

Golden Living Center Petersburg

287 South Boulevard
Petersburg, VA 23805
Phone: (804) 733-1190
Fax: (804) 733-2118

To: *Colaine Cacciatore, LTC Supv. 804-527-4502*

From: *Paula Ruffin*

Date: *11-7-16*

Number of Pages including Cover: *9*

RE: *POC for 2567 (Revisit)*

*Colaine, it's only 9 pgs. I counted the entire packet
rec'd which you don't need (smile). Enjoy your
evening & thanks*

RECEIVED

NOV 07 2016

VDH/OLC

This document accompanying this transmission contains confidential protected health information that is legally privileged. This information is intended only for the use of the individual or entity named above. The authorized recipient of this information is prohibited from disclosing the information to any other party unless required to do so by law or regulation and is required to destroy the information after its stated need has been fulfilled.

If you are not the intent recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of these documents is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of these document(s).

November 3, 2016

Department of Health

Office of Licensure and Certification

Attention: Elaine Cacciatore, LTC Supervisor

9960 Mayland Drive, Suite 401

Richmond, Virginia 23233-1485

RE: Golden Living Center Petersburg

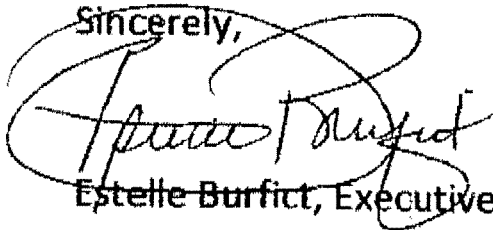
CCN: 495144

Dear Ms. Cacciatore,

Please find attached our POC from our most recent 2567 received via email on 10-31-16 for a revisit survey held on October 19-20, 2016. Should you have concerns or questions, please feel free to contact me via email or work phone (804-733-1190) or cell (804-931-1534).

Thank you for your time and I look forward to hearing from you.

Sincerely,



Estelle Burfict, Executive Director

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/20/2016
NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-PETERSBURG		STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805	
(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)

{F 000} INITIAL COMMENTS

An unannounced Medicare/Medicaid revisit to the standard survey ending 09/1/16, was conducted 10/19/16 through 10/20/16. Corrections are required for compliance with the following 42 CFR Part 483 Federal Long Term Care Requirements. Uncorrected deficiencies are identified within this report. Corrected deficiencies are identified on the CMS 2567-B.

The census in this 120 certified bed facility was 95 at the time of the survey. The survey sample consisted of 11 current resident reviews (Residents 101 through 111) and no closed record reviews.

{F 000}

Preparation and/or execution of the Plan of Correction does not constitute admission or agreement of the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The Plan of Correction is prepared and/or executed safely because it is required by the provision of Federal and State Laws.

This plan of correction is the facility's credible allegation of compliance.

{F 314} 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES
SS=D

Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

{F 314}

1) Elbow Protectors/Palm Protectors are being applied as ordered on Resident # 103, by the direct care givers. The Care Card was updated to reflect Application of the devices. 11-13-16

2) The DNS/designee will conduct an audit of all residents with assistive and pressure relieving devices to validate devices (settings, etc) are utilized as ordered to ensure MD orders are followed. Nursing staff will be educated on applying assistive and pressure relieving devices.

This REQUIREMENT is not met as evidenced by:

Based on observation, staff interview, facility documentation review, and clinical record review, the facility staff failed to assess and implement preventative measures for pressure ulcers for one Resident (Resident #103) in a survey sample of 11 Residents.

1. For Resident #103, the facility staff failed to

RECEIVED
NOV 07 2016
VDH/OLC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X5) DATE 11-3-16
---	-----------------------------	----------------------

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/20/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805
--	---

(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 314} Continued From page 1
apply elbow protectors as a preventative measure to prevent pressure ulcers; and

The findings included:

1. For Resident #103, the facility staff failed to apply elbow protectors as a preventative measure to prevent pressure ulcers.

Resident #103, a female, was admitted to the facility 10/1/02. Her diagnoses included Alzheimer's, urinary tract infection, urinary retention, aphasia, cataracts, unspecified psychosis, general anxiety disorder, open angle glaucoma, peptic ulcer, arteriosclerotic cardiovascular disease, type II diabetes mellitus, cardiac arrhythmia, hypertension, and peripheral vascular disease.

Resident #103's most recent MDS (minimum data set) with an ARD (assessment reference date) of 9/29/16 was coded as a quarterly assessment. Resident #103 was coded as having short and long term memory deficits and required total assistance with making daily life decisions. Resident #103 was coded as needing extensive to total assistance of one staff member to perform her activities of daily living. She was also coded as being at risk for the development of pressure ulcers, however was coded as having no pressure ulcers. Resident #103 was also coded as having no behaviors including rejection of care.

Resident #103 was observed during initial tour of the facility 10/19/16 at approximately 11:50 a.m. Resident #103 was lying on her right side, sleeping. A specialty mattress was in place. A

{F 314} 3) Department managers will validate during daily rounds that assisted devices and pressure relieving devices are in place and submit audits to Executive Director. Director will work with the DNS/Designee on concerns.

Unit Managers will conduct random audits of assistive and pressure relieving devices to validate they are applied/in place as ordered and submit to DNS daily Monday - Friday.

4) DNS/ Designee will report findings of audits to Executive Director weekly.

DNS/Designee will report findings monthly to Quality Assurance & Performance Improvement (QAPI) committee meeting.

RECEIVED
NOV 07 2016
VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/20/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 207 EAST SOUTH BOULEVARD PETERSBURG, VA 23805
--	---

(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 314)	<p>Continued From page 2</p> <p>Foley catheter was observed and was in a privacy bag. Her right elbow was visible and no elbow protector was in place.</p> <p>Resident #103 was also observed 10/19/16 at 3:30 p.m. She was lying on her left side, with a pillow to her back. No elbow protectors were noted on either elbow.</p> <p>Resident #103 was also observed 10/19/16 at 3:42 p.m. Resident #103 was still lying on her left side. LPN (licensed practical nurse) B was in Resident #103's bedroom. Both of Resident #103's elbows were observed with an area noted on her left elbow that was depigmented in color. The area was noted to be where a previous pressure area had healed. No elbow protectors were evident on either elbow.</p> <p>Resident #103 was observed 10/20/16 at 7:52 a.m. She was lying on her right side with a pillow to her back. An elbow protector was noted on her left elbow and palmar protectors were noted in both hands. An elbow protector is a soft white device applied to the elbow area to help prevent pressure. The protector is held in place with hook and loop tape and may be slipped over the elbow.</p> <p>Review of Resident #103's clinical record revealed a signed physician's order that included:</p> <p>"Bilateral elbow protectors at all times as tolerated. May remove for skin integrity check and during activities of daily living care." The order was initially dated as 6/10/16.</p> <p>Review of Resident #103's care plan included:</p> <p>"5/6/16 Actual pressure ulcer and at risk for future</p>	{F 314}		
---------	---	---------	--	--

RECEIVED
NOV 07 2016
VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/20/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805
--	---

(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 314) Continued From page 3 (F 314)

skin alteration r/t (related to) dependence for position changes, transfers, incontinence, ostomy stoma, PVD (peripheral vascular disease), DM (diabetes mellitus), and intervals of motor-restlessness.
6/6/16 left elbow pressure ulcer (noted 5/6/16)...7/31/16 area resolved."

One of the interventions was "initiated 6/10/16 Elbow protectors provided by hospice as ordered."

CNA (certified nursing assistant) B stated 10/19/16 at 3:52 p.m., she cared for Resident #103. CNA B stated the staff had to carefully open her hands to put in a protective device such as a wash cloth. CNA B did not indicate anything about applying elbow protectors. CNA B did say Resident #103 did not resist care or refused to have the protective devices in her hands.

CNA A, caring for Resident #103 10/20/16 at 8:32 a.m., stated Resident #103 was cooperative and never resisted having her elbow protectors applied. CNA A stated Resident #103 should have elbow protectors and palmar positioning devices in place.

Review of the CNA "Care Card" for Resident #103 revealed no indication the elbow protectors should be in place. LPN B stated the "Care Card" was the care plan for CNA care of Resident #103. LPN B stated use of elbow protectors should have been entered on the "Care Card" as guidance to the CNA staff. LPN B stated the unit manager was responsible for updating the "Care Card." LPN B said the unit manager was new and had only been at the facility one day and she was unaware why the previous unit manager had

RECEIVED
NOV 07 2016
VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/20/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805
--	---

(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 314} Continued From page 4 {F 314}

not ensured guidance was provided to CNAs that elbow protectors should be in place.

LPN A stated 10/20/16 at 9:14 a.m., the responsibility for having the elbow protectors in place was with the nurse who signed on the TAR (treatment administration record) that the elbow protectors were in place. Review of the TAR revealed nurses' initials indicating the protectors were in place, even though on 10/19/16 from initial tour until 3:52 p.m., no elbow protectors were applied to Resident #103's elbows. LPN A also said that if Resident #103 refused to allow the protectors to be applied, the staff should notify the nurse. A thorough review of Resident #103's clinical record revealed no evidence Resident #103 refused to allow the elbow protectors to be applied.

Documentation revealed Resident#103 had a previous pressure ulcer on her right elbow that developed 5/6/16. Treatment was instituted, including the use of elbow protectors, and the area was documented as having healed 7/31/16.

Review of the facility's policy for "Skin Integrity Guideline" revealed:

*General Guideline:

*DNS (director nursing service) or designee will be responsible to implement and monitor the skin integrity program. Wound status is monitored on a weekly basis.

*The interdisciplinary plan of care will address problems, goals and interventions directed toward prevention of pressure ulcers and/or skin integrity concerns identified.

RECEIVED
NOV 07 2016
VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 485144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/20/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805
--	---

(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 314} Continued From page 5 {F 314}

Documentation and Care Interventions for Skin Integrity:

"If identified risk present, the interventions will be documented in the Immediate Plan of Care or Comprehensive Care Plan.

Documentation of Weekly Skin Evaluation/Observations:

"Care plan is to implemented, evaluated and revised based on the needs of the resident."

Guidance was provided at www.ahrq.gov
<<http://www.ahrq.gov>>

"Pressure ulcers develop when capillaries supplying the skin and subcutaneous tissues are compressed enough to impede perfusion, leading ultimately to tissue necrosis. Since 1930, we have understood that normal blood pressure within capillaries ranges from 20 to 40mm Hg; 32mm Hg (millimeters of Mercury) is considered the average.¹⁷ Thus, keeping the external pressure less than 32 mm Hg should be sufficient to prevent the development of pressure ulcers. However, capillary blood pressure may be less than 32 mm Hg in critically ill patients due to hemodynamic instability and comorbid conditions; thus, even lower applied pressures may be sufficient to induce ulceration in this group of patients. Therefore, the key to preventing pressure ulcers is to accurately identify at-risk individuals quickly, so that preventive measures may be implemented."

The administrator, DON (director of nursing), and corporate consultant were advised of the failure

RECEIVED
NOV 07 2016
VDH/OLC

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/27/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 495144	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R-C 10/20/2016
--	--	--	---

NAME OF PROVIDER OR SUPPLIER GOLDEN LIVINGCENTER-PETERSBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 287 EAST SOUTH BOULEVARD PETERSBURG, VA 23805
--	---

(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 314) Continued From page 6
of the staff to apply preventative elbow protectors
for Resident #103 at 10/20/16 at 11.04 a.m.

(F 314)

RECEIVED
NOV 07 2016
VDH/OLC