STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 standard, licensure and COVID-19 Focused Emergency Preparedness Survey was conducted on 9/21/21 through 9/23/21. The facility was in substantial compliance with 42 CFR Part 483.73, Requirement for Long-Term Care Facilities.	E 000		
F 000	INITIAL COMMENTS An unannounced Medicare/Medicaid standard survey was conducted 9/21/21 through 9/23/21. One complaint [VA00052948 unsubstantiated] was investigated during the survey. Corrections are required for compliance with 42 CFR Part 483 Federal Long Term Care requirements. The Life Safety Code survey/report will follow. The census in this 51 bed Medicare certified facility was 43 at the time of the survey. The survey sample included nineteen current resident reviews and three closed record reviews.	F 000		
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 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	F 622		10/8/21

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

Electronically Signed | 10/08/2021

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 622	Continued From page 1	F 622		

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 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:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 622	Continued From page 2 (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 the facility staff failed to provide documented evidence of facility-initiated transfer requirements for two of 22 residents in the survey sample, Residents #48 and #12.	F 622	1) Corrective action for affected residents #48 and #12. All checklist information was reviewed and found to be available should they need to transfer out again. Staff re-education on the importance of completing checklist when residents are sent out of the facility.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 622	Continued From page 3 The facility staff failed to provide evidence that all required information was provided to the hospital staff when Resident #48 was transferred to the hospital on 7/8/21, and failed to provide Resident #12's comprehensive care plan goals to the receiving hospital upon the residents transfer to the hospital on 8/26/21. The findings include: 1. Resident #48 was admitted to the facility on 7/8/21. Resident #48's diagnoses included but were not limited to pneumonia, chronic kidney disease and high blood pressure. Resident #48's admission minimum data set assessment with an assessment reference date of 7/15/21, coded the resident's cognition as severely impaired. Review of Resident #48's clinical record revealed a nurse's note dated 8/12/21 that documented the resident was discharged to the hospital for shortness of breath and a low oxygen level. Further review of Resident #48's clinical record failed to reveal documentation to evidence that all required information, including physician contact information, resident representative contact information, special instructions for ongoing care, advance directives and comprehensive care plan goals, was provided to the hospital staff. On 9/22/21 at 11:49 a.m., ASM (administrative staff member) #2 (the director of health services) presented a blank checklist form that documented, "Resident Name ____Date___ CHECKLIST FOR TRANSFERRING A RESIDENT TO THE HOSPITAL Check off as you complete:	F 622	2) Other Residents' potential for deficiency: An audit was performed for all resident records to make sure all information was available to the nurse in order to complete the transfer checklist. All resident records were found to be complete. 3) A new process to ensure that all records are sent out with the resident or in emergency situations will be faxed on behalf of the resident. The Director of Health Services, the Assistant Director of Health Services or their appointee, will examine and sign off on all Resident transfer checklists before the checklist can be filed in the resident's chart. A file folder labeled "transfer checklist to be signed off" will be in every nursing care base. The DHS, ADHS or appointee will check the list to make sure everything listed was sent out. A second reviewer signature line will be added to the checklist. If not, then they will fax the remaining information to the outside provider/facility. 4) Monitor the new practice: The Director of Health Services will compare the resident transfers and discharges for the week and then review the chart for the signed off checklist verifying all items were sent. This will be done weekly for 4 weeks and then monthly for the next 12 months. 5) All staff education, new process put into place and review will be done by 10/22/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 622	Continued From page 4	F 622		

1. __Receive order from MD (medical doctor)
2. __Notify '911' or (name of transportation company) - or if longer than necessary wait- Utilize '911' for emergency situations.
3. __ Notify the Front Desk that rescue personnel will be arriving.
4. __ Send the following to the hospital in an ORANGE FOLDER/ENVELOPE via the emergency personnel.
4.1 __ 2 Copies of the Face Sheet (1 copy to EMT [emergency medical technician]/ 1 copy in the folder)
4.2 __ Copy of the DNR (do not resuscitate) document
4.3 __ Copy of any Advance Directive [Living Will, Durable Power of Attorney for Health Care, 5 Wishes]
4.4 __ MAR (medication administration record)
4.5 __ eInteract Transfer form
4.6 __ Print off Care Plan send to hospital...
Nurses' Signature ___ Date ___."
At this time, ASM #2 stated she could not locate a checklist for when Resident #48 was discharged to the hospital on 8/12/21 and was unable to validate information provided to the hospital staff.

On 9/22/21 at 1:30 p.m., an interview was conducted with RN (registered nurse) #1, regarding information provided to hospital staff when a resident is transferred to the hospital. RN #1 stated the nurses have a checklist and provide a face sheet (that includes the doctor's information and family contact information), living will information, power of attorney information, any information possibly related to treatment in the hospital, the medication administration record, the interact transfer form and the care plan. RN #1 stated this information is sent with the resident when they leave the facility unless there is an

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 622	Continued From page 5	F 622		

emergent situation such as providing cardiopulmonary resuscitation. RN #1 stated that in the case of an emergent situation, information is faxed to the hospital. RN #1 stated nurse's evidence the information provided to hospital staff by completing and signing the checklist form, by documenting a nurse's note or by a fax confirmation.

On 9/22/21 at 4:34 p.m., ASM #1 (the administrator) and ASM #2 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: i) Contact information of the practitioner who was responsible for the care of the resident; ii) Resident representative information, including contact information; iii) Advance directive information; iv) Special instructions and/or precautions for ongoing care, as appropriate, which must include, if applicable, but are not limited to: Treatments and devices (oxygen, implants, IVs tubes/catheters); v) Precautions such as isolation or contact; vi) Special risks such as risk for falls, elopement, bleeding, or pressure injury and/or aspiration precautions; vii) The resident's comprehensive care plan goals; and viii) All information necessary to meet the resident's needs, which includes, but may not be limited to: (1) Resident status, including baseline and current mental, behavioral, and functional status, reason for transfer, recent vital signs; (2) Diagnoses and allergies; (3) Medications (including when last received); and (4) Most

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 622	Continued From page 6	F 622		

recent relevant labs, other diagnostic tests, and recent immunizations..."

No further information was presented prior to exit.

2. Resident #12 was admitted to the facility on 7/2/2021 with a recent readmission on 8/31/2021. with diagnoses that included but were not limited to: pneumonia (1), COPD (chronic obstructive pulmonary disease) (2), and repeated falls. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 9/7/2021, coded Resident #12 as not completing the interview for the BIMS (brief interview for mental status) score, but coded the resident as having no short or long term memory difficulties.

A nurse's note dated, 8/26/2021 at 10:47 a.m. documented, "Resident's pendant and call light ringing. Went to go to room when resident was seen lying on the floor between his doorway and hall. Resident unresponsive and not breathing. CPR (cardiopulmonary resuscitation) initiated. 911 contacted and security called. Continued with CPR until AED (automated external defibrillator) arrived. ESD (sic) in place and instructions began. CPR and breaths given, O2 (oxygen) at 15/L (liters per minute). Suction given for possible mucous plug in mouth. Resident taking breaths at this time sporadically. Arrival of 911. Resident transferred to (initials of hospital)."

The "SNF/NF (skilled nursing facility/non skilled nursing facility) to Hospital Transfer Form" dated 8/26/2021, documented the resident's name, vital signs, responsible party contact information, primary care physician name, and functional status. The form did not document if the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 622	Continued From page 7	F 622		

comprehensive care plan goals were sent/provided to the hospital.

A request was made on 9/22/2021 at 10:30 a.m., to ASM #2 for the documentation that Resident #12's comprehensive care plan goals were sent to the hospital upon the residents transfer on 8/26/21.

On 9/22/21 at 11:49 a.m., ASM (administrative staff member) #2 (the director of health services) presented a blank checklist form that documented,
"Resident Name ____Date___
CHECKLIST FOR TRANSFERRING A RESIDENT TO THE HOSPITAL
Check off as you complete:
1. __Receive order from MD (medical doctor)
2. __Notify '911' or (name of transportation company) - or if longer than necessary wait- Utilize '911' for emergency situations.
3. __ Notify the Front Desk that rescue personnel will be arriving.
4. __ Send the following to the hospital in an ORANGE FOLDER/ENVELOPE via the emergency personnel.
4.1 __ 2 Copies of the Face Sheet (1 copy to EMT [emergency medical technician]/ 1 copy in the folder)
4.2 __ Copy of the DNR (do not resuscitate) document.
4.3 __ Copy of any Advance Directive [Living Will, Durable Power of Attorney for Health Care, 5 Wishes]
4.4 __ MAR (medication administration record)
4.5 __ eInteract Transfer form
4.6 __ Print off Care Plan send to hospital.
Nurses' Signature ___ Date ___."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 622	Continued From page 8	F 622		

9/22/2021 at 12:35 p.m. ASM (administrative staff member) #2, the director of health services) stated she could not validate that the care plan was provided upon transfer to the hospital. ASM #2 stated it was a crazy morning with (Resident #12) coding and CPR initiated.

On 9/22/21 at 1:30 p.m., an interview was conducted with RN (registered nurse) #1, regarding information provided to hospital staff when a resident is transferred to the hospital. RN #1 stated the nurses have a checklist and provide a face sheet (that includes the doctor's information and family contact information), living will information, power of attorney information, any information possibly related to treatment in the hospital, the medication administration record, the interact transfer form and the care plan. RN #1 stated this information is sent with the resident when they leave the facility unless there is an emergent situation such as providing cardiopulmonary resuscitation. RN #1 stated that in the case of an emergent situation, information is faxed to the hospital. RN #1 stated nurses evidence the information provided to hospital staff by completing and signing the checklist form, by documenting a nurse's note or by a fax confirmation.

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of health services, were made aware of the above concern on 9/22/2021 at 4:30 p.m.

No further information was provided prior to exit.

References:
(1) Pneumonia: An infection in one or both of the lungs. Many germs, such as bacteria, viruses,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 622	Continued From page 9 and fungi, can cause pneumonia. This information was obtained from the following website: https://medlineplus.gov/pneumonia.html. (2) COPD (chronic obstructive pulmonary disease) - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 622		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		10/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 657	Continued From page 10 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, facility document review and clinical record review, it was determined that the facility staff failed to review and revise the comprehensive care plan for two of 22 residents in the survey sample, Residents #13 and #2. 1. The facility staff failed to review and revise Resident #13's comprehensive care plan to address the care needs and use of oxygen. 2. The facility staff failed to review and revise Resident #2's comprehensive care plan to reflect interventions documented in the nurses notes to ensure implementation after the resident sustained a fall on 4/1/21. The findings include: 1. Resident #13 was admitted to the facility on 4/13/17. Resident #13's diagnoses included but were not limited to a history of pneumonia, heart failure and muscle weakness. Resident #13's quarterly minimum data set assessment with an assessment reference date of 7/1/21, coded Resident #13 as being cognitively intact. Section O coded Resident #13 as receiving oxygen while a resident. Review of Resident #13's clinical record revealed a physician's order dated 2/13/21 for oxygen at two liters per minute via nasal cannula as needed for an oxygen saturation level less than 89 percent. Review of Resident #13's comprehensive care plan initiated on 7/6/17 failed	F 657	1) Corrective action for resident #13 and resident #2: a complete audit of both the resident's care plans was done to make sure no other inconsistencies between physician orders or interventions for falls were present in the their care plans. No other discrepancies were found. Current orders and interventions are now in their care plans. 2) Other residents potentially affected by this deficiency: A complete audit was done on 9/24/2021 to make sure no other resident' care plans had deficiencies concerning physician orders and fall interventions were present in their care plans. No deficiencies were found. 3) Measures put into place to avoid future deficiencies: Our MDS coordinator will run a new orders report in our EHR system each morning for the preceding 24 hours. This report lists all new orders given. From there she can update the resident's care plan to reflect those new orders. For fall interventions that need to be updated in the care plans, our MDS coordinator will update care plans after daily Nursing Stand-up where we discuss resident falls. At our weekly Falls committee meeting, the team can audit the resident care plan at that time. 4) Monitoring the new procedures: For new orders the Director of Health Services, the Assistant Director of Health Services, the Administrator or appointee will monitor weekly for the first 4 weeks	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 657	Continued From page 11 to reveal the care plan was reviewed or revised for oxygen use. On 9/21/21 at 12:10 p.m., Resident #13 was observed in a wheel chair receiving oxygen at two liters per minute via nasal cannula. On 9/22/21 at 8:50 a.m., ASM (administrative staff member) #2 (the director of health services) presented a portion of Resident #13's care plan that documented, "(Resident #13) has an ADL (activities of daily living) self-care performance deficit r/t (related to) Impaired balance, unsteady gait, deconditioning, OA (osteoarthritis) Dx (diagnosis), and Osteoporosis Dx." A red line was drawn beside the intervention, "Treatments per orders. Date Initiated: 12/20/2020." This portion of the care plan did not address oxygen use. ASM #2 also presented a revision of Resident #13's care plan dated 9/22/21 that documented, "Focus: The resident has oxygen therapy ordered at night due to hypoxia (low oxygen levels in your tissues). Goal: The resident will have no s/sx (signs or symptoms) of poor oxygen absorption through the review date. Interventions: OXYGEN SETTINGS: O2 (Oxygen) via NC (nasal cannula) per orders and PRN (as needed). Monitor for s/sx of respiratory distress and report to MD (medical doctor) PRN..." On 9/22/21 at 9:01 a.m., an interview was conducted with LPN (licensed practical nurse) #1, the staff responsible for reviewing and revising care plans. LPN #1 stated oxygen was addressed under the ADL portion of the care plan that documented, "Treatments per orders." LPN #1 was made aware that "Treatments per orders" on the ADL portion of the care plan was dated	F 657	and monthly for the next 12 months. 5) These procedures will be in place by 10/22/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 657	Continued From page 12	F 657		

before Resident #13's oxygen was ordered and the ADL care plan documented nothing regarding the resident's respiratory status or oxygen use. LPN #1 stated "That was my catch all. I put treatment per order; it covers if I miss something." LPN #1 stated a resident's care plan should be reviewed and revised for the use of oxygen if she knows about the new order for and implementation of oxygen. LPN #1 stated the care plan should include the reason for use if she knows what it is, whatever the goal might be and "Keep sats (oxygen saturation level) above something (a certain level) or to comfort." LPN #1 stated Resident #13's care plan was revised this morning (9/22/21) to include the use of oxygen. When asked the purpose of a care plan, LPN #1 stated, "It is supposed to be for nursing staff to know what the issues are, what our hopes are and what we plan to achieve." When asked if the ADL portion documenting "Treatments per orders" of Resident #13's care plan reflected the purpose for oxygen use, LPN #1 stated, "But this is a catch all."

On 9/22/21 at 4:34 p.m., ASM #1 (the administrator) and ASM #2 were made aware of the above concern.

The facility policy titled, "Resident Assessment using the Minimum Data Set (MDS 3.0)/Resident Instrument (RAI)" documented, "9. The care plan will be reviewed and revised by the interdisciplinary team and will be reviewed and/or modified as resident status changes and new needs/preferences are identified."

The facility policy titled, "Oxygen Therapy- Mask, Nasal Cannula, and Humidification" documented, "Oxygen is administered appropriately to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 657	Continued From page 13	F 657		

residents to improve oxygenation and provide comfort to residents experiencing respiratory difficulties...13. Update Care Plan as needed."

No further information was presented prior to exit.
2. Resident #2 was admitted to the facility on 6/13/2020 with diagnoses that included but were not limited to: Alzheimer's disease (1), glaucoma (2), and Meniere's disease. (3)

The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 9/9/2021 coded Resident #2 as scoring a "12" on the BIMS (brief interview for mental status) score, indicating the resident was moderately impaired to make daily cognitive decisions. The resident was coded as requiring limited assistance of one staff members for moving in the bed, transfers, ambulation, and locomotion. The resident was coded as requiring extensive assistance of one staff member for dressing, eating, toileting and personal hygiene.

A nurse's note dated 4/1/2021 at 3:40 p.m. documented, "Resident sitting in w/c (wheelchair) & (and) slid down onto her buttocks behind the leg rests with feet in front of the leg rests. Resident's head was leaning back against w/c seat & cushion. No injuries notes [Sic.], resident moving all extremities. Assisted to recliner with use of maxi-lift. Neuro (neurological) checks in progress r/t [related/to] unwitnessed fall. Resident to be placed in recliner with pressure alarm for decreased awareness & fall prevention."

A nurse's note dated, 4/7/2021 at 5:32 p.m. documented, "Resident was being assisted from the chair to wheelchair, once in w/c 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 _____	C 09/23/2021

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 657	Continued From page 14	F 657		

attempted to move herself back but wheelchair wasn't locked, as she went to move she lifted her bottom chair moved and she landed on floor on her buttocks. No injury noted, does c/o (complain of) bottom hurting while setting on the floor waiting to be assisted off floor with maxi lift."

The comprehensive care plan for Resident #2 dated, 6/24/2020 and last reviewed on 4/14/2021, documented in part, "I (Resident #2) am at risk for falls. I have a history of falls." The "Interventions" were dated from 6/24/2020 through 2/24/2021. The "Interventions" dated, 4/7/2021, documented, "Ambulate with staff and assistance device as needed. Re-education staff. Use wheelchair for transfers off unit only. Wheelchair to be used on for transport off of community." The comprehensive care plan failed to include the interventions documented in the nurses note after the fall on 4/1/21, for: "Resident to be placed in recliner with pressure alarm for decreased awareness & fall prevention."

An interview was conducted with LPN (licensed practical nurse) #1, the MDS coordinator, on 9/22/2021 at 2:21 p.m. When asked who updates the care plans, LPN #1 stated she was the only one that touches care plans. LPN #1 stated, "No nurse's here update care plans but me. When asked if she attends morning meetings to find out if anyone fell, LPN #1 stated most of the time they mention the fall and then move on, no details are shared unless I ask."

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of health services, were made aware of the above concern on 9/22/2021 at 4:30 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 657	Continued From page 15 No further information was provided prior to exit. References: (1) Alzheimer's disease: a progressive loss of mental ability and function, often accompanied by personality changes and emotional instability. Barron's Dictionary of Medical Terms, 5th edition, Rothenberg and Chapman, page 26. (2) Glaucoma a disease in which elevated pressure in the eye, due to obstruction of the outflow of aqueous humor, damages the optic nerve and causes visual defects. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 247. (3) Meniere's disease a disease of the inner ear, characterized by recurrent episodes of dizziness, progressive hearing loss and ringing in the ears. Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 360.	F 657		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on staff interview, facility document review, and clinical record review it was determined the facility staff failed to ensure one of	F 684	1) Corrective action for resident #32 affected by deficiency: Reeducation for staff and discussion of Furosemide order	10/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 684	Continued From page 16 22 residents in the survey sample, received the care and services in accordance with professional standards and the comprehensive care plan for Resident #32. The facility staff failed to administer the physician ordered diuretic medication, Furosemide to Resident #32 as ordered. The findings include: Resident #32 was admitted to the facility on 8/10/2021 with diagnoses that included but were not limited to: fracture of right hip, high blood pressure, and GERD (gastroesophageal reflux disease - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn). (1) The most recent MDS (minimum data set) assessment, a Medicare 5 day/Admission assessment, with an assessment reference date of 8/17/2021, coded Resident #32 as scoring a "14" 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 all of her activities of daily living, except eating in which she was coded as being independent. The physician order dated 8/20/2021, documented, "Daily weight, if weight > (greater than) 122 administer PRN (as needed) Lasix (diuretic) per order one time a day related to hypertension (high blood pressure)." The physician order dated 8/10/2021, documented, "Furosemide (Lasix) Tablet (used to treat high blood pressure and edema) (2) 20 MG	F 684	for clarification. 2) Other residents that may have been affected by the deficiency: A complete audit was done on 9/24/2021 to ensure any resident on Furosemide (that require parameters) had clear parameters and were in compliance with physician's orders. 3) New procedures for compliance with Furosemide orders: Reeducate staff on weight parameters for Furosemide and the seriousness of daily compliance concerning medication administration procedures and regulations. The nurses will call the physician when orders are unclear. Educate physician on the inclusion of clear and concise orders. 4) Monitor new procedure to avoid future deficiencies: MAR audits every week for 4 weeks and then monthly for the next 12 months. 5) The audit and reeducation will be in place by 10/22/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 684	Continued From page 17	F 684		

(milligrams); give 1 tablet by mouth every 24 hours as needed for weight over 122."

The August MAR (medication administration record) for Resident #32 was reviewed and documented the above physicians order for Lasix.

On 8/20/2021, Resident #32's weight was documented as 126.4. There was a blank on the MAR for the administration of Furosemide on 8/20/2021. Review of the nurse's notes failed to evidence documentation of the administration of the Furosemide as ordered by the physician.
On 8/21/2021 there was no weight for Resident #32 documented on the MAR or in the vital sign section of the clinical record. Review of the nurse's notes failed to evidence documentation for the administration Furosemide or a weight for Resident #32.
On 8/23/2021, Resident #32's weight was recorded as 127.4. There was a blank on the MAR for the physician prescribed Furosemide on 8/23/2021. Review of the nurse's notes failed to evidence documentation for the administration of the Furosemide (Lasix) as ordered by the physician.

The physician order dated, 9/1/2021, documented, "Daily weight, if weight > 128, administer PRN (as needed) Lasix per order one time a day related to hypertension." The physician order dated, 9/21/2021, documented, "Furosemide Tablet 20 mg; give 1 tablet by mouth every 24 hours for weight over 128, give additional dose if weight >128."

Review of the September MAR for Resident #32, revealed the above documented the physician order for Furosemide. On 9/20/2021, Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 684	Continued From page 18	F 684		

#32's weight was documented as 128.4. There was a blank on the MAR for administration of the physician ordered Furosemide on 9/20/2021. Review of the nurse's notes failed to evidence documentation for the administration of the Furosemide as ordered by the physician.

The care plan dated, 8/26/2021, documented in part, "Focus: The resident has hypertension." The "Interventions" documented in part, "Give antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate. Monitor for and document any edema. Notify MD (medical doctor)."

An interview was conducted with LPN (licensed practical nurse) #3 on 9/22/2021 at 2:00 p.m. The above physician orders for Furosemide and MARs were reviewed with LPN #3. When asked what a blank on the MAR indicated, LPN #3 stated, "I don't know if it was documented, we don't know if that was given." When asked if the resident should have received the PRN (as needed) Lasix on the above days, LPN #3 stated, "Yes."

The facility policy, "Medication Administration - General Guidelines" documented in part, "Standard: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis, in accordance with local, state, and federal laws, rules and regulations...Responsibility of the person administering medications is to be aware of the classification, action, correct dosage, and side effects of a medication before administration....Medications are administered in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 684	Continued From page 19	F 684		

accordance with written orders of attending physicians, manufacturer's specifications and professional standards of practice... Only the licensed or legally authorized personnel who prepares a medication may administer it. This individual records the administration on the resident's MAR after the medication is given. AT the end of each medication pass, the person administering the medications reviews the MAR to ascertain that all necessary doses were administered and all administered doses were documented. In case should the individual who administered the medications report off-duty without first recording the administration of any medications....When PRN medications are administered, the following documentation is provided: date and time of administration, dose, route of administration (if other than oral), and if applicable, the injection site. Complaints or symptoms for which the medication was given."

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 684	Continued From page 20 ASM (administrative staff member) #1, the administrator, and ASM #2, the director of health services, were made aware of the above concern on 9/22/2021 at 4:30 p.m. No further information was provided prior to exit. References: (1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243. (2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682858.html	F 684		
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: Based on observation, staff interview, facility document review and clinical record review, it was determined the facility staff failed to provide respiratory care and services according to professional standards of practice for one of 22 residents in the survey sample, Resident #12. The facility staff administered oxygen to Resident #12 without specific physician ordered	F 695	1) Corrective action for the resident affected by the deficiency: New order for his oxygen with parameters was obtained by the afternoon of 9/23/2021. 2) Other residents with the potential to be affected by the deficiency: A complete audit was done on 9/24/2021 for all residents with oxygen orders. No more	10/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 21 parameters for titration of the oxygen flow rate. The findings include: Resident #12 was admitted to the facility on 7/2/2021 with a recent readmission on 8/31/2021, with diagnoses that included but were not limited to: pneumonia (An infection in one or both of the lungs. Many germs, such as bacteria, viruses, and fungi, can cause pneumonia) (1), COPD (chronic obstructive pulmonary disease - general term for chronic, nonreversible lung disease that is usually a combination of emphysema and chronic bronchitis) (2), and repeated falls. The most recent MDS (minimum data set) assessment, a significant change assessment, with an assessment reference date of 9/7/2021, coded the resident as not completing the interview for the BIMS (brief interview for mental status) score, but coded the resident as having no short or long term memory difficulties. The resident was coded as requiring extensive assistance to being dependent upon one or more staff members for all of his activities of daily living. In Section - O, Special Treatment, Procedures and Programs, documented Resident #12's use of oxygen while a resident at the facility. Observation was made of Resident #12 on 9/21/2021 at 12:45 p.m. The resident was lying across the bed, appearing restless. Resident #12 had oxygen on via a nasal cannula connected to any oxygen concentrator. The flow meter of the oxygen concentrator was set at 3.5 LPM (liters per minute). On 9/22/2021, at 9:57 a.m., Resident #12 was	F 695	deficiencies were found. 3) New system put into place: the nurse will examine all new oxygen orders upon admission and when there is a change to the order. The nurse will check for exact parameters for titration of oxygen and be in compliance at all times with the order. If order is unclear the nurse will contact the physician to clarify and submit the new order. The nurse will educate the CNAs on the floor to be in compliance with the order. 4) The shift nurses will complete an audit form weekly to show compliance with oxygen orders. They will list weight parameters and titration parameters every shift. They will give the completed weekly form to the Director of Health Service to review. This will occur weekly for the next 6 months. 5) Staff education and auditing will be in place by 10/22/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 22	F 695		

observed sitting on the side of the bed, his oxygen was not on, and the nasal cannula was observed around his neck. Resident #12 was observed mouth breathing and restless. The oxygen concentrator flow meter was set at 5 LPM. CNA (certified nursing assistant) #1 entered the room and assisted Resident #12, with reclining in the bed. CNA #1 then requested a housekeeper get the nurse. LPN (licensed practical nurse) # 2 entered the room at 10:05 a.m., and was asked to read what Resident #12's oxygen concentrator flow rate was currently set at, LPN #2 stated, "5 LPM [liter per minute]." LPN #2 stated the night nurse stated he was on 4.5 LPM through the night. At this time, LPN #2 was asked to check Resident #12's oxygen saturation level (O2 sat) with a pulse oximeter. LPN #12 was observed checking Resident #12's oxygen saturation using a pulse oximeter. The resident's O2 saturation was 91%. LPN #2 stated the nurses can titrate his [Resident #12's] oxygen up if he drops below something and we titrate him up until he levels out. At this time, the physician orders were reviewed with LPN #2. When asked if the nurse is allowed to titrate oxygen, LPN #2 stated, "yes." LPN #2 stated, "His (Resident #12) COPD has gotten worse while he was in the hospital this past time."

The physician order dated, 8/23/2021, documented, "O2 (oxygen) at 2 LPM [liters per minute] via NC (nasal cannula - a plastic tube with two prongs that insert into the nostrils), may titrate up to 6 L (LPM) for comfort every shift for shortness of breath related to pneumonia, chronic obstructive pulmonary disease."

Resident #12's TAR (treatment administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 23	F 695		

record) for September 2021, documented the above physicians order for oxygen. The TAR documented the resident received oxygen at the flow rate of 2 - 5 LPM on the day shift, 3 - 6 LPM on the evening shift, and 4 - 5 LPM on the night shift throughout September. The TAR documented the Resident #12's oxygen concentration levels as: 90 -98% on the day shift, 90 -95% on the evening shift and 90 -95% on the night shift.

The comprehensive care plan for Resident #12, dated, 9/9/2021, documented in part, "Focus: I [Resident #12] tested positive for COVID." The "Interventions" documented in part, "Provide supplemental O2 as ordered."

An interview was conducted with ASM (administrative staff member) #3, the facility nurse practitioner, on 9/22/2021 at 12:04 p.m. The above physicians order for oxygen was reviewed with ASM #3. When asked how a staff nurse knows how and what flow rate to titrate the oxygen to for Resident #12, ASM #3 stated, "Great question. Off that order, I wouldn't know how to do it. The man has COPD." ASM #3 stated, "Before he was using oxygen, his O2 sat was between 93% - 94%." When asked if the order should have parameters, ASM #3 stated, "Absolutely."

An interview was conducted with ASM #2, the director of health services, on 9/22/2021 at 12:40 p.m. The above physician's order for oxygen was reviewed with ASM #2. When asked how the staff nurse knows what flow rate of oxygen to administer, ASM #2 stated, (ASM #3) is making modifications to the order now. ASM #2 stated the staff have no parameters for the oxygen flow

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 24	F 695		

rate. When asked if it is within a nurse's scope of practice to decide the amount of oxygen to be given, ASM #2 stated she would have to look that up. ASM #2 stated, "Oxygen can be considered a medication and titrating it without parameters could be considered prescribing."

The facility policy, "Oxygen Therapy - Mask, Nasal Cannula and Humidification" documented in part, "Standard: Oxygen is administered appropriately to resident to improve oxygenation and provide comfort to residents experiencing respiratory difficulties. Policy: Oxygen administration requires a physician and/or primary care provider order. Oxygen is administered by licensed staff and/or by the resident under supervision of the licensed nurse...Procedures: 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 check the level at least twice a shift."

According to Fundamentals of Nursing, Perry and Potter, 6th edition, page 1122, Oxygen should be treated as a drug. It has dangerous side effects, such as atelectasis or oxygen toxicity. As with any drug, the dosage or concentration of oxygen should be continuously monitored. The nurse should routinely check the physician's orders to verify that the client is receiving the prescribed oxygen concentration. The six rights of medication administration also pertain to oxygen administration."

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of health services, were made aware of the above concern

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 25 on 9/22/2021 at 4:30 p.m. No further information was provided prior to exit. References: (1) This information was obtained from the following website: https://medlineplus.gov/pneumonia.html. (2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 124.	F 695		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by:	F 757		10/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 757	Continued From page 26 Based on staff interview, facility document review, and clinical record review, it was determined the facility staff failed to ensure the drug regimen for one of 22 residents in the survey sample, was free of unnecessary medications, Resident #32. 1. The facility staff administered an antihypertensive medication to Resident #32 for a weight of 128, when the physician's order directed staff to administer the medication for a weight greater than / over 128 pounds. 2. The facility staff administered the as needed narcotic pain medication Hydrocodone - Acetaminophen, to Resident #32 , with no assessed pain rating and or for a pain rating below the physician ordered Pain Scale of 6-10, on 8/15/21, and on multiple dates in September 2021. The findings include: 1. Resident #32 was admitted to the facility on 8/10/2021 with diagnoses that included but were not limited to: fracture of right hip, high blood pressure, and GERD (gastroesophageal reflux disease - backflow of the contents of the stomach into the esophagus, usually caused by malfunction of the sphincter muscle between the two organs; symptoms include burning pain in the esophagus, commonly known as heartburn) (1). The most recent MDS (minimum data set) assessment, a Medicare 5 day/Admission assessment, with an assessment reference date of 8/17/2021, coded the resident as scoring a "14" on the BIMS (brief interview for mental status) score, indicating the resident was capable	F 757	1) Corrective action for resident #32 affected by deficiency: 2)Other residents that could be potentially affected by deficiencies: an audit was completed on all residents' medication orders with parameters listed. No other deficiencies were found. 3) New procedures set in place to avoid future deficiencies: Staff re-education to discuss reading/understanding parameters correctly, to ask questions of the Director of Health Services, the Assistant Director of Health Services or a charge nurse if more clarification is needed. Reeducate staff to call physician if orders written are unclear and obtain corrected orders. Reeducate staff to be in compliance with all parts of the order and to document the correct data and ensure completion before moving on to the next task. 4) Monitoring to avoid future deficiencies: Audits of all medications with parameters will be completed by the Director of Health Services, Assistant Director of Health Services or appointee on a weekly basis for the first 4 weeks and then biweekly for the next 12 months. 5) Staff reeducation and Auditing will begin no later than 10/22/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 757	Continued From page 27	F 757		

of making daily cognitive decisions. The resident was coded as requiring extensive assistance of one or more staff members for all of her activities of daily living, except eating in which she was coded as independent.

The physician order dated, 9/1/2021, documented, "Daily weight, if weight > 128, administer PRN [as needed] Lasix (Furosemide) per order one time a day related to hypertension." The physician order dated, 9/21/2021, documented, "Furosemide Tablet (used to treat high blood pressure and edema) (2) 20 mg (milligram); give 1 tablet by mouth every 24 hours for weight over 128, give additional dose if weight >128."

The September MAR [medication administration record] was reviewed and documented the above physician orders for Lasix. On 9/17/2021, Resident #32's weight was documented as, "128." The Lasix was documented as administered on 9/17/2021.

Review of the comprehensive care plan dated, 8/19/2021, failed to evidence documentation related to the use of diuretic therapy. The care plan dated, 8/26/2021, documented in part, "Focus: The resident has hypertension." The "Interventions" documented in part, "Give antihypertensive medications as ordered. Monitor for side effects such as orthostatic hypotension and increased heart rate. Monitor for and document any edema. Notify MD (medical doctor)."

An interview was conducted with LPN (licensed practical nurse) #3 on 9/22/2021 at 2:00 p.m. LPN #3 administered the Lasix on 9/17/2021.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 757	Continued From page 28	F 757		

The above orders and MARs were reviewed with LPN #3. When asked if the Lasix should have been given on 9/17/2021 per the physician's order, LPN #3 stated, "I was confused as she [Resident #32] was on the border. The weight was 128. The order if the weight is greater than 128 was reviewed again with LPN #3. When asked if the Lasix should have been given, LPN #3 stated, "I guess not."

The facility policy, "Medication Administration - General Guidelines" documented in part, "Standard: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis, in accordance with local, state, and federal laws, rules and regulations...Responsibility of the person administering medications is to be aware of the classification, action, correct dosage, and side effects of a medication before administration....Medications are administered in accordance with written orders of attending physicians, manufacturer's specifications and professional standards of practice... Only the licensed or legally authorized personnel who prepares a medication may administer it. This individual records the administration on the resident's MAR after the medication is given. At the end of each medication pass, the person administering the medications reviews the MAR to ascertain that all necessary doses were administered and all administered doses were documented. In case should the individual who administered the medications report off-duty without first recording the administration of any medications....When PRN medications are administered, the following documentation is

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 757	Continued From page 29	F 757		

provided: date and time of administration, dose, route of administration (if other than oral), and if applicable, the injection site. Complaints or symptoms for which the medication was given."

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

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of health services, were made aware of the above concern on 9/22/2021 at 4:30 p.m.

No further information was provided prior to exit.

References:
(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 243.
(2) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a682858.html.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 757	Continued From page 30	F 757		

2. The physician order dated, 8/10/202, documented, "Hydrocodone - Acetaminophen Tablet (Norco) (used to treat moderate to severe pain)(3) 5-325 mg (milligram); Give 1 tablet by mouth every 4 hours as needed for Pain Scale 6-10 [zero no pain and 10 being the worse pain] related to fracture of right femur."

The August MAR (medication administration record) documented the above order for Norco. On 8/15/2021 at 1:10 p.m., the Norco was documented as administered. The Pain Scale documented a pain level of "4."

The September MAR (medication administration record) documented the above physician's order for Hydrocodone - Acetaminophen, and documented the medication was administered on the following dates and times with pain ratings not assessed and or below the physician ordered Pain Scale 6-10 as follows:
On 9/1/2021 at 8:37 a.m., the Norco was documented as administered. An "N/A" (not applicable) was documented where the pain scale is normally documented. The nurse's note dated 9/1/2021 at 8:37 a.m. documented, "Administered prior to therapy session."
On 9/2/2021 at 8:23 a.m., the Norco was documented as administered. An "N/A" was documented where the pain scale is normally documented. The nurse's note dated, 9/2/2021 at 8:23 a.m. documented, "Administered prior to PT (physical therapy) session."
On 9/3/2021 at 7:42 a.m. the Norco was documented as administered. The Pain Scale documented a pain level of "4." The nurse's note dated, 9/3/2021 at 7:42 a.m. documented, "Resident requested r/t (related to) hip pain 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 _____	C 09/23/2021

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 757	Continued From page 31	F 757		

prior to therapy."
On 9/4/2021 at 8:19 a.m., the Norco was documented as administered. The Pain Scale documented a pain level of "5." The nurse's note dated 9/4/2021 at 8:19 a.m. documented, "Resident requested r/t increase right hip pain."
On 9/6/2021 at 8:45 a.m., the Norco was documented as administered. An "N/A" was documented where the pain scale is normally documented. The nurse's note dated 9/6/2021 at 8:45 a.m. documented, "Administered prior to PT session."
On 9/9/2021 at 7:54 a.m., the Norco was documented as administered. The Pain Scale documented a pain level of "5." The nurse's note dated 9/9/2021 at 7:54 a.m. documented, "Resident requested r/t lower back and hip pain."
On 9/10/2021 at 8:04 a.m., the Norco was documented as administered. The Pain Scale was documented as, "0." The review of the nurse's notes for 9/10/2021 failed to evidence documentation as to why the medication was given.
On 9/11/2021 at 9:03 a.m., the Norco was documented as administered. The Pain Scale documented a pain level of "1." There was no documentation in the nurse's notes related to the administration of Norco.
On 9/15/2021 at 8:27 a.m., the Norco was documented as administered. An "N/A" was documented where the pain scale is normally documented. The nurse's note dated, 9/15/2021 at 8:27 a.m. documented, "Administered prior to therapy session."
On 9/16/2021 at 8:45 a.m., the Norco was documented as administered. An "N/A" was documented where the pain scale is normally documented. The nurse's note dated, 9/16/2021 at 8:45 a.m. documented, "Administered prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 757	Continued From page 32	F 757		

therapy session."
On 9/19/2021 at 7:42 a.m., the Norco was documented as administered. The Pain Scale documented a pain level of "5." The nurse's note dated, 9/19/2021 at 7:42 a.m. documented, "Resident requested r/t lower back/hip pain."
On 9/21/2021 at 8:30 a.m. the Norco was documented as administered. A "0" was documented where the pain scale is documented. The nurse's note dated, 9/21/2021 at 8:30 a.m. documented, "Administered prior to therapy session this am."

The comprehensive care plan dated, 8/26/2021, documented in part, "Focus: The resident has a right hip fracture." The "interventions" documented in part, "Monitor/document pain on a scale of 0 to 10 before and after implementing measures to reduce pain." Review of the comprehensive care plan dated, 8/26/2021 failed to evidence documentation of a care plan further addressing pain.

An interview was conducted with LPN (licensed practical nurse) #3 on 9/22/2021 at 2:00 p.m. When asked to explain the steps a nurse takes when a resident complains of pain, LPN #3 stated, "You asked where the pain is, when the pain started, how they got the pain, such as hip fracture, and have them rate it on the pain scale." LPN #3 stated staff should offer non-pharmacological interventions such as ice or heat, if they are not effective you give the medication that is ordered. When asked if staff should give a pain medication for a pain scale of zero, LPN #3 stated, "It depends, everyone's pain is different, may still want it prior to therapy or any type of procedures or treatments." The above orders were reviewed with LPN #3. LPN #3 sated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 757	Continued From page 33	F 757		

that every resident is different and this resident requests her pain medication prior to therapy. When asked if the medication was administered according to the physicians order when there was no pain scale rating and or zero pain documented, LPN #3 stated, No, not according to the order. When asked what the "N/A" meant, LPN #3 stated she didn't know what that meant. When asked what the nurse should do if the resident is requesting the pain medication when the pain rating is outside the physician ordered parameters, LPN #3 stated the order should be clarified with the physician.

The facility policy, "Medication Administration - General Guidelines" documented in part, "Standard: All medications are administered safely and appropriately to aid residents to overcome illness, relieve and prevent symptoms and help in diagnosis, in accordance with local, state, and federal laws, rules and regulations...Responsibility of the person administering medications is to be aware of the classification, action, correct dosage, and side effects of a medication before administration....Medications are administered in accordance with written orders of attending physicians, manufacturer's specifications and professional standards of practice..."

The facility policy, "Pain Management in the Long Term Care Setting," documented in part, "Assist the resident to describe the quality of pain by cueing with such words as throbbing, stabbing, burning, and aching. Some resident will relate pain or discomfort in connection with certain times of the day or specific movement or activity. Teach the resident to use the intensity scale with which they are most comfortable...Administer the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 757	Continued From page 34 medications as ordered by the provider on the MAR." ASM (administrative staff member) #1, the administrator, and ASM #2, the director of health services, were made aware of the above concern on 9/22/2021 at 4:30 p.m. No further information was provided prior to exit. (3) This information was obtained from the following website: https://medlineplus.gov/druginfo/meds/a601006.html	F 757		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by:	F 812		10/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 812	Continued From page 35 Based on observation, staff interview and facility document review, it was determined that the facility staff failed to store food in a sanitary manner. The facility staff failed to discard an opened 16 ounce carton of liquid egg yolks with an expiration date of 9/14/21, failed to discard an opened half gallon carton of whole milk with a best if used by date of 9/10/21 and failed to discard a container of mushrooms labeled with a use by date of 9/14/21. The findings include: On 9/21/21 at 11:15 a.m., observation of refrigerator #37 in the satellite health care center kitchen was conducted with OSM (other staff member) #2 (the executive chef). The following was observed: -One opened 16 ounce carton of liquid egg yolks with a manufacturer's printed expiration date of 9/14/21. -One opened half gallon carton of whole milk with a manufacturer's printed date of 9/14/21 (the date did not specify if it was an expiration date, sell by date or best if used by date; however, the manufacturer's documentation for the milk documented the stamped printed date was a best if used by date). -One metal container of mushrooms covered with plastic wrap and labeled with a prep date of 9/8 and a use by date of 9/14. All of the above items were discarded by OSM #2 during the observation. On 9/22/21 at 10:53 a.m., an interview was conducted with OSM #1 (the dining services manager). OSM #1 stated the cooks should	F 812	1) Corrective action for expired food products: Each cook on each shift will be responsible for taking all items out of the (#37) reach in at the end of their shift. They will complete a check to see if any products are expired, not labeled correctly or are past the best if used by date. They will throw out any/all products they find that are out of date, expired or labeled incorrectly. The cook will then store the rest of the nonexpired food items in the main walk in to be used the next day. 2) This corrective action will be ongoing every day going forward. no further residents will be affected by expired, incorrectly labeled or out of the best if used by date food items. 3) After every shift Reach-in #37 will be checked for expired, out of date or mislabeled food items. At the end of the day, reach in (#37) will be cleared out and cleaned. All food items that are within the expiration and best if used by dates will be stored in the main walk in refrigerator in the main kitchen. Only that day's food items will be stored in reach in (# 37) going forward. A food production label will be on each item indicating the production date and the use by date which will be the expiration date. 4) The dining supervisor or appointee will check daily for 14 days and then biweekly for the next twelve months. 5) The corrective action was put into place on 9/24/2021.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 812	Continued From page 36 inspect the refrigerator daily. OSM #1 stated the cooks should make sure everything is labeled/dated and discard items the day before an item's expiration date or best if used by date. OSM #1 stated items with a labeled use by date should be discarded on that date. On 9/22/21 at 4:34 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, "Food Safety" documented, "15. Food left over on the self-service bars, buffets, or food lines after the meal period may be reused only if the self-service stations are monitored consistently throughout the service by SERVSAFE-trained employees. Leftover food must be discarded if so required by local, state, or provincial health department regulations." No further information was presented prior to exit.	F 812		
F 909 SS=D	Resident Bed CFR(s): 483.90(d)(3) §483.90(d)(3) Conduct Regular inspection of all bed frames, mattresses, and bed rails, if any, as part of a regular maintenance program to identify areas of possible entrapment. When bed rails and mattresses are used and purchased separately from the bed frame, the facility must ensure that the bed rails, mattress, and bed frame are compatible. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility document review, it was determined the facility	F 909	1. Address how corrective action will be accomplished for those residents/found to	10/8/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 909	Continued From page 37 staff failed to ensure the bed for one of 51 resident beds within the facility had been inspected on an annual basis, Resident #23's bed. The findings include: Resident #23 was admitted to the facility 3/9/2021 with diagnoses that included but were not limited to: multiple sclerosis (a progressive disease in which nerve fibers of the brain and spinal cord lose their myelin cover) (1), and quadriplegia (Paralysis affecting all four limbs and the trunk of the body below the level of spinal cord injury. Trauma is the usual cause.) (2). The most recent MDS (minimum data set) assessment, a quarterly assessment, with an assessment reference date of 7/27/2021, coded the resident as having a BIMS (brief interview for mental status) score, indicating he was capable of making daily cognitive decisions. The resident was coded as being dependent upon one or more staff members for bed mobility. A physician order for Resident #23 dated, 3/9/2021, documented, "1/4 (one quarter) SR (side rails) x (times) 2 to assist in turning and repositioning." Review of Resident 23's comprehensive care plan dated, 3/11/2021, failed to evidence documentation related to the use of side rails. The "Side Rail & Entrapment Risk Evaluation" dated, 3/9/2021, for Resident #23, documented the resident was safe to have side rails. A "Side Rail Consent" dated 3/9/2021, was signed	F 909	have been affected by the deficient practice: Each bed will be inspected annually for dangers regarding rails and gap between frame and mattress. They will also be inspected when a mattress or bed is replaced. The remaining four beds were inspected on 9/23/2021. All were found to be in compliance with safety standards. 2. Address how the community will identify other residents/staff having the potential to be affected by the same deficient practice: This policy will provide coverage for the entire resident population of our Health Care neighborhoods. 3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice would not recur: The risk assessment book will be reviewed annually, and a floor plan will be utilized in conjunction with each inspection to ensure that every apartment is inspected. 4. Indicate how the community plans to monitor its performance to make sure that solutions are sustained: An annual work order will be created for all Health Care rooms utilizing our WORXhub maintenance software program. Nurses were instructed to put in a work order whenever a new mattress or bed is replaced. 5. Include dates when corrective action will be accomplished: The procedure will be put in place no later than 9/27/21.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 909	Continued From page 38	F 909		

by Resident #23.

The annual bed inspections were requested from the administrator on 9/22/2021 at approximately 8:00 a.m. A book of bed inspections was presented OSM (other staff member) #7, the director of environmental services at approximately 8:30 a.m. Review of the book of bed inspections failed to evidence documentation of an inspection for Resident #23's bed. At this time, the book of bed inspections was reviewed with OSM (other staff member) #7, the director of environmental services.

On 9/22/2021 at 9:16 a.m., OSM #7 stated he looked for the missing bed inspections and could not locate them. OSM #7 stated the only thing he can think of, is they [Resident #23] was on isolation. He stated could not think of any other reason it was not completed. OSM #7 stated he might have forgotten to go back to do the inspection. OSM #7 stated he would complete the inspection today, (9/22/2021).

The facility policy, "Bed Entrapment Assessment" documented in part, Evaluate Equipment: Prior to using any model of bed in the community, the bed is evaluated by trained Environmental Services staff member. The staff member is responsible to: ensure compatibility of the bed, mattresses intended to use with the bed, side rails and any accessories. Install any rails or devices according to manufacturer's instructions with no adaptations made. Confirm the mattress fits relative to the width and height of any rails on the bed according to manufacturer or FDA (federal drug administration) guidelines. Test the functionality of the bed to ensure that all equipment is in good condition, functional and without spaces created

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495165	A. BUILDING _____ B. WING _____	C 09/23/2021

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 909	Continued From page 39	F 909		

during operation. Use the FDA Guide to Bed to evaluate any spaces or 'gaps' created using bed rails or mattresses. As part of the community's routine preventive maintenance program, resident beds, mattresses and attached equipment (including side rails) are assessed on an annual or as needed basis."

ASM (administrative staff member) #1, the administrator, and ASM #2, the director of health services, were made aware of the above concern on 9/22/2021 at 4:30 p.m.

No further information was provided prior to exit.

(1) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 380.
(2) Barron's Dictionary of Medical Terms for the Non-Medical Reader, 5th edition, Rothenberg and Chapman, page 489.