State of Virginia

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | NH2585 | A. BUILDING _____ B. WING _____ | 12/13/2018 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| CEDARFIELD PINNACLE LIVING | 2300 CEDARFIELD PARKWAY RICHMOND, VA 23233 |

| (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) COMPLETE DATE |
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| F 000 | Initial Comments<br><br>An unannounced biennial State Licensure Inspection was conducted 12/12/18 through 12/13/18. The facility was not in compliance with the Virginia Rules and Regulations for the Licensure of Nursing Facilities. No complaints were investigated during the survey.<br><br>The census in this 60 licensed bed facility was 55 at the time of the survey. The survey sample consisted of 6 resident reviews. | F 000 | ***The statements made within this Plan of Correction are not an admission to and do not constitute an agreement with the alleged deficiencies herein.***<br><br>***Our Allegation of Compliance Date is January 25, 2019.*** | |
| F 001 | Non Compliance<br><br>The facility was out of compliance with the following state licensure requirements:<br><br>This RULE: is not met as evidenced by:<br>The facility was not in compliance with the following Virginia Rules and Regulations for the Licensure of Nursing Facilities:<br><br>1. 12VAC5-371-150 (G)<br>Based on staff interview and facility documentation review the facility failed to register with the Virginia State Police to receive automatic notification from the sex offender registry.<br><br>Prior to the survey, no facility staff was registered to receive automatic notification from the sex offender registry.<br><br>The findings included:<br><br>On 12/13/18 at 10:15 a.m., the administrator stated that there was no facility staff registered to receive notification from the state police. The Administrator stated that she registered earlier in the morning. | F 001 | **12VAC5-371-150 (G)**<br><br>**Corrective Action:**<br><br>On 12/12/18, the facility registered with the Virginia State Police to receive automatic notifications from the Sex Offender Registry.<br><br>**Other Potential Residents Affected:**<br><br>Current residents had the potential to be affected.<br><br>**Systemetic Changes:**<br><br>On 12/13/18, facility Management were educated regarding the importance of facility receiving automatic notifications from the sex offender Registry. | 1/25/19<br><br>1/25/19<br><br>1/25/19 |

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

Lucille C. Hewett, HSM — 12/24/18

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| F 001 | Continued From Page 1<br><br>2. 12VAC5-371- 220 (B)<br>Based on observation, staff interview and clinical record review the facility staff failed to implement physician ordered fall precautions for 1 resident (Resident #6) of 6 residents in the survey sample.<br><br>Resident #6 was observed in bed without a fall mat in place on two occasions.<br><br>The findings included:<br><br>Resident #6, a 79 year old, was admitted to the facility on 2/16/18. Diagnoses included Parkinson's disease, diabetes, scoliosis, restless leg syndrome, and dementia. The most recent Minimum Data Set assessment was a quarterly assessment with an assessment reference date of 11/18/18. The resident was coded with severe cognitive impairment and required extensive assistance with activities of daily living.<br><br>On 12/12/18 at 12:00 p.m., Resident #6 was observed in bed lying on her right side. She was uncovered. The bed was in the highest position against the wall. There was no fall mat in place at the left side of the bed. The personal sitter sat in an arm chair near the bed.<br><br>On 12/13/18 at 8:15 a.m., Resident #6 was observed lying in bed on her back and slightly to the left side. The bed was in the highest position against the wall. There was no fall mat in place at the left side of the bed. The private sitter sat in an arm chair near the bed. The sitter was covered with a sheet.<br><br>Resident #6 had a physician order dated 2/16/18 for "Fall mat left side of bed every shift for fall risk"<br><br>On 12/13/18 at 11:30 a.m., the Administrator and | F 001 | **Monitoring System:**<br><br>Beginning 12/31/18, a weekly audit of facility management emails will be conducted by the DON and/or her designee for compliance with receiving automatic notifications from the sex offender registry.<br><br>Audits will be conducted for four weeks and then for 1 month thereafter.<br><br>Identified discrepancies will be addressed accordiningly and as appropriate. Such will be forwarded to the Q. A & A Committee for further review and/or possible revisions to facility protocol.<br><br>**12VAC5-371-220 (B)**<br><br>**Corrective Action:**<br><br>On 12/13/18, upon the fall mat resident #6, was place on the floor beside the bed.<br><br>**Other Potential Residents Affected:**<br><br>On 12/13/18, an audit of residents with current physician orders for fall mats was completed with no discrepancies noted. | 1\|25\|19<br><br>1\|25\|19<br><br>1\|25\|19 |

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| F 001 | Continued From Page 2<br><br>Director of Nursing were notified that Resident #6 had been observed in bed on two occasions without the fall mat in place.<br><br>3. 12VAC5-371-220 (H)<br>Based on observations, staff interviews, clinical record review, and facility documentation, the facility staff failed to notify physician timely of Resident's change in condition for one Resident (Resident #2) in a sample size of 6 residents.<br><br>The findings included:<br><br>Resident #2, a 99-year old female, was admitted to the facility on 04/14/2018. Diagnoses include heart failure, hypertension, atrial fibrillation, anemia, and history of falling.<br><br>Resident #2's most recent Minimum Data Set with an ARD of 10/18/2018 was coded as a quarterly assessment. Resident #2's Brief Interview for Mental Status was coded as a "4" out of a possible "15" indicative of severe cognitive impairment. Functional status for dressing, transferring, toileting, and personal hygiene were coded as requiring extensive assistance from staff. Resident #2 was coded as requiring one person for physical assistance when transferring between surfaces.<br><br>On 12/12/2018 at approximately 11:30 AM, the Resident was observed seated in her recliner. The Resident was dressed and a dressing to the left lower leg was visualized. The Resident's personal sitter, Employee A was in the room. When asked about the dressing, Employee A stated that the Resident fell on 11/20/2018 during a transfer and hurt her leg. Employee A stated she was not present when the fall occurred. She also stated the Resident had a "sac of water" on her leg from the fall and that "it burst." | F 001 | **Systemic Change:** 1\|25\|19<br><br>Beginning 12/13/18, the private duty sitter and nursing staff were re-inserviced regarding the importance of keeping the fall mat at the bedside per physician orders.<br><br>**Monitoring System:** 1\|25\|19<br><br>Beginning 12/31/18, a weekly observation audit of 10% of residents with current physician orders for fall mats will be conducted by the DON and/or her designee for compliance with fall mats being in place per physician orders.<br><br>Audits will be conducted for four weeks and monthly for 1 month thereafter.<br><br>Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol. | |

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| F 001 | Continued From Page 3<br><br>An incident note in the clinical record dated 11/20/2018 at 11:50 AM documented, "Observation: Resident noted with a hematoma now a skin tear LLE moderate bleeding/bruising to LLE. (sic) Assessment: Skin tear 5x4cm with discomfort voiced. Intervention: VS (vital signs) 98.0-71-18-158/84. Notification: MD/RP (medical doctor/responsible party) aware."<br><br>A physician's order dated 11/20/2018 documented "Cleanse LLE (left lower extremity) with NS (normal saline) apply bacitracin oint (ointment), adhesive. Cover with 4 x 4 and wrap with kling QD (every day) until healed in the evening for skin tear." The order was discontinued on 11/30/2018.<br><br>A physician's order entry dated 11/30/2018 documented, "Cleanse LLE with NS, apply silvadene ointment, apply non adhesive and kling wrap x 10 days in the evening for skin tear until 12/09/2018."<br><br>The Medication Administration Record was reviewed. The entry, "Cleanse LLE (left lower extremity) with NS (normal saline) apply bacitracin oint (ointment), adhesive. Cover with 4 x 4 and wrap with kling QD (every day) until healed in the evening for skin tear" was signed off as administered daily from 11/20/2018 through 11/29/2018.<br><br>The entry "Cleanse LLE with NS, apply silvadene ointment, apply non adhesive and kling wrap x 10 days in the evening for skin tear until 12/09/2018" was signed off as administered daily from 11/30/2018 through 12/09/2018.<br><br>The nurse's notes were reviewed. An entry dated Sunday 11/25/2018 at 11:36 PM documented, "Writer notified [physician's name] of Resident | F 001 | **12VAC5-371-220 (H)**<br><br>**Corrective Action:**<br><br>On 12/20/18, the physician for resident #2, was notified of the untimely notification of the residents change in condition on 11/26/18.<br><br>**Other Potential Residents Affected:**<br><br>Residents experiencing changes in condition had the potential to be affected.<br><br>**Systemic Changes:**<br><br>On 12/14/18, and in collaboration with the facility Medical Director, the Notification of Change In resident Status policy & procedure was revised to reflect what to do if the physician cannot be reached.<br><br>Beginning 12/14/18, licensed nursing staff were re-educated regarding the importance of notifying a physician timely of a resident's change in condition. | 1\|25\|19<br><br>1\|25\|19<br><br>1\|25\|19 |

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| F 001 | Continued From Page 4<br><br>having large amounts of yellowish, no smell drainage on the LLE.(sic) Resident has been asking for Tylenol more for pain. Waiting for response from MD. 11-7 shift notified of fax to MD."<br><br>A nurse's note dated 11/26/2018 at 12:05 PM documented, "Call placed and message left with [physician name]'s nurse r/t (related to) yellow drainage and c/o (complaints of) pain to LLE over the weekend."<br><br>A nurse's note dated 11/27/2018 at 12:15 PM documented, "Call and spoke with a representative from MD office. Inform her that we need MD to sign off on x-ray result and notified her of drainage from hematoma. Representative informed this writer that she will give MD message and have her call the facility. Awaiting return call."<br><br>A nurse's note dated 11/28/2018 at 4:23 PM documented, "Writer spoke with MD concerning LLE. No drainage noted this shift. Dressing intact. MD to see on Friday."<br><br>A nurse's note dated 11/30/2018 at 1:05 PM documented, "New orders received from [physician's name] for Cipro 250 mg BID (twice a day) x 7 days for left leg wound. Silvadene ointment to left leg for 10 days and keep area covered. Message left for RP to return call."<br><br>The Medication Administration Record was reviewed. The medication Cipro 250 mg, one tablet two times a day had a start date of 12/01/2018 at 9:00 AM. The medication was signed off as administered twice a day from 12/01/2018 through 12/07/2018.<br><br>On 12/13/2018 at approximately 8:15 AM, the Resident was observed seated in her wheelchair | F 001 | **Monitoring System:**<br><br>Beginning 12/31/18, a weekly audit of 10% of residents noted to be experiencing a change in condition will be reviewed by the DON and/or her designee for compliance with notifying a physician timely of a resident's change in condition.<br><br>Audits will be conducted for four weeks and monthly for 1 month thereafter.<br><br>Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol. | 1/25/19 |

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| F 001 | Continued From Page 5 | F 001 | | |

eating breakfast. The dressing to the left lower leg was dry and intact.

On 12/13/18 at approximately 9:00 AM, an interview with the DON was conducted. When asked about the expectation for nurses notifying the attending physician about a change in resident status, the DON states it is the expectation that the nurses should call the attending physician and if the physician does not call back "by the end of their shift", they should then notify the Medical Director.

The facility policy for "Notification of Change in Resident Status" was reviewed. It documented, "In the event of an accident, significant change of physical, mental or emotional status or death, the attending physician and responsible persons shall be notified." The procedure of what to do when an attending physician cannot be reached was not addressed.

In summary, the Resident was observed to have a large amount of yellow drainage from a left leg wound and the attending physician was notified three days later, examined the wound on the fifth day and oral antibiotic therapy was initiated 6 days after the drainage was first observed.

On 12/13/2018 at approximately 11:45 AM, the DON and Executive Director were notified of findings and they offered no further information.

4. 12 VAC5 371-220 (C)(3)
Based on observation, staff interview, clinical record review, and facility documentation review, the facility staff failed for 1 resident (Resident #4) in the survey sample of 6 residents, to ensure that physician-ordered catheter care was provided.

**12VAC371-220 (C) (3)**

**Corrective Action:** 1/25/19

On 12/20/18, the physician for resident #4 was notified of the documentation omissions regarding physician ordered cathether care.

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| F 001 | Continued From Page 6 | F 001 | | |

The facility staff failed to provide physician-ordered catheter each shift for 5 dates between October - December 2018.

The Findings included:

Resident #4 was an 85 year old who was admitted to the facility on 10/6/16. Resident #4's diagnoses included Congestive Heart Failure, Colon Cancer, Mood Disorder, Hypertension, and Seizures.

The Minimum Data Set, which was a Quarterly Assessment with an Assessment Reference Date of 9/18/18 was reviewed. Resident #4 was coded as having a Brief Interview of Mental Status Score of 10, indicating moderately impaired cognition. He was also coded as having a Foley Catheter.

On 12/13/18 a review was conducted of Resident #4's clinical record. The physicians' orders for October through December 2018 read, "10/7/18. Catheter care every shift."

The Treatment Administration Record was reviewed. There was no documentation that catheter care had been administered on the Day shift for the following dates: 10/11/18, 11/20/18, 11/27/18, 11/29/18, and 12/5/18.

The nurses notes did not contain documentation that the treatments had been administered.

On 12/13/18, a review was conducted of facility documentation, revealing a catheterization-Foley Policy dated 8/1/18. It read, "It is the policy to...Maintain constant urinary drainage; facilitate frequent bladder irrigation; evacuate blood clots; to monitor renal function in seriously ill residents."

On 12/13/18 at 10:00 A.M., an interview was conducted with the facility Director of Nursing

**Other Potential Residents Affected:** 1/25/19

Residents with physician Orders for cathether care had The potential to be affected.

**Systemic Changes:** 1/25/19

Beginning 12/14/18, licensed nursing staff were re-educated regarding the importance of documenting physician ordered cathether care.

**Monitoring System:** 1/25/19

Beginning 12/31/18, a weekly audit of of residents with physician orders for cathether care will be reviewed by the DON and/or her designee for compliance with notifying a physician timely of a resident's change in condition.

Audits will be conducted for four weeks and monthly for 1 month thereafter.

Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol.

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| F 001 | Continued From Page 7<br><br>(DON Administration B). The DON was asked to describe the process and importance of catheter care. She stated, "Clean the penis, clean tubing with soap and water. This is to prevent infection, to make sure there is no trauma to the area. You look at the color of the urine and make sure there is no sediment, make sure that the tubing is anchored properly, and that there are no kinks in the tube. Also, make sure that the resident isn't laying on the tubing."<br><br>No further information was received.<br><br>5. 12 VAC5-371-340 (A)<br>Based on observation, staff interview and facility documentation review, the facility staff failed to wear hair restraints in the kitchen.<br><br>Two dietary staff members failed to wear hair restraints in the kitchen.<br><br>The Findings included:<br><br>On 12/12/18 at 11:00 A.M., an observation was conducted of the facility kitchen. The Assistant to the Dining Director (Employee C), and the Executive Chef (Employee D) were near the front of the kitchen in a food preparation area. They were not wearing hair restraints.<br><br>The Assistant to the Dining Director was asked why she wasn't wearing a hair restraint, and asked about the importance of wearing hair restraints. She stated "I usually wear a hairnet if I am working in the kitchen. It is important to make sure that hair doesn't get into peoples' food for sanitary purposes."<br><br>The Executive Chef stated, "I don't have one on because I just came out of the office. It's | F 001 | **12VAC4-371-340 (A)**<br><br>**Corrective Action**<br><br>On 12/12/18, the Assistant to the Dining Director and the Executive Chef immediately placed restraints on.<br><br>**Other Potential Residents Affect:**<br><br>Residents receiving food items from this facility kitchen had the potential to be affected.<br><br>**Systemic System:**<br><br>Beginning 12/13/18, dining services staff who work in the kitchen were re-inserviced regarding the importance of wearing hair restraints when working with food or while in a food prep area. | 1/25/19<br><br>1/25/19<br><br>1/25/19 |

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| F 001 | Continued From Page 8<br><br>important to wear one so hair doesn't get into food and contaminate food."<br><br>There were no hair restraints available outside the kitchen door, or available upon first entering the kitchen. The dietary office is located near the back of the kitchen. Staff have to pass by two food preparation areas and an area where clean cooking pots and pans are stored on open rack. in order to get to the dietary office.<br><br>On 12/13/18 the facility Administrator (Employee A) was informed of the findings. No further information was received. | F 001 | **Monitoring System:**<br><br>Beginning 12/31/18, a weekly observation audit will be conducted by the Director of Dining Services and/or his designee for compliance with wearing hair restraints when working food or while in a food prep area.<br><br>Audits will be conducted for four weeks and monthly for 1 month thereafter.<br><br>Identified discrepancies will be addressed accordingly and as appropriate. Such will be forwarded to the QA&A Committee for further review and/or possible revisions to facility protocol. | 1/25/19 |