Department of Veterans Affairs Community Living Center Survey Report

This document or report and the information contained herein, which resulted from the Community Living Center Unannounced Survey, has been de-identified to remove individually identifiable health information (also known as protected health information) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other federal and state laws. De-Identification was completed in accordance with guidance published by the Office for Civil Rights to protect the privacy of the Community Living Center's residents.

General Information:

Location: Central Arkansas Veterans Healthcare System Eugene J. Towbin Healthcare Center (North Little Rock, AR)

Dates of Survey: 1/15/2019 to 1/17/2019

Total Available Beds: 137

Census on First Day of Survey: 94

F-Tag	Findings

F246
 	
483.15(e) *Accommodation of Needs. A resident has a right to §483.15(e)(1) Reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered; SEE INTERPRETIVE GUIDANCE AT TAG F247*
 	
Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy
 	
Residents Affected - Few
	Based on observation, interview and record review, the CLC did not ensure the resident's right to receive services in the CLC with reasonable accommodation of needs. Findings included:
	
	Resident #302, [LOCATION]
	
	• Resident #302 was admitted to the CLC on [DATE] with diagnoses including Alzheimer's disease; the resident had a history of falling. The comprehensive Minimum Data Set (MDS) dated 09/04/18 was coded to indicate the resident had short-term and long-term memory problems and moderately impaired cognitive skills for daily decision making; the resident required limited assistance with bed mobility, transfers, and toilet use; and extensive assistance with walking in the room and corridor, dressing and personal hygiene. According to the MDS, the resident used a walker and wheelchair for mobility and did not experience any falls. The resident's quarterly MDS dated 11/28/18 was coded to indicate the resident was independent with bed mobility and transfers; and required supervision with walking in the room and corridor, dressing, toilet use and personal hygiene; the resident used a cane for mobility. The staff assessment for mental status and Brief Interview for Mental Status (BIMS) were not completed in the quarterly MDS.
	• During the initial tour on 01/15/19 at 10:15 a.m., an RN stated, "He [Resident #302] stays in his room most often, he uses a walker and is hard of hearing."
	• During an interview on 01/15/19 at 12:45 p.m. when asked about the resident's room and care at the CLC, the resident stated, "I can't get ahold of people." The resident explained that he had to "wait for someone" to come in the room or he goes to "find someone" if he needs something; a call bell cord was not connected to the wall and accessible to the resident. The resident did not state how long the call cord had been missing or indicate that he reported the missing call cord to staff. According to staff interview and record review, the resident had resided in the same room since admission. A nurse manager (NM) was asked to come into the room and the NM confirmed the call bell cord was missing; a call cord was immediately hooked up.
	• The resident's care plan dated 09/13/18 included a statement addressing cognitive loss and dementia with approaches:
	  ○ "Staff will provide me with assistance to complete ADLs [activities of daily living] if needed." 09/13/18
	  ○ "Staff will assist me with incontinence care if needed." 09/13/18
	• An admission assessment dated [DATE] stated, "ORIENTATION TO UNIT/ROOM SAFETY [emphasis not added] …. Call Light – Yes."
	• During an interview on 01/17/19 at 9:00 a.m., the quality management consultant (QM) stated, "The IT [information technology] specialist says they have a data manager system that keeps track of call light records and responses…. We will run the data for Resident #302 room. The report should indicate if the call bell was unhooked and for how long."
	• During the exit conference with leadership staff on 01/17/19 at 9:30 a.m., the QM consultant provided the "TQI for Windows Report" that included data for the call light in

Resident #302's room. It was indicated the report would state "cord out" with the resident's name if the resident's call light cord was not connected to the wall. Although the cord was not observed connected to the wall on 01/15/19, there was no documentation of the cord being out of the wall. The report did not indicate any days that the cord was not connected for Resident #302 since admission. The QM consultant agreed the report did not indicate the call cord was disconnected on 01/15/19 and stated he would check the resident's cord to make sure it was working properly.

Resident #305, [LOCATION]

- Resident #305 was admitted to the CLC on [DATE] with diagnoses including dementia and depression. The admission history and physical dated [DATE] indicated, "Assessment: Patient [Resident #305] is at risk for delirium and was assessed for mental status change, confusion and disorientation." The admission assessment dated [DATE] indicated, "ORIENTATION TO UNIT/ROOM SAFETY [emphasis not added]….Call light: Yes."
- The comprehensive MDS dated 12/04/18 was coded to indicate the resident was independent with all ADLs, did not have functional limitations in range of motion of the upper or lower extremities, and did not use a mobility device; the resident did not have a history of falls. The staff assessment for mental status and Brief Interview for Mental Status (BIMS) in the quarterly MDS were not completed by staff, as confirmed by the quality management coordinator on 01/17/19.
- During the initial tour on 01/15/19 at 10:15 a.m. the RN indicated, "He likes to stay in his room."
- A provider's order dated 11/28/18 stated, "Fall Precautions. Bed in lowest position, hip pads, orthostatic blood pressure on admission."
- On 01/15/19 at approximately 12:00 p.m., the neighborhood NM and NM of clinical operations accompanied the surveyor to check resident rooms for call light cords. The NM indicated Resident #305 did not have a call light cord. On 01/15/19 at 4:50 p.m., the neighborhood NM stated, "The [call light] cord [in Resident #305's room] was there but it was the old call bell with the push button [and a short cord] and I didn't notice it; it [the call light cord] is too short to reach the bed." The NM agreed that staff should have reported the call light cord was not long enough to reach the resident's bed. The NM requested all call lights and cords be updated, and indicated engineering staff came into the[LOCATION] to complete this task. There were no other missing call cords in the neighborhood and no concerns related to call cords were identified in other neighborhoods.
- During an interview on 01/16/19 at 11:40 a.m., Resident #305 indicated, "I never really use it [the call light], I come out and get someone [if needing something]….I didn't really know it was there."

F281

483.20(k)(3)(i) *The services provided or arranged by the facility must (i) Meet professional standards of quality;*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not provide services that met professional standards of quality. Findings include:

The CLC's policy dated April 2018 and titled, "Central Venous Catheter (CVC) Care: Central Venous Line (CVL) and Peripherally Inserted Central Catheter (PICC)" was provided by the quality manager on 01/15/19 at 2:40 p.m. The policy indicated, "CVCs: all ports are to be aspirated for blood return then flushed every 8 hours with 10 ml [milliliters] 0.9% Bacteriostatic Sodium Chloride (Multi-Lumen, PICC, Hickman/Broviac, Groshong, Cook). Aspirate and flush port before and after infusions of medications or blood draws…."

Resident #104, [LOCATION]

- During an observation on 01/15/19 at 1:08 p.m., a licensed practical nurse (LPN) administered intravenous ceftriaxone sodium [Rocephin] 2 grams in 100 ml of normal saline through a PICC for Resident #104. The RN did not aspirate for blood return prior to flushing the line with a 10 ml flush of normal saline. When asked about the observation the LPN stated, "I was never taught to do that [aspirate before flush]."
- During the daily meeting with leadership staff on 01/14/19 at 4:00 p.m., the staff was informed about the LPN not aspirating for blood return prior to providing a flush through a PICC line; no additional information was provided by staff.

F314

Based on observation, interview and record review, the CLC did not ensure a resident who entered the CLC without pressure ulcers did not develop pressure ulcers and received

483.25(c) *Pressure Sores. Based on the comprehensive Assessment of a resident, the facility must ensure that (1) 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 (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

necessary treatment and services to promote healing. Findings include:
The CLC's policy dated March 2013 and titled, "Skin and Wound Management Program, " was provided by the safe patient handling coordinator on 01/15/19 at 10:00 a.m. The policy stated,

- "A Braden Scale…initial assessment will be completed within 24 hours of admission.
- Every patient [resident] will be assessed for alterations in skin integrity on admission, transfer, when condition changes, and at discharge.
- Patients identified at risk will be assessed for alterations in skin integrity every 24 hours.
- An interdisciplinary skin integrity management and surveillance program will be provided for all patients identified as being at risk or has [having an] existing pressure ulcer.
- Pressure Ulcer Prevention Interventions: A comprehensive prevention program will be implemented for all patients identified as being at risk for pressure ulcer development. Interventions will be tailored to identify specific high risk scores on Braden Scale."

Resident #103, [LOCATION]

- Resident #103 was admitted to the [LOCATION] neighborhood on [DATE] with diagnoses including dementia, osteoarthritis, PTSD (posttraumatic stress disorder) diabetes, and ankle joint pain.
- The resident's comprehensive Minimum Data Set (MDS) dated 09/26/18 was coded to indicate the resident had moderate difficulty with hearing and vision, had clear speech, and was understood by and understood others. The comprehensive MDS was coded to indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 suggesting intact cognition; the MDS did not indicate the resident rejected care. The MDS indicated the resident required supervision with bed mobility and limited assistance with transfers. The MDS indicated the resident was at risk for skin breakdown, had no pressure ulcers; and skin and wound treatments included a pressure reducing device for the bed and chair. The resident's quarterly MDS dated 12/18/18 was coded to indicate the resident had moderate difficulty with hearing and vision, had clear speech, was understood by and understood others. The quarterly MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 11 suggesting moderately impaired cognition and rejected care 1 to 3 days during the assessment period. The MDS indicated the resident required supervision with bed mobility and transfers. According to the quarterly MDS, the resident was at risk for skin breakdown and had two unstageable pressure ulcers with the surface area of the largest pressure ulcer measuring 4 centimeters (cm) by 4.5 cm. Skin and wound treatments included a pressure reducing device in the bed and chair, nutrition or hydration interventions, pressure ulcer care, and application of dressings to the feet.
- The resident's most recent Braden Scale score in the nursing RN reassessment note dated 01/14/19 indicated the resident had a score of 17 suggesting mild risk for skin breakdown. The reassessment note stated the resident had a 1 cm by 1 cm open area on the left ankle and the right heel had an approximate 3 cm by 3 cm area with eschar.
- On 01/15/19 at 10:11 a.m., a nurse indicated Resident #103 developed unstageable pressure ulcers over the right heel and left ankle after admission to the CLC.
- Resident #103's care plan dated 12/05/18 stated, "Pressure Ulcers: I have unstageable pressure ulcers to my right heel and lateral malleolus [ankle] areas. I am resistant to getting out of bed and turning and repositioning while in bed. Goal: Will display signs of healing without signs of infection.
    - Approach: Nutritional support and evaluation per dietician.
    - Approach: CWOCN [certified wound ostomy continence nurse] to evaluate, make treatment recommendations and follow progress. Provide wound care as ordered and monitor effectiveness.
    - Approach: Pressure relieving device P-500 mattress, heel manager, and Prevalon boot.
    - Approach: Provide education to resident/family regarding wound healing.
    - Approach: Encourage me to be out of bed more to comply with turning and repositioning (staff reports he is often resistant to repositioning and prefers to stay in bed most of the day)."
- Provider orders prior to the identification of skin breakdown on 11/20/18 included the following:
    - 09/20/18: "CLC Pressure Ulcer Prevention Bundle – If head of bed > [greater than] 30 degrees, elevate knees. Pressure Relief: Use Atmos air (regular unit mattress)."
    - 09/26/18: "Patient must get up to dining room for all meals."
- A wound care nursing (WCN) note dated 11/20/18 and completed by the WCN stated, "Noted resident [Resident #103] had bloody drainage on his bed and sock. Inspected right foot and noted that he had unroofed blister to right medial heel. Measures 3.5 x

2.8 [cm]. Moderate amount of bloody drainage noted and wound bed dark red to purple. Surrounding skin is red. Resident denies pain. Wound was cleansed with normal saline and Telfa applied and wrapped with kerlix. Recommendations: Apply a piece of Xeroform to the right heel ulcer, cover with gauze and kerlix daily. Provide a heel manager to use in bed. Will consult with orthotics for a [an] MPO 2000 active [boot with] ambulatory attachment. Will continue to follow."

- An advanced practice nurse's (APN's) note dated 11/20/18 (provided by the safe patient handling coordinator on 01/17/19) stated, "Per staff report, pt. [patient] found with unroofed blister on R [right] medial heel. Blister seen this a.m. [morning] With red base, and ecchymosis surrounding blister area. *Patient lies in bed on L [left] side with medial heel against bed. He frequently refuses care and turning to R [right] side. He gets up for meals and immediately after wants to go back to bed….Talked to pt. this a.m. about his wound. He does not understand that he must turn frequently. Explained to him that he must stay up in chair longer during the day and must turn in bed to relieve pressure on right heel. WOCN [wound, ostomy, continence nurse] has seen pt. and will obtain heel manager and Prevalon boot. WOCN is requestion [requesting] a MPO 2000 Active boot with ambulatory attachment….Pt. did get up this a.m. to shower with strong encouragement. Explained to him the seriousness of wound in light of diabetes. Explained that he is at risk of infection which could have serious consequences including loss of his foot."
- The resident had the following provider orders dated 11/20/18:
    - 11/20/18: "Patient must be turned while in bed Q2 hrs [every two hours] off of his left side."
    - 11/20/18: "Heel manager while in bed. Posey boots while in bed.
- Documentation was requested by a surveyor regarding approaches that were in place prior to the resident developing an "unroofed blister to right medial heel" on 11/20/18, documentation to show the resident refused to stay off the resident's left side prior to 11/20/18, and documented approaches to assist the resident to stay off the left side. No documentation was provided other than the plan of care dated 09/20/18 that read, "If head of bed > [greater than] 30 degrees, elevate knees. Pressure Relief: Use Atmos air (regular unit mattress)," and approaches to address the resident's pain. No additional notes or documentation were provided prior to 11/20/18.
- A nursing note dated 11/21/18 indicated, "[Resident #103's] right heel cleansed with normal saline. Xeroform applied then wrapped with kerlix. Area was an open sore that appeared dark purple – the [resident] grimaced as the area was cleanse [cleansed]. He also stated that it hurt. LPN attempted to turn [Resident #103] to right side but refused stating that it hurts to turn to that side. The APN [advanced practice nurse] was notified."
- A nursing note dated 11/21/18 (provided by the safe patient handling coordinator on 01/17/19) stated, "Tried to encourage [resident] to turn on his right side for a while to take pressure off of his right medial heel, he refused. Explained that if he doesn't take pressure off of that heel that DTI [deep tissue injury] could become worse and he could possibly lose his foot. [Resident #103] verbalized understanding. Will continue to encourage and educate [resident]. APN notified."
- The resident had a provider order dated 11/21/18 that read, "If patient will not lie on left side, please place wedge or position right medial heel where it [the left medial heel] is not receiving pressure from bed or heel manager. Patient at great risk of complications from his wound."
- An APN noted dated 11/27/18 (provided by the safe patient handling coordinator on 01/17/19) stated, "Pt continues to turn to L [left] side which places his right medial heel on the surface of mattress. He does wear Prevalon boot, but continues to demand to go back to bed right after meals where he stays until the next meal. Pt is re-educated again today about the seriousness of this wound, including infection and loss of foot. He does not grasp seriousness of or consequences of his actions due to his dementia."
- A wound care nursing note dated 12/04/18 completed by the WCN indicated, "New left lateral malleolus ulcer – follow up regarding right medial heel. [Resident #103] was wearing the light blue heel protector to the right foot, not the Prevalon boot given two weeks ago. Orthotic [orthotics] has ordered multipodis boot – waiting on arrival.
    - Pressure ulcer #1: Right medial heel – unstageable 4 x 5 [cm] 7% necrotic tissue, 30% red tissue. Moderate serous drainage, surrounding skin maceration. Treatment: silvasorb gel and gauze.
    - Pressure Ulcer #2: Left lateral malleolus – unstageable 1.8 x 2 [cm] 67% slough, 37% red tissue. Serous drainage, slight redness surrounding tissue. Treatment: silvasorb gel and gauze.
    - Damage from lying on left side. [Resident #103] is apparently lying on his left side while in bed due to location of tissue damage. Recommend: silvasorb gel and gauze. Will provide a new pair of Prevalon boots. Also use heel manager. Place on a P-500 air mattress. May help some."

- The resident had the following provider orders dated on or after 12/04/18:
    - 12/04/18: “Change bridge heels off mattress, use either a heel manager or Prevalon boot which have been placed at bedside to bridge heels off mattress, use heel manager and Prevalon boots.”
    - 12/04/18: “Change Prevalon boots to LLE [left lower extremity]. Refrain from placing shoes until wound healed as this results in pressure to left ankle to Prevalon boot to both feet. Refrain from placing shoes until wound healed as this results in pressure to left ankle.”
    - 12/04/18: “Please provide [resident] with P-500 mattress.”
    - 12/04/18: “Change pressure ulcer: right medial heel, unstageable to pressure ulcer: right medial heel and left lateral malleolus ulcers, unstageable.”
    - 12/05/18: “Notify provider for refusals of care, including skin assessments, getting up in chair and turning.”
    - 12/05/18: “Patient must be turned off left side – he continues to lay in bed with lateral malleolus towards bed. Please get ankle and both heels off of bed. Notify provider of refusals and chart them.”
    - 12/07/18: “Patient to wear MPO [Multi-Podus] boot on right foot at night. Remove during the day and place Prevalon boot on left foot continuous and keep feet elevated on heel manager.”
    - 01/11/19: “Wound Care: Location: right medial heel and left lateral malleolus ulcers. Prep: clean with normal saline. Skin Protection: Protective barrier wipes to surrounding skin. Product: Apply Plurogel, cover with 2x2 [2-inch by 2-inch] gauze damp with 0.25% Dakin’s, cover with 4x4 [inch] gauze and kerlix, secure with paper tape. Frequency: BID [two times a day].”
    - 01/11/19: “Wound Care: Location: right medial heel ulcer. Prep: clean with normal saline. Skin Protection: Protective barrier wipes to surrounding skin. Product: Apply Plurogel, cover with a small piece of Xeroform, 4x4 gauze, kerlix, secure with tape. Frequency: daily.”
- On 01/15/19 at 5:03 p.m., a nursing assistant was observed in Resident #103’s room encouraging the resident to go to the dining room for the meal. The resident indicated, “I don’t want to go to the dining room.” When asked by the surveyor why he did not want to go to the dining room, the resident stated, “My feet hurt. I have sores on my feet.” When asked how long he had the “sores” on the feet, the resident stated, “I don’t know, I’ve had them [pressure ulcers] for a while.” The assistant nurse manager was present and indicated she would follow-up on the resident’s concerns related to pain. During the observations, the resident was lying on a P-500 mattress wearing Prevalon boots with the resident’s feet elevated on Heel Managers™. No concerns were observed with the head of the bed being greater than 30 degrees with the resident’s knees elevated as indicated in the provider’s order dated 09/20/18.
- During observations on 01/16/19 at 12:58 p.m. in the resident’s room, an LPN, a registered nurse and the assistant nurse manager performed wound care for the resident’s right heel and left malleolus. The LPN asked if the resident was experiencing pain and the resident stated, “No;” however, the resident was heard moaning when the left and right leg were elevated using the ceiling lift and flinched when the LPN touched the right heel and left malleolus pressure ulcer areas. The RN measured the pressure ulcers and the right heel ulcer measured 5 cm x 4.5 cm and was covered in eschar. The left malleolus measured 1 cm x 0.5 cm with eschar surrounded by reddened tissue. After the wound care, Prevalon boots were applied to the resident’s feet and the feet were elevated on Heel Managers.
- During an interview and medical record review with the RN, assistant nurse manager, and safe patient handling coordinator on 01/16/19 at 1:48 p.m., the RN indicated the resident “will not let us turn him; he becomes very verbally abusive when we turn him, he will turn back; he has a little bit of dementia. He was wearing boots, but still broke done. We tried to get him up in a Geri chair, we could talk until we were blue in the face. We had the wound care nurse [WCN] look at him. The wound was discovered in November [2018], he continued to lie that way [on left side].” The RN did not indicate if the resident refused care related to pain. When asked about the type of mattress used at the time the right heel pressure ulcer was discovered, the RN stated, “He was on a regular mattress.” When asked who could request a specialty pressure reducing mattress, the RN stated, “Nursing can request an overlay mattress that can be obtained in-house when available. The WCN orders special beds that come from outside vendors. His heel was reddened at the time and we had the WCN come and assess him. The WCN ordered a special mattress for him.”
- During an interview with the night shift RN and assistant nurse manager on 01/17/19 at 8:07 a.m., the night shift RN stated, “I found both of his [resident’s] pressure ulcers, he would not stay off of his left side.” The night shift RN indicated Resident #103 “was encouraged to lie on [the resident’s] right side.” When asked about a specialty mattress for the resident, the RN indicated, “We could have gotten him an overlay in house if it was available; he did not have one [overlay].” When asked if the resident wore the

Multi Podus boot, the RN stated, “Yes, he would wear the boot in bed; he recently stopped wearing the boot;” the RN did not indicate why the resident stopped wearing the boot. A note entered by orthotics staff dated 11/20/18 indicated the resident was “educated on splint [Multi Podus boot], adjusted to fit him. Keep feet elevated on pillow.” The RN that worked the night shift indicated the resident used to get out of bed “all of the time, but just stopped one day and has been resistant to getting up [out of bed] since.”

- On 01/16/19 at 4:00 p.m. and 01/17/19 at 8:30 a.m., leadership staff was informed about the concerns related to Resident #103’s pressure ulcers.
- In summary, on 01/15/19 at 5:03 p.m., a nursing assistant was observed in Resident #103’s room encouraging the resident to go to the dining room for the meal. The resident indicated he did not want to go to the dining room because his “feet hurt. I have sores on my feet.” During observations on 01/16/19, an RN measured Resident #103’s pressure ulcers; the right heel ulcer measured 5 cm x 4.5 cm and was covered in eschar, and the left malleolus measured 1 cm x 0.5 cm with eschar surrounded by reddened tissue. Based on documentation review and staff interview, approaches to prevent pressure ulcers including to assist the resident to position off the left side were not implemented until 11/20/18, after the blister to the right heel was discovered. A wound care nursing (WCN) note dated 11/20/18 stated, “Provide a heel manager to use in bed. Will consult with orthotics for a [an] MPO 2000 active [boot with] ambulatory attachment.” A nursing note dated 11/21/18 indicated, “[Resident #103’s] right heel cleansed with normal saline. Xeroform applied then wrapped with kerlix. Area was an open sore that appeared dark purple – the [resident] grimaced as the area was cleanse [cleansed]. He also stated that it hurt. LPN attempted to turn [Resident #103] to right side but refused stating that it hurts to turn to that side.” A wound care nursing note dated 12/04/18 indicated, “New left lateral malleolus ulcer – follow up regarding right medial heel. [Resident #103] was wearing the light blue heel protector to the right foot, not the Prevalon boot given two weeks ago. Orthotic [orthotics] has ordered multipodis boot – waiting on arrival.” Documentation did not indicate preventative approaches were implemented prior to development of the pressure ulcer over the left lateral malleolus on 12/05/18; a pressure reducing mattress was ordered on 12/05/18. It was not evident the CLC determined why the resident refused to remain out of bed or preferred to lie on the left side (e.g., pain, position of bed related to room door/window /television, depression). (See Mental and Psychosocial Functioning)

F319

483.25(f)(1) *Mental and Psychosocial Functioning. Based on the comprehensive assessment of a resident, the facility must ensure that: A resident who displays mental or psychosocial adjustment difficulty, receives appropriate treatment and services to correct the assessed problem; and*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure a resident with mental or psychosocial adjustment difficulty received appropriate treatment and services. Findings include:

Resident #102, [LOCATION]

- Resident #102 was admitted to the CLC on [DATE] with diagnoses including right BKA (below knee amputation), history of two cerebrovascular accidents (CVAs) and diabetes. The resident’s comprehensive MDS dated 11/22/18 was coded to indicate the resident had clear speech, was understood by and understood others. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 suggesting intact cognition. According to the MDS, the resident had a Resident Mood Interview (PHQ-9©) score of 12 suggesting moderate depression, experienced verbal behavioral symptoms directed toward others and required extensive to total assistance with activities of daily living (ADLs). The Care Area Assessment (CAA) summary completed in conjunction with the comprehensive MDS indicated under Mood State, “Staff has noted some withdrawn/angry behaviors and s/s [signs and symptoms of] depression noted on admission mood interview.”
- The admission MDS assessment dated [DATE] under mood interview indicated the resident answered yes to the following and indicated the symptoms occurred 7 to 11 days during the assessment period:
    - Little interest or pleasure in doing things.
    - Feeling down, depressed, or hopelessness.
    - Trouble falling or staying asleep, or sleeping too much.
    - Feeling tired or having little energy.
    - Trouble concentrating on things.
    - Thoughts that you would be better off dead or hurting yourself in some way.
- The resident’s care plan dated 12/07/18 did not address mood state or behavioral symptoms of potential distress, as confirmed by an RN on 01/16/19 at 2:31 p.m.
- Resident #102 did not have provider orders to receive psychopharmacologic

medications including an antidepressant medication.

- During an interview with Resident #102 on 01/15/19 at 3:16 a.m., the resident indicated he was being seen “by KT [kinesiotherapy] and OT [occupational therapy].” The resident indicated KT was being provided to “get me home.” The resident’s affect appeared to be flat; the resident used a monotonous tone and had diminished facial expressions. When asked about staff response to call lights, the resident stated, “I was calling for a bedpan and it took them long enough to [be incontinent].” Resident #102 pointed to the resident’s roommate and stated, “It happened to him too.” The resident indicated he watched TV all night and did not get up in the morning. The resident stated he had no pain except shoulder pain caused by a new wheelchair. When asked how soon he would be going home, the resident stated, “ASAP [as soon as possible].”
- During an interview with an RN on 01/16/19 at 2:31 p.m., the RN stated, “When he [Resident#102] first came in, he was more withdrawn.” When asked about behavioral symptoms experienced by the resident, the nurse indicated, “He is still…inappropriate…we still have to redirect him.” When asked about documentation of the resident’s behavioral symptoms, the nurse stated, “Some nurses do document. He was depressed and mean to the techs [nursing assistants], refusing care. They [nursing assistants] would ask to turn him and he would tell them to get out of his room. When asked if the resident saw a psychologist or psychiatrist, the nurse stated, “I think so.” The RN and safe patient handling coordinator were asked for documentation by psychology or psychiatry staff; however, no documentation was provided.
- During the daily meeting on 01/16/19 at 4:00 p.m., Resident #102’s care was discussed with leadership staff. Concerns were discussed including the resident experiencing signs and symptoms of depression with no indication the resident saw psychology or psychiatry staff, and the resident not having a plan in place to address verbal behavioral symptoms of potential distress and rejection of care. The medical director stated, “When the resident arrived at the CLC, he was very angry. Everything happened quickly. No one prepares residents for things like this [right BKA]; this is something a mental health professional should address to prepare someone for a change like this. The CLC does not have a dedicated psychologist.” The medical director indicated the resident would be seen on 01/17/19 at 8:30 a.m. by a “psychiatry fellow” in response to inquiry by the surveyor.

Resident #103, [LOCATION]

- Resident #103 was admitted to the [LOCATION] neighborhood on [DATE]. The resident’s diagnoses included dementia, osteoarthritis, PTSD (posttraumatic stress disorder), diabetes, ankle joint pain, low back pain, and degenerative joint disease.
- The resident’s admission MDS dated [DATE] was coded to indicate the resident had moderate difficulty with hearing and vision, had clear speech, and was understood by and understood others. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 suggesting intact cognition and rejected care. According to the MDS, the resident required supervision with bed mobility and limited assistance with transfers. A quarterly MDS dated 12/18/18 was coded to indicate the resident had moderate difficulty with hearing and vision, had clear speech, and was understood by and understood others. The quarterly MDS was coded to show a BIMS score of 11 suggesting moderately impaired cognition; the resident rejected care 1 to 3 days during the assessment period. According to the MDS, the resident required supervision with bed mobility and transfers.
- During an interview and medical record review with the RN, assistant nurse manager, and safe patient handling coordinator on 01/16/19 at 1:48 p.m., the RN indicated Resident #103 “would not let us turn him; he would become very verbally abusive to the techs [nursing assistants]; when we turned him, he would turn back; he has a little bit of dementia.”
- The following behavior notes dated 01/03/19, 01/04/19, and 01/07/19 indicated the resident refused medications. Behavior notes dated 01/04/19, 01/06/19, 01/08/19 and 01/15/19 indicated the resident refused to get out of bed for meals. A behavior note dated 01/06/19 showed the resident was “hitting fist against wall; disturbed resident [roommate] and family and demanded staff open the curtain. The behavior note dated 01/07/19 indicated Resident #103 was moved to a different room after the disruptive incident on 01/06/19. The note did not indicate what was possibly causing or contributing to the behavioral symptoms.
- Review of a clinical psychology consult note dated 01/10/19 indicated the consult was requested on 01/04/19 “due to increased anger and refusals of care over the last few days.” The note did not indicate what was possibly causing or contributing to the behavioral symptoms. The note indicated the resident “is refusing to get up for meals and refusing to get up in chair during the day.” The goal stated, “Increase activity participation.” The following approaches were recommended:
    - Decrease noisy environment.
    - Engage in therapeutic activity.
    - Use calm supportive approach while setting limits and offering explanation.

    - Ask about pain or anxiety.
    - Identify staff the resident responds to positively.
    - Decrease stimuli (has PTSD) particularly when distressed.
- During an interview with on 01/17/19 at 8:07 a.m., the assistant nurse manager (ANM) confirmed recommendations made by psychology staff were not incorporated into the resident's care plan. The resident's current plan of care did not address refusals of care, refusals to get out of bed, or angry and disruptive behavioral symptoms as confirmed by the ANM.
- In summary, during interviews and record review during the survey, it was indicated that Resident #103 "would not let us turn him; he would become very verbally abusive to the techs [nursing assistants]; when we turned him, he would turn back." Behavior notes in January 2019 indicated the resident "refused medications," "refused to get out of bed for meals," and was "hitting fist against wall; disturbed resident [roommate] and family and demanded staff open the curtain." A clinical psychology consult note dated 01/10/19 indicated the consult was requested on 01/04/19 "due to increased anger and refusals of care over the last few days." The notes including the psychology consult note did not indicate what was possibly causing or contributing to the behavioral symptoms to identify directed approaches to address the behavioral symptoms. The resident's plan of care did not did not address behavioral symptoms of potential distress.

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483.65 *Infection Control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.*

Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy

Residents Affected - Some

Based on observation, interview and record review, the CLC did not maintain an infection prevention and control program designed to help prevent the development and transmission of disease and infection. Findings include:

Transmission-based Precautions

The undated CLC policy titled, "Central Arkansas Veterans Healthcare System Little Rock/North Little Rock Policy 4.6 Guidelines for Implementation of Methicillin-Resistant Staphylococcus Aureus (MRSA) Prevention Initiative in the Central Arkansas Veterans Healthcare System (CAVHS)" was provided by the quality management consultant on 01/15/19 at 10:00 a.m. The policy stated, "(4) Transmission-based precautions (e.g. Contact Precautions) should be used only as long as necessary to prevent the transmission of infection. The least restrictive approach (Modified Contact of Neighborhood Watch) should be used whenever possible for colonization or infection to provide adequate protection for the resident and others." The Attachment B MDRO (multidrug-resistant organisms) Precaution Reference Chart indicated under Contact Precautions, "Hand hygiene upon entry and exit of room, before and after direct contact with patients, after contact with inanimate objects, after contact with blood, body fluids and before and after removing gloves and gowns….Gloves and gown upon entry to the room."

Prior to the initial tour on 01/15/19 the associate chief of staff for geriatrics and extended care (GEC) indicated the "Neighborhood Watch" transmission-based precautions required staff to clean hands before entering and before leaving the resident room, and gloves and gowns should be used with resident contact or contact with the environment.

Resident #304, [LOCATION]

- Resident #304 had the following provider's order dated 01/02/19, "CONTACT ISOLATION PRECAUTIONS [emphasis not added] instructions: Initiate Isolation for MRSA."
- On 01/16/19 at 12:30 p.m., the surveyor accompanied a nursing assistant (NA) and the nurse manager (NM) of clinical operations into Resident #304's room to observe the noon meal. The sign on the door to the resident's room stated, "Neighborhood Watch VISITORS [emphasis not added]: Wash hands upon entry to room, after patient contact and before leaving." The NA sanitized her hands, donned a gown and gloves and set up the resident's meal. The NA's gown was tied but did not fully cover the back of the NA's clothing or the side of the NA's pants. The NA's clothing came into contact with both of the privacy curtains in the resident's room, and the resident's bedding and side rails multiple times.
- The observation of the gown not covering the back of the NA's clothing and the side of the NA's pants was shared with the NM of clinical operations. The NM of clinical operations confirmed this observation and the possibility that the NA's clothing came into contact with the resident's environment.
- On 01/16/19 at 3:30 p.m. the "infection control nurse" (infection preventionist) clarified that the provider order was not updated to indicate that Contact Isolation Precautions were no longer required but indicated the resident should be on "Neighborhood Watch" precautions as the sign posted on the resident's door indicated.

Resident #201, [LOCATION]

- On 01/15/19 at approximately 10:00 a.m. during the initial tour of [LOCATION], a Contact Precautions sign and personal protective equipment (PPE) storage unit were observed on the door to Resident #201's room. The sign read, "STOP: Only exception: Staff can view or talk without PPE if stand[ing] in door threshold (swing arc of door). Wear Gloves upon entering room. Wear Gown upon entering room." The nurse manager stated anyone entering Resident #201's room was to perform hand hygiene and don gloves and a gown prior to entering the room. It was indicated staff were to implement Contact Precautions for the resident related to a diagnosis of vancomycin-resistant enterococcus (VRE).
- On 01/15/19 at 12:35 p.m., the nurse manager (NM) and a program analyst for quality management (PA QM) were accompanying the surveyor to a resident's room. Resident #201 was heard requesting help in a loud tone of voice as the NM, surveyor and PA QM neared the resident's room. The NM performed hand hygiene and entered Resident #201's room without first donning PPE (gown and gloves) as indicated on the Contact Precautions sign posted on the door to Resident #201's room. Resident #201 requested a drink of water which was provided by the NM. Upon exiting Resident #201's room the NM performed hand hygiene.
- On 01/16/19 at 3:10 p.m., the PA QM and surveyor reviewed the Contact Precautions sign on the door to Resident #201's room. The PA QM verified the Contact Precautions sign instructed staff to perform hand hygiene and don gloves and a gown prior to entering the room. The PA QM verified the NM had not donned gloves and a gown after performing hand hygiene and before entering Resident #201's room on 01/15/19 at 12:35 p.m.
- On 01/16/19 at 3:45 p.m., the observation on 01/15/19 at 12:35 p.m. was reviewed with the NM and PA QM. The NM stated, "I admit I did that. I should have donned gloves and a gown before entering the room."

Resident #104, [LOCATION]

- On 01/15/19 at 1:08 p.m., an LPN was observed administering intravenous medication for Resident #104. A Neighborhood Watch sign and PPE storage unit were observed on the door to Resident #104's room. The LPN indicated the resident tested positive for MRSA of the nares.
- The LPN positioned the medication cart inside the resident's room against the wall and performed hand hygiene; the LPN did not don a gown and gloves. The LPN retrieved the Bar Code Medication Administration (BCMA) scanner from the cart and went to the resident's bedside to scan the resident's wristband. The LPN lifted the resident's arm with one ungloved hand and scanned the resident's wristband with the BCMA scanner in the other ungloved hand; the nurse's clothing was observed to come into contact with the resident's bed. The RN held the scanner with ungloved hands while walking back to the medication cart. The RN placed the scanner on top of the medication cart without first placing a barrier or disinfecting the scanner with a germicidal wipe; the front of the RN's gown came into contact with the front of the medication cart.

Resident #301, [LOCATION]

- Resident #301 had the following provider orders dated 07/10/18, "Change CONTACT ISOLATION PRECAUTIONS to CONTACT ISOLATION PRECAUTIONS [emphasis not added]. Instructions: Initiate Isolation for: MRSA colonized Modified (NW [Neighborhood Watch])."
- On 01/16/19 at 11:50 a.m., the surveyor accompanied a nursing assistant (NA) and the nurse manager (NM) of clinical operations into Resident #301's room to observe the noon meal. The sign on the door to the resident's room stated, "Neighborhood Watch – VISITORS [emphasis not added]: Wash hands upon entry to room, after patient [resident] contact and before leaving." The NA sanitized her hands prior to entering the room; the NA did not don gloves and gown. The NA placed the resident's meal tray on the overbed table coming into contact with the resident's bedding, table, and side rails. The NA held containers of Ensure Plus (nutritional supplement) and milk while the resident drank from the containers. The NA cut a banana and attempted to offer the resident a bite from a fork but the resident refused.
- On 01/16/19 at approximately 12:00 p.m., the NM of [LOCATION] confirmed that the NA should have worn gloves and a gown while assisting Resident #301 with the meal. The NM of [LOCATION] educated the NA upon exiting the resident's room.

During the daily meetings on 01/15/19 and 01/16/19 at 4:00 p.m., CLC leadership staff was informed about staff not following posted Neighborhood Watch or Contact Precautions including donning gowns and gloves. It was also indicated that PPE gowns did not fully cover the back of staff clothing and as a result, the clothing came into contact with the environment in resident rooms where PPE was required. CLC leadership acknowledged the concerns and did not offer additional information.