m. A request was made for a policy on the use of incentive spirometers was requested. On 2/21/2020 at 7:42 a.m., ASM #2 stated the facility did not have a policy regarding the use of incentive spirometers. No further information was obtained prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55. (2) This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000451.htm	F 695		
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:	F 880		4/4/20

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 _____	02/21/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 35 §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 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.	F 880		

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	495165	A. BUILDING _____ B. WING _____	02/21/2020

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F 880	Continued From page 36 §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 observation, staff interview, resident interview and facility document review, it was determined the facility staff failed to implement infection control practices for two of 27 residents, Residents #35 and #100 in the survey sample and in the laundry room. The facility staff failed to store a CPAP (continuous positive airway pressure) machine in a manner to prevent infection for Resident #35 and failed to store an incentive spirometer in a manner to prevent infection for Resident #100. The sprinkler head in the clean -side of the facility dryer room were observed covered in dust potentially contaminating clean clothing and linens. The findings include: 1. Resident #35 was admitted to the facility on 4/2/19 with diagnoses that included but were not limited to: sleep apnea - (condition in which the patient has transient periods of apnea [not breathing] during sleep) (1), diabetes, and high blood pressure. The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 1/4/2020,	F 880	F-tag 880 1. Corrective Action On 2/20/2020 the CPAP mask and tubing for Resident #35 was properly stored in a plastic bag and the incentive spirometer for Resident #100 was placed in her wardrobe in a plastic bag and resident educated on why. The sprinkler head on the clean side of the dryer room was cleaned on 2/21/2020. 2. Other Potential Residents All residents with respiratory equipment may be affected. All sprinkler heads in the laundry and on the healthcare courts are potentially affected. On 2/20/2020, an audit for all residents with any respiratory equipment was conducted to insure proper storage. No additional sprinkler heads were found with dust. 3. Systems Change Licensed staff will be educated on the following SVWC policies: Infection Control; Oxygen Therapy-Mask, Nasal Cannula and Humidification; Continuous Positive Airway Pressure (CPAP) and	

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F 880	Continued From page 37 coded the resident as scoring a "13" on the BIMS (brief interview for mental status) score, indicating the resident was capable of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for his activities of daily living except eating in which he was independent after set up assistance was provided. Observation was made of Resident #35's room during the initial screening of the facility on 2/19/2020 at approximately 4:45 p.m. A CPAP (Continuous Positive Airway Pressure) (2) machine was observed sitting on the night stand. The tubing and mask were uncovered resting on the surface of the nightstand. A second observation was made of the CPAP machine with mask and tubing resting on the nightstand on 2/19/2020 at 5:42 p.m. and on 2/20/2020 at 2:25 p.m. The physician orders dated 4/2/19 documented, "Assist resident each night with applying CPAP. Setting #9/ Remove in am (morning) Fill with distilled H2O (water) at bedtime for CPAP application." The comprehensive care plan dated, 4/2/19 documented in part, "Focus: (Resident #35) has altered respiratory status requiring the use of CPAP machine QHS (every bedtime) r/t (related to) sleep apnea." The "Interventions" failed to evidence any documentation related to the storage of the CPAP mask and tubing. An interview was conducted with RN (registered nurse) #3 on 2/20/2020 at 2:32 p.m. When asked how a CPAP tubing and mask are stored when not in use, RN #3 stated they should be covered.	F 880	Incentive Spirometer with a focus on proper storage and monitoring of ordered respiratory equipment. Documentation of proper storage will be noted on the treatment record. Laundry staff were educated on cleaning procedures and required equipment as well as modifying the weekly checklist. 4. Monitoring Random audits for infection control and proper storage of oxygen/respiratory equipment will be done by the nurse educator weekly for four weeks, then quarterly for one year. Laundry/Housekeeping will inspect weekly and document on the revised logs all sprinklers in the laundry area. EVS staff will monitor all other sprinklers in Healthcare on a monthly basis and document their findings. All findings above will be reported to the QAPI Committee 5. Date Corrective Action will be completed by 4/4/2020.	

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F 880	Continued From page 38	F 880		

An interview was conducted with administrative staff member (ASM) #2, the director of health services, on 2/20/2020 at 3:42 p.m. When asked how a CPAP mask and tubing should be stored when not in use, ASM #2 sated they should be cleaned, dried, placed on a clean surface such as a towel. When asked if they should be just sitting directly on the surface of the resident's nightstand, ASM #2 stated, no.

The facility policy, "Continuous Positive Airway Pressure (CPAP)" documented in part, "Cleaning of Equipment: All circuits (tubing, mask, head gear) are disposable and should be discarded upon discontinuation of therapy. If using a resident's own machine, wash the water tube and air tubing in warm water using a mild detergent. Rinse tubing thoroughly and allow to air dry. Clean the external surfaces of the devices with appropriate Sani-Cloth. Allow to air dry before using again."

ASM #1, the administrator and ASM #2, the director of health services, were made aware of the above information on 2/20/2020 at 5:49 p.m. When asked what standard of practice they follow, ASM #2 stated they follow their policies.

No further information was obtained prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 534.
(2) The Merck Manual, 16th Edition, 1992 page 639.

2. Resident #100 was admitted to the facility on

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F 880	Continued From page 39	F 880		

2/8/2020 with diagnoses that included but were not limited to: knee replacement, high blood pressure, and atrial fibrillation (a condition characterized by rapid and random contraction of the atria of the heart causing irregular beats of the ventricles and resulting in decreased heart output and frequently clot formation in the atria) (1). The most recent MDS (minimum data set) assessment, an admission assessment, with an assessment reference date of 2/15/2020 coded the resident as scoring a "15" on the BIMS (brief interview for mental status) score, indicating she was capable of making daily cognitive decisions.

On 2/29/2020, at approximately 4:05 p.m., Resident #100 was observed sitting in her recliner. An incentive spirometer (2), was observed sitting on the nightstand uncovered. When asked if she uses the incentive spirometer, Resident #100 said she used when she first got to the facility but since she's up more, she hasn't used it as much.

Review of the clinical record failed to reveal a physician's order for the use of a spirometer.

The baseline care plan dated 2/8/2020 failed to evidence any documentation of the use of a spirometer.

An interview was conducted with RN (registered nurse) #3 on 2/20/2020 at 2:07 p.m. When asked if there needs to be an order for a resident to use an incentive spirometer, RN #3 stated she's didn't know and would have to ask someone. When asked if she was aware of how often Resident #100 uses the incentive spirometer, or if the resident uses it, RN #3 stated, "No, I have to talk to the nurse practitioner." When asked how a

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F 880	Continued From page 40	F 880		

piece of respiratory equipment should be stored, RN #3 stated, it should be covered. When asked why is should be covered, RN #3 stated to keep it clean.

An interview was conducted with administrative staff member (ASM) #2, the director of health care services, on 2/20/2020 at 3:42 p.m. When asked if there should be a physician's order for the use of a spirometer, ASM #2 sated, yes. When asked how the incentive spirometer should be stored when not in use, ASM #2 sated it should be in a plastic bag.

ASM #1, the administrator and ASM #2, the director of health services, were made aware of the above information on 2/20/2020 at 5:49 p.m. A request was made for a policy on the use of incentive spirometers was requested.

On 2/21/2020 at 7:42 a.m., ASM #2 stated the facility did not have a policy regarding the use of incentive spirometers.

No further information was obtained prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 55.
(2) This information was obtained from the following website: https://medlineplus.gov/ency/patientinstructions/000451.htm
3. During the tour of the laundry room on 2/21/20 at 10:00 AM, three fire sprinkler heads were observed covered with dust in the clean side-dryer room, potentially contaminating clean clothing and linens.

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F 880	Continued From page 41 An interview was conducted with 2/21/20 at 10:10 am with OSM (other staff member) #1, the laundry manager. When asked to describe the cleaning process for the laundry, OSM #1 stated, "We clean the dryer lint traps at the end of every shift." OSM #1 presented the log for review and stated this is the log where we document that. OSM #1 stated, "We clean the floors at end of shift." When asked who cleans the fire sprinkler heads, OSM #1 stated, "The laundry staff cleans them." When asked how frequently the fire sprinkler heads are cleaned, OSM #1 stated, "We clean them every week." OSM #1 was then shown the sprinkler heads covered in dust. OSM #1 stated, "They are to be cleaned today. We use a high duster to clean them." When asked if there was documentation of cleaning the sprinkler heads, OSM #1 stated, "No, we do not document that." An interview was conducted on 2/21/20 at 10:30 with OSM #2, the director of environmental services, laundry and maintenance. When asked if there were logs for cleaning the fire sprinkler heads, OSM #2 stated, "No, we do not have that. The sprinkler heads are checked by (fire alarm Company) and the system would alarm if dust was preventing the sensor activation." ASM (administrative staff member) #1, the administrator, was informed of the finding on 2/21/20 at 10:50 AM. No further information was provided prior to exit.	F 880		