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: Augusta VA Medical Center (Augusta, GA)

Dates of Survey: 7/31/2018 to 8/2/2018

Total Available Beds: 96

Census on First Day of Survey: 93

F-Tag	Findings
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 ensure services provided met professional standards of quality. Findings include: Resident #201, [LOCATION] • Resident #201 was admitted to the CLC on [DATE] with diagnoses including non-Alzheimer's dementia and congestive heart failure. The resident's quarterly Minimum Data Set (MDS) dated 07/10/18 was coded to indicate the resident was usually understood and usually understood others; the resident had moderately impaired cognitive skills for daily decision making based on staff assessment. According to the MDS, the resident was dependent on staff for dressing. • Current provider orders included an order dated 07/18/18 that stated, "Apply ted [thrombo-embolic deterrent] hose in the a.m. [morning] and remove q hs [every night]." • The resident's most recent care plan dated 07/10/18 did not address use of TED hose. • During an interview on 07/31/18 at 3:15 p.m. while the resident was lying in bed in his room, Resident #201 was observed wearing gripper socks on both feet; the resident was not wearing TED hose. • During an observation on 08/01/18 at 9:00 a.m., the resident was lying in bed in his room; the resident was not wearing TED hose. • The nurse manager (NM) and assistant nurse manager (ANM) were interviewed on 08/01/18 at 9:25 a.m. While checking the computerized patient record system (CPRS), the ANM verified the TED stockings were ordered on 07/20/18. The ANM stated the resident should wear the TED stockings during the day including when the resident was in bed. On 08/01/18 at 9:50 a.m., the charge nurse indicated that when the provider's order was entered on 07/20/18, "STD [supply] did not have any [TED hose] in his [the resident's] size and so they [the TED hose] are on backorder." • On 08/02/18 at approximately 11:30 a.m., the NM stated, "Yesterday I found some thigh highs in supply and put them on him [the resident]." When asked if the stockings were to be thigh or knee high, the ANM said "The order didn't specify."
F309 483.25 *Quality of Care. Each resident 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).*	Based on observation, interview and record review, the CLC did not ensure each resident received the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Findings include: Pain Management *Resident #303, [LOCATION]* • Resident #303 was admitted to the CLC on [DATE] and readmitted on [DATE]. Admission diagnoses included peripheral vascular disease, Alzheimer's disease, metabolic encephalopathy, and "extremity contractures due to cerebrovascular accidents [CVAs] and falls." On 07/26/18 Resident #303 began receiving hospice care.

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

The resident's admission Minimum Data Set (MDS) dated [DATE] was coded to indicate the resident had a Brief Interview for Mental Status (BIMS) score of 4 suggesting severely impaired cognition, required extensive to total assistance of two or more for most activities of daily living, and did not transfer or walk; the resident had functional limitations in range of motion of the bilateral upper and lower extremities. The MDS indicated the resident did not receive scheduled pain medication, received as needed (PRN) pain medication and nonpharmacologic approaches for pain, had occasional pain that did not limit the resident's sleep or activities, and was unable to provide a verbal description of the pain; the MDS indicated staff provided non-pharmacologic approaches for pain.

- Following the initial tour on 07/29/18 at approximately 10:35 a.m. and review of the CMS 802-form, the assistant nurse manager (ANM) indicated Resident #303 had diagnoses including metabolic encephalopathy and recently began receiving hospice care. According to the ANM, Resident #303 required total assistance with all care, had a poor appetite, was admitted with contractures, was recently changed to Phase 3 restorative therapy (to be provided by neighborhood staff and not restorative staff) due a decline in status, was not receiving any scheduled pain medication, did not complain of pain, and was able to move independently "all over" in bed.
- Resident #303's care plan dated 07/06/18 included a statement that read, "I have occasional pain and would like to be kept comfortable." Approaches included the following:
    - Staff will observe for non-verbal indications of pain and/or discomfort such as facial grimacing, withdrawal, or vocalizing. 07/06/18
    - 325 mg (milligrams) acetaminophen available PRN every 6 hours. If medication is not effective, will notify provider of needed interventions. Diclofenac gel also administered 4 times daily for left knee pain. 07/06/18
    - Staff will use the PAINAD (Pain Assessment in Advanced Dementia) Scale to assess presence and severity and provide treatment as indicated. 07/06/18
    - Non-pharmacologic interventions will be used to promote comfort including aromatherapy, soft music, pillows, one-to-one at bedside. 07/06/18
    - Reposition for comfort regularly throughout the day to relieve pressure from boney prominences. 07/06/18
- Provider orders included the following:
    - 06/20/18 - Acetaminophen 325 mg every 6 hours PRN pain, discomfort or elevated temperature. (Changed to 650 mg on readmission on [DATE].)
    - 07/17/18 - Diclofenac gel, topical 4 grams to left knee 4 times daily.
    - 07/27/18 - Acetaminophen 650 mg every 6 hours for pain as needed for mild pain or fever. (Originally ordered on readmission on [DATE])
    - 07/27/18 Methocarbamol 250 mg po (oral) BID (twice daily) for "mm [muscle]" contractures and spasms related to contracted joints, for comfort care on hospice. (Originally ordered on readmission on [DATE]).
    - 07/27/18 - Acetaminophen 650 mg per rectum every 6 hours as needed for pain or fever.
- The extended care medical admission note dated [DATE] stated, "He [Resident #303] appears comfortable though indicating pain in left knee. Left lower extremity in chronic contracture with pain when moved passively. Knee pain: Tylenol 325 mg every 6 hours prn. ASA [acetylsalicylic acid] 81 mg EC [enteric coated] daily." An addendum dated 06/20/18 stated, "Pain, Chronic due to OA [osteoarthritis] at left knee and CVA associated left lower extremity contracture and other chronic pain, stable, though fluctuates. On Tylenol prn. Monitor and adjust as indicated."
- The extended care nursing admission assessment note dated [DATE] stated, "Pain Assessment: Pain level 4 [on a scale of 0 to 10 with 10 being the worst pain possible]. Current pain level is 1-10. No: the patient cannot tolerate pain at the current level. Location of pain: other: left knee. Frequency of pain: other: stimulated by the bumpy ride. What causes or increases the pain: repositioning. Relief measures: medication, rest....2. Systems review: Decreased range of motion. LLE [left lower extremity] slight contracture and difficult to extend."
- The restorative nurse evaluation note dated 07/03/18 stated, "Deficits: He is alert to person and place at times. His left leg appears to be contracted at 90 degrees but he will not allow me to extend any further due to pain."
- The extended care medical admission note dated [DATE] stated, "He [Resident #303] is able to report pain to his contracted joints when moved and in need of tilts and turns. For that, he reports painful knees, lower legs, ankles and sometimes hips that are intermittent and temporarily discomforting." The note stated, "Active inpatient medications: Tylenol 650 mg every 6 hours prn. Diclofenac gel top [topical] 4 grams to left knee topical qid [four times daily] for pain r/t [related to] contractures and DJD [degenerative joint disease] X [for] 30 days then re-eval[uate] effect. May apply to right knee as well." Pain Management, "Contractures, spasms, joint and muscle stiffness. Restorative care continues for pain reduction, circulation and comfort. Methocarbamol for spasms and pain BID [twice daily] to start as veteran [Resident #303] is

maneuvered in bed and repositioned as this can be painful. If this helps may need TID-QID [3 to 4 times daily] scheduled or increased dosing. APAP [acetaminophen] every 6 hours prn. Diclofenac top gel for pain r/t MM [muscle] or joints, usually knees bilateral lower extremities, lower back, sacrum.

- Pain management notes between 06/20/18 and 07/30/18 and the "Inpatient Medication History" related to administration of acetaminophen (as ordered) were provided by the administrative officer on 08/02/18 at 9:10 a.m.; the notes included (but were not limited to) the following:
    - 06/25/18 at 3:55 p.m. acetaminophen was administered. At 3:57 p.m., the pain management note stated the resident was rubbing his left leg. The resident rated the pain at 5. The pain duration was documented as being intermittent.
    - 06/27/18 at 6:34 p.m. acetaminophen was administered. At 8:23 p.m., the pain management note indicated the resident was rubbing his left leg. The resident rated the pain at 3, and described the pain as aching and the duration as constant.
    - 06/29/18 at 6:25 p.m., acetaminophen was administered. At 8:28 p.m., the pain management note indicated the resident's left leg was aching. The resident rated the pain at 4, and described the pain as aching and the duration as constant. According to the resident, the pain was exacerbated by movement.
    - 06/30/18 at 5:19 p.m., acetaminophen was administered. At 6:28 p.m., the pain management note stated the resident's left leg was aching. The resident rated the pain at 5, and described the pain as aching and the duration was constant.
    - 07/04/18 at 7:21 a.m., the pain management note indicated both of the resident's arms and legs had sharp and aching pain. The resident rated the pain at 2 and described the duration as constant.
    - 07/04/18 at 6:20 p.m., acetaminophen was administered. At 6:54 p.m., the pain management note stated both of the resident's arms and legs had sharp aching pain. The resident rated the pain at 5 and described the duration as constant.
    - 07/05/18 at 4:58 p.m., acetaminophen was administered. At 6:30 p.m., the pain management note indicated both of the resident's arms and legs had "crushing, aching pain." The resident rated the pain at 5 and described the duration as intermittent. The exacerbating factor was described as "restorative care: pain secondary to condition and prior to doing restorative."
    - There were no pain management notes between 07/05/18 and 07/21/18.
    - On 07/21/18 at 7:19 p.m., acetaminophen 325 mg was administered for a pain score of 6. At 8:45 p.m., the pain management note stated the resident's lower extremities had aching pain. The resident rated the pain at 5 and described the duration as constant. The exacerbating factor was "movement."
    - On 07/23/18 at 8:47 a.m., acetaminophen 650 mg was administered for a pain score of 6; there was no pain management note documented.
    - On 07/24/18 at 7:09 a.m., the note stated the resident's knees, left greater than the right, had "dull aching pain." The resident rated the pain at 5 and described the duration as constant. On 07/24/18 at 12:56 a.m. acetaminophen 650 mg was administered for pain score of "99 [unable to determine]" and at 7:09 a.m. for a pain score of 5.
    - On 07/26/18 at 7:22 a.m., acetaminophen 650 mg was administered for a pain score of 7. At 8:39 a.m. the pain management note indicated the resident had "sharp, stabbing pain in his head."
    - On 07/29/18 at 9:09 p.m. acetaminophen 650 mg was administered for a pain score of "99."
    - On 07/30/18 at 2:34 p.m. acetaminophen 650 mg was administered for a pain score of "99." At 4:33 p.m., the pain management note stated the resident "verbalized [he was having] pain" in his head. The resident was unable to describe the pain.
- According to the medication administration history, the resident received the diclofenac gel four times a day as ordered.
- On 07/31/18 at 1:02 p.m., Resident #303 was observed being transported from the dining room to his room by two nursing assistants (NA). As NA #1 removed Resident #303's sweatshirt, the resident stated his left knee hurt. NA #2 stated as soon as the resident was in bed NA #2 would tell the nurse the resident was having pain. While connecting the resident to the ceiling lift, NA #2 told the resident multiple times to relax as the resident said, "Ow, Ow, Ow. My knee." As the resident was being lifted by the ceiling lift, the resident stated, "Oh. Oh. Be careful of my knee. It hurts." After the resident was placed in bed, as the transfer sling was removed from under the resident, Resident #303 repeated, "Be careful of my knee. It hurts. Ow. Ow." NA #2 stated as soon as they were finished she would tell the nurse about his pain. NA #2 removed the adult brief from the resident and the resident stated, "My knee it hurts. Ow. Ow. Ow." During perineal care, the resident stated, "Be careful, my knee hurts." While a clean adult brief was being placed and NA #1 touched the resident's left leg, the resident stated, "Ow. Ow. Ow. It hurts." The resident again stated his "left knee hurt; please be

careful" while a pillow was placed between the resident's knees. NA #1 stated she would tell the nurse to give the resident something for pain when they finished the resident's care.

- Following the observation, NA #1 stated she had not heard the resident complain of pain in the past. NA #1 was observed speaking with the nurse administering medications following the observation. Review of the resident's inpatient medication history record indicated the resident did not receive PRN pain medication on 07/31/18.
- On 07/31/18 at 4:15 p.m. during an interview related to Resident #303's pain, a different NA than the NAs observed on 07/30/18 at 1:02 p.m. stated the resident would complain of pain in his lower extremities especially his left knee when he was moved; however, when the resident was in bed and not moving or sitting in a Geri-chair, the resident did not complain of pain.
- On 08/01/18 at 9:00 a.m., during an interview related to Resident #303's pain, an RN stated the resident would voice pain at times related to his legs. The RN indicated the resident did not receive a scheduled pain medication (other than diclofenac gel and methocarbamol) but had an order for Tylenol (acetaminophen) 650 mg PRN. The RN stated that during medication pass, the resident was asked if he had pain and he usually reported he did not have any pain.
- On 08/01/18 at 4:38 p.m. during an interview with the nurse manager (NM), assistant nurse manager (ANM), chief nurse and CLC medical director, the medical director stated Resident #303 began receiving hospice care (07/26/18) due to his declining condition and advanced dementia, indicating Resident #303 was very confused and did not always make his needs known. The CLC medical director stated nursing staff needed to determine a baseline pain level and offer PRN Tylenol when needed. The CLC medical director stated Resident #303 was receiving comfort care now and he (the medical director) would assess the resident for use of alternative pain medications including a scheduled pain medication. During the interview, the ANM stated Resident #303's medications were crushed due to the resident's inability to swallow the medication whole, and the resident frequently refused to take medication. The ANM stated Resident #303 received diclofenac to the knees four times daily. The ANM stated staff dealt with Resident #303's left knee pain with repositioning with pillows in the past; however, the resident would remove the pillows and move around in bed. No other non-pharmacologic approaches for pain were identified by the ANM.
- On 08/01/18 at 4:42 p.m., the charge RN stated that at times Resident #303 did not want the diclofenac cream applied to the knees and although the resident would express concerns that the cream was too cold, the nurses would apply the gel. The charge RN stated Resident #303 did not complain of pain except when being repositioned.
- In summary, on 07/31/18 at 1:02 p.m., Resident #303 expressed knee pain throughout observations of care including while connecting the resident to the ceiling lift, when being lifted by the ceiling lift, and as the transfer sling was removed from under the resident; NA #2 stated as soon as they were finished she would tell the nurse about the resident's pain. The resident again complained of pain when the resident's adult brief was removed, when a clean adult brief was placed and NA #1 touched the resident's left leg, and while a pillow was placed between the resident's knees. NA #1 stated she would tell the nurse to give the resident something for pain when the resident's care was completed. The NAs did not discontinue the care when the resident expressed pain and attempt pharmacologic or nonpharmacologic approaches; PRN pain medication was not provided for the resident on 07/31/18. The resident received diclofenac gel to the knees QID as ordered. Pain management notes between 06/20/18 and 07/30/18 indicated the resident received acetaminophen on 8 occasions; on 4 of the 8 occasions, the resident indicated the pain was constant and aching. According to the notes and based on staff interview, the resident's pain was exacerbated by movement. It was not evident the CLC determined the causal and contributing factors to the resident's pain (e.g., repositioning, movement) and developed approaches to address the factors (e.g., administration of pain medication prior to care, scheduled oral pain medication, additional nonpharmacologic approaches).

Positioning

Resident #103, [LOCATION]

- Resident #103 was admitted to the CLC on [DATE] with diagnoses that included dementia, stroke, left-sided weakness, left hand contractures, Parkinson's disease, and congestive heart failure.
- The annual comprehensive MDS dated 11/28/17 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 suggesting the resident was cognitively intact; the resident required extensive assistance from one staff person for bed mobility and transfers; had functional limitations in range of motion in the upper and lower extremities on one side (left); and used a wheelchair. According to the 11/28/17 MDS, the resident was at risk for pressure ulcer development and had no pressure ulcers.

The most recent quarterly MDS dated 05/15/18 was coded similarly; however, the quarterly MDS indicated the resident was not at risk for pressure ulcers. Skin and ulcer treatments coded on the quarterly MDS included pressure reducing devices for the bed and chair.

- The care plan included an approach dated 05/10/18 that read, “When providing daily care monitor my skin for redness and bruising. Record the condition of my skin weekly and note signs of redness or skin breakdown.” There were no other approaches on the care plan that addressed positioning of the resident’s left leg, pressure ulcer prevention or management of lower extremity edema.
- There were no provider orders regarding positioning or elevation of the lower extremities.
- A physical therapy note dated 01/29/18 indicated it was a “bedside” evaluation. The noted stated, “Appears too large for his [wheel]chair. Please evaluate. Pt [patient] states his wheelchair is broken and needs replacement. States he can propel wheelchair around CLC ward [neighborhood] using right UE/LE [upper extremity and lower extremity].” The note did not reference positioning of the resident’s left leg or foot.
- An extended care nursing monthly summary note dated 07/01/18 documented, “Requires assistance with completing his ADL’s [activities of daily living] due to left side weakness.”
- The RN skin reassessment notes for 01/28/18 through 07/26/18 included the following:
    - 01/28/18, “Skin turgor: abnormal left foot, edematous,” the note indicated the resident had no wounds, pressure ulcers, or other skin problems.
    - 04/06/18, “Skin turgor: abnormal LLE [left lower extremity] edema;” the note indicated the resident had no wounds, pressure ulcers, or other skin problems.
    - 06/01/18, “Skin turgor: abnormal left foot, edematous;” the note indicated the resident had no wounds, pressure ulcers, or other skin problems.
    - 07/26/18, “Skin turgor: abnormal left foot, edematous. No wounds, pressure ulcers, or other skin problems.”
- On 07/31/18 at approximately 1:00 p.m., Resident #103 was observed seated in the dining room; the resident appeared to be asleep. The resident was wearing a yellow anti-skid sock on his left foot with the medial aspect of the left ankle resting against the edge of the wheelchair footrest; the bottom of the resident’s foot was not resting on the footrest but rather the left foot was in between the lowered footrests. The left leg was flexed at the knee approximately 60 degrees in a dependent position and there was no elevated leg rest in place to support the lower extremity or provide elevation. The resident’s leg and foot were covered and could not be observed for edema.
- On 07/31/18 at approximately 3:43 p.m., the resident was observed in the same position in the wheelchair in the dining room; the resident had been viewing a movie with the recreational therapist. During the observation, the resident was wearing a yellow anti-skid sock on the left foot and the lateral aspect of the left ankle was resting against the edge of the wheelchair footrest. In addition, the left leg was flexed at the knee approximately 60 degrees in a dependent position and had no elevated leg rest in place to support the lower extremity or provide elevation. The resident’s leg and foot were covered and could not be observed for edema.
- On 07/31/18 at approximately 4:30 p.m., the resident was observed seated in the wheelchair and appeared to be sleeping. The resident’s left heel rested on top of the upper edge of the wheelchair foot rest. The left leg was flexed at the knee approximately 60 degrees and in a dependent position; there was no elevated leg rest in place to support the lower extremity or provide elevation. The resident’s leg and foot were covered and could not be observed for edema.
- On 08/01/18 at 7:25 a.m., Resident #103 was observed seated at a table in the dining room. The resident was wearing a yellow anti-skid sock on the left foot and the left lateral ankle rested against the wheelchair footrest. The resident’s left leg was flexed at the knee approximately 60 degrees and in a dependent position; there was leg rest in place to support the lower extremity or provide elevation. At one point the resident elevated his left heel and rested the left heel on the top edge of the footrest. The resident’s leg and foot were covered and could not be observed for edema.
- On 08/01/18 at approximately 9:20 a.m., Resident #103 was observed seated in the wheelchair in the hallway near the nursing station. The resident’s left lateral ankle was positioned adjacent to the edge of the left footrest and near the wheelchair’s right footrest; the resident’s foot was in-between but not touching either footrest. The left leg was flexed at the knee approximately 60 degrees and in a dependent position; there was no elevated leg rest in place to support the lower extremity or provide elevation. The resident’s leg and foot were covered and could not be observed for edema.
- On 08/01/18 at 3:50 p.m., Resident #103 was observed seated in the wheelchair in the hallway. The resident was wearing a yellow non-skid sock on the left foot and the resident’s left leg was flexed at the knee approximately 60 degree with the resident’s heel but not the sole of the foot resting directly on the floor. The resident was interviewed and indicated that he had been on an outing after lunch and did not intend to lay down (to elevate his leg). The resident stated he suffered a stroke and could not

wear shoes on the left foot; the resident indicated that wearing shoes “hurts my foot.” During the observations and interview, staff was standing in the area and did not offer the resident a device to elevate or support the resident’s left foot. The resident’s leg and foot were covered and could not be observed for edema.

- On 08/01/18 at 4:28 p.m., the charge nurse was observed administering medication for Resident #103. During the observation, the wheelchair left leg support was elevated approximately 60 to 90 degrees; however, the leg extension did not have a padded calf pad in place to support the lower extremity. The resident’s left lateral foot was resting against the wheelchair footrest. The resident’s leg and foot were covered and could not be observed for edema.
- On 08/01/18 at 4:45 p.m., the nurse manager and clinical nurse educator were interviewed. The nurse manager explained that physical therapy issued the wheelchair to the resident after nursing asked for support for the resident’s left foot and left leg. The nurse manager indicated that the wheelchair did not meet the resident’s needs for leg support and stated, “The chair doesn’t support his [left] leg.”
- On 08/02/18 at 8:04 a.m., Resident #103 was observed seated in the dining room; the resident appeared to be asleep. The resident wore a yellow anti-skid sock on the left foot and the left heel rested directly on the edge of the wheelchair footrest. The resident’s leg and foot were covered and could not be observed for edema.
- On 08/02/18 at 8:45 a.m. during an interview with the charge nurse and clinical nurse educator, the charge nurse indicated she had no knowledge of Resident #103 developing pressure ulcers while at the CLC. Following the interview, Resident #103 was observed seated in the wheelchair in his room; the clinical nurse educator and charge nurse were present during the observation. The clinical nurse educator removed the sock from Resident #103’s left foot. The sock left an indentation just above the ankle and the clinical nurse educator stated, “It is 2 plus [pitting] edema.” The left foot appeared to be extended at the ankle and the second toe, distal aspect, was observed to have a black, adherent eschar that was approximately 0.5 cm [centimeters] to 1.0 cm. When the clinical nurse educator and charge nurse were asked to describe the wound, the clinical nurse educator stated, “It’s unstageable…not sure what’s under there.” The clinical nurse educator indicated the toe wound was a pressure ulcer. The resident was asked what may have caused the wound and the resident stated, “I don’t know.” The resident was asked if he was able to rest his left foot on or against the wheelchair footrest, and the resident stated, “Not really…I can’t [fully] bend my knee.” When the clinical nurse educator elevated the left wheelchair leg rest and placed the resident’s left leg on the leg rest so that the resident’s calf rested on the support, the resident stated his leg would “slide off…it won’t stay there.” The resident’s left foot did not rest against the footrest when the charge nurse and clinical nurse educator attempted to reposition the left foot to provide support. At approximately 9:00 a.m., the nurse manager was interviewed and asked if she was aware of the second toe “unstageable” wound. The nurse manager stated, “I knew about it;” the nurse manager could not locate documentation regarding the onset and/or etiology of the wound.
- On 08/02/18 at 9:01 a.m., the physical therapist (PT) who evaluated the resident on 01/29/18 and provided the resident’s wheelchair (as observed above) was interviewed. When asked when she last evaluated Resident #103 for wheelchair positioning, the PT stated, “Not since the consult for the wheelchair [01/29/18].” It was indicated the wheelchair was provided in March or April 2018. The PT indicated that she attempted to use a box-like lower leg support but the device could not be adjusted to fit the current wheelchair. When asked if other wheelchairs had been considered, the PT stated there had been no other attempts to identify a wheelchair that would provide left lower leg support while allowing the resident to propel with his right foot if he desired.
- On 08/02/18 at approximately 12:05 p.m. during the meeting with leadership staff, the surveyor provided information regarding the “unstageable” pressure ulcer on the resident’s left toe. The nurse manager reported that the wound nurse was called to assess Resident #103’s left foot and determined that the left foot, second toe, distal wound was determined to be related to “trauma” and “not a pressure ulcer.”
- In summary, Resident #103 was observed on 07/31/18 at 1:00 p.m., 3:43 p.m. and 4:40 p.m.; on 08/01/18 at 7:25 a.m., 9:20 a.m., 3:50 p.m., 4:28 p.m. and 4:45 p.m., and on 08/02/18 at 8:04 a.m. seated in a wheelchair with his left foot resting adjacent to or on the edge of the wheelchair footrest. The resident’s left leg was flexed at the knee approximately 60 degrees and in a dependent position; there was no elevated leg rest in place to support the lower extremity or provide elevation. RN skin assessments dated 01/28/18, 04/06/18. 06/01/18 and 07/26/18 documented, “Skin turgor: Abnormal LLE [left lower extremity] edematous.” On 08/02/18 at 8:45 a.m., the resident was asked if he was able to rest his left foot on or against the wheelchair footrest, and the resident stated, “Not really…I can’t [fully] bend my knee.” When the clinical nurse educator elevated the left wheelchair leg rest and placed the resident’s left leg on the leg rest so that the resident’s calf rested on the support, the resident stated his leg would “slide off…it won’t stay there.” The clinical nurse educator removed the sock

from Resident #103's left foot. The sock left an indentation just above the ankle and the clinical nurse educator stated, "It is 2 plus [pitting] edema." The left foot second toe, distal aspect, was observed to have a black, adherent eschar that was approximately 0.5 cm [centimeters] to 1.0 cm. When the clinical nurse educator and charge nurse were asked to describe the wound, the clinical nurse educator stated, "It's unstageable…not sure what's under there." The clinical nurse educator indicated the toe wound was a pressure ulcer. On 08/02/18 at approximately 12:05 p.m., the nurse manager stated the wound nurse was called to assess Resident #103's left foot and determined that the left foot, second toe, distal wound was determined to be related to "trauma" and "not a pressure ulcer." The CLC did not provide appropriate seating and positioning for the resident to support the resident's left leg and foot and manage the resident's left lower extremity edema. The resident was observed to have a black, adherent eschar on the left foot second toe that was first identified as a pressure ulcer and later determined to be the result of "trauma." It was not evident the CLC conducted a comprehensive assessment to determine the cause of the trauma (e.g., trauma resulting from the resident's toe striking the wheelchair footrests).

Resident #202, [LOCATION]

- Resident #202 was admitted to the CLC on [DATE]. The resident's history and physical dated [DATE] indicated the resident had "progressive bilateral lower extremity swelling;" diagnoses included dementia and type 2 diabetes. The 5-day MDS dated [DATE] was coded to indicate the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition. According to the MDS, the resident needed limited assistance with activities of daily living (ADLs) and used a wheelchair for mobility.
- On 07/31/18 during an interview at 10:00 a.m. prior to the initial tour, the assistant nurse manager (ANM) stated Resident #202, "has advanced dementia," "just completed IV [intravenous] [antibiotic] therapy for cellulitis," and the resident's legs were "still swollen."
- The resident's most recent care plan included approaches dated 07/31/18 at 12:28 p.m. that read, "My skin infection will resolve with treatment from my doctor" and "I will keep my leg elevated as much as possible until my next review."
- Provider orders included:
    - 07/17/18, "Wrap left leg with ace wrap each morning and remove hs [at night]." On 08/01/18 at 12:30 p.m., the nurse manager (NM) provided a physician's order indicating the order dated 07/17/18 had expired and was discontinued on 07/31/18. Additional information was requested from the NM as to the time the stop order was written; no additional information was provided.
    - 07/17/18, "Maintain left leg elevated at all times.
- The resident was observed on 07/31/18 at 9:35 a.m., 12:20 p.m.,1:55 p.m. 3:15 p.m., 5:30 p.m., and on 08/01/18 at 7:21 a.m. in his wheelchair with both legs in a dependent position; the resident was either moving in the wheelchair throughout the neighborhood or sitting still with his feet resting directly on the floor. The resident's left leg was not wrapped and/or elevated. During the observations, staff did not approach the resident to suggest leg elevation and the resident's wheelchair was not equipped with a leg extender (for elevation).
- On 08/01/18 at 11:10 a.m., the resident was observed in the living room with his left leg elevated on a pillow on a chair while watching television; the leg was not wrapped. The recreational therapist [RT] said, "He [Resident #202] broke his ankle before he was admitted and just completed an antibiotic but his leg is still swollen." When asked if the resident refused to have his leg elevated, the RT said, "No, he likes it up and the family said he would sit for hours with it up at home." The RT indicated when sitting with the resident during the "Price Is Right" game show, the resident had his leg elevated.
- On 08/01/18 at 12:30 p.m., the nurse manager (NM) provided a physician's order dated 07/17/18 (as above). The 07/17/18 order to "maintain left leg elevated at all times" remained active. The CLC did not develop approaches to ensure the resident's left leg was elevated at all times including when in the wheelchair.

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*

Based on observation, interview and record review, the CLC did not implement preventive measures to ensure residents who entered the CLC without pressure ulcers did not develop pressure ulcers. Findings included:

<u>Resident #303, [LOCATION]</u>

- Resident #303 was admitted to the CLC on [DATE] and was re-admitted on [DATE]. Admission diagnoses included peripheral vascular disease, Alzheimer's disease, metabolic encephalopathy, and "extremity contractures due to cerebrovascular

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

accidents and falls." On 07/26/18 Resident #303 began receiving hospice care. The extended care nursing admission assessment dated [DATE] indicated Resident #303's Braden Scale for Predicting Pressure Ulcer Risk score was 15 (mild risk). According to the note, Resident #303 had an unstageable pressure ulcer over the left heel that measured 1 cm (centimeter) by 1 cm on admission to the CLC. There was no further documentation regarding the pressure ulcer. Staff reported during survey that they did not recall the resident ever having a pressure ulcer.

- The resident's admission MDS dated [DATE] was coded to indicate the resident had a Brief Interview for Mental Status (BIMS) score of 4 suggesting severely impaired cognition; the resident required extensive to total assistance of two or more staff for most activities of daily living including bed mobility, and used a wheelchair. The MDS indicated the resident had functional limitations in range of motion of the bilateral upper and lower extremities. According to the MDS, Resident #303 was at risk for developing pressure ulcers and had no pressure ulcers. Skin and ulcer treatments included a pressure reducing device in bed.
- The resident's care plan dated 07/06/18 included a statement that read, "I am at risk for skin breakdown due to immobility and incontinence." Approached included:
    - "Peri care in a timely manner. Keep skin clean and dry. Barrier cream to be applied as needed."
    - "Skin will be monitored during daily care. Abnormalities or changes in skin will be reported to the charge nurse and/or appropriate staff."
    - "Reposition for comfort throughout the day to off-load pressure from bony prominences. Air loss mattress also utilized."
    - "RN skin assessments conducted weekly. Wound care team to be consulted as needed."
    - The care plan did not address the use of pressure reducing boots or the use of pillows or foam blocks to elevate the resident's heels.
- There were no provider's orders related to prevention of pressure ulcers and/or wound treatment.
- The RN skin reassessment note dated 07/24/18 indicated Resident #303's Braden Scale score was 13 (moderate risk); the note indicated the following interventions were implemented, "Elevate heels using pillows or foam blocks. Apply heel/elbow pads. Reduce friction and shear."
- The restorative nurse coordinator's quarterly note dated 07/30/18 indicated Resident #303's left leg could only be extended to 90 degrees. According to the description in the note, the resident was "lying in a fetal position in bed with his knees drawn up to his chest."
- On 07/31/18 from 12:15 p.m. to 1:02 p.m., Resident #303 was observed in the dining room seated in a reclining Geri chair wearing gripper socks on both feet. Resident #303's left leg was flexed and drawn up to his chest during the observation. The resident was not wearing a pressure reducing device (boot) on his left foot. The resident's left heel rested directly on foam like padding on the Geri chair.
- On 07/31/18 at 1:02 p.m., Resident #303 was observed being transported from the dining room to his room to lay down. Upon entering Resident #303's room a blue Prevalon® boot was observed hanging on the spindle on the left side of the foot of the bed. Two nursing assistants provided incontinence care for the resident. While removing Resident #303's adult brief for incontinence care, NA #2 was observed to partially position Resident #303 on his right side, and remove the adult brief by pulling the brief from underneath the resident. During the observation Resident #303 yelled out and stated, "Ow, Ow, Ow! It hurts!" Resident #303's skin including the resident's heels was observed to have no redness or skin breakdown. After positioning Resident #303 onto his right side, NA #1 stated, "I forgot to apply his boot." NA #1 placed the Prevalon boot on Resident #303's right foot, positioned a pillow between Resident #303's right and left knees and covered Resident #303 with the bed linens. NA #1 stated Resident #303 only wore a boot on his right foot when in bed. NA #1 stated Resident #303 did not have any skin breakdown on his heels.
- On 08/01/18 at 4:38 p.m., the nurse manager (NM), assistant nurse manager (ANM), the chief nurse and the CLC medical director were interviewed regarding the observations made on 07/31/18. The chief nurse, NM and ANM indicated NA #2 should not have pulled the adult brief out from under Resident #303 while he was on his right side; stating the NAs should have positioned Resident #303 from side to side while removing the adult brief. The ANM and NM stated they did not know why Resident #303 only wore a Prevalon boot on the right foot in bed or why he did not wear the Prevalon boots while up in the chair. The ANM and NM indicated that Resident #303 was at risk for skin breakdown due to his declining physical condition.
- On 08/01/18 at 4:42 p.m., the charge RN stated she was not sure why Resident #303 did not wear the Prevalon boots while seated in his chair. The charge nurse stated Resident #303 "was supposed to have the boots on [in bed];" however, the resident "moves around in bed and kicks them off." The charge RN stated the boots were used as a preventive measure and it was up to the RN to determine if the boots were

needed. The RN stated Resident #303 did not currently have any skin breakdown; this was confirmed during observation of the resident's skin during the survey on 07/31/18.

Resident #301, [LOCATION]

- Resident #301 was admitted to the CLC on [DATE]. Admission diagnoses included non-small cell cancer of the lung, diabetes, osteoarthritis of the knees, chronic obstructive pulmonary disease, and paralysis of the vocal cords/larynx. During the initial tour on 07/31/18 at approximately 10:10 a.m., Resident #301's heels were observed resting directly on the mattress. The assistant nurse manager stated Resident #301 had been referred for a wound consult due to further skin breakdown since admission. The assistant nurse manager stated Resident #301 had been admitted "with friction and shearing on his buttocks…" and Resident #301 "is at high risk for skin breakdown."
- The admission MDS dated [DATE] was coded to indicate Resident #301 had a BIMS score of 15 suggesting intact cognition; the resident required supervision with transfers, was independent with bed mobility, and had functional limitations in range of motion of the bilateral lower extremities. The resident was at high risk for development of pressure ulcers and did not have any pressure ulcers; skin and ulcer treatments coded on the MDS included a pressure reducing device for the bed and applications of dressings to the feet (with or without topical medication).
- Resident #301's care plan included the following statement dated 07/10/18, "I am at risk for skin breakdown due to limited mobility." Approaches dated 07/10/18 included:
    - "RN skin assessments weekly. Wound care team to follow up as needed."
    - "Skin will be monitored daily during pericare and/or ADL assistance. Abnormalities will be reported to the charge nurse or appropriate staff."
    - "Low air loss mattress in place to relieve pressure from boney prominences. Encourage repositioning for comfort throughout the day."
    - "Moisturize skin daily. Barrier cream applied as needed."
    - The care plan did not indicate the resident was to wear pressure reducing devices on his feet or have his heels elevated off the mattress when in bed.
- Resident #301 had the following active provider's orders:
    - [DATE]: "Patient admitted with early skin breakdown of sacral region, reposition every 2 hours…"
- The nursing treatment plan note dated 06/23/18 indicated the resident's Braden Scale score was 18 suggesting "mild risk for development of pressure ulcers." Interventions identified in the note included a "Hill-Rom" bed; a pressure reducing wheelchair cushion, elevation of the resident's heels using pillows or foam blocks; and application of protective barrier cream.
- The wound care nursing note dated 06/26/18 stated, "Plan: Heels noted to be dry and cracked, moisture repair cream applied….Hydrocerin lotion daily and prn [as needed]. Off load heels. Resident is at high risk for skin breakdown."
- The nursing skin assessment-RN assessment note dated 07/12/18 indicated, "Pressure Redistribution Measures: Use low air loss mattress; encourage small, frequent position changes; turn and reposition every 2 hours while in bed, using pillows to separate pressure areas; use wheelchair cushion while in wheelchair; elevate heels using pillows or foam blocks; apply heel/elbow pads; and avoid turning/positioning on side at greater than 30-degree angle."
- The wound care consult note dated 07/31/18 stated, "Heels noted to be dry and cracked. Moisture repair cream applied. Plan: Continue hydrocerin lotion daily and prn; off load heels, Resident is at high risk for breakdown."
- On 07/31/18 at 12:22 p.m., Resident #301 was observed eating lunch while lying in bed with the head of the bed elevated. Resident #301's bilateral heels were resting directly on the mattress. Resident #301 stated sometimes his "heels hurt."
- On 07/31/18 at 4:35 p.m., during medication administration, Resident #301's bilateral heels were observed resting directly on the mattress. The LPN did not reposition Resident #301's lower extremities on pillows or foam blocks to elevate the resident's heels off the mattress.
- On 08/01/18 at 8:43 a.m., Resident #301 was observed eating breakfast while lying in bed with the head of the bed elevated. The resident's bilateral heels were resting directly on the mattress.
- On 08/01/18 at 3:40 p.m., Resident #301 was observed in bed with his bilateral heels resting directly on the mattress. Resident #301 stated he was "supposed to wear [pressure reducing] boots on his heels." The resident said he only wore the boots sometimes as he didn't like to wear them as they were "too hot." The resident stated the boots did not fit right and would fall off when he moved. The resident stated "sometimes" the staff would elevate his heels on a pillow. The resident stated staff had not tried other pressure reducing devices for his feet that would not fall off or that were cooler to wear. The resident stated staff told him his heels were dry and cracked. The resident stated sometimes his heels were sore when they were resting on the mattress.
- On 08/01/18 at 4:15 p.m., the chief nurse, CLC medical director, nurse manager (NM),

and assistant nurse manager (ANM) were interviewed related to the observations of Resident #301's heels resting directly on the mattress. The NM and ANM verified Resident #301's heels were dry and cracked, the resident was at high risk for skin breakdown on his heels and the resident should have his heels floated or wear Prevalon boots. The CLC medical director stated the wound nurse had assessed Resident #301's heels and "identified both heels were dry and cracked." The medical director said, "Moisture repair cream is to be applied to the resident's bilateral heels and his heels are to be off-loaded at all times as the resident is at high risk for skin breakdown." The surveyor confirmed that the resident did not have skin breakdown on his heels/feet during observations made during the survey.

F323

483.25(h)(2) *The facility must ensure that: Each resident receives adequate supervision and assistance devices to prevent accidents.*

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 ensure residents received adequate supervision to prevent accidents and the environment was free from accident hazards. Findings include:

Aspiration Precautions

On 08/02/18, the CLC quality manager provided a copy of the Charlie Norwood VAMC policy and memorandum 126-17-12 dated 11/06/17 and titled, "Management of patients with swallowing (oropharyngeal dysphagia) and feeding disorders." The policy stated under "Attachment A Symptoms and signs of swallowing (oropharyngeal dysphagia) and feeding problems," "2. Oral preparatory and oral transport phase…p. *Coughing or choking before, during or after the swallow." According to the policy, the asterisk (*) "denotes a sign that has been associated with aspiration risk." The policy further stated at "Attachment B Early identification and referral for swallowing (oropharyngeal dysphagia) problems," "Community Living Center (CLC) or Long-Term Care Setting….Patients with a chronic or progressive disorder with oropharyngeal dysphagia should be seen for regular reassessment as recommended by the speech-language pathologist to ensure the effectiveness and appropriateness of long-standing compensatory strategies….The medical providers or nursing staff members may request a reassessment as needed if a change in swallowing or feeding is observed…."

Resident #103

- Resident #103 was admitted to the CLC on [DATE] with diagnoses that included dementia, stroke, left-sided weakness, left hand contractures, Parkinson's disease, and congestive heart failure.
- On 07/31/18 at 10:22 a.m. during the initial tour of the [LOCATION] neighborhood, the registered charge nurse was interviewed while the clinical educator was present. The charge nurse indicated Resident #103 was at risk for aspiration, required supervision, and "eats too fast." At approximately 1:00 p.m., Resident #103 was observed seated in the dining room; the resident had eaten and appeared to be asleep.
- The resident's annual comprehensive Minimum Data Set (MDS) dated 11/28/17 and most recent quarterly MDS dated 05/15/18 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 suggesting intact cognition, did not experience behavioral symptoms of potential distress, and had functional limitations in range of motion of one upper and one lower extremity. According to the MDS assessments, the resident had signs and symptoms of a possible swallowing disorder including coughing or choking during meals or when swallowing medications and was to receive a mechanically altered diet. The annual MDS dated 11/28/17 indicated the resident required limited assistance of one staff person when eating; the quarterly MDS dated 05/15/18 indicated the resident required supervision and set-up assistance when eating.
- A provider's order dated 04/04/18 stated, "Mechanical thick liquid nectar diet;" there were no orders specific to swallowing precautions.
- A speech (therapy) note dated 04/13/18 stated, "Dysphagia. LTG [long-term goal]: Pt. [patient] will tolerate the least restrictive diet without pulmonary compromise. Pt. will tolerate a MECHANICAL SOFT/NECTAR THICK [emphasis not added]….Compensatory swallowing strategies: upright seating, small bites/sips….'
- The care plan dated 05/10/18 with a revision date of 06/26/18 indicated Resident #103 had (a diagnosis of) dysphagia and was "at risk for choking due to eating too fast which causes me to cough. Goal: I will not eat too fast and will not cough or choke while eating. Approaches (05/10/18): Remind me to eat slowly and chew my food completely. Continue with diet per speech evaluation."
- An extended care nursing monthly summary dated 07/01/18 stated, "On mechanical, thick liquid nectar diet…requires tray set up at meals but feeds himself independently. Staff provides ongoing reminders to chew food completely and to eat slowly. Requires

assistance with completing his ADL's [activities of daily living] due to left side weakness."

- On 07/31/18 at approximately 3:43 p.m., an LPN was observed administering a tablet of carbidopa/levodopa for Resident #103. The resident was observed to be seated in a wheelchair in the dining room. The LPN poured thin consistency water into a cup and after the resident consumed the medication and drank some of the water, he coughed briefly two times; the resident did not appear to be in any further distress. No thickened water or other thickened beverages were observed on the medication cart.
- On 08/01/18 at 7:25 a.m., Resident #103 was observed seated in the dining room eating breakfast at a table; the resident's back was to the dining room and the resident was facing an outdoor window. On the other side of the resident's table, and approximately 6 feet away, a nursing assistant (NA) was feeding a resident; according to a nurse manager on 08/01/18 at 4:45 p.m., Resident #103 was not being supervised by the NA since the NA was assigned to provide one-to-one supervision for the other resident. Resident #103 was observed independently eating cut up pieces of French toast that measured approximately 4-inches by 1-inch to 2-inches wide. The resident's tray included nectar-thick water and milk. The resident was observed to pick up a piece of French toast with his hand and insert most of toast into his mouth. The resident began to cough briefly and reached for the nectar-thick water and took a sip. The resident repeated this process three to four times with the French toast and with ham that was cut into pieces that measured approximately 1-inch to 2-inches; each time the resident coughed forcefully and was able to clear the food. During the third coughing episode, the NA seated on the other side of the table asked the resident if he was okay. The resident turned his head and stated, "No;" the resident used a clothing protector to wipe and blow his nose. The NA did not get up or prompt the resident at any time and no other staff approached the resident when the resident coughed. At approximately 7:45 a.m., the resident had scrambled eggs and two containers of nectar-thick milk remaining on the meal tray when another NA asked about taking the resident's meal tray. When the resident indicated he was not finished with the meal, the NA placed the plate on top of the place mat, opened both containers of milk and poured the milk into Styrofoam cups. The resident returned to the table and independently ate 50% of the scrambled eggs and drank 100% of both containers of milk. The resident was not observed coughing or choking or with other signs of aspiration or difficulty swallowing.
- On 08/01/18 at 4:28 p.m., the charge nurse was observed administering one tablet of metoprolol for Resident #103. The charge nurse provided a container of water labeled, "nectar." The resident swallowed the pill and nectar-thick water and did not cough or experience other signs of difficulty swallowing or aspiration.
- On 08/01/18 at 4:45 p.m., the observations on 07/31/18 during medication administration and on 08/01/18 during the breakfast meal were shared with the nurse manager and clinical nurse educator. The nurse manager stated the resident should receive nectar consistency liquids.
- On 08/02/18 at 8:04 a.m., Resident #103 was observed seated in the dining room and was sleeping; the resident had eaten all of the meal and consumed the beverages. The resident awoke at approximately 8:09 a.m., coughed and appeared to fall asleep. At 8:10 a.m., the resident awoke and vigorously coughed. An NA in the dining room was feeding another resident; the NA's back was to the resident and the NA did not turn around to observe the resident when the resident coughed. There were no other staff in the dining room during the observation. At 8:12 a.m., the resident coughed and a small piece of what appeared to be scrambled egg was noted on the resident's lower lip; the resident stated that he woke himself up coughing.
- In summary, on 07/31/18 at approximately 3:43 p.m., an LPN was observed administering a tablet of carbidopa/levodopa for Resident #103. The LPN poured thin consistency water into a cup and after the resident consumed the medication and drank some of the water, he coughed briefly two times; the resident did not appear to be in any further distress. No thickened water or other thickened beverages were observed on the medication cart. On 08/01/18 at 7:25 a.m., Resident #103 was observed seated in the dining room eating breakfast at a table; the resident's back was to the dining room and the resident was facing an outdoor window. Resident #103 was observed independently eating cut up pieces of French toast that measured approximately 4-inches by 1 to 2-inches wide and pieces of ham that measured approximately 1-inch by 2-inches. The resident's tray included nectar-thick water and milk. The resident was observed to pick up a piece of French toast with his hand and insert most of toast into his mouth. The resident coughed briefly, and reached for the nectar-thick water and took a sip. The resident repeated this process three to four times with the French toast and the ham; each time the resident coughed forcefully and was able to clear the food. During the third coughing episode, a NA assisting another resident asked Resident #103 if he was okay. The resident turned his head and stated, "No;" the resident used a clothing protector to wipe and blow his nose. The NA did not get up or prompt the resident and no other staff approached the resident when the

resident coughed to encourage the resident to take small bites as indicated in the speech note (04/13/18).

Smoking Receptacles

On 08/01/18, a quality manager provided a copy of the Charlie Norwood VAMC policy and memorandum 01-16-10 dated 01/13/16 and titled, "Medical Center Smoke-free Policy." The policy stated, "Uptown Division [Charlie Norwood campus]: a. For patients and visitors: smoking shelter adjacent to door 43…in designated courtyards, at least 35 feet from the entrance." The policy indicated "Signs: Conspicuous signs will be posted at each entrance and throughout the Medical Center…will also be posted to designate or areas striped to define limits where the use of tobacco products by…patients and long-term care patients [residents] are or are not permitted."

- On 07/31/18 during observations with a clinical nurse educator at approximately 10:55 a.m., a third-floor outdoor enclosed patio was observed to be accessible to residents and visitors. There was no signage to indicate whether the courtyard was approved or not approved as a smoking area as indicated in the CLC's policy, although it was later determined that this was an approved smoking area. The outdoor patio contained a large centralized fountain with mulch and flowers, as well as a bag containing cardboard. At least three waste cans were observed with open metal ashtrays on top of the waste cans; the ashtrays contained discarded burned ends of cigarettes. One ashtray, located near the bag of cardboard, contained 18 burned ends of cigarettes and one lit cigarette that was burning and emitting smoke. The clinical nurse educator stated, "A cigarette is still burning." The clinical nurse educator approached the ashtray and extinguished the cigarette that was resting directly against the burned end of another cigarette.
- The findings from this observation were shared at the daily meeting on 07/31/18 at approximately 3:00 p.m. The director of the CLC stated the CLC was in transition including developing new smoking areas that would include appropriate smoking receptacles that would extinguish smoking materials.

F325

483.25(i)(1) *Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident: Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible;*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure a resident maintained acceptable parameters of nutritional status, such as body weight. Findings include:

The CLC policy dated January 4, 2016 and titled, "Weight Protocol for Community Living Center Residents," was provided by the nurse educator on 08/01/18 at 10:30 a.m. According to the policy, "Residents with a weight change of +/- [gain or loss] 5 lbs will be reweighed to confirm accuracy."

Resident #201, [LOCATION]

- Resident #201 was admitted to the CLC on [DATE] with diagnoses including non-Alzheimer's dementia and congestive heart failure. During the initial tour and review of the Roster/Sample Matrix CMS-802 form on 07/31/18, it was reported the resident experienced weight loss.
- The resident's quarterly Minimum Data Set (MDS) dated 07/10/18 was coded to indicate the resident was usually understood and usually understood others; the resident had moderately impaired cognitive skills for daily decision making based on staff assessment. The MDS indicated the resident had a significant weight loss of 5% or more in the last month or 10% or more in the last 6 months and weighed 134 pounds; the resident required total assistance for eating and did not resist care.
- The resident's care plan dated 03/21/18 included a statement dated 07/31/18 at 11:40 a.m. that read, "Nutritional status: I have had a recent weight loss due to fluid and actual weight loss. I am on a diet that will help promote maintenance. Please provide me my ordered diet and snacks. Staff will monitor my weight as ordered. Assist me at meal times as needed."
- Current provider's orders included:
  - 06/05/18: "Weight q a.m. [every morning]."
  - 07/11/18: "Mechanical carb [carbohydrate] consist [consistent]"
- According to information in the computerized patient record system, the resident had an order for furosemide (diuretic) that was discontinued on 07/20/18.
- Resident #201's weights included (but were not limited to) the following:
  - 06/01/18 was 160.9
  - 07/01/18 - 139.99 pounds

    - 07/08/18 - 136.47 pounds
    - 07/15/18 - 133.16 pounds
    - 07/16/18 - 132.28 pounds, 07/16/18 -136 pounds (The resident was weighed twice on 07/16/18)
    - (07/20/18 - furosemide discontinued)
    - 07/21/18 - 130.29 pounds
    - 07/30/18 - 136.91 pounds (the resident was not reweighed)
    - 08/01/18 - 132.72 pounds
- The resident was not weighed daily according to the provider's order including on 07/06/18, 07/07/18, 07/13/18, 07/14/18, 07/17/18 through 07/20/18, 07/22/18, 07/26/18 through 07/29/18, and 07/31/18.
- The nutritional assessment dated 07/05/18 stated "-20# [20-pound loss] weight loss over past month, however suspect due to combination of fluid and actual weight (continues on diuretic). Obtain new weight as feasible. Please cancel out all blankets/pillows if using bed scale. Glucerna BID [twice daily]." On 08/01/18 at 10:00 a.m., the dietitian stated Glucerna was delivered on meal trays.
- Resident #201 was interviewed on 07/31/18 at 3:15 p.m. and said, "The doctor said I have lost weight and need to gain about 20 pounds. I eat everything but am not gaining anything." When asked if the resident received a supplement (e.g., shake) on the meal tray or as a snack, the resident said, "No." The resident's meal trays were observed on 07/31/18 and 08/01/18 and did not include Glucerna as recommended in the nutritional assessment dated 07/05/18; based on resident and staff interviews, the Glucerna was not served at another time on 07/31/18 or 08/01/18. The resident's snack card indicated the resident received a peanut butter and diet jelly sandwich and a diet cola as a snack. Observation on 08/01/18 confirmed the resident received these items.
- In summary, Resident #201 weighed 160.9 pounds on 06/01/18, 139.99 pounds on 07/01/18 and 132.72 pounds on 08/01/18; an approximate 28-pound (17%) loss since 06/01/18 and an approximate 7-pound (5%) loss since 07/01/18 (last 30 days). The resident's meal trays were observed on 07/31/18 and 08/01/18 and did not include Glucerna as recommended in the nutritional assessment dated 07/05/18; based on resident and staff interviews, the Glucerna was not served at another time on 07/31/18 or 08/01/18. The resident was not consistently reweighed when there was a weight change of 5 pounds or more as indicated in the CLC's policy.

Resident #204, [LOCATION]

- Resident #204 was admitted to the CLC on [DATE] with diagnoses including Lewy body dementia. During the initial tour and review of the Roster/Sample Matrix CMS-802 form on 07/31/18, it was reported the resident experienced a decline in condition including weight loss. The resident's significant change MDS dated 05/29/18 indicated the resident's cognition was moderately impaired based on staff assessment. According to the MDS, the resident needed total assistance of one staff person for eating and experienced a weight loss of 5% or more in the last month or 10% or more in the last 6 months. The MDS indicated the resident weighed 191 pounds.
- The resident's current care plan dated 05/31/18 stated, "I am at risk for weight loss due to my condition. Dietary to order supplements-shakes high protein." During the survey it was noted that the dietary supplements were provided; however, the amount consumed was not documented.
- The nutritional assessment dated 06/21/18 stated, "Recommend weekly standing weights." Weights documented for the resident included (but were not limited to) the following:
    - 03/01/18 - 200.4 pounds
    - 04/01/18 - 201.6 pounds
    - 05/01/18 - 200.4 pounds
    - 05/10/18 - 223.7 pounds
    - 05/17/18 - 199.5 pounds
    - 05/21/18 - 196.9 pounds, 05/21/18 - 190.6
    - 06/01/18 - 182.9 pounds
    - 07/01/18 - 196.8 pounds
- A nutritional assessment dated 07/01/18 indicated staff was to obtain weekly standing weights and the resident was to continue to receive a regular diet.
- In summary, Resident #204 weighed 200.4 pounds on 03/01/18 and 196.8 pounds on 07/01/18, suggesting a 3.6-pound (1%) weight loss in 4 months. The resident weighed 182.9 pounds on 06/01/18 and 196.8 pounds on 07/01/18, suggesting a 13-pound (7%) weight gain in one month. The resident was not consistently reweighed when there was a weight change of 5 or more pounds as indicated in the CLC's policy. Based on documentation provided, weekly weights were not obtained as recommended in nutritional assessments. It was not evident a comprehensive assessment was conducted in an effort to determine the cause of and develop approaches to address the resident's weight changes.

Resident #203, [LOCATION

- Resident #203 was admitted to the CLC on [DATE] with diagnoses including Alzheimer's disease. During the initial tour and review of the Roster/Sample Matrix CMS-802 form on 07/31/18, it was reported the resident experienced weight loss and verbal behavioral symptoms of potential distress. The resident's quarterly MDS dated 05/15/18 indicated the resident's cognition was severely impaired based on staff assessment. According to the MDS, the resident was totally dependent on staff for all activities of daily living (ADLs), and experienced a weight loss of 5% or more in the last month or 10% or more in the last 6 months; the resident weighed 182 pounds.
- The resident had an active provider's order dated 05/29/18 for feeding assistance at all meals and a regular diet.
- The resident's weights were documented as follows:
    - 12/06/17 - 222.2 pounds
    - 02/01/18 - 205.3 pounds
    - 03/01/18 - 186.2 pounds
    - 04/01/18 - 188.2 pounds
    - 05/01/18 - 182.2 pounds
    - 06/01/18 - 189.5 pounds
    - 07/01/18 - 201.6 pounds; following the weight on 07/01/18, a reweight was not documented.
- The nutritional assessment dated 07/19/18 stated, "[Weight] appears to be trending up, however, unsure if more recent weight is accurate. Continue regular diet per SLP [speech language pathologist]; supplements not indicated at this time as intake exceeds needs." On 07/31/18, a note was added by the dietitian that stated, "When using bed scale to obtain weight please ensure all blankets/pillows are cancelled to ensure most accurate weight."
- In summary, Resident #203 weighed 205.3 pounds on 02/01/18 and 201.6 pounds on 07/01/18, suggesting a 3.7-pound (1%) loss; the resident weighed 189.5 pounds on 06/01/18 and 201.6 pounds on 07/01/18, suggesting a 12-pound (6%) weight gain in the last month. The resident was not consistently reweighed when there was a weight change of 5 or more pounds as indicated in the CLC's policy. Based on documentation provided, weekly weights were not obtained as recommended in nutritional assessments. It was not evident a comprehensive assessment had been conducted in an effort to determine the cause of and develop approaches to address the resident's weight changes.

Resident #302

- Resident #302 was admitted to the CLC on [DATE] and readmitted on [DATE]. Diagnoses included diabetes mellitus, dementia, and right lateral calcaneus osteomyelitis. Resident #302's diet order on admission was a "carbohydrate consistent diet."
- Resident #302's admission MDS dated [DATE] indicated Resident #302 weighed 215 pounds, had not had a significant weight loss or gain, and received a therapeutic diet.
- Resident #302's care plan dated 07/12/18 included a statement that read, "I have increased nutrient needs for wound healing" with the following approaches:
    - "Please provide me with my ordered diet, snacks and supplements." 07/12/18
    - "Staff will assist me at mealtimes and monitor my weight as ordered." 07/12/18
    - "Nutritional services will adjust supplements prn [as needed] to help provide adequate kcal [kilocalories]/protein for wound healing." 07/12/18
- Weights recorded since the resident's admission to the CLC were documented as follows:
    - [DATE] – 215 pounds
    - 07/09/18 – 190.7 pounds (24.3 pound or 11.3% loss)
    - 07/20/18 – 190 pounds
    - 07/22/18 – 191.5 pounds
    - 07/23/18 – 190.6 pounds, 191.00 pounds
    - 07/24/18 – 194.6 pounds
    - 07/26/18 – 194 pounds
    - 08/01/18 – 194.2 pounds
- The 06/29/18 nutrition treatment plan note stated Resident #302 consumed approximately 50% of his morning meal and had a good appetite at other meals. The note stated, "On [DATE] Resident #302's weight was 215 pounds. The resident's usual body weight appears to be around 215 pounds. Weight change: Fluctuations noted likely due to fluids and difference of scales." "Please cancel out blankets/pillows when using bed scale if unable to use standing or lift scale."
- There was no documentation to address the resident's weight loss of 24.3 pounds as indicated by the weight on 07/09/18 until the nutritional assessment/therapy plan note dated 07/23/18 that stated, "He [Resident #302] is eating well despite recent charted weights….Weight change: Greater than 10% in 6 months. Appears stable

now….Nutritional Problem: Unintended weight loss related to predicted decreased oral intake as evidenced by over 10% loss in less than 6 months."
- The 07/25/18 nutritional assessment/therapy plan note read, "Weight change of 9% in 6 months. Not significant. Weight stable since CLC admission."
- The 07/2718 CLC nutrition long-term care note stated, "No significant weight loss noted in past 6 months."
- The resident's 24.3-pound weight loss from [DATE] to 07/09/18 was not addressed in the provider and nursing notes provided by the CLC.
- On 08/02/18 at 4:50 p.m., the nurse manager (NM), assistant nurse manager (ANM), CLC medical provider and chief nurse were interviewed related to Resident #302's weight loss. The NM and ANM stated normally the resident would have been reweighed with the 24.3-pound weight loss and if a reweight was completed the weight would have been documented in the weight record.

Systems-level Review

- The CLC dietitian was interviewed on 08/01/18 at 9:25 a.m.; the dietitian stated, "CLC staff are struggling with the accuracy of the bed scale. If there is a big change in weight I will ask for a re-weigh."
- On 08/02/18 at 4:50 p.m., the nurse manager (NM) indicated residents were to be weighed weekly.
- The CLC did not consistently reweigh residents when there was a weight change of 5 or more pounds as indicated in the CLC's policy, did not conduct a comprehensive assessment following weight changes, did not follow provider orders related to daily weights, and did not provide dietitian recommended supplements.

F332

483.25(m)(1) *The facility must ensure that: It is free of medication error rates of 5 percent or greater.*

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 medication error rate of less than 5 percent. Twenty-seven (26) opportunities were observed with three medication errors identified resulting in a 11.1% error rate. Findings include:

On 08/01/18, the CLC clinical nurse educator provided a copy of Elsevier's Clinical Skill titled, "Feeding tube – medication administration," retrieved on-line on 08/01/18. The clinical skill stated, "...return the aspirated contents to the stomach....flush with 30 ml [milliliters] of water."

Elsevier's Clinical Skills titled, "Feeding Tube: Medication Administration" and published December 2017 was retrieved online on 08/10/18; the clinical skill stated, "Check for gastric residual volume (GRV)….Return aspirated gastric contents to the stomach unless the volume exceeds 500 ml or an amount determined by the organization's practice or practitioner's order….Close the NG [nasogastric] or enteric tube and remove the syringe. Draw 30 ml of water into a 30-ml or larger syringe, insert the tip of the syringe into the feeding tube, and flush the tube."

According to the U.S. National Library of Medicine policy retrieved on-line on 08/02/08, "Prescription lansoprazole is used to treat gastroesophageal reflux disease (GERD). It works by decreasing the amount of acid made in the stomach." The medication instructions for administration stated, "Prescription lansoprazole is usually taken once a day, before a meal."

Medication Administration, Percutaneous Endoscopic Gastrostomy (PEG) Tube
Resident #105

- Resident #105 was admitted to the CLC on [DATE] with diagnoses that included [Diagnosis]; the resident required the use of a PEG tube for hydration and nutrition.
- On 08/01/18 at 9:25 a.m., an LPN was observed administering a bolus tube feeding and medications including levetiracetam 750 milligrams (mg)/7.5 milliliters (ml), twice daily; amlodipine 2.5 mg, daily; metoprolol 25 mg, twice daily; polyethylene glycol 17 grams, daily; and lansoprazole 30 mg SA (sustained action), daily through the resident's PEG tube. The LPN was observed to crush, dilute and prepare all medications in separate 30 ml clear plastic cups. Prior to administering the medications, the LPN used a piston syringe and instilled 30 ml of sterile water into the PEG tube, withdrew 50 ml of gastric contents and returned the contents to the resident's stomach. The LPN did not flush the tube with sterile water before administering by gravity one of the two dissolved medications, amlodipine or metoprolol; the LPN could not recall which medication was administered first. The LPN flushed the tube with approximately 30 ml of sterile water and administered all of the medications except lansoprazole, flushing in between each medication. After the LPN administered levetiracetam, amlodipine, metoprolol, and polyethylene glycol, she administered 250 ml of Fibersource HN. After administering the Fibersource HN, the

LPN was asked when she planned to administer the lansoprazole. The LPN stated, “I give that last…it’s for his stomach acid.” At the conclusion of medication and tube feeding administration, the LPN was asked if she was aware of the manufacturer’s instructions related to lansoprazole and she stated, “It [lansoprazole] probably should be given first, I give it last to protect his stomach.”

- On 08/02/18 at approximately 10:00 a.m. a quality manager indicated that the pharmacist planned to coordinate with the provider to make changes to the timing of administration of Resident #105’s lansoprazole to ensure the medication was administered prior to meals (tube feeding formula).

Medication Administration, Ophthalmic
Resident #106

- Resident #106 was admitted to the CLC on [DATE] with diagnoses including Alzheimer’s dementia, partial blindness, and bilateral cataracts.
- On 08/01/18 at 12:07 p.m., an RN was observed administering brimonidine 0.2% ophthalmic medication, one drop in each eye for the resident who was seated in a wheelchair in the resident’s room. The RN requested the resident tilt his head back and when the RN attempted to instill the eye drop in the right eye, the medication touched the lower eyelid and rolled down the resident’s right cheek. The RN successfully instilled one eye drop into the left eye. After the medication observation was completed, the RN was interviewed and acknowledged that she did not administer the full and complete dose of brimonidine to the resident’s left eye; the RN stated, “I’m not sure how much of the medication he received [in the left eye].”

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

Residents Affected - Few

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

The CLC policy titled, “Infection Prevention and Control Guidelines,” and dated March 15, 2016, was provided by a quality manager on 07/31/18 at 11:00 a.m. According to the policy, for Enhanced Barrier Precautions, “hand hygiene, gloves, and gown required for entering room. Remove gloves and gown on EXIT [emphasis not added]. Clean/disinfect or discard supplies or equipment on EXIT [emphasis not added].” This information was also indicated by signs shaped like a butterfly that were posted on resident doors if Enhanced Barrier Precautions were to be implemented for a resident. According to the policy, “The delivery of meal trays to residents on transmission-based precautions, including enhanced barrier precautions, is to be coordinated with nursing staff. All staff, including dietary staff members that deliver and pick up meal trays of residents that are on precautions will follow isolation signage as noted on entry into the resident’s room.”

Resident #201, [LOCATION]

- Resident#201 was admitted to the CLC on [DATE]. During the initial tour on 07/31/18 at 9:35 a.m., the ANM said that Resident #201 had “MRSA [methicillin-resistant *Staphylococcus aureus*] colonized in the nares.” A butterfly sign was posted on the resident’s room door; the ANM stated the butterfly indicated, “Enhanced Barrier Precautions [were to be implemented] related to MRSA” and that “gloves and gown are required [when entering the resident’s room].”
- On 08/01/18 at 7:21 a.m., an environmental management services (EMS) staff member was observed exiting the resident’s room wearing gloves and a gown. The EMS staff member continued down the hallway wearing the items until out of sight by the surveyor.
- On 08/01/18 at approximately 7:45 a.m., a nutrition and food service staff person was observed entering the resident’s room carrying the resident’s breakfast tray while wearing gloves. The nutrition and food service staff member did not conduct hand hygiene, and don a gown and clean gloves prior to entering the resident’s room to deliver the meal tray in accordance with Enhanced Barrier Precautions. Upon exiting the resident’s room, the nutrition and food service staff member did not doff gloves, conduct hand hygiene and don clean gloves prior to delivering meal trays to other residents.

F514

483.75(l) *Clinical Records. (1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are: (i) Complete; (ii) Accurately documented: (iii) Readily accessible; and (iv) Systematically organized.*

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

Residents Affected - Few

Based on interview and record review, the CLC did not maintain accurate clinical records for one resident. Findings include:

Resident #302

- Resident #302 was admitted to the CLC on [DATE] and readmitted on [DATE] with diagnoses including diabetes mellitus, dementia, and right lateral calcaneus (heel bone) osteomyelitis.
- The resident's admission Minimum Data Set (MDS) dated [DATE] was coded to indicate the resident was not at risk of developing pressure ulcers and had an unstageable pressure ulcer that was present on admission; the dimensions of the pressure ulcer or eschar with the largest surface area was coded as 2.7 cm (centimeters) length by 0.5 cm width by 0 cm depth. Skin and ulcer treatments coded on the MDS included pressure reducing devices for the chair and bed, pressure ulcer care and application of dressings to feet.
- Resident #302's admission note dated [DATE] stated, "Patient with rheumatoid arthritis, gout and pressure injury to heel….Bilateral foot wounds, dressing to right heel intact….right heel decubitus ulcer with osteomyelitis....Left toes painted with betadine. Open to air."
- The nursing inpatient admission evaluation note dated [DATE] indicated the resident had a Braden Scale for Predicting Pressure Ulcer Risk score of 19 suggesting no risk. The note stated Resident #302 had a right foot wound with a dressing in place. The intervention stated, "The pressure ulcer prevention protocol wasn't needed. Patient is not at risk."
- The wound care notes documented by the wound care nurse included the following:
    - The note dated 07/12/18 stated, "Last podiatry visit 6/28/18 at 1:13 p.m….Dermatologic: Ulceration is noted right lateral heel measuring 2.0 cm X [by] 0.8 cm X 0.2 cm….A mostly fibrotic wound bed is noted." The note did not indicate the wound was debrided.
    - The note dated 07/13/18 indicated Resident #302 had two pressure ulcers over the right foot including a Stage 3 over the right mid heel and (stage not specified) over the right lateral heel. This was the first note that identified two areas on Resident #302's right heel.
    - The note dated 07/17/18 stated, "Stage III pressure ulcer on his right mid heel, oval in shape, has decreased in size….right lateral heel. Healing."
- Daily wound care nursing notes completed by neighborhood nurses dated 07/02/18, 07/07/18 through 07/11/18, 07/16/18, 07/20/18, 07/24/18, 07/28/18, and 07/29/18 indicated Resident #302 had one pressure ulcer located on the right heel. The weekly wound care nursing notes dated 07/12/18 and 07/17/18 indicated Resident #302 had one pressure ulcer over the right mid heel and the right lateral heel was "healing." No additional daily or weekly wound care nursing notes were provided.
- The 07/26/18 interdisciplinary review note stated, "Pressure ulcers: Stage 3 two areas located mid and lateral right heel. Weekly registered nurse skin assessment, wound care team and podiatry to follow."
- The nursing skin assessment note dated 07/30/18 indicated the resident's Braden Scale score was 19. The note stated, "Skin problems: Pressure ulcer Stage III on right [mid] heel. Stage III pressure ulcer right lateral heel. Unstageable pressure ulcer to left second toe….Interventions: The pressure ulcer prevention protocol was not needed – patient not at risk." There was no other documentation that addressed the unstageable pressure ulcer to the left second toe.
- On 08/01/18 at 4:20 p.m., during an interview with the chief nurse, nurse manager, assistant nurse manager and chief of staff, the nurse manager stated after the two pressure ulcers located on the right lateral heel and right mid heel were debrided by the podiatrist the pressure ulcers were determined to be Stage 3 pressure ulcers by the wound care nurse and the podiatrist (no date provided). The assistant nurse manager stated the documentation was not clear, indicating the nurses "must have clicked the wrong box when documenting their assessments. Possibly at the time the nurses documented only one pressure ulcer the two areas [pressure ulcers] which were close together had opened into only one pressure ulcer."
- Resident #302's medical record did not include documentation indicating the two pressure ulcers formed one pressure ulcer as confirmed by the assistant nurse manager. The CLC medical director was interviewed on 08/01/18 at 4:20 p.m. and stated Resident #301 had two pressure ulcers including one on the right lateral heel and one on the right mid heel.