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Shenandoah Place, Inc.
50 Burkholder Lane
New market, VA 22844
(540) 740-4300

Current Inspector: Jill James (540) 418-2631

Inspection Date: Feb. 16, 2021

Complaint Related: No

Areas Reviewed:

22VAC40-73 ADMINISTRATION AND ADMINISTRATIVE SERVICES
22VAC40-73 STAFFING AND SUPERVISION
22VAC40-73 ADMISSION, RETENTION, AND DISCHARGE OF RESIDENTS
22VAC40-73 RESIDENT CARE AND RELATED SERVICES

Comments:

This inspection was conducted by licensing staff using an alternate remote protocol necessary due to a state of emergency health pandemic declared by the Governor of Virginia.

A focused monitoring inspection was initiated on 02/16/2021 and concluded on 03/15/2021. The administrator was contacted to initiate the inspection. The administrator reported that the current census was 11. The inspector emailed the administrator a list of items required to complete the inspection. The inspector reviewed a selected portion of nine resident records ,licenses and certifications for five staff, staff schedule and incident reports submitted by the facility to ensure documentation was complete.

Information gathered during the inspection determined non-compliance(s) with applicable standards or law, and violations were documented on the violation notice issued to the facility.

Please complete the plan of correction and date to be corrected for each violation cited on the violation notice and return to the inspector within 10 days. The plan of correction is to include the following: 1) steps to correct the non-compliance with the standards, 2) measures to prevent the non-compliance from occurring again, and 3) person(s) responsible for implementing each step and or monitoring any preventative measure(s).

Violations:

Standard #:	22VAC40-73-70-A
Description:	Based upon review of residents' records, the facility failed to report within 24 hours, a major incident that has negatively affected or that threatens the life, health, safety or welfare of any resident. FINDINGS: 1) A review of requested incident reports submitted for this focused inspection indicate resident A had a falls on 01/24/21 at 12:15am and on 01/30/21 at 10:22pm. a. Neither of the above listed incidents were reported to the regional licensing office within 24 hours. 2) Nurses notes for resident E dated 02/02/21 indicate ?Skilled nursing evaluation completed for buttock wounds. Stage II pressure ulcers were found to left and right buttocks due to shears friction.? Notes dated 02/25/21 indicate ?Skilled nursing visit for wound care. New openings to left and right buttocks were noted, old areas are healed.? a. This was not reported to the regional licensing office within 24 hours. b. Communication received from the administrator on 03/02/21 "there are wounds, but there are no pressure areas." 3) A review of requested incident reports submitted for this focused inspection indicate resident E had falls on 12/14/20 at 3:32pm; 01/18/21 at 9:30pm ; date unknown on another report at 5:00pm; and 02/07/21 at 6:05am. a. These incidents were not reported to the regional licensing office within 24 hours. 4) A review of requested incident reports submitted for this focused inspection indicate resident F had falls on 01/21/21 at 6:30pm; 01/23/21 at 6:02pm; 01/27/21 at 6:42pm; 01/27/21 at 11:15am and 02/10/21 at 3:15pm. a. These incidents were not reported to the regional licensing office within 24 hours. 5) A review of requested incident reports indicate resident H had a fall on 02/07/21 at 6:40am and another incident report indicates a fall but does not include date or time. a. This was not reported to the regional licensing office within 24 hours. 6) A review of requested incident report indicate resident I had a fall on 02/04/21 at 7:32pm. a. This was not reported to the regional licensing office within 24 hours.

Plan of Correction: Not available online. Contact Inspector for more information.

Plan of Correction:	Not available online. Contact Inspector for more information.

Standard #:	22VAC40-73-70-B
Description:	Based upon review of incident reports, the facility failed to ensure the reports contained all required information. FINDINGS: 1)There are two submitted reports requested for this focused inspection for resident C that do not include date of incident and actions taken in response to the incident. Both incident reports indicate time of incident as 5:00pm. 3) There are two submitted reports (01/23/21 at 6:02pm and 01/27/21 at 11:15am) requested for this focused inspection for resident F that do not include actions taken in response to the incident. 4) The submitted incident report requested for this focused inspection for resident H does not include a date or time and actions taken in response to the incident. 5) The submitted incident report requested for this focused inspection for resident I, (02/04/21 at 7:32pm) does not include actions taken in response to the incident.
Plan of Correction:	Not available online. Contact Inspector for more information.

Standard #:	22VAC40-73-70-C
Description:	Based upon review of residents' records and communication with the administrator, the facility failed to submit a written report within seven days from the date of the incident. FINDINGS: 1) A review of requested incident reports submitted for this focused inspection indicate resident A had a fall on 01/24/21 at 12:15am and on 01/30/21 at 10:22pm. a. Written reports for the above listed incidents were not submitted to the regional licensing office within seven days of the incident. 2) Nurses notes requested for this focused inspection for resident E dated 02/02/21, indicate ?Skilled nursing evaluation completed for buttock wounds. Stage II pressure ulcers were found to left and right buttocks due to shears friction.? Notes dated 02/25/21 indicate ?Skilled nursing visit for wound care. New openings to left and right buttocks were noted, old areas are healed.? a. A written report was not submitted to the regional licensing office within seven days of the incident. b. Communication received from the administrator on 03/02/21 "there are wounds, but there are no pressure areas." 3) A review of requested incident reports submitted for this focused inspection indicate resident E had a fall on 12/14/20 at 3:32pm; 01/18/21 at 9:30pm ; date unknown on another report at 5:00pm; and 02/07/21 at 6:05am. a. Written reports for the above listed incidents were not submitted to the regional licensing office within seven days. 4) A review of requested incident reports submitted for this focused inspection. indicate resident F had falls on 01/21/21 at 6:30pm; 01/23/21 at 6:02pm; 01/27/21 at 6:42pm; 01/27/21 at 11:15am and 02/10/21 at 3:15pm. a. Written reports of the above listed incidents were not reported to the regional licensing office within seven days. b. Three of the five reports reviewed did not contain the signature of the administrator. 5) A review of requested incident reports submitted for this focused inspection indicate resident H had a fall on 02/07/21 at 6:40am and another incident report indicates a fall but does not include date , time and administrator signature. 6) A review of requested incident report submitted for this focused inspection indicates resident I had a fall on 02/04/21 at 7:32pm.
Plan of Correction:	Not available online. Contact Inspector for more information.

Standard #:	22VAC40-73-325-C
Description:	Based upon review of submitted documentation, the facility failed to ensure documentation of an analysis of the circumstances of the fall and interventions that were initiated to prevent or reduce risk of subsequent falls was completed as required. 1) The incident report for resident C dated 01/20/21 indicates "resident rang call bell and was on floor." a. There is no documentation of analysis of the circumstances of the fall. Intervention initiated is documented as "remind resident to call for help." 2) The incident report for resident F dated 02/10/21 indicates "resident was observed on floor, we got him up and put resident in wheelchair and brought resident out for coffee." a. As completed, the post fall form does not document the circumstances of the fall or interventions initiated to prevent or reduce the risk of subsequent falls. The post fall form indicates the analysis of the circumstances of the fall as resident is "actively dying." Intervention initiated is documented as ?checks.?
Plan of Correction:	Not available online. Contact Inspector for more information.

Standard #:	22VAC40-73-450-C
Description:	Based upon review of residents' records. the facility failed to ensure the assessed needs of the resident are included on the Individualized Service Plan (ISP). FINDINGS: 1) The Uniform Assessment Instrument (UAI) dated 02/23/21 for resident A indicates the assistance of two staff is needed for dressing. This is not reflected on the ISP (dated 02/23/21) a. The ISP does not include a description of identified needs sufficient to explain the inconsistencies between reports. The for resident A indicates ?wandering/passive, weekly or more.? The ISP and hospice plan of care indicate resident A is bedbound. b. The hospice plan of care indicates resident has an indwelling foley catheter. The UAI indicates the resident wears briefs. The ISP indicates ?Client does not currently use the restroom; is incontinent of both bowel and bladder and will be provided incontinent care while in bed.? c. The UAI indicates the assistance of two staff is needed for bathing. The ISP indicates one or two staff is needed. 2) The UAI for resident C (dated 02/23/21) indicates wandering passive weekly or more and disorientation to some spheres some of the time. This is not reflected on the ISP dated 02/23/2021. 3) Nurses notes dated 02/02/21 indicate resident E has a stage II pressure ulcer. This identified need is not indicated on

	3) Nurses notes dated 02/02/21 indicate resident E has a stage II pressure ulcer. This identified need is not indicated on the ISP review dated 02/09/21. The ISP indicates resident is as risk for alteration in skin integrity and has a history of wounds. 4) Post fall assessment tool dated 01/23/2021 indicates resident F has a fall mat and requires frequent checks due to falls. This need for frequent checks is not reflected on the ISP.
Plan of Correction:	Not available online. Contact Inspector for more information.

Standard #:	22VAC40-73-450-D
Description:	Based upon review of residents' records, the facility failed to ensure services provided by hospice is included on the Individualized Service Plan (ISP). FINDINGS: 1) The hospice plan of care for resident A indicates resident receives skilled nursing services, volunteer services and social worker services. a. The ISP indicates comfort medications, care/oversight services.
Plan of Correction:	Not available online. Contact Inspector for more information.

Standard #:	22VAC40-73-470-F
Description:	Based upon review of documentation, the facility failed to ensure medical attention was received immediately from a licensed health care professional when a resident suffers a serious accident, injury, illness, medical condition or there is reason to suspect that such has occurred. 1) Incident reports that were requested for this focused inspection and submitted by the administrator show that resident F had falls on 01/23/21 at 6:02pm; 01/27/21 at 6:42pm; 01/27/21 at 11:15am and 02/10/21 at 3:15pm. a. There is no documentation indicating the resident was seen by a licensed health care professional for the falls that occurred on 01/23/21 at 6:02pm; 01/27/21 at 6:42pm; 01/27/21 at 11:15am and 02/10/21 at 3:15pm. b. There is no documentation the resident's physician was notified within 24 hours of the falls that occurred on 01/23/21 at 6:02pm; 01/27/21 at 6:42pm; 01/27/21 at 11:15am and 02/10/21 at 3:15pm as required by 22 VAC 40-73-470-F.1. 2) Incident reports that were requested for this focused inspection and submitted by the administrator show that resident E had falls on 12/14/20 at 3:32pm; 01/18/21 at 9:30pm ; date unknown on another report at 5:00pm; and 02/07/21 at 6:05am. a. Documentation indicates resident hit head on night stand and rescue squad was called on 02/07/21 but resident refused to go to the hospital. b. There is no documentation of resident being seen by a licensed health care professional for the falls that occurred on 12/14/20 at 3:32pm; 01/18/21 at 9:30pm ; date unknown on another report at 5:00pm; and 02/07/21 at 6:05am.. c. There is no documentation the resident?s physician?s was notified within 24 hours of the falls that occurred on 12/14/20 at 3:32pm; 01/18/21 at 9:30pm ; date unknown on another report at 5:00pm; and 02/07/21 at 6:05am as required by 22 VAC 40-73-470-F.1.
Plan of Correction:	Not available online. Contact Inspector for more information.

Standard #:	22VAC40-73-670-1
Description:	Based upon review of staff records and resident records, the facility failed to ensure staff administering medications are licensed by the Commonwealth of Virginia or is registered with the Virginia Board of Nursing as a medication aide. FINDINGS: Documentation submitted by the facility indicates staff A received an Associate of Applied Science Degree in Nursing on 05/08/2017. a. Staff A has not successfully taken the National Council Licensure Examination to obtain licensure as a registered nurse. b. Communication received from the administrator via email on 02/24/21 indicates that staff A is able to test for the National Council Licensure Examination from 02/24/21 through 08/23/21. c. Staff A has not taken the Virginia Board of Nursing competency exam for registered medication aides. d. Communication received from the administrator via email on 02/22/21 included a copy of an application to take the registered medication aide competency exam for staff A dated 02/22/21. Administrator indicated that staff A had been pulled from the medication cart. e. The file for staff A contains a Registered Medication Aide job description signed by staff A dated 02/01/2021. The job description indicates a requirement is having a current registration in Virginia as a registered medication aide. f. Communication received from the administrator on 03/01/21 states staff A passed medications on 02/06/21 from 11p-11a, 02/07/21 11p-7a, 02/11/21 3p-11p, 02/12/21 7p-7a, 2/18/21 3p-11p and 2/20/21 3p-7a. g. Based upon review of the Medication Administration Records (MARs) documentation indicates staff A administered medications to residents A, B, C, D, E, and F on 02/01/21; 02/02/21; 02/04/21; 02/06/21; 02/07/21; 02/08/21; 02/11/21; 02/12/21; 02/13/21 and 02/14/21. h. Based upon review of the MARS for resident F, documentation indicates staff A administered medication to resident F on 03/08/21 and 03/09/21.
Plan of Correction:	Not available online. Contact Inspector for more information.

Standard #:	22VAC40-73-680-D
Description:	Based upon review of resident records, the facility failed to ensure medications are administered in accordance with the physician's instructions and consistent with the standards of practice outlined in the current registered medication aide curriculum approved by the Virginia Board of Nursing. FINDINGS: 1)Resident F has the following two orders: Ondansetron 8mg tablet-Take one tablet by mouth 30 minutes before getting out of bed for nausea. Ondansetron 8mg tablet-Take one tablet by mouth every four hours as needed for nausea.

	a. Documentation in the Medication Administration Record (MAR) indicates medication was administered by staff A on 02/08/21 at 4:44am and at 6:00am. Resident F received two doses of medication in less than four hours apart. 2) Resident G has the following order: Novolog Insulin 100U/ML Pen-Inject 6 units into the skin three times daily before meals . Hold if blood sugar is less than 90. a. Documentation in the MAR indicates resident's blood glucose was 90 on 01/25/21 at 7:30am and insulin was not administered. b. Documentation in the MAR indicates resident's blood glucose was 90 on 02/12/21 at 7:30am and insulin was not administered.
Plan of Correction:	Not available online. Contact Inspector for more information.

Standard #:	22VAC40-73-680-E
Description:	Based upon review of medication administration records, the facility failed to ensure medical procedures are provided according to the physician's instructions. FINDINGS: 1) Resident A has the following order: Check blood pressure daily. Notify MD if Systolic (top) is greater than 160 and/or diastolic (bottom) is greater than 90. a. Documentation in the Medication Administration Record (MAR) indicates resident's blood pressure was 167/53 on 01/15/21; 166/86 on 01/16/21; 176/63 on 01/17/21; 181/67 on 01/18/21; 175/64 on 01/21/21; 176/62 on 01/22/21; 166/53 on 01/23/21; 165/57 on 01/25/21; 171/51 on 01/27/21; 187/60 on 01/29/21; 175/56 on 01/30/21; 170/55 on 01/31/21; 177/59 on 02/03/21. b. There is no documentation of physician notification for systolic blood pressure over 160 on the days indicated above.
Plan of Correction:	Not available online. Contact Inspector for more information.

Standard #:	22VAC40-73-680-K
Description:	Based upon review of resident's records, the facility failed to ensure physician's orders include all required information. FINDINGS: 1) Resident G has the following order: Glucose 4 GM tablet-Chew 4 tablets by mouth as needed for low blood sugar. Notify MD if no relief. a. The order on the MAR and the physician?s order sheet does not specify time frame to notify physician if no relief. . 2) Resident G has the following order: Nitroglycerin SL 0.4mg tablet-Place one tablet (0.4 mg total) under the tongue every 5 minutes as needed for chest pain. a. The order on the MAR and the physician?s order sheet do not indicate specific indications such as maximum dose to be given within a specified time frame and actions to take if symptoms persist.
Plan of Correction:	Not available online. Contact Inspector for more information.