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To: Elaine Cacciatore, LTC Supervisor
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From: Estelle Burfict, ED

Date: 11-30-16

Number of Pages including Cover: 17

RE: 2567 & POC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	495144	A. BUILDING _____ B. WING _____	R 11/16/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOLDEN LIVINGCENTER-PETERSBURG	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 000}	INITIAL COMMENTS An unannounced Medicare/Medicaid revisit to the previous revisit ending 10/20/16 to the standard survey ending 9/1/16 , was conducted 11/15/16 through 11/16/16. Significant 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. One complaint was investigated. The census in this 120 certified bed facility was 98 at the time of the survey. The survey sample consisted of 12 current resident reviews (Residents 201 through 212) 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.	11-30-16
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	• Resident # 202 was readmitted on 11/22/16 where as his care plans have been revised as indicated per his current readmission. Resident # 209 was assessed by nursing on 11/22/16 for side rails and was deemed in appropriate for side rails at this time. Care plan has been updated accordingly. • Residents with falls within the last 30 days have had their care plans revised and updated as appropriate. An audit of current residents with devices will be conducted to ensure interventions are in place and corrections made as appropriate.	11-30-16

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

Executive Director 11-30-16

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.

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F 280	Continued From page 1	F 280	• Nursing staff will be educated regarding causes of falls, implementation of new interventions and fall prevention measures. IDT will review falls during Clinical Start- Up Monday- Friday to discuss how the resident fell, review of current interventions, new interventions, as well as updating care plans. DNS/DOR/Designee will review therapy evaluations and outcomes/recommendations during Clinical Start- Up Monday- Friday. Weekly risk meetings will occur with the IDT for recommendations/ follow up as appropriate. • Managers/ Designee will validate daily during rounds that fall interventions are in place and submit audits daily Monday- Friday to the DNS/Desginee for discussion with the Executive Director. DNS/Designee will report findings of audits to Executive Director weekly to be discussed in the monthly QAPI committee meeting for follow up as needed x 3 months.	

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview and facility documentation review, and in the course of a complaint investigation, the facility staff failed for two residents (Residents # 202 and #209) to review and revise the comprehensive care plan.

1. Resident #202's care plan had not been revised with new fall prevention interventions (non skid footwear, therapy evaluations and a toileting plan) after the falls of 2/3/16; 8/3/16; 9/22/26; 10/26/16.

2. Resident #209's care plan had not been revised with new fall prevention interventions (bilateral half side rails) after the fall on 9/27/16.

The findings included:

Resident #202's care plan had not been revised with new fall prevention interventions after falls.

Resident #202 was admitted to the facility on 1/15/16, and was readmitted on 11/2/16 after a fall with fracture. Resident #202's diagnoses included anemia, high blood pressure, bipolar disorder, left hip fracture and anxiety.

The Minimum Data Set, which was a quarterly assessment done prior to the fall with fracture, with an Assessment Reference Date of 8/4/16, coded Resident #202 as having a Brief Interview

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of Mental Status (BIMS) Score of "5" out of a possible 15, indicating severe cognitive impairment. The resident was coded as not having walked on or off the unit and was using the wheelchair for locomotion off and on the unit with standby assistance of one staff member. The resident was coded as being "not steady" moving between sitting and standing and surface to surface transfers with the resident requiring staff to steady during transfers.

There were no observation of the resident during the days of survey as the resident was at a physician's appointment on 11/15 16 and was admitted to the hospital from the physician's office that evening.

Review of the clinical record revealed the resident sustained a fall on 10/26/16, resulting in a right hip fracture, according to the hospital discharge summary dated 11/2/16. The resident required surgery to correct the fracture.

Fall risk assessments were conducted on 1/15/16 (admission), on 8/12/16, and on 11/2/16. The scores, respectively, were "8" (above 10 deemed resident at risk), "9", and "9". Review of the care plan prior to the fall with fracture, dated 1/29/16 (no new fall interventions added since 1/29/16). The resident was care planned for "At risk for falls related to history of falls, dementia, bipolar, dependent for transfers and mobility. Interventions included:

Assess for pain
Bed in low position
Call light or personal items available and in easy reach or provide reacher
Contour mattress

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F 280	Continued From page 3 Observe for side effects of medications Therapy referral Review of the facility's fall investigations and post fall analysis revealed the following: 2/3/16 at 3:00 AM: found supine on floor between wall and hallway door. The resident was wearing regular socks and it was recommended to wear non skid socks. 8/3/16 at 11:42 PM, found sitting on floor in front of toilet in his bathroom. A therapy screen was done and the resident was on a restorative program for active range of motion and ambulation. On 9/29/16 at 2:21 PM, the resident was found sitting on the floor in the shower room, trying to get to the bathroom. A therapy screen was recommended as well as offer the resident toileting every two hours. On 10/26/16 at 2:00 AM, the resident was found sitting on the bathroom floor in front of the toilet. Resident stated he had to use the bathroom. The resident was wearing regular socks. The recommendations were to use a bed and chair alarm, and gripper (non skid) socks. The resident was quickly sent to the hospital and a right hip fracture was diagnosed with subsequent surgery. On 11/16/16 at 10:00 AM, the DON (director of nursing) stated the unit manager was supposed to order a therapy referral and to initiate toileting	F 280		

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every two hours. "It was not done" (the referral to therapy and every two hour toileting).

None of the above recommendations were added to the current care plan.

On 11/16/16 at 10:30 AM, an interview with CNA (certified nursing assistant) A was conducted. CNA (A) stated, "All ADL's (activities of daily living-dressing, toileting) are total" (requiring all care to be done by staff). She stated the resident did not walk and required two staff members to get him out of bed.

On 11/16/16 at approximately 12:00 PM, the Administrator and DON were notified of above findings.

2. Resident #209's care plan had not been revised with new fall prevention interventions (bilateral half side rails) after the fall.

Resident #209 was admitted to the facility on 4/5/05 with diagnoses including anemia, hypotension, Parkinson's Disease, seizure disorder, mild intellectual disability and schizophrenia.

The Minimum Data Set, which was an annual assessment, with an Assessment Reference Date of 9/15/16, coded Resident #209 as having a Brief Interview of Mental Status (BIMS) Score of "9" out of a possible 15, indicating moderate cognitive impairment. The resident was coded as not having walked on or off the unit or having

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been transferred out of bed during the lookback period.

On 11/15/16 at 2:45 PM, Resident #209 was observed in the bed. There were no alarms, side rails, mats and the bed was in a high position. The call bell was in reach.

On 11/15/16 at 4:20 PM, the resident was again observed in the bed. The bed was not in a low position. CNA (certified nursing assistant) B was questioned about the bed height. CNA (B) lowered the bed to the lowest position (8 and a half inches from the floor, measured) and was approximately twice the height of the original position. There were no side rails on the bed.

On 11/16/16 at 8:55 AM, Resident #209 was observed in bed. The bed was in a low position.

On 11/16/16 at 10:30 AM, CNA (A) was interviewed concerning the resident's ADL's (activities of daily living such as toileting and bed mobility. CNA (A) stated, "He is total care- needs to be set up for feeding." She stated the Resident "did not walk."

On 11/16/16 at 11:20 AM, CNA (A) was asked to come into the resident's room. When asked if the resident had any side rails on the bed, CNA (A) stated. "No, ma'am."

Resident #209 had a fall screen (risk form for determining fall risk) on 7/16/16, which scored the resident with a "15". Above 10 or above deemed the resident to be at risk.

The resident's care plan dated 6/28/16 revealed the resident to be "At risk for falls related to use

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of psychotropics, unsteady gait, seizure disorder and history of falls." Interventions included the following:

Activity as resident allows
Administer medications for orthostatic hypotension, Vital signs as ordered per MD order/nursing protocol
Assess that wheelchair is of appropriate size, assess need for footrests, assess for need to have wheelchair locked/unlocked for safety.
Bed in low position
Contour mattress
Encourage resident to call for assistance
Encourage resident to wear shoes when ambulating.
Encourage resident in activity prior to dinner
Keep environment well lit and free of clutter
Monitor for positioning in bed frequently. Remind resident to assure he is positioned correctly at the bedside before attempting to sit down on bed
Personal items available and in easy reach.
Encourage me to use call bell for assistance prn (as needed)
Pharmacy to review medications monthly
Psych consult: Therapy working with resident
Rearrange furniture in room for easy access to personal belongings
Remind resident to change position slowly to prevent falls
Staff to round on resident to ensure safety measures are in place as resident allows
Therapy referral as needed/prn

There were no new interventions added to the care plan since 1/16/15. Assist rails times two was not added to the care plan.

Review of the resident's current signed physician

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F 280	Continued From page 7 orders dated 10/19/16 (initial date 4/8/15) included the following: "Assist rails times two for turning and repositioning. Clinical record review revealed the resident sustained a fall on 9/27/16 at 12:15 AM. The resident was found on the floor beside his bed next to the air conditioner. The resident suffered no injuries. The post fall analysis/plan dated 9/27/16 included the following recommendation to "keep bed on low position." An Occupational therapy screen was completed on 9/28/16 and included the following: "Patient with recent fall out of bed while reaching for objects from bed; Patient does not have bed rails. Patient needing bed rails for safety and falls prevention to prevent further Injury." As of 10/16/16, no side rails were in place. On 11/16/16 at 10:00 AM, the DON (director of nursing) stated the unit manager was supposed to order therapy referrals . "It was not done" On 11/16/16 at approximately 12:30 PM, the Administrator and DON were notified of above findings.	F 280		
F 323 SS=G	Complaint deficiency 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	• Resident #202 was readmitted on 11/22/16, evaluated by therapy on 11/23/2016 and picked up for services by PT, OT, and ST. Resident #202 and #209 can plans have been updated to reflect current fall interventions.	11-30-16

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F 323	Continued From page 8	F 323	• Residents with falls within the last 30 days have had their care plans revised and updated as appropriate. An audit of current residents of falls in the past 30 days was conducted to ensure appropriate devices are in place. • Nursing staff will be educated regarding causes of falls, implementation of new interventions, and fall prevention measures. IDT will review falls during daily Clinical Start-Up Monday- Friday to discuss specifics of the fall, interventions needed, and updating the care plans as appropriate. The DNS/DOR/Designee will review therapy evaluation and outcomes/ recommendations daily during Clinical Start- Up Monday- Friday for discussion with the direct care staff. • Managers/ Designee will validate Monday - Friday during rounds that fall interventions are in place and submit audits daily to the DNS/Designee for discussion / review with the Executive Director DNS/Designee will report findings of audit to Executive director weekly and to the QAPI commitee monthly x 3 months.	

This REQUIREMENT is not met as evidenced by:
Based on observation, staff interview, facility documentation and clinical record review, and in the course of a complaint investigation, the facility failed for two residents (Resident #202 and Resident #209) to implement fall prevention interventions, resulting in harm for Resident #202.

1. For Resident #202, the facility failed to implement a therapy screen and a toileting plan, as well as non skid footwear, resulting in a fall with fracture while toileting without assistance in regular socks.

2. Resident #209 did not have recommended post fall interventions of keeping the bed in low position and adding two half side rails.

The findings included:

1. For Resident #202, the facility failed to implement a therapy screen and a toileting plan, as well as non skid footwear, resulting in a fall with fracture while toileting without assistance in regular socks.

Resident #202 was admitted to the facility on 1/15/16, and was readmitted on 11/2/16 after a fall with fracture. Resident #202's diagnoses included anemia, high blood pressure, bipolar disorder, left hip fracture and anxiety.

The Minimum Data Set, which was a quarterly

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assessment done prior to the fall with fracture, with an Assessment Reference Date of 8/4/16, coded Resident #202 as having a Brief Interview of Mental Status (BIMS) Score of "5" out of a possible 15, indicating severe cognitive impairment. The resident was coded as not having walked on or off the unit and was using the wheelchair for locomotion off and on the unit with standby assistance of one staff member. The resident was coded as being "not steady" moving between sitting and standing and surface to surface transfers with the resident requiring staff to steady during transfers.

There were no observations of the resident during the days of survey as the resident was at a physician's appointment on 11/15 16 and was admitted to the hospital from the physician's office that evening.

Review of the clinical record revealed the resident sustained a fall on 10/26/16, resulting in a right hip fracture, according to the hospital discharge summary dated 11/2/16. The resident required surgery to correct the fracture.

Fall risk assessments were conducted on 1/15/16 (admission), on 8/12/16, and 11/2/16. The scores, respectively, were "8" (above 10 deemed resident at risk), "9", and "9". Review of the care plan prior to the fall with fracture, dated 1/29/16 had no new fall interventions added since 1/29/16. The resident was care planned for "At risk for falls related to history of falls, dementia, bipolar, dependent for transfers and mobility. Interventions included:

Assess for pain
Bed in low position

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Call light or personal items available and in easy reach or provide reacher
Contour mattress
Observe for side effects of medications
Therapy referral

Review of the facility's fall investigations and post fall analysis revealed the following:

2/3/16 at 3:00 AM: found supine on floor between wall and hallway door. The resident was wearing regular socks and it was recommended to wear non skid socks.

8/3/16 at 11:42 PM, found sitting on floor in front of toilet in his bathroom. A therapy screen was done and the resident was on a restorative program for active range of motion and ambulation.

On 9/29/16 at 2:21 PM, the resident was found sitting on the floor in the shower room, trying to get to the bathroom. A therapy screen was recommended as well as offer the resident toileting every two hours.

On 10/26/16 at 2:00 AM, the resident was found sitting on the bathroom floor in front of the toilet. Resident stated he had to use the bathroom. The resident was wearing regular socks. The recommendations were to use a bed and chair alarm, and gripper (non skid) socks. The resident was quickly sent to the hospital and a right hip fracture was diagnosed with subsequent surgery.

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On 11/16/16 at 10:00 AM, the DON (director of nursing) stated the unit manager was supposed to order a therapy referral and to initiate toileting every two hours. "It was not done" (the referral to therapy and every two hour toileting).

On 11/16/16 at 10:30 AM, an interview with CNA (certified nursing assistant) A was conducted. CNA (A) stated, "All ADL's (activities of daily living-dressing, toileting) are total" (requiring all care to be done by staff). She stated the resident did not walk and required two staff members to get him out of bed.

On 11/16/16 at approximately 12:00 PM, the Administrator and DON were notified of a harm level deficiency for this resident.

A four point POC (plan of correction) was submitted by the DON. The initial inservice was done on 11/1/16. 100% audits were not completed (twenty one days following the fracture) and an AOC (allegation of compliance) date of 11/25/15 was included. However, another resident (Resident #209) was found not to have had fall interventions of adding 1/2 side rails to the bed and keeping the bed in low position during the days of survey.

2. Resident #209 did not have recommended post fall interventions of keeping the bed in low position and adding two half side rails.

Resident #209 was admitted to the facility on 4/5/05 with diagnoses including anemia, hypotension, Parkinson's Disease, seizure

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disorder, mild intellectual disability and schizophrenia.

The Minimum Data Set, which was an annual assessment , with an Assessment Reference Date of 9/15/16, coded Resident #209 as having a Brief Interview of Mental Status (BIMS) Score of "9" out of a possible 15, indicating moderate cognitive impairment. The resident was coded as not having walked on or off the unit or having been transferred out of bed during the lookback period.

On 11/15/16 at 2:45 PM, Resident #209 was observed in the bed. There were no alarms, side rails, mats and the bed was in a high position. The call bell was in reach.

On 11/15/16 at 4:20 PM, the resident was again observed in the bed. The bed was not in a low position. CNA (certified nursing assistant) B was questioned about the bed height. CNA (B) lowered the bed to the lowest position (8 and a half inches from the floor, measured) and was approximately twice the height of the original position. There were no side rails on the bed.

On 11/16/16 at 8:55 AM, Resident #209 was observed in bed. The bed was in a low position.

On 11/16/16 at 10:30 AM, CNA (A) was interviewed concerning the resident's ADL's (activities of daily living such as toileting and bed mobility. CNA (A) stated, "He is total care- needs to be set up for feeding." She stated the Resident "did not walk."

On 11/16/16 at 11:20 AM, CNA (A) was asked to come into the resident's room. When asked if the

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	495144	A. BUILDING _____ B. WING _____	R 11/16/2016

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

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resident had any side rails on the bed, CNA (A) statec, "No, ma'am."

Resident #209 had a fall screen (risk form for determining fall risk) on 7/16/16, which scored the resident with a "15". Above 10 or above deemed the resident to be at risk.

The resident's care plan dated 6/28/16 revealed the resident to be 'At risk for falls related to use of psychotropics, unsteady gait, seizure disorder and history of falls." Interventions included the following:

Activity as resident allows
Administer medications for orthostatic hypotension, Vital signs as ordered per MD order/nursing protocol
Assess that wheelchair is of appropriate size, assess need for footrests, assess for need to have wheelchair locked/unlocked for safety.
Bed in low position
Contour mattress
Encourage resident to call for assistance
Encourage resident to wear shoes when ambulating.
Encourage resident in activity prior to dinner
Keep environment well lit and free of clutter
Monitor for positioning in bed frequently. Remind resident to assure he is positioned correctly at the bedside before attempting to sit down on bed
Personal items available and in easy reach.
Encourage me to use call bell for assistance prn (as needed)
Pharmacy to review medications monthly
Psych consult; Therapy working with resident
Rearrange furniture in room for easy access to personal belongings
Remind resident to change position slowly to

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prevent falls
Staff to round on resident to ensure safety measures are in place as resident allows
Therapy referral as needed/prn

There were no new interventions added to the care plan since 1/16/15.

Review of the resident's current signed physician orders dated 10/19/16 (initial date 4/8/15) included the following: "Assist rails times two for turning and repositioning.

Clinical record review revealed the resident sustained a fall on 9/27/16 at 12:15 AM. The resident was found on the floor beside his bed next to the air conditioner. The resident suffered no injuries. The post fall analysis/plan dated 9/27/16 included the following recommendation to "keep bed on low position." An Occupational therapy screen was completed on 9/28/16 and included the following: "Patient with recent fall out of bed while reaching for objects from bed; Patient does not have bed rails. Patient needing bed rails for safety and falls prevention to prevent further injury." As of 10/16/16, no side rails were in place.

On 11/16/16 at 10:00 AM, the DON (director of nursing) stated the unit manager was supposed to order therapy referrals . "It was not done"

On 11/16/16 at approximately 12:30 PM, the Administrator and DON were notified of above findings.

Complaint deficiency

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