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: Lexington VA Medical Center: Leestown Division (Lexington, KY)

Dates of Survey: 12/4/2018 to 12/5/2018

Total Available Beds: 50

Census on First Day of Survey: 27

F-Tag	Findings
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 that it was free of a medication error rates of 5 percent or greater. Thirty-one (31) opportunities were observed with three medication errors identified resulting in an error rate of 9.6%. Findings include: Ophthalmic Medication Administration At 8:29 a.m. on 12/05/18, the [LOCATION] nurse manager (NM) provided Elsevier's clinical skill titled, "Medication Administration: Eye," and dated December 2017. The clinical skill stated the following under Administering Eye Drops, "Instill the prescribed number of medication drops into the exposed conjunctival sac. If more than one drop is prescribed, allow 5 minutes between drops…." *Resident #204, [LOCATION]* • Resident #204 had a provider's order dated 11/04/18 for 1.4% povidone (artificial tears) eye drops, 2 drops, both eyes every 6 hours for dry eyes. • At 4:10 p.m. on 12/04/18, an LPN conducted hand hygiene, donned gloves and brought a prefilled one dose plastic 2 milliliter (ml) vial of artificial tears into Resident #204's room. The LPN administered 2 drops consecutively into Resident #204's left eye and 2 drops consecutively into the resident's right eye; the LPN did not wait 5 minutes between administration of the two drops in each eye. The LPN used a tissue to wipe the excess artificial tears that were running down Resident #204's face. • After leaving Resident #204's room and returning to the medication cart, the surveyor asked the LPN if she administered the 2 drops into each eye consecutively. The LPN stated, "Yes, I did." Ophthalmic and Metered-dose Inhaler Medication Administration • At approximately 11:15 a.m. on 12/05/18, the nurse manager (NM) from the [LOCATION] neighborhood provided the pharmacy package insert for administration of Symbicort 80/4.5 (budesonide 80 mcg [micrograms] and formoterol fumarate dihydrate 4.5 mcg) inhalation aerosol. The package insert stated, "Administration information….After inhalation the patient should rinse the mouth with water without swallowing." • Elsevier's clinical skill titled, "Medication Administration: Metered-Dose Inhalers [MDI]," and dated November 2018 was retrieved online on 12/10/18. The clinical skill stated, "Instruct the patient to rinse his or her mouth with warm water and then spit the water out after each MDI use especially when using corticosteroids." *Resident #205, [LOCATION]* • Resident #205 had the following provider orders: ○ 10/19/18: Dexamethasone 0.1/Tobramycin 0.3% is indicated to be given to Resident #205 as follows: 2 drops to the right eye twice daily "for keratitis." ○ 10/19/18: Budesonide 160/Formoterol 4.5 mcg (Symbicort) is indicated to be given as 2 puffs inhalation twice daily for chronic obstructive pulmonary disease (COPD).

- At 8:27 a.m. on 12/05/18 a different LPN than the LPN observed administering medications for Resident #204, conducted hand hygiene, donned gloves and entered Resident #205's room with a bottle of dexamethasone eye drops, several oral medications, and a Symbicort inhaler. The LPN administered two dexamethasone drops into Resident #205's right eye consecutively without waiting 5 minutes between the drops. Drops were observed running down Resident #205's right cheek.
- The LPN explained the procedure for the Symbicort inhaler to the resident and the number of required inhalations. The resident properly administered the Symbicort. Immediately following the inhalations, the LPN handed the resident a medicine cup with oral medications and a cup of water. The resident proceeded to swallow the medications and drink the water. The LPN did not instruct the resident to rinse and spit immediately after using Symbicort inhaler.
- After the LPN left the room and returned to the medication cart, the surveyor asked if the LPN had administered the 2 eye drops consecutively and the LPN stated, "Yes."

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:

Transmission-based Precautions

The resident assessment coordinator provided the April 30, 2018 policy titled, "Standard and Transmission Precautions," at 4:00 p.m. on 12/04/18. The policy indicated that for Enhanced Barrier Precautions staff were to perform "hand hygiene on entering room. Hand hygiene on leaving room."

At 1:19 p.m. on 12/05/18, the nurse manager (NM) of the [LOCATION] neighborhood provided Elsevier's clinical skill dated August 2018 and titled, "Bathing: Bed Bath." The policy described each step in providing a bed bath. The policy stated, "Perform hand hygiene and don gloves." The policy indicated that staff were to wash the resident's face, upper extremities, trunk and lower extremities, and then provide perineal care. Following perineal care the policy indicated, "Remove gloves and perform hand hygiene…."

Resident #202, [LOCATION]

- A sign posted outside Resident #202's room indicated that Enhanced Barrier Precautions were to be implemented. The sign stated, "Hand hygiene on leaving room." At 12:14 p.m. on 12/04/18, a registered dietitian (RD) was observed leaving Resident #202's room without performing hand hygiene. The NM of the [LOCATION] neighborhood accompanied the surveyor and agreed the RD should have performed hand hygiene prior to leaving the resident's room.
- At 11:45 a.m. on 12/05/18, an RN and a nursing assistant (NA) provided a bed bath for Resident #202. The NA asked the RN, "Do you want to change his [the resident's] bed [linens]?" The RN indicated that the bed linen could be changed. Without doffing gloves, conducting hand hygiene and donning new gloves, the NA handed a clean sheet to the RN. When Resident #202's cell phone began ringing, the NA wore the same gloves to pick up the resident's cell phone and hand it to Resident #202. The NA removed the bed linen from the bed and placed it in a hamper in the resident's bathroom. The NA doffed gloves, performed hand hygiene at the sink and donned a new pair of gloves before applying lotion to Resident #202's skin.
- The NM later indicated the NA should have "changed her gloves" and performed hand hygiene after the perineal care.
