APPROVED

VIRGINIA BOARD OF LONG –TERM CARE ADMINISTRATORS
INFORMAL CONFERENCE COMMITTEE
MINUTES

The Virginia Board of Long-Term Care Administrators Special Conference Committee convened for an informal conference on Monday, March 31, 2008 at the Department of Health Professions, Perimeter Center, 9960 Mayland Drive, 2nd Floor, Suite 201, Hearing Room #1, Richmond, Virginia.

COMMITTEE MEMBERS PRESENT:

Mary Smith, NHA, Presiding Chair
Kathleen R. Fletcher, MSN

DHP STAFF PRESENT:

Lisa R. Hahn, Executive Director
Emily A. Field, Adjudication Specialist
Rashaun K. Minor, Discipline Operations Manager

OTHERS PRESENT:

Gayle Miller, DHP-Senior Investigator
Shannon Roberson, DHP-Case Intake Analyst
LaRhonda Carter, DHP-Adjudication Specialist

MATTER SCHEDULED

Respondent: Jeffrey M. Peters, Nursing Home Administrator
Case Number: 113315

CALLED TO ORDER

Ms. Smith called the conference to order at 9:40 a.m.

DISCUSSION

Mr. Peters appeared before the Committee in person in accordance with the Notice of the Board dated February 25, 2008 and amended notice dated March 7, 2008.

The Committee fully discussed with Mr. Peters the allegations as outlined in the Notice, specifically Mr. Peters may have violated 18 VAC 95-20-470(1) and (2) of the Regulations Governing the Practice of Nursing Home Administrators in that between on or about March 3, 2006, and January 9, 2007, during the course of Mr. Peters employment as the Administrator of

Ruxton of Westover Hills, Richmond, Virginia, Mr. Peters failed to supervise staff to ensure the health, safety, and well-being of residents. More specifically:

1. Mr. Peters failed to ensure that call bells were within reach of residents. At least four call bells were left lying on the floor. When asked about one of the resident's call bells, a staff person responded that the call bell didn't matter and that the resident would yell for help.

2. Mr. Peters failed to ensure that activities were provided for residents. Some residents laid in bed all day with the lights turned out. The few activities that were provided to some of the residents failed to engage residents, who slept, wandered in and out, or stared blankly ahead during activities.

3. Mr. Peters failed to ensure infection control by preventing residents from wandering into the rooms, or lying in or on the beds of other residents.

4. Mr. Peters failed to ensure that a resident who self-administered medications had an assessment detailing her ability to do so.

5. Mr. Peters failed to ensure that residents were shaved, or had their fingernails cleaned and trimmed.

6. Mr. Peters allowed staff to disrobe residents without closing privacy curtains around the residents, leaving them open to view.

7. Mr. Peters allowed staff to line residents up in the shower area so that residents had a view of others who were showering.

8. Mr. Peters failed to ensure that two residents were able to vote using absentee ballots.

9. Mr. Peters failed to ensure that Do Not Resuscitate Forms were completed for three residents.

10. Mr. Peters failed to obtain the required numbers of reference checks for two employees.

11. Mr. Peters failed to ensure that residents had straws, so they drank directly from milk cartons.

12. Mr. Peters failed to ensure that residents knew of and had access to 1-800 numbers for agencies that act as client advocates.

13. Mr. Peters failed to ensure that residents had access to telephones where they could make calls in private.

14. Mr. Peters allowed a pervasive smell of urine to exist in parts of the facility, including hallways and resident rooms.

15. Mr. Peters failed to update the Minimum Data Set (MDS) for residents, to reflect changes that impact their care planning decisions.

16. Mr. Peters failed to ensure that staff completed timely resident assessments. For example, a resident's MDS dated October 3, 2006, indicated that the resident had one stage one pressure ulcer. Weekly wound assessments viewed between November 6, 2006, and November 8, 2006, showed that the resident had five pressure ulcers (two stage two pressure ulcers, one stage three pressure ulcer, and two stage four pressure ulcers).

17. Mr. Peters failed to ensure that residents' care plans were updated to reflect their current status.

18. Mr. Peters failed to ensure that staff dated medications when they were opened, or disposed of expired medications.

19. Mr. Peters failed to ensure that staff positioned a resident properly during a tube feeding to prevent possible aspiration.

20. Mr. Peters failed to ensure that residents were screened for rehabilitation therapy services after they were re-admitted to the facility.

21. Mr. Peters failed to ensure that staff took appropriate steps to prevent pressure ulcers from developing or becoming worse on five residents. More specifically, skin and wound assessments and care were not provided as ordered, nutritional interventions did not take place to prevent residents from suffering from weight loss, and pressure relieving interventions were not taken.

    a. One resident developed two new pressure ulcers (stage two and stage four) while at the facility.

    b. A second resident developed two new ulcers (stage two and stage three).

    c. A third resident developed two new ulcers (stage two and an unstageable wound).

    d. A fourth resident was admitted with one pressure ulcer, which increased in severity (from a stage two to a stage three) and developed five new ulcers. These were not found by facility staff until two had reached stage four, one had reached stage three, and two had reached stage two.

e. A fifth resident was admitted with one pressure ulcer, which increased in severity (from a stage two to a stage three) and developed four new ulcers. These were not found by facility staff until one had reached stage three, two had reached stage two, and one was inaccessible. On or about November 2, 2006, this resident was provided wound care, and was observed to be grimacing. The nurse gave the resident pain medication, and left the resident for 45 minutes with a positioner between her legs. When wound care resumed, drainage from the resident's wounds had leaked onto the positioner.

22. Mr. Peters failed to ensure that nurse aides used appropriate procedures when washing residents' genital areas.

23. Mr. Peters failed to supervise staff to ensure that medication carts were locked when they were unattended.

24. Mr. Peters failed to ensure that residents received appropriate nutrition and related supports to prevent severe weight loss. One resident had a documented weight loss of 72 pounds in one month, and there was no documentation in the resident's medical record to explain this weight loss. Another resident (who was being tube fed) had a documented weight loss of 18 pounds, or 10.9 percent in four months. A third resident had a documented weight loss of 26 pounds in one month, and a fourth resident had a documented weight loss of 9.6 percent in 17 days.

25. Mr. Peters failed to supervise staff to ensure that water pitchers were accessible for two residents.

26. Mr. Peters failed to supervise staff to keep the facility's medication error rate below five percent.

27. Mr. Peters failed to ensure that adequate numbers of staff were available to meet resident needs. Based on facility documentation, there were inadequate numbers of staff on a total of 31 (out of 60) days in March and April, 2006.

28. Mr. Peters failed to ensure that perishable foods were kept at an adequately low temperature.

29. Mr. Peters failed to supervise staff to ensure that physicians followed up on a resident's low blood sugar and on an abnormal lab result. Mr. Peters also failed to ensure that the Medical Director provided guidance and oversight of resident care policies.

30. Mr. Peters failed to ensure that each resident was seen by a physician on a regular basis, and that physician notes were completed for each visit. One resident was admitted to the facility on July 6, 2006, and as of November

8, 2006, there were no physician notes or orders for this resident, and there was no documentation to support that the resident had been seen by a physician. Several other residents had gaps of three to six months between documented physician visits.

31. Mr. Peters failed to ensure that medications were kept at proper temperature when refrigerated. There were no temperature control logs for two of the medication refrigerators prior to November, 2006. Logs for the other two refrigerators showed improper temperatures for 17 days in four months, and for 15 days in four months (with no recorded temperatures for 81 days), respectively.

32. Mr. Peters failed to ensure that staff washed their hands for the proper amount of time when providing care to residents.

33. Mr. Peters failed to provide adequate seating to residents on the Alzheimer's Unit, who then had difficulty finding seats for activities, and who ate from over-bed tables. One resident was unable to eat in the dining room due to the lack of seating, and instead ate in her room.

34. Mr. Peters failed to ensure that the Quality Assurance Committee received facility audit results. Further, Mr. Peters failed to maintain a list of quality deficiencies or assure that a plan of action was developed. When asked, the Quality Assurance Nurse stated that when a problem was identified, each department was responsible for their own solutions.

35. Mr. Peters failed to ensure that residents' legal representatives received quarterly statements of residents' patient fund accounts.

36. Mr. Peters failed to supervise staff to ensure that bed and chair alarms were turned on.

CLOSED SESSION

Upon a motion by Ms. Fletcher and duly seconded by Ms. Smith, the Committee convened a closed meeting pursuant to §2.2-3711.A (28) of the *Code of Virginia,* for the purpose of deliberation to reach a decision in the matter of Jeffery M. Peters, Nursing Home Administrator. Additionally, Ms. Fletcher moved that Ms. Hahn, Ms. Field, and Ms. Minor attend the closed meeting because their presence in the closed meeting was deemed necessary and would aid the Committee its deliberations. The vote was unanimous in favor of the motion.

OPEN SESSION

Ms. Fletcher certified that the matters discussed in the preceding closed session met the requirements of §2.2-3712 of the *Code of Virginia* and the Committee re-convened in open session.

DECISION

Ms. Field read the Findings of Fact and Conclusions of Law adopted by the Committee. A summary of the Findings of Fact and Conclusions of Law are as follows:

1. Jeffrey M. Peters, Nursing Home Administrators (NHA), holds license number 1701-002080, issued by the Virginia Board of Long-Term Care Administrators August 10, 2004 and due to expire March 31, 2009.

2. Mr. Peters failed to ensure that call bells were within reach of residents. At least four call bells were left lying on the floor. When asked about one of the resident's call bells, a staff person responded that the call bell didn't matter and that the resident would yell for help.

3. Mr. Peters failed to ensure that activities were provided for residents. Some residents laid in bed all day with the lights turned out. The few activities that were provided to some of the residents failed to engage residents, who slept, wandered in and out, or stared blankly ahead during activities.

4. Mr. Peters failed to ensure infection control by preventing residents from wandering into the rooms, or lying in or on the beds of other residents.

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16. Mr. Peters failed to update the Minimum Data Set (MDS) for residents, to reflect changes that impact their care planning decisions.

17. Mr. Peters failed to ensure that staff completed timely resident assessments. For example, a resident's MDS dated October 3, 2006, indicated that the resident had one stage one pressure ulcer. Weekly wound assessments viewed between November 6, 2006, and November 8, 2006, showed that the resident had five pressure ulcers (two stage two pressure ulcers, one stage three pressure ulcer, and two stage four pressure ulcers).

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21. Mr. Peters failed to ensure that residents were screened for rehabilitation therapy services after they were re-admitted to the facility.

22. Mr. Peters failed to ensure that staff took appropriate steps to prevent pressure ulcers from developing or becoming worse on five residents. More specifically, skin and wound assessments and care were not provided as ordered, nutritional interventions did not take place to prevent residents from suffering from weight loss, and pressure relieving interventions were not taken.

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also failed to ensure that the Medical Director provided guidance and oversight of resident care policies.

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35. Mr. Peters stated during the informal conference that he had identified issues at Ruxton, and was working on assessments of those issues.

36. Mr. Peters stated that he recognized that the Ruxton facility was too big and had too many issues for his experience level.

The decision was read by Ms. Field:

Findings of Fact Numbers 2 through 35 constitute violations of 18 VAC 95-20-470(1) and (2) of the Regulations Governing the Practice of Nursing Home Administrators.

1. Within ten days of course completion, and prior to March 31, 2009, Mr. Peters shall submit written proof of completion of 24 hours of Board-approved courses in the area of leadership development. The courses shall be submitted to the Board for prior approval, and shall be related to accountability, critical thinking, dealing with challenging employees, and

assuming responsibility. These shall be classroom hours, and not internet or self-study hours.

2. Mr. Peters shall obtain a Board-approved preceptor. As part of the Board approval process, the preceptor shall certify in writing to the Board that he or she has received and read a copy of the complete Board Order for Mr. Peters.

3. Mr. Peters shall provide written proof from the Board-approved preceptor of successful completion of an Administrator-in-Training ("AIT") program consisting of 40 actual hours in Quality Assurance. Mr. Peters shall submit written certification of his completion of the program within 10 days of completion, but prior to March 31, 2009.

4. Mr. Peters shall maintain a course of conduct in his capacity as a nursing home administrator commensurate with the requirements of § 54.1-3100 *et seq*. of the Code and the Regulations Governing the Practice of Nursing Home Administrators.

Pursuant to §§ 2.2-4023 and 54.1-2400.2 of the Code, the signed original of the Order shall remain in the custody of the Department of Health Professions as public record and shall be made available for public inspection or copying upon request.

Upon a motion by Ms. Fletcher and duly seconded, the decision of the Committee was adopted. The vote was unanimous in favor of the motion.

ADJOURNMENT

The Committee adjourned at 12:07 p.m.

________________________________	________________________________
Mary Smith, NHA, Presiding Chair	Lisa R. Hahn, Executive Director
________________________________	________________________________
Date	Date