# 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:**

CLC: [LOCATION]ern California Health Care System - Martinez (Martinez, CA)

Dates of Survey: 11/27/2018 to 11/29/2018

Total Available Beds: 120

Census on First Day of Survey: 119

| F-Tag | Findings |
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| F176<br><br>483.10(n) *Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.*<br><br>**Level of Harm** - No actual harm with potential for more than minimal harm that is not immediate jeopardy<br><br>**Residents Affected** - Few | Based on observation, interview and record review, the CLC did not ensure the interdisciplinary team determined that self-administration of medication was safe for a resident. Findings include:<br><br>Resident #206, [LOCATION]<br>• Resident #206's admission history and physical dated [DATE] indicated the resident had diagnoses including chronic obstructive pulmonary disease (COPD).<br>• The resident's most recent quarterly Minimum Data Set (MDS) dated 11/01/18 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition. The MDS indicated the resident was independent with locomotion on the unit (neighborhood) and eating.<br>• During observations of medication administration on 11/28/18 at 8:45 a.m., a licensed vocational nurse (LVN) scanned an albuterol/ipratropium Combivent Respimat inhaler and a budesonide/formoterol (Symbicort®) inhaler and returned the inhalers to the resident's medication drawer. The LVN stated the resident had the same inhalers at the bedside. During the medication administration, the resident self-administered the Combivent Respimat inhaler and the budesonide/formoterol inhaler while the LVN stood nearby. The resident administered the inhalers in a correct manner and at the correct dose.<br>• The resident's provider orders dated 08/14/18 indicated there were orders for albuterol/ipratropium Combivent Respimat one puff oral inhalation four times a day for shortness of breath and budesonide/formoterol oral inhalation two puffs twice a day for shortness of breath and COPD. There were no medical orders provided for self-administration of medications. There was no documentation provided to indicate an assessment was conducted to determine the resident's ability to self-administer the medications.<br>• Although requested, a policy related to self-administration of medications was not provided by staff.<br>• On 11/28/18 at 4:20 p.m., the nurse management team for [LOCATION] stated the team thought the resident had an order to have the inhalers at the bedside but could not locate the order. Following the discussion, the nurse management team provided a new order dated 11/28/18 and timed at 5:00 p.m. for Resident #206's inhalers. The orders stated, "Albuterol/Ipratropium Combivent Respimat oral inhalation one puff four times a day for shortness of breath, may leave at bedside," and "Budesonide/Formoterol oral inhalation two puffs oral inhaler twice a day for shortness of breath and chronic obstructive pulmonary disease, may leave at bedside." |
| F253<br><br>483.15(h)(2) *Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and* | Based on observation, interview and record review, the CLC did not provide services to maintain a sanitary and orderly interior. Findings include:<br><br>The undated policy titled, "CPAP/BIPAP [continuous positive airway pressure/bi-level positive airway pressure] Cleaning and Maintenance" was provided by the chief nurse on 11/28/18 at |

*comfortable interior;*

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

**Residents Affected** - Few

12:15 p.m. According to the policy, "After each nightly use rinse mask with tap water and lay out to dry on clean towel….Place mask in a clean plastic bag and place next to the unit….BIPAP/CPAP masks MUST [emphasis not added] be in a plastic treatment bag at the bedside when not in use." The policy stated, "Documentation and Training: Document daily and weekly training," and " **PLEASE NOTE: NO TASK IS CONSIDERED COMPLETED UNTIL THE DOCUMENTATION AND REQUIRED REPORTING OCCURS** [emphasis not added]…."

Resident #303, [LOCATION]

- On 11/27/18 at 9:12 a.m., Resident #303 was observed sleeping in bed while wearing a CPAP mask. On 11/28/18 at 8:25 a.m., a nursing assistant (NA) stated the CPAP "is removed each morning right before he eats breakfast," and indicated an RN removed the mask a "few minutes ago." The resident's mask was observed in the top drawer of the resident's bedside table with other personal belongings; the mask was not in a plastic bag.
- On 11/28/18 at 10:00 a.m. during an interview, the respiratory therapist (RT) stated, "A blue folder is placed at the bedside of every resident who is using a CPAP. The folder includes instructions for the nursing staff and a log for the nursing assistants to complete as daily cleaning occurs."
- On 11/28/18 at 10:10 a.m., the quality manager (QM) and surveyor observed the resident's room for a blue folder; a folder could not be located. An NA present in the room indicated she had never seen a blue folder. The charge RN entered the resident's room at 10:20 a.m. and said staff from the day shift were responsible for cleaning the CPAP; the charge RN stated, "This morning I was the one that removed it [the CPAP mask]." The charge RN opened the resident's top drawer, placed the CPAP mask into a plastic bag, and hung the bag on the wall behind the resident's bed.
- On 11/28/18 at 10:25 a.m., the charge RN stated a blue folder with a cleaning log was not used; instead, daily cleaning of the equipment should be documented by the NAs in the computerized patient record system (CPRS). CPRS documentation was reviewed with the QM and the charge RN; staff confirmed that documentation of daily cleaning as indicated in the CLC's policy was not available in the CPRS. (See Professional Standards of Quality)

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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:

Resident #303, [LOCATION]

- Resident #303 had current diagnoses included dementia and traumatic brain injury (TBI). The quarterly MDS dated 10/19/18 indicated the resident had severely impaired cognitive skills for daily decision making based on staff assessment; the resident required extensive assistance with activities of daily living (ADLs) including personal hygiene.
- The resident's current care plan dated 10/25/18 did not include approaches related to the use of continuous positive airway pressure (CPAP) other than, "At risk for sleep disturbance related to diagnosis of dementia. Goal is to have a good night's sleep as evidenced by use of CPAP."
- On 11/27/18 at 9:12 a.m. and on 11/28/18 at 8:15 a.m., Resident #303 was observed sleeping in bed wearing a CPAP mask.
- On 11/28/18 at 8:25 a.m., an RN indicated that residents with CPAP machines might or might not have oxygen saturation levels routinely monitored with pulse oximetry. The RN stated that pulse oximetry was conducted "depending on the provider order" and that most residents were not monitored routinely.
- On 11/28/18 at 10:00 a.m., the respiratory therapist stated, "The provider order will indicate when nursing staff should put on and take off the CPAP. It will depend on the resident's level of care."
- Current provider orders provided by the QM did not address use of CPAP. According to the provider's order with a start date of 09/16/15 and end date of 03/16/16, "CPAP nightly as per sleep neurologist (auto CPAP with heated humidifier at a pressure of 5-20 cm [centimeters] H20 [water]) when provided by their service." There were no current provider orders for the use of CPAP.

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F309

483.25 *Quality of Care. Each resident*

Based on observation, interview and record review, the CLC did not ensure necessary care and services to attain or maintain each resident's highest practicable physical, mental, and psychosocial well-being. Findings include:

*must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by §483.25(a)-(m).*

**Level of Harm** - Actual harm that is not immediate jeopardy

**Residents Affected** - Few

Pain Management

On 11/28/18 at 9:44 p.m., the health and rehabilitation patient care (HRPC) nursing practice manager provided the VA Northern California Health Care System Policy Statement 11-50, dated November 13, 2014, and titled, "Pain Management." Section 5 of the policy titled Procedures, included directions for staff that stated, "Pain will be screened and the response to pain management interventions will be evaluated using a scale of 0 – [to] 10: 0 = no pain, 5 = moderate pain; 10 = pain as bad as can be imagined. For those non-verbal or unresponsive patients [residents], pain will be assessed using the non-communicative, physical signs and symptoms found on the pain sheet (Attachment A included non-communicative signs and symptoms including sleeping, calmed, relaxed or grimacing with movement or moaning with movement or restless or constant moaning without stimuli). The pain assessment will include: Intensity, location of pain, duration of pain, quality of the pain and relieving factors and functionality-lifestyle activities impacted by pain." Attachment B titled, "CPRS [computerized patient record system] Pain Assessment," included directions for staff to conduct a pain reassessment and enter a new pain score in CPRS." According to Attachment B, the information entered into the CPRS was to be communicated to the provider to assess the "Pain Treatment Plan."

*Resident #204, [LOCATION]*

- Review of Resident #204's medical record indicated the resident was admitted to the CLC on [DATE] with multiple medical conditions including Parkinson's disease and functional quadriplegia. The resident's comprehensive MDS dated 09/26/18 indicated the resident's cognition was severely impaired based on staff assessment, and the resident was sometimes understood by and sometimes understood others. According to the MDS, the resident required total assistance of one to two staff with bed mobility, eating and bathing; the resident was unable to transfer. The resident required extensive assistance with dressing, toilet use and personal hygiene. The comprehensive MDS stated the resident had vocal complaints of pain, facial expressions of pain, and protective body movements or postures. The resident was receiving a scheduled pain medication, as needed (PRN) pain medication and non-medication interventions for pain.
- A provider's order dated 09/20/18 stated, "Tylenol [acetaminophen] solution 650 mg/20 ml [650 milligrams in 20 milliliters] per G-tube [gastrostomy tube] Q [every] 6 hours as needed [PRN] for pain or fever."
- A pain assessment dated 10/08/18 indicated the location of the pain was in the left hand and the pain was "aching, soreness." The resident's pain was exacerbated with movement and affected the resident's activities of daily living (ADLs) and sleep. The resident's pain score was documented as 99 and the assessment indicated the resident had "no non-verbal signs of pain or discomfort."
- A restorative nursing note dated 11/14/18 stated, "Resident was awake, alert and responsive when he was seen in his room. He has no signs of pain or discomfort during the exercise session. He was grunting when his extremities were being moved. Restorative Nursing Passive Range of Motion Program; on all possible joints and planes of all extremities with a slight stretch at the end of motion." Although the noted indicated the resident was "grunting" when the resident's extremities were moved, the resident's Bar Code Medication Administration (BCMA) record did not indicate the resident was medicated prior to or after the exercise session.
- The resident's care plan dated 11/20/18 stated, "Note complaints of pain. Note intensity, region, radiation, and associated symptoms. Medicate as ordered…indicated for pain. Evaluate the effect of pain medication. Ensure patient's [resident's] comfort."
- The long-term care monthly summary dated 11/20/18 stated, "Patient's current pain is the same pain that has been previously reported and assessed…Acceptable level of pain is 2." The resident's pain score was recorded at 0 (zero). The monthly summary stated, "Resident received the Pain Management education handout and questions were answered. The patient acknowledges an understanding of the topic readiness to learn, the patient is ready to learn and is receptive. Barriers to learning; the patient has a potential barrier to learning due to cognitive limitations. The patient has a potential barrier to leaning [learning] due to a physical [limitation]."
- During observations on 11/27/18 at 11:48 a.m., Resident #204 was sitting up in a tilt-back Broda® wheelchair. The resident did not respond to questions and remained silent and motionless with his eyes closed. Staff stated the resident seldom talked and would respond to yes or no questions. The resident did not express verbal or non-verbal indicators of pain at the time of the observation.
- Resident #204 was observed on 11/27/18 at 12:40 p.m. The resident was sitting up in bed and a staff member was assisting the resident to eat. The resident moaned when the head of the bed was adjusted by staff.
- During medication administration on 11/27/18 at 5:00 p.m., an LVN administered 650 mg of acetaminophen in 20 ml through the resident's gastrostomy tube. The LVN

adjusted the head of the bed and the resident moaned and had a furrowed brow. The LVN stated that when the resident was moved, he had verbalizations indicating he was in pain. A family member visiting the resident at the time told the LVN that every time the resident's position was changed, he moaned. The family member asked the LVN if the resident received pain medication on a scheduled basis. The LVN stated the resident received pain medication (acetaminophen) when he demonstrated signs of pain and not at other times.

- During observations on 11/28/18 at 9:30 a.m., the resident was sitting up in a tilt-back Broda wheelchair. The resident's feet were observed with the assistance of an assistant nurse manager. The resident moaned and grimaced during the process of removing the resident's Podus pressure reducing boots from both feet and examining the resident's heels at which point the observation was discontinued. When asked about the resident moaning, the nursing assistant (NA) providing the resident's care stated, "Yes, the resident does exhibit pain when moved; he has contractures. He makes noises and makes facial expressions."
- During the observations on 11/27/18 and 11/28/18 (as above) when the resident was asked by a surveyor if he was experiencing pain, the resident did not respond.
- Review of the Bar Code Medication Administration (BCMA) record indicated the resident last received acetaminophen on 11/27/18 at 5:05 p.m. when the resident's pain level was 2.
- On 11/28/18 at 2:30 p.m., a quality management staff member provided Resident #204's nursing monthly summary. Since the resident's admission on [DATE], the resident received the PRN acetaminophen 24 times including on 11/27/18 at 5:05 p.m. when the resident had an acceptable pain level of 2. The resident received 650 mg/20 ml of PRN acetaminophen through his gastrostomy tube on each of the following dates for pain at a level greater than 2. There was no documentation to indicate an assessment for the effectiveness of the pain medication was completed after administration. Acetaminophen was administered on 09/21/18 through 09/25/18 for pain at a level between 4 and 7 or when the resident was unable to verbalize pain (score of 99); on 10/01/18, 10/03/18, twice on 10/04/18, 10/08/18, 10/09/18, 10/12/18, and 10/23/18 for pain at a level between 4 and 6; and on 11/07/18, 11/08/18, 11/12/18, 11/13/18; 11/16/18 through 11/19/18, and 11/21/18 for pain at a level 6; and on 11/24/18 for pain at 5. Documentation did not indicate the location, duration, and quality of the pain, according to the CLC's policy.
- On 11/27/18 at 8:28 p.m. (during the survey), a new order was written for "Acetaminophen 325 mg/10 ml via G-tube, BID [twice daily], start 11/27/18."
- In summary, Resident #204 was observed on 11/27/18 and 11/28/18 in bed or a Broda wheelchair; the resident was overheard moaning, grimacing and/or with a furrowed brow when the head of the bed was adjusted by staff and when the resident's pressure reducing boots were removed. A family member visiting the resident stated that every time the resident's position was changed, he moaned. A nursing assistant (NA) providing the resident's care stated, "Yes, the resident does exhibit pain when moved; he has contractures. He makes noises and makes facial expressions." Documentation indicated the resident received PRN acetaminophen on 23 days since admission on [DATE]; the documentation did not indicate the location, duration and quality of the pain or if the pain medication was effective in addressing the resident's pain. During the survey on 11/27/18, an order was written for scheduled acetaminophen.

Wound Care
*Resident #204, [LOCATION]*

- Resident #204 was admitted to the CLC on [DATE] with multiple medical conditions including Parkinson's disease, dementia and functional quadriplegia. The resident's admission history and physical dated [DATE] indicated the resident's heels were "reddened." The resident's comprehensive MDS dated 09/26/18 indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment; the resident sometimes understood and was sometimes understood by others. According to the MDS, the resident required total assistance of one to two staff with bed mobility, eating and bathing; the resident was unable to transfer and required extensive assistance with dressing, toilet use and personal hygiene. The MDS indicated the resident was at risk for developing pressure ulcers and the resident had no pressure ulcers. Skin and ulcer treatments coded on the MDS included a pressure reducing device for the bed and application of ointments/medications other than to the feet.
- The care plan dated 09/21/18 indicated the resident had an "alteration in skin integrity." The care plan included approaches that read, "Keep clean and dry, encourage scheduled toileting. Wheelchair cushion will be well fitted." No other approaches related to pressure ulcer prevention were identified in the resident's care plan.
- There were no provider orders related to pressure ulcer prevention.
- The long-term care nurse monthly summary dated 10/20/18 indicated the resident was at high risk for pressure ulcer development with a Braden Scale score of 10. The

long-term care nurse monthly summary dated 11/20/18 indicated the resident was at high risk for pressure ulcer development with a Braden Scale score of 11. A subsequent assessment dated 11/22/18 indicated the resident had a Braden Scale score of 15 suggesting mild risk.

- During observations of the resident on 11/27/18 and 11/28/18, Podus boots were applied to both of the resident's feet to reduce pressure and protect the resident's heels. On 11/28/18 at 9:30 a.m., the resident was observed sitting in a Broda® wheelchair. The resident's feet and heels were observed with the assistance of an assistant nurse manager. Podus boots were removed from the resident's feet. The resident's heels were without redness; there was a scabbed area observed over each of the second, third and fourth toes of the right foot. The areas were over bony prominences between the distal and middle phalanges and measured approximately 0.25 centimeters (cm). The assistant nurse manager and staff caring for the resident had no additional information regarding the areas on the resident's toes such as information regarding causal and contributing factors.
- Review of the resident's record indicated the areas on the toes were not identified in the 11/20/18 long-term care nurse monthly summary.
- In summary, based on staff interview and record review, the scabbed areas over each of the resident's second, third and fourth toes of the right foot were not identified prior to the observation on 11/28/18. It was not evident an assessment had been conducted to identify potential causal and contributing factors related to the scabbed areas and develop approaches to address the areas over the toes.

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F312

483.25(a)(3) *A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.*

**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 care for residents unable to carry out activities of daily living (ADLs) to maintain good personal hygiene. Findings include:

Resident #301, [LOCATION]

- Resident #301's admission history and physical dated [DATE] stated, "dependent for all ADLs [activities of daily living]."
- The resident's quarterly MDS dated 11/11/18 indicated the resident's cognition was severely impaired based on staff assessment and the resident required extensive assistance with all ADLs. The resident's care plan dated 11/21/18 stated, "Extensive assist [assistance] with ADLs."
- The resident's skin assessments dated 10/26/18 and 11/26/18 indicated the resident had a Braden Scale score of 12 suggesting a high risk for pressure ulcer development. Approaches included, "Keep fingernails trimmed to avoid scratching self."
- On 11/27/18 at 11:00 a.m. during observations with the quality manager (QM), Resident #301 was in bed wearing a hospital gown; the resident's right hand appeared to be contracted and an NA was asked about keeping the resident's hand clean. When the NA attempted to open the resident's right hand, the QM and surveyor observed elongated nails approximately 1/4 to 1/2-inch long that created indentations in the resident's palm. The NA stated, "His fingernails grow rapidly but I give him a bath or shower twice a week." The NA did not know when the resident's fingernails were last trimmed. The QM stated, "…his fingernails need to be trimmed."
- On 11/28/18 at 10:30 a.m. during observations with the QM, the resident was lying in bed. The resident's fingernails appear to be elongated as observed on 11/27/18.
- On 11/28/18 at 11:45 a.m. during observations with the QM, the resident was lying in his bed. The QM stated the resident's fingernails had not been trimmed and indicated she would make sure the fingernails were trimmed. (See Range of Motion)

Resident #303, [LOCATION]

- Resident #303 had diagnoses included dementia and traumatic brain injury (TBI). The quarterly MDS dated 10/19/18 indicated the resident had severely impaired cognitive skills for daily decision making based on staff assessment; the resident required extensive assistance with activities of daily living (ADLs) including personal hygiene. The care plan dated 10/25/18 indicated the resident needed "total care with all ADLs." The current skin assessment dated 10/26/18 indicated the resident was "in need of toenail care."
- On 11/27/18 at 2:00 p.m., a podiatry consult for Resident #303 dated 02/08/18 was provided by the QM. According to the consult, "Minimal incurvation of right hallux nail, no paronychia, nails dystrophic and elongated. Hallus valgus b/l [bilaterally] with crossover 2nd toe deformity. Palliative prophylactic debridement of dystrophic nails and incurvated toenails with symptomatic relief. Trimmed nails. Follow up 2-3 months unless he just wants to get his nail care in the CREC [community and rehabilitation extended care]."
- A nursing progress note, dated 05/25/18, indicated, "Vet [Veteran] agreeable to have

me trim his toenails. Treatment reduced 10 elongated and dystrophic toenails without incident. Alcohol post debridement." No further documentation was provided related to foot care after 05/25/18.

- On 11/27/18 at 11:50 a.m. during observations with the quality manager (QM), the resident was lying in bed wearing gripper socks. An NA removed the resident's socks and the resident was observed with bilateral yellow, elongated toenails that were approximately 1/2-inch long; the toenails on the great toes were approximately 1/4-inch thick. The resident had three overlapping toes on the right and left feet. The resident stated, "Ouch" when the NA touched his toes. The NA said, "He doesn't like his toes touched but I am able to clean between them." When asked if she trimmed the resident's toenails, the NA said, "No, the nurses do that."

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F314

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** - 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 to ensure that residents who entered the CLC without pressure ulcers did not develop pressure ulcers. Findings include:

Resident #301, [LOCATION]

- Resident #301 was admitted to the CLC on [DATE] with diagnoses including altered mental status and degenerative joint disease (DJD). The history and physical dated [DATE] read, "Mostly bedbound, no longer feeds self, dependent for all ADLs."
- The quarterly MDS dated 11/11/18 indicated the resident had severely impaired cognitive skills for daily decision making based on staff assessment; the resident required extensive assistance with ADLs including bed mobility and had functional limitations in range of motion of the bilateral lower extremities. According to the quarterly MDS, the resident was at risk for developing pressure ulcers and had no pressure ulcers; skin and ulcer treatments coded on the MDS included a pressure reducing device for the bed.
- The resident's care plan dated 11/21/18 indicated the resident needed "extensive assist [assistance] with ADLs" and included the following: "Alteration in skin integrity related to [because the resident is] incontinent at times. Keep clean and dry, encourage scheduled toileting, wheelchair cushion will be well fitted." No other approaches related to pressure ulcer prevention were included on the care plan.
- A current provider's order dated 11/08/18 stated, "Please turn patient on his side using wedges every 3-4 hours. Place him in the wheelchair at least once or twice a week during meal times."
- Skin assessments dated 10/26/18 and 11/26/18 noted a Braden Scale score of 12 suggesting high risk for pressure ulcer development. Approaches identified in the skin assessments included, "Turn and reposition every two hours while in bed using pillows to separate pressure areas and elevate heels using pillows or foam blocks."
- On 11/27/18 at 11:00 a.m., the resident was observed with the quality manager (QM) present lying in bed on his back, wearing a hospital gown. The resident was wearing gripper socks and the resident's feet were not elevated using pillows or foam blocks. The resident's heels were resting directly on the mattress. The resident did not have a wedge positioning device in place and was noted to be sliding down in the bed; there was not a pressure reducing mattress on the bed as confirmed by the QM. An NA who was present in the room indicated that no positioning devices were used for the resident. When asked if the resident's feet were elevated or if the resident had pressure reducing devices for his feet or heels, the NA responded, "No."
- On 11/27/18 at 12:55 p.m., the resident was observed lying in bed on his back wearing a hospital gown and gripper socks. The resident's feet were not elevated using pillows or foam blocks. The resident's heels were resting directly on the mattress and the resident had moved farther down in the bed than observed at 11:00 a.m. The resident appeared to try and reposition himself by raising his hip and trying to extend his legs. At 1:32 p.m., an RN passed by the resident's room and with the assistance of an NA repositioned the resident higher in the bed and placed the resident's head on a pillow; after the resident was repositioned the resident's heels were not floated.
- On 11/28/18 at 10:30 a.m. during observations with the QM, the resident was lying in bed on his back wearing a hospital gown and gripper socks; the resident's feet were not elevated and pillows were not used to separate the resident's ankles that were crossed. The resident's left heel was resting directly on the mattress. The RN present for the observation was able to uncross the resident's ankles with some difficulty. An NA entered the room a few minutes later with a new pair of Podus pressure reducing boots and applied the boots to the resident's feet.
- On 11/28/18 at 11:45 a.m., the resident was observed lying in bed on his back, wearing the Podus boots; a pillow was placed between the resident's knees and a wedge was placed against the left side of the resident's back.
- In summary, during observations made on 11/27/18 at 11:00 a.m. and 12:55 p.m., and

11/28/18 at 10:30 a.m., Resident #301 was observed lying in bed on his back. The resident's feet were not elevated using pillows or foam blocks and the resident's left heel or both of the resident's heels rested directly on the mattress; there was not a pressure reducing mattress on the bed. On 11/27/18 at 1:32 p.m., an RN passed by the resident's room and with the assistance of an NA repositioned the resident higher in the bed; after the resident was repositioned the resident's heels were not floated. On 11/28/18 at 10:30 a.m., the resident's ankles were crossed and a pillow was not used to separate pressure areas. Skin assessments dated 10/26/18 and 11/26/18 indicated a Braden Scale score of 12 suggesting high risk for pressure ulcer development. Approaches identified in the skin assessments included, "Turn and reposition every two hours while in bed using pillows to separate pressure areas and elevate heels using pillows or foam blocks."

Resident #303, [LOCATION]

- Resident #303 had current diagnoses including dementia, posttraumatic stress disorder (PTSD) and traumatic brain injury (TBI). The quarterly MDS dated 10/19/18 indicated the resident had severely impaired cognitive skills for daily decision making based on staff assessment; the resident required extensive assistance with activities of daily living (ADLs) including bed mobility, was at risk of developing pressure ulcers and had no pressure ulcers. According to the quarterly MDS, skin and ulcer treatments included a pressure reducing device for the bed.
- The care plan dated 10/25/18 indicated the resident required "total care with all ADLs" and stated, "Alteration in skin integrity related to [because the resident is] incontinent at times. Observe, reposition, monitor, provide good perineal care at all times." No other approaches related to pressure ulcer prevention were identified.
- There were no provider orders related to pressure ulcer prevention (e.g., use of Sage boots).
- The resident had a wound care treatment note dated 09/19/18 that read,
    - "Apply skin prep to bilateral heels then cover with Mepilex to right heel for prevention. Skin intact and blanching normal skin color. Float heels when on bed with sage boots."
- The most recent skin assessment dated 10/26/18 noted a Braden Scale for Predicting Pressure Ulcer Risk score of 12 suggesting high risk for pressure ulcer development. Approaches identified in the skin assessment included, "Turn and reposition every two hours while in bed using pillows to separate pressure areas and elevate heels using pillows or foam blocks." The 10/26/18 skin assessment did not indicate the resident had pressure ulcers.
- On 11/27/18 at 9:20 a.m., an RN stated the resident "has been here [CLC] quite a while. He is spending more time in bed and is slowly declining."
- On 11/27/18 at 9:12 a.m. during the initial tour, the resident was lying in bed on his back wearing a hospital gown. On 11/27/18 at 11:50 a.m., during observations with the quality manager, the resident remained in bed on his back. The resident was wearing gripper socks and the resident's heels were resting directly on the mattress; the resident's feet were not elevated using pillows or foam blocks. The resident's bed was not observed with a pressure reducing mattress.
- On 11/28/18 at 8:25 a.m., the resident was observed with the QM present while the resident was lying in bed wearing a hospital gown and gripper socks. The resident's feet were not elevated using pillows or foam blocks. The QM commented, "He should at least have a pressure reducing mattress." On 11/28/18 at 10:10 a.m. and 10:40 a.m., the resident remained in the same position in bed.
- In summary, on 11/27/18 at 9:12 a.m. and 11:50 a.m.; and on 11/28/18 at 8:25 a.m., 10:10 a.m. and 10:40 a.m., Resident #303 was observed lying in bed on his back; the resident's feet were not elevated using pillows or foam blocks and the resident's heels were resting directly on the mattress. The resident's bed was not observed with a pressure reducing mattress. The most recent skin assessment dated 10/26/18 indicated a Braden Scale score of 12 suggesting high risk for pressure ulcer development. Approaches identified in the skin assessment included, "Turn and reposition every two hours while in bed using pillows to separate pressure areas and elevate heels using pillows or foam blocks."

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F318

483.25(e)(2) *Range of Motion. Based on the comprehensive assessment of a resident, the facility must ensure that: A resident with a limited range of motion receives appropriate*

Based on observation, interview and record review, the CLC did not ensure that a resident with a limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Findings include:

Restorative Services

The CLC policy dated January 2, 2013, and titled, "Restorative Care Nursing Program," was provided by the quality manager (QM) on 11/27/18 at 4:20 p.m. According to the policy,

*treatment and services to increase range of motion and/or to prevent further decrease in range of motion.*

**Level of Harm** - Actual harm that is not immediate jeopardy

**Residents Affected** - Few

"Restorative Care Program Goals….b. Early intervention to preserve and enhance functional capabilities and reduce and prevent functional decline." The scope of services identified in the policy included "range of motion: active and passive."

*Resident #301, [LOCATION]*

- Resident #301 was admitted to the [LOCATION] neighborhood with diagnoses included altered mental status and corticobasal degeneration. The history and physical dated [DATE] stated, "Mostly bedbound, no longer feeds self, dependent for all ADLs [activities of daily living]."
- The quarterly MDS dated 11/11/18 indicated the resident had severely impaired cognition based on staff assessment. The quarterly MDS indicated the resident required extensive assistance with ADLs including bed mobility, and had functional limitations in range of motion (ROM) of the bilateral lower extremities with no functional limitations in ROM of the upper extremities. According to the quarterly MDS, active ROM was provided one day (during the assessment period) as part of a restorative nursing program.
- The resident's care plan dated 11/21/18 stated the resident needed "extensive assist [assistance] with ADLs." The care plan did not address limitations in range of motion, a restorative plan, or contracture prevention approaches.
- The monthly nursing summaries dated 10/26/18 and 11/26/18 did not address limitations in range of motion or contractures.
- A restorative consult dated 11/07/18 stated, "Bed mobility and positioning: Both upper extremities were only functional for gross holding or grasping with redirection due to absence of purposeful voluntary movement related to corticobasal degeneration. Lower extremities were zero functional due to absence of purposeful voluntary movement related to corticobasal degeneration." Active or passive range of motion was not initiated following the consult.
- On 11/27/18 at 9:10 a.m. during the initial tour with the QM and nurse manager (NM), Resident #301 was observed lying in bed with his right hand clenched tightly closed without palm protection in place, as confirmed by the QM.
- On 11/27/18 at 11:00 a.m. during observations with the QM, the resident was in bed wearing a hospital gown. The resident's right hand appeared to be contracted and held tightly closed. An NA was asked about keeping the resident's hands clean. The NA attempted to open the resident's right hand and the QM and surveyor observed elongated nails approximately 1/4 to 1/2 inch long that were digging into the resident's palm, creating indentations from the fingernails. The NA stated, "It hurts him to open his hand but I can get in there to clean it;" as the NA opened the resident's right hand, the resident moaned and grimaced. When asked if any protection was provided for the resident's hand (to help prevent the indentations from the fingernails), the NA stated, "No." The QM stated, "A washcloth or something should be in his hand to prevent the contracture and his fingernails need to be trimmed."
- On 11/27/18 at 3:15 p.m., the restorative RN was interviewed regarding the consult dated 11/07/18. The restorative RN stated, "The consult was for positioning to prevent bed sores." The restorative RN indicated the RN did not think the resident had a hand contracture and stated it was not addressed by restorative. The restorative RN and surveyor went to the resident's room and the restorative RN attempted to open the resident's right hand and stated the fingernails were digging into the palm of the resident's hand; the resident moaned and grimaced as the restorative RN attempted to open the right hand. The restorative RN stated, "I don't think this is a permanent contracture because sometimes he can relax it [the hand]." When asked about approaches to address the resident's hand, the restorative RN stated, "I will see about providing some passive range of motion."
- On 11/28/18 at 10:30 a.m. during observations with the QM, the resident was lying in bed. The resident's right hand was clenched closed without a wash cloth or cone present as confirmed by the QM.
- On 11/28/18 at 11:45 a.m. during observations with the QM, the resident was observed in bed with a rolled washcloth in the right hand.

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F323

483.25(h)(1) *Accidents. The facility must ensure that: The resident environment remains as free of accident hazards as is possible;*

**Level of Harm** - No actual harm with potential for more than

Based on observation, interview and record review, the CLC did not ensure the environment was free of accident hazards and residents received supervision to prevent accidents. Findings include:

<u>Accident Prevention Related to Falls</u>
The CLC policy dated June 11, 2018, and titled, "VA Northern California Health System Fall Prevention Policy," was provided by the quality manager (QM) on 11/28/18 at 9:20 a.m. According to the policy, "Fall risk interventions will be implemented for all…residents. The initial care plan will outline individual fall prevention plan for patients/residents designated as

minimal harm that is not immediate jeopardy

**Residents Affected** - Few

high risk. Universal Fall Precautions will be implemented for all patients/residents…The patient/resident's fall risk care plan must be reevaluated, modified, and updated to reflect additional measures to prevent future falls."

*Resident #303, [LOCATION]*

- Resident #303 was admitted to the [LOCATION] neighborhood with current diagnoses including dementia, posttraumatic stress disorder (PTSD), and traumatic brain injury (TBI). The quarterly MDS dated 10/19/18 indicated the resident's cognition was severely impaired based on staff assessment, and the resident was sometimes understood by and sometimes understood others. The MDS indicated the resident required extensive assistance with activities of daily living (ADLs) including bed mobility and transfers, had no functional limitations in range of motion of the upper or lower extremities, and had falls in the past 2-6 months without injury. According to the quarterly MDS, bed (side) rails were not used.
- Resident #303's care plan dated 10/25/18 included a concern that stated, "At risk for falls related to dementia…last fall 02/19/18." The care plan did not identify approaches related to fall prevention. A side rail assessment included in the care plan stated, "Rationale [for side rail use]: comfort, bed control access, repositioning. Risk for side rail entrapment assessed: Resident shows he can safely move in bed without entrapment. Resident does not attempt to climb under or over sides [side rails]. Education: Risks and benefit of side rails explained to include risk of entrapment or distress. Recommended number: 2 [side rails]. Reassess monthly and prn [as needed]."
- The event investigation form dated 10/22/18 stated, "On 10/21/18 at 12:15 a.m., staff responded to a bed alarm and found resident sitting on the floor mat beside his bed. No visible injury noted. On call MD [medical doctor] notified…[and] ordered companion for tonight and will be revaluated in the morning. No harm." The documentation did not describe the environment when Resident #303 was found (e.g., to indicate if side rails were in use, the bed was in a low position, the call light was within reach). Documentation did not indicate what the resident was attempting to do at the time of the fall (e.g., get to the bathroom, obtain food or assistance) to determine the causes or contributing factors to the fall. Actions taken included, "Vet [Veteran] has diagnosis of shingles. He is compulsive secondary to his dementia. 1:1 [one-to-one] companion initiated. Bed moved against the wall, kept in lowest position, and a mat placed on the floor. Contributing factors: inadequate/inappropriate precautions for high risk or impaired patients [statement not further clarified]." The post fall assessment dated 10/21/18 indicated the resident had a Morse Fall Scale score of 90 suggesting a high fall risk, and stated, "1:1 for the rest of the night." No changes were made to the resident's care plan based on the assessment. The event investigation form indicated universal fall precautions in place included, "Orient to surroundings, use of nonskid socks, remind to request assistance, purposeful use of assistive devices, place pt. [patient] call light within easier reach, call light answered promptly, bed in low position, lock bed and wheelchair wheels, provide proper lighting, keep floor clean of clutter, clean up spills immediately, modify room for safe transfers, reinforce MD instructions for prevention, review meds [medications], complete surveillance rounds every 30 minutes, make sure ambulatory devices are in good repair." The post fall assessment did not indicate if side rails were in use at the time of the fall or what Resident #303 was attempting to do (e.g., get to the bathroom, obtain assistance).
- The event investigation form dated 10/22/18 at 6:20 a.m. stated, "Found resident sitting on the floor mat beside his bed. His back against the side of the bed. Appears he slid down from his low bed. Bed alarm did not go off. No visible injury noted. Bed alarm pad was changed and [resident] assisted back to bed. No harm. Action taken: increase surveillance of pt [patient].…move bed against wall to limit exit points. Put mat on floor to reduce injury. Ensure bed alarm is properly functioning every shift. Companion sitting outside of room." The post fall assessment dated 10/22/18 indicated Resident #303 had a Morse Fall Scale score of 90. No changes were made to the care plan and the universal fall precautions remained unchanged since the previous fall on 10/21/18. The event investigation form and the post fall assessment did not indicate if side rails were in use at the time of the fall or what the resident was attempting to do.
- A restorative consult dated 10/30/18 stated, "Upper extremities both were 100% functional with no weakness. Lower extremities, both capable of full weight bearing slightly unstable." The consult did not indicate if restorative services were to be implemented.
- The event investigation form dated 11/01/18 at 8:20 a.m. stated, "Found resident on the mattress on the floor beside bed on side lying position. Alert and verbal. Action taken: reinforce importance of purposeful rounding to ensure resident's needs are met proactively." The post fall note dated 11/01/18 indicated the resident had a Morse Fall Scale score of 80 suggesting high risk. The post fall note stated, "Alarm sounding, bed in low position, pain in right arm when moved. Suspected impact to head." There were no changes to the resident's plan of care or fall precautions other than to change the

30-minute surveillance rounds to one hour. Staff did not indicate why surveillance rounds changed from every 30 minutes to every hour. The event investigation form and the post fall assessment did not indicate if side rails were in use at the time of the fall or what Resident #303 was attempting to do. An x-ray of the resident's shoulder on 11/01/18 was negative for injury. The resident had not had any falls since 11/01/18. Staff did not indicate why they thought the resident had not fallen since 11/01/18.

- During the initial tour on 11/27/18 at 9:15 a.m., Resident #303 was observed in bed asleep. The left side of the resident's bed was pushed against the wall and the top left side rail was in the raised position. The NM stated, "He is at a high risk for falls and we limit his safe exit to one side. It's to keep him safe." The resident was not observed moving while in bed or attempting to get out of bed.
- On 11/28/18 at 8:00 a.m. during observations with the nurse manager (NM), the resident was in bed asleep. The left side of the resident's bed was pushed against the wall with the top two side rails in the raised position. There was a chair against the bottom right side of the bed, blocking exit from the right side. When asked about the bed being against the wall in addition to the raised side rails and the chair, the NM stated, "It's been the practice on the neighborhood to put beds against the wall for safety when a resident is not able to follow directions." The NM was not aware of who made this decision, did not know the purpose of the chair at the bottom ride side of the bed, did not know if the arrangement had been assessed for safety; the NM thought the bed had been placed against the wall since one of the resident's last falls. Two nursing assistants (NAs) were interviewed regarding the use of the chair at the bottom right side of the bed; the NAs did not know the purpose of the chair. One of the NAs said, "He has had the side rails for a very long time to prevent falls."
- In summary, Resident #303 was observed in bed asleep on 11/27/18 and 11/28/18. On 11/27/18, the left side of the resident's bed was pushed against the wall and the top left side rail was in the raised position. On 11/28/18, the left side of the resident's bed was pushed against the wall with the top two side rails in the raised position. There was a chair against the bottom right side of the bed, blocking exit from the right side. The NM did not know the purpose of the chair. Resident #303 experienced a fall on 10/21/18, 10/22/18 and 11/01/18. Documentation on 10/21/18, 10/22/18 and 11/01/18 indicated the resident was found sitting on the floor mat beside his bed. Post-fall documentation related to the fall on 10/21/18 did not describe the environment when Resident #303 was found (e.g., to indicate if side rails were in use, the bed was in a low position, the call light was within reach). Documentation did not indicate what the resident was attempting to do at the time of the fall (e.g., get to the bathroom, obtain food or assistance) to determine the causes or contributing factors to the fall. No changes were made to the resident's care plan based on the post-fall assessment. The event investigation form and the post fall assessment related to the resident's fall on 10/22/18 did not indicate if side rails were in use at the time of the fall or what the resident was attempting to do. No changes were made to the resident's care plan and the universal fall precautions remained unchanged since the previous fall on 10/21/18. The event investigation form and post-fall assessment regarding the resident's fall on 11/01/18 did not indicate if side rails were in use at the time of the fall or what Resident #303 was attempting to do. There were no changes to the resident's plan of care or fall precautions other than to change the 30-minute surveillance rounds to one hour. It was not evident the CLC determined causal and contributing factors to the resident's falls to develop approaches to address the falls.

Accident Prevention Related to Side Rail Use

The CLC policy dated October 4, 2013, and titled, "Side Rail Entrapment Risk Assessment" was provided by the QM on 11/28/18 at 9:45 a.m. According to the policy, the purpose of the risk assessment was "to assess, identify and document resident's potential risk for side rail entrapment. Provide ongoing identification and intervention to prevent entrapment. Identify individual resident's rationale for use of side rails."

*Resident #301, [LOCATION]*

- Resident #301 was admitted to the [LOCATION] neighborhood with diagnoses including altered mental status and corticobasal degeneration. The history and physical dated 02/05/18 stated, "Mostly bedbound, no longer feeds self, dependent for all ADLs [activities of daily living]." The quarterly MDS dated 11/11/18 indicated the resident's cognition was severely impaired based on staff assessment, and the resident was sometimes understood and sometimes understood others. According to the MDS, the resident required extensive assistance with ADLs including bed mobility and transfers, had functional limitations in range of motion of the bilateral lower extremities with no limitations of the upper extremities, and did not use side rails.
- The resident's care plan dated 11/21/18 addressed falls with approaches that read, "Keep bed in lowest position when care is not being delivered, raise top bed [side] rail to use for balance." The side rail assessment in the plan of care stated, "Rationale: comfort, bed control access, repositioning. Risk for side rail entrapment assessed:

Resident has shown he can safely move in bed without entrapment. Resident does not attempt to climb under or over sides [side rails]. Resident able to voice side rail safety. Education: Risks and benefit of side rails explained to include risk of entrapment or distress. Recommended number [of side rails]: 2." The care plan did not indicate which 2 side rails were to be raised.

- The monthly nursing summaries dated 10/26/18 and 11/26/18 indicated the resident had a Morse Fall Scale score of 30 suggesting a moderate risk for falls; the summaries stated staff were to, "Raise top bed rail to use for balance….Rationale: comfort, bed control access, repositioning. Risk for side rail entrapment assessed: Resident has shown he can safely move in bed without entrapment. Resident does not attempt to climb under or over sides [side rails]. Resident able to voice side rail safety. Education: Risks and benefits of side rails explained to include risk of entrapment or distress. Recommended number: 2." The summaries did not indicate which 2 side rails were to be raised.
- A restorative consult dated 11/07/18 stated, "Bed mobility and positioning: Both upper extremities were only functional for gross holding or grasping with redirection due to absence of purposeful voluntary movement related to corticobasal degeneration. Lower extremities were zero functional due to absence of purposeful voluntary movement related to corticobasal degeneration."
- A current provider's order dated 11/16/18 stated, "Lorazepam tab [tablet] 0.5 mg [milligrams] PO [orally] BID [twice daily] for suppression of involuntary movements related to CBD [corticobasal degeneration]."
- During the initial tour on 11/27/18 at 9:10 a.m., Resident #301 was observed lying in bed with the upper two rails nearest the head of the bed and the lower right side rail nearest the foot of the bed in the raised position. The resident was not observed moving while in bed.
- On 11/28/18 at 7:55 a.m., the resident was observed in bed with the upper two rails and lower right side rail in the raised position; the resident was not observed moving while in bed. The charge RN stated, "I will have to check the care plan, but he usually has the three rails up at night and then top two [side rails] up during the day because he slides down in his bed."
- In summary, Resident #301 was observed in bed on 11/27/18 and 11/28/18. During the observations, the upper two side rails nearest the head of the bed and the lower right side rail nearest the foot of the bed were in the raised position. An assessment for side rail use documented in the resident's plan of care and monthly nursing summaries (as above) indicated two side rails and not three were to be raised when the resident was in bed; documentation did not indicate which two rails were to be raised.

Accident Prevention Related to Smoking

- During the initial tour of the CLC on 11/27/18 at 9:00 a.m., the NM indicated there were several residents living in the CLC who smoked. The designated smoking area was in an enclosed smoke shack across a road from the CLC entrance.
- On 11/27/18 at 12:15 p.m., the QM and surveyor observed the smoking area. The "smoke shack" had a fire extinguisher and two sections including one for residents and the other for employees. Both sections were observed with discarded cigarette butts on the cement floor along with Styrofoam containers, paper cups, and paper wrappers. The receptacle for cigarette disposal in the area used by residents was a large open cement pot that was filled approximately one-inch deep with cigarette butts and other trash. The outside of the smoke shack was observed with cigarette butts but no paper or plastic trash. The QM was not sure who was responsible for cleaning the designated smoking area.
- On 11/27/18 at 12:30 p.m., an environmental management services (EMS) staff member indicated that EMS staff were assigned to monitor the area but the EMS staff person was not certain when the area was last cleaned.
- On 11/27/18 at 1:10 p.m., the QM stated, "Housekeeping staff were sent to clean up the smoke shack."

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F428

483.60(c) *Drug Regimen Review. (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (2) The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon*

Based on interview and record review, the CLC did not ensure the drug regimen of each resident was reviewed at least once a month by a licensed pharmacist. Findings include:

On 11/29/18 at 9:00 a.m., a quality management staff member provided a copy of the VA Northern California Health Care System Policy Statement 11-16 dated January 14, 2016 and titled, "Assessment/Reassessment of Patients." Attachment B of the policy stated, "Pharmacist: Assessment and chart review to identify drug related problems and medication monitoring. At least [monitoring at least] monthly, annually and at a frequency appropriate to resident's condition and at discharge."

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

**Residents Affected** - Some

Resident #204, [LOCATION]

- Resident #204 was admitted to the CLC on [DATE] with multiple medical conditions including Parkinson's disease, dementia and functional quadriplegia. The resident had a history of falls prior to admission.
- The resident's comprehensive MDS dated 09/26/18 indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment; the resident could sometimes understand and was sometimes understood by others. According to the MDS the resident required total and extensive assistance for activities of daily living. The MDS indicated the resident had vocal complaints of pain, facial expressions of pain and protective body movement or postures suggesting pain; the resident was not on a scheduled pain medication regimen.
- The resident's medications included but were not limited to acetaminophen 650 milligrams (mg), every 6 hours, as needed for pain or fever and doxazosin 1 mg daily for blood pressure.
- A pharmacy drug regimen review was not completed for the month of October 2018.

Resident #202, [LOCATION]

- Resident #202 was admitted to the CLC with multiple diagnoses including Parkinson's disease, nerve pain, BPH (benign prostatic hyperplasia) and high blood pressure.
- The resident's MDS dated 05/02/18 indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment. The MDS indicated the resident required extensive assistance with all activities of daily living. The resident had a recent history of falls including falls on 09/25/18, 11/16/18, 11/21/18 and 11/23/18.
- The resident's current medications included but were not limited to carbidopa/levodopa, acetaminophen, aspirin, duloxetine, finasteride and lisinopril.
- A pharmacy drug regimen review was completed in August 2018 and October 2018 but had not been conducted in September 2018 to ensure medications were appropriate and met the needs of the resident during that month.

Resident #303, [LOCATION]

- Resident #303 was a resident in the CLC for a long-term stay with current diagnoses including dementia, posttraumatic stress disorder (PTSD), and traumatic brain injury (TBI). The drug regimen reviews provided were dated 04/10/18, 05/03/18, and 09/25/18. The QM stated on 11/29/18 at 8:15 a.m. that monthly drug regimen reviews were not completed for Resident #303 for the months of August 2018 or October 2018.

Systems-level Review

- On 11/27/18 at approximately 10:00 a.m., drug regimen reviews were requested from the quality management team for the past three months as applicable based on each resident's admission date.
- During an interview with the CLC pharmacists on 11/29/18 at 9:30 a.m., it was indicated that one pharmacist left employment in April 2018 and another in May of 2018. A pharmacist hired in July 2018, left in September 2018. Pharmacists assigned to each neighborhood were responsible for dispensing medications, providing discharge instructions, and interactions with medical providers. The CLC reached out to other pharmacists with a goal of "catching up" on drug regimen review notes. It was reported that a formerly employed pharmacist would be working weekends to catch up on monthly drug regimen reviews. In addition, a pilot program was initiated to streamline the process and complete monthly summary notes.

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F441

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

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:

On 11/28/18 at 9:20 a.m. the chief nurse executive provided a copy of the VA Northern California Health Care System policy dated 08/02/17 and titled, "Hand Hygiene." The policy stated, "All staff must adhere to hand hygiene by using an alcohol-based hand rub or antimicrobial soap and water in the following situations....g) before donning gloves and after removing gloves regardless whether sterile or non-sterile gloves….j) if moving from a contaminated body site to another body site during care of the same patient." The policy further indicated, "gloving requirements....d) gloves must be removed or changed when visibly soiled or performing patient care on a contaminated site, before moving to another body site on the same patient, device, or environment."

**Residents Affected** - Few

On 11/28/18 at 10:02 a.m. the quality manager provided policy statement 111-19 dated 08/24/15 and titled, “Standard Precautions and Transmission-Based Precautions.” The policy indicated, “Wear a gown and gloves when entering a patient’s room who is on Contact Precautions.” The policy further indicated, “Enhanced Barrier Precautions (EBP)…PPE [personal protective equipment] is required to be worn by staff in the resident’s bedroom to prevent contamination of their skin and clothing during resident care activities when contact with the resident or any potentially contaminated device or environmental surface is anticipated.”

Resident #104, [LOCATION]

- Resident #104 was admitted to the CLC on [DATE] with diagnoses that included a right femoral bypass graft wound.
- A provider’s order dated 10/09/18 indicated, “Contact isolation for VRE [vancomycin-resistant enterococci] to right inguinal wound and JP [Jackson-Pratt] drain on 10/02/18.”
- On 11/28/18 at 11:15 a.m., a wound care RN was observed providing wound care for Resident #104. A sign indicating Contact Precautions was posted outside the resident’s room. Prior to entering the resident’s room, the wound RN sanitized her hands, and donned a gown and gloves. The resident had two surgical wounds, each covered with a protective dressing. One wound was located in the right groin area and the other wound was located on the right medial calf. The wound RN removed the right groin dressing that visibly contained a tan drainage and revealed the surgical wound. Without doffing gloves, conducting hand hygiene, and donning a new pair of gloves, the RN removed the right medial calf dressing. After the RN removed the dressings, the RN doffed gloves, conducted hand hygiene, and applied new gloves to continue providing wound care. No further concerns were identified during the observation. Immediately following the observation, the RN was interviewed and acknowledged that she should have doffed gloves, sanitized her hands, and applied new gloves after removing the right inguinal dressing and prior to removal of the right calf dressing.
- On 11/28/18 at approximately 4:00 p.m. during the daily meeting, the CLC chief nurse acknowledged the RN should have doffed gloves, sanitized hands, and applied new gloves after removing the right inguinal dressing and prior to removal of the right calf dressing.

Resident #106, [LOCATION]

- On 11/28/18 at 8:55 a.m., an RN was observed during medication administration for Resident #106. Enhanced Barrier Precautions were to be implemented for the resident as indicated by a yellow octagonal-shaped sign posted near the entrance to the resident’s room that read, “Enhanced Barrier Precautions;” it was indicated the precautions were to be implemented for methicillin-resistant *Staphylococcus aureus* (MRSA) colonization of the nares. The sign indicated that staff were to conduct hand hygiene, and don gloves and a gown before entering the room when direct contact with the resident or resident’s environment was anticipated.
- The resident was scheduled to receive medication administered intravenously (IV) through a double-lumen central venous access device located in the resident’s left chest. Prior to entering the resident’s room, the RN sanitized hands and donned gloves and a gown. Just prior to administering the intravenous medication, the RN removed the previously administered empty IV medication bag from the connecting tubing. When the IV bag was removed, the RN rolled the bag, lifted the RN's gown and placed the IV bag in the left front pocket of the RN’s scrub pants. The RN did not doff gloves, conduct hand hygiene, and don new gloves after touching the RN’s uniform and prior to flushing the IV access device and connecting the new IV antibiotic bag. After connecting the new IV antibiotic medication to existing tubing and adjusting the medication pump settings, the RN lifted the left side of the RN's gown and reached inside the RN’s uniform pocket to obtain a 10 milliliter normal saline syringe and alcohol wipes. The RN did not doff gloves, conduct hand hygiene, and don new gloves after touching the RN’s uniform and prior to retrieving the normal saline syringe and alcohol wipes. Immediately following the observation, the RN stated, “I should have left the [used, empty] IV bag on the table.” The RN acknowledged that the syringe containing normal saline and alcohol wipe supplies could have been brought into the room rather than keeping those items in the pockets of the RN’s clothing.