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: Togus VA Medical Center (Augusta, ME)

Dates of Survey: 7/23/2018 to 7/25/2018

Total Available Beds: 62

Census on First Day of Survey: 54

F-Tag	Findings
F241 483.15(a) *Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.* **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 promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity. Findings include: Resident #201, [LOCATION] • Resident #201 was admitted to the CLC on [DATE] with diagnosis including Alzheimer's disease. The resident's annual Minimum Data Set (MDS) dated 05/12/18 indicated the resident had severely impaired cognitive skills for daily decision making, required total assistance for all activities of daily living (ADLs), and was incontinent of bowel and bladder. • The care plan dated 06/21/18 included the following approach related to assistance with dressing, "He [Resident #201] has never worn PJs [pajamas] and likes to sleep in his day time clothing." • On 07/24/18 at 1:30 p.m., Resident #201 was observed lying in his bed covered with a blanket; the resident's eyes were open. The resident was asked by the charge RN for permission to remove the blanket to observe the resident's positioning. The resident was wearing an adult incontinence brief and was lying on an incontinence pad. The resident's grey sweatpants had been pulled down around his ankles. When asked about the positioning of the resident's sweatpants, the charge RN stated, "His pants should have been removed."
F272 483.2 *Resident Assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.* **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 conduct an assessment regarding the use of side rails and seat belts. Findings include: The CLC policy titled, "Restraint and Seclusion," and dated March 9, 2018, was provided by the quality manager (QM) on 07/24/18 at 9:20 a.m. According to the policy, "Practices that meet the definition of restraints include, but are not limited to….(3) using devices in conjunction with a chair, such as trays, tables, bars or belts, that the resident cannot remove easily, that prevent the resident from rising." Adaptive devices referenced in the policy included, "Orthopedic appliances and device used to provide postural support for a patient such as orthotic body devices." Seat Belts *Resident #201, [LOCATION]* • Resident #201 was admitted to the CLC on [DATE] with diagnoses including Alzheimer's disease. During the initial tour on 07/23/18 at 10:30 a.m., the charge RN indicated that Resident #201, "has a seat belt for posture and positioning. He had acquired a pressure ulcer from slouching in his chair without the device [seat belt].

According to the charge RN, the resident had Alzheimer's disease and was "unable to remove the device."

- The resident's annual MDS dated 05/12/18 indicated the resident had severely impaired cognitive skills for daily decision making based on staff assessment, required total assistance for all activities of daily living (ADLs), and was incontinent of bowel and bladder. According to the MDS the resident used bed, chair and wander alarms daily; the MDS did not indicate the resident used a trunk or limb restraint.
- The care plan dated 06/21/18 stated, "[Resident #201] has seat belt to maintain posture." The resident had a provider's order dated 01/18/18 that read, "Indication for wheelchair seat belt usage: Belt is for positional needs due to right pelvic twist in chair. This chair is appropriate for vet [Veteran] as he often foot propels so any sort of tilt/recline wheelchair will not allow him to self propel when desired."
- An occupational therapy [OT] assessment dated 06/28/18 documented, "At this time vet no longer self propels manual wheelchair…continue use of seat belt for positioning to greatest degree possible to prevent sheer when seated in manual wheelchair." No other assessments including evaluation of the risks and benefits for use were completed prior to use of the seat belt.
- The occupational therapist (OT) was interviewed on 07/24/18 at 9:15 a.m. regarding Resident #201's seat belt. The OT said the resident developed a pressure ulcer because "…the resident slid forward and caused shearing. The seat belt prevents him from sliding forward." When asked how the seat belt should be applied, the OT said, "Because the chair doesn't tilt, it [the seat belt] needs to be tightened to a certain degree to avoid him from sliding forward to prevent shearing. The OT said that he planned to reassess the resident for a tilt-in-space chair but "he [Resident #201] has been spending most of his time in bed."
- On 07/24/18 at 8:35 a.m., the certified wound specialist (CWS), who provided care for Resident #201, was interviewed regarding Resident #201's pressure ulcer and use of the seat belt to prevent shearing. The certified wound specialist said, "The seat belt? No, I don't know anything about that."
- Resident #201 was observed on 07/23/18 from 4:25 p.m. when he was assisted out of bed until approximately 5:45 p.m.; and on 07/24/18 from 7:30 a.m. until the residents was assisted back to bed at 8:07 a.m., and from 11:00 a.m. when the resident was assisted out of bed until he was assisted back into bed at approximately 12:30 p.m. During the observations, the resident was wearing a buckled seat belt when in the wheelchair, was sitting erect, did not lean to either side and was not sliding forward. The belt was applied loosely across the resident's waist. The resident did not attempt to get out of the wheelchair during the observations. On 07/24/18 at 7:30 a.m., an NA who was assisting the resident to eat breakfast, indicated that she applied the seat belt when she assisted the resident into the wheelchair; the NA said, "I don't know what the belt is for;" the NA indicated that the resident was not able to release the seat belt. A different NA than the NA who assisted the resident with breakfast stated on 07/24/18 at 11:15 a.m., "Sometimes families will request a belt for safety, his wife may have wanted it."
- The CLC did not conduct an assessment of the resident's use of a seat belt to determine ongoing need for use of the belt and to ensure the belt provided a safe approach for the resident.

<u>Side Rails</u>

Resident #105, [LOCATION]

- Resident #105 was originally admitted to the CLC on [DATE] and most recently readmitted on [DATE]. The resident's diagnoses included cancer, dizziness, vertigo, anxiety, depression, and posttraumatic stress disorder (PTSD).
- The resident's annual comprehensive MDS dated 03/04/18 was coded to indicate the resident had moderately impaired cognitive skills for daily decision making based on staff assessment; the resident required extensive assistance with bed mobility and transfers. The MDS did not indicate the resident used bed (side) rails. The resident's quarterly MDS dated 06/01/18 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition; the resident required extensive assistance for bed mobility, and transfers did not occur during the review period. The MDS did not indicate the resident used bed (side) rails.
- During observations of medication pass on 07/23/18 at 5:21 p.m., an RN raised the fourth side rail on Resident #105's bed following medication administration; prior to medication administration the resident had three side rails raised on the bed. Following medication administration, the resident was observed on his back in the middle of the bed with very little movement and all four side rails in the elevated position.
- During an observation on 07/24/18 at 7:53 a.m., Resident #105 was observed in bed

with all four side rails elevated; the resident was on his back, appeared to be asleep, remained still and did not exhibit any movement. The assistant service line director (ASLD) who was present during the observation, confirmed four side rails were elevated and indicated that the resident requested to have all four side rails raised. The resident was not observed attempting to get out of bed during the survey. When a side rail assessment policy was requested on 07/24/18 at 9:53 a.m., the ASLD indicated the CLC did not have a side rail assessment policy.

- During an interview the morning of 07/24/18 at approximately 8:31 a.m., a quality manager (QM) provided a provider's order dated 03/23/18 that read, "Per pt. [patient] request 4 bedrails up when resting in bed." The QM also provided the resident's care plan dated 07/18/18 that indicated under "CAA #11 Falls…[Resident #105] will have 4 side rails up while in bed per his request." The QM indicated the resident "is alert and oriented" and "an assessment was done but information is not all in one place." The QM did not provide documentation to show the resident was assessed for safe use of four side rails. During observations during the survey, the resident was sleeping and not interviewed regarding the resident's request for four side rails.

During the daily meeting with leadership staff on 07/24/18 at 4:00 p.m., leadership staff was informed about side rail and seat belt assessments. Leadership staff acknowledged concerns with use of seat belt and side rail assessments.

F281

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

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

Residents Affected - Few

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

Insulin Administration

The CLC's policy titled, "Administration of Medication" and dated 03/07/17 was provided by the assistant service line manager on 07/24/18 at 9:29 a.m. The policy/circular did not address scanning of medication prior to administration.

Resident #106

- During an observation on 07/23/18 at 4:48 p.m., a registered nurse (RN) was observed administering aspart insulin 12 units for Resident #106 in [LOCATION]. The RN drew the insulin into a syringe and a second RN confirmed the correct medication and dosage of insulin in accordance with CLC policy. After the insulin was administered, the RN realized the vial of insulin was not scanned prior to administration and stated, "I forgot to scan it [insulin into BCMA].

Peripherally Inserted Central Catheter (PICC)

The CLC's policy titled, "Care of Intravenous Access Catheter" and dated 02/20/18 was provided by the quality manager on 07/24/18 at 3:45 p.m. The policy indicated, "CVC [central venous catheter]/Midline patency should be checked by aspirating for a brisk blood return prior to infusion of intermittent IV [intravenous] solution and every 8 hours for unused lumens." The policy also indicated that each lumen of a midline catheter or peripherally inserted central catheter (PICC) should be flushed with 10 ml [milliliters] of normal saline before and after each use.

Elsevier's (formerly Mosby's) policy was obtained on-line on 08/01/18. The policy dated February 2017 and titled, "Peripherally Inserted Central Catheter: Maintenance and Dressing Change," stated, "Attach a 10-ml (milliliter) syringe filled with preservative-free 0.9% sodium chloride to the appropriate port on the catheter….Open the clamp and gently aspirate until a blood return is visible in the tubing. **Each time aspiration occurs during a flush, gently apply pressure against the syringe plunger to avoid catheter or vein damage** [emphasis not added]. Slowly inject the flushing solution into the port, noting any resistance or sluggishness of flow. **Never inject against resistance** [emphasis not added]." The policy stated, "Flush and clamp the catheter with normal saline before and after all medication administration. Rationale: Flushing before and after administering medication clears the catheter and prevents medication precipitates from forming."

The Infusion Nursing Standards of Practice, revised 2016, Standard 57, Practice Criteria I stated, "Assess vascular access device (VAD) function and patency prior to administration of parenteral solutions and medications (refer to Standard 40, *Flushing and Locking*)." Standard 40.1 states, "Vascular access devices (VADs) are flushed and aspirated for a blood return

prior to each infusion to assess catheter function and prevent complications."

Resident #107, [LOCATION]

- Resident #107 had a provider's order dated 07/22/18 that stated, "Vancomycin INJ [intravenous injection], 1000 mg [milligrams] in dextrose 5% INJ SOLN [solution] 250 ml IVPB [intravenous piggyback] – infuse over 90 minutes Q8H [every 8 hours] to start 7/22 [2018] at 1600 [4:00 p.m.]"
- During an observation on 07/23/18 at 4:58 p.m., an RN administered intravenous vancomycin 1000 mg in 5% dextrose 250 ml through a PICC line for Resident #107. The RN did not aspirate for blood return or flush the PICC line with 10 ml of normal saline prior to administering the intravenous vancomycin. When asked about the observation the RN stated, "I did this [aspirated for blood return and flushed the PICC] earlier [time not specified] so when [laboratory] results [vancomycin trough] came back I would be ready to go [start infusion]." A nursing note dated 07/23/18 entered at 10:06 a.m. indicated a flush was provided; however, the note did not indicate the time the flush was provided.
- During the daily meeting with leadership staff on 07/24/18 at 4:00 p.m., leadership staff was informed about the RN not scanning insulin into the BCMA system prior to administration and not aspirating for blood return or providing a normal saline flush prior to administering vancomycin through a PICC line. Leadership staff acknowledged the concerns and did not provide additional information.

F282

483.20(k)(3)(ii) *The services provided or arranged by the facility must (ii) Be provided by qualified persons in accordance with each resident's written plan of care*

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 care was provided by qualified persons in accordance with each resident's plan of care. Findings include:

The CLC power-point training, "Sitter Responsibilities in One to One [1:1] Observation" was provided on 07/24/18 at 10:15 a.m., by a quality manager. According to the training, "You [1:1 sitter] may assist the patient to ambulate, set up the [meal] tray so they [resident] can eat if directed by the primary nurse. A sitter should not feed the patient."

Resident #205, [LOCATION]

- Resident #205 was admitted to the CLC on [DATE] with diagnoses including "dementia with behavioral disturbances." The resident's quarterly MDS dated 07/16/18 indicated the resident had severely impaired cognitive skills for daily decision making based on staff assessment; the resident rarely or never understood others and was rarely or never understood. The MDS indicated the resident required total assistance with eating.
- The resident's care plan dated 07/19/18 addressed approaches related to eating and stated, "Dysphagia pureed diet, needs much assistance and encouragement to stay focused during meals, [Resident #205] is still able to feed himself at times." The care plan also indicated, "Veteran is with 1:1 caregiver during the evening hours of 16-2000 (4:00 p.m. to 8:00 p.m.)."
- During the initial tour on 07/23/18 at approximately 10:30 a.m., the charge nurse stated Resident #205 "is always looking for something to do, is most active from 4-8 p.m. and has a 1:1 [sitter] during that time." When asked if the 1:1 "sitter" was a scheduled staff member, the charge RN indicated that the 1:1 sitter could be someone who worked elsewhere within the VA medical center "that has been scheduled to walk with him [the resident]."
- On 07/23/18 at approximately 4:15 p.m., Resident #205 was observed ambulating in the hallway accompanied by an assigned 1:1 sitter who identified himself as a staff member who routinely worked in the hospital; it was later determined that the staff member was a "unit clerk" and did not provide care in the hospital.
- On 07/23/18, the evening meal trays were delivered to the neighborhood dining room at 4:40 p.m.; the neighborhood LPN assigned the 1:1 sitter to assist Resident #205 with the meal. The 1:1 sitter stated, "This is the first time I've done this" as he attempted to feed the resident using a spoon. The resident sat for a few seconds before getting up and leaving the table. The 1:1 sitter followed the resident with the spoon of food attempting to get the resident to eat; there were no other staff present in the dining room while this occurred. No staff intervened or assisted the 1:1 sitter as the resident took a drink of coffee and poured the coffee into another cup, causing it to

spill. The 1:1 sitter encouraged the resident to open his mouth for several bites of food before the resident got up and moved again. Resident #205 then left the dining area with the 1:1 sitter following the resident. The resident's meal remained uneaten when the observation ended at 5:30 p.m.
- On 07/24/18 at 9:50 a.m., the deputy nurse executive (DNE) was asked about the 1:1 sitter program. The DNE stated that the 1:1 sitters "should not provide care and [the 1:1 sitters] are there for distraction and redirection." On 07/25/18 at 9:30 a.m., the nurse manager indicated that some 1:1 sitters were trained to provide feeding assistance but verified that the staff member assigned to assist Resident #205 on 07/23/18 was not qualified to feed a resident.

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).*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

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

Pain Management

Resident #104, [LOCATION]

- Resident #104 was admitted to the CLC on [DATE] with diagnoses including Parkinson's Disease, Lewy body dementia, encephalopathy, quadriplegia and a Stage 4 pressure ulcer over the coccyx. During the initial tour on 07/23/18 at 10:57 a.m., the nurse manager stated the resident was admitted with a Stage 4 pressure ulcer and experienced pain in the coccyx area.
- The resident's admission MDS dated [DATE] was coded to indicate the resident had severely impaired cognitive skills for daily decision making based on staff assessment, had signs of delirium including inattention and an altered level of consciousness, and required total assistance with activities of daily living (ADLs). According to the MDS and based on staff assessment, the resident received PRN (as needed) pain medication three to four days during the review period and experienced non-verbal sounds and facial grimacing suggesting pain. A quarterly MDS dated 06/17/18 was code similarly for cognition and ADLs; however, the resident received scheduled and PRN medication for pain and non-pharmacologic interventions for pain daily. The quarterly MDS indicated that based on staff assessment, the resident experienced facial grimacing suggesting pain . The Care Area Assessment (CAA) Summary completed in conjunction with the most recent comprehensive MDS dated 03/26/18 indicated the resident's pain warranted further review and the decision was made to proceed with care planning.
- The resident's care plan dated 07/11/18 stated, "CAA #19 Pain Problem: [Resident #104]] has advanced dementia and difficulty communicating his/her acute and/or chronic pain related to sacral ulcer." The goal read, "[Resident #104] will have his/her pain quickly recognized and effectively treated by nursing as evidenced by improved mood/wellbeing and return of functional ability to baseline." Approaches indicated,
  - "[Resident #104] will be monitored for changes in and/or worsening behaviors such as changes in facial expression, verbalizations/ vocalizations, bodily movements, interactions with staff/peers, and activity patterns.
  - [Resident #104] will be assessed using PAINAD [Pain Assessment in Advanced Dementia] Scale (non-verbal pain score for advanced dementia residents).
  - [Resident #104] will have scheduled pain medications administered as ordered.
  - [Resident #104] will be offered cognitive behavioral techniques such as deep breathing, relaxation, diversion, distraction, decreasing external stimuli, providing emotional/social support, application of heat/ice, etc.
  - [Resident #104] will have provider notified when PRN pain medication interventions are ineffective or if scheduled meds [medications]/cognitive behavioral techniques are ineffective and no PRN is ordered.
  - [Resident #104] will have site of pain examined and worsening changes documented and reported to provider."
  - The care plan did not address pain management related to wound care.
- Current provider orders included the following:
  - An order dated 07/16/18 for "acetaminophen liquid, oral 640 mg [milligrams]/20 ml [milliliters] G-tube [gastrostomy tube] TID [three times daily] for pain…." An order dated 07/19/18 for "acetaminophen liquid, oral 640 mg/20 ml G-tube Q day PRN [as needed] for pain or fever...."
  - An order dated 07/23/18 that read, "Change oxycodone liq. [liquid] Soln. [solution], oral 5 mg/5 ml PO [orally] Q daily [each day] administer 30 minutes

prior to wound care; administer 10 a.m. to oxycodone liq. Soln., oral 5 mg/5 ml PO Q daily administer 60 minutes prior to wound care."

- Bar Code Medication Administration (BCMA) documentation and the computerized patient record system (CPRS) for 07/21/18 to 07/25/18 indicated the following:
  - 07/21/18 at 9:40 a.m., oxycodone 5 mg was administered. Wound care was performed at 10:05 a.m., 25 minutes after oxycodone was administered.
  - 07/22/18 at 1:18 p.m., oxycodone 5 mg was administered. Wound care was performed at 1:40 a.m., 22 minutes after oxycodone was administered.
  - 07/23/18 at 9:57 a.m., oxycodone 5 mg was administered. Wound care was performed at 11:10 a.m., 73 minutes after oxycodone was administered.
  - 07/24/18 at 9:16 a.m., oxycodone 5 mg was administered. Wound care was performed at 10:38 a.m., 82 minutes after oxycodone was administered.
- During wound care observations on 07/24/18 at 10:38 a.m. (82 minutes after oxycodone was administered at 9:16 a.m.), Resident #104 was moaning while receiving treatment conducted by an RN and certified wound care nurse (CWCN). The resident was observed to have a Stage 4 coccyx pressure ulcer measuring 4.5 cm (centimeters) x (by) 2.5 cm x 1.6 cm with 2.5 cm undermining and exposed bone; these measurements were confirmed by the CWCN during the wound care. The resident's moaning increased when the RN used a normal saline soaked gauze pad to cleanse the wound; the wound actively bled during cleansing. When asked if the resident usually moaned during wound care, the CWCN indicated, "He [resident] makes noises whenever we touch him." The resident's body appeared to flinch and the resident's moaning increased when the CWCN measured the depth and undermining of the wound by placing a swab inside the wound. A nursing assistant held and repositioned the resident during wound care and apologized to the resident for having to move him [and causing pain]. After the wound care the resident moaned while being repositioned.
- During an interview and record review with the CWCN, nurse manager, and nurse director of the acute care hospital on 07/25/18 at 9:51 a.m., the CWCN indicated the CWCN and physician assistant (PA) noted the resident was experiencing "increased pain [during wound care] last week." A wound care nursing noted dated 07/20/18 read, "[Resident #104] demonstrated pain with today's dressing change even after being medicated with oxycodone 5 mg;" recommendations included, "Please consider additional or different medication to manage pain with dressing changes."
- The CWCN indicated there was a delay in making a change to the provider orders because 07/20/18 was a Friday and the PA and CWCN worked with the resident's wife to come up with a plan to address the resident's pain. The plan on 07/21/18 was for the resident to receive oxycodone 60 minutes prior to wound care; a provider's order for staff to administer oxycodone 60 minutes prior to wound care was documented on 07/23/18.
- During wound care on 07/25/18 at 9:51 a.m., the CWCN indicated the resident did not display as much facial grimacing, and had less rigidity than during wound care the previous day. The resident was turned on his side facing away from the CWCN and RN, and the surveyor could not see if the resident displayed facial grimacing; however, the resident moaned throughout the wound care and the moaning increased during wound cleansing and measuring of the wound.
- During a meeting with leadership staff on 07/25/18 at 11:30 a.m., leadership staff acknowledged concerns about pain management for Resident #104.
- In summary, during wound care observations on 07/24/18 and 07/25/18, Resident #104 grimaced and moaned throughout wound care provided for a Stage 4 coccyx pressure ulcer with exposed bone; the moaning increased during wound cleansing and measuring of the wound. A wound care nursing note dated 07/20/18 recommended, "Please consider additional or different medication to manage pain with dressing changes." The CWCN indicated there was a delay in making a change to the provider orders because 07/20/18 was a Friday and the PA and CWCN worked with the resident's wife to come up with a plan to address the resident's pain. The plan on 07/21/18 was for the resident to receive oxycodone 60 minutes prior to wound care. On 07/23/18, a provider's order indicated a change in the timing of oxycodone from 30 minutes prior to wound care to 60 minutes prior to wound care; there was no change in medication or additional medication ordered. It was not evident the provider was notified on 07/24/18 when the scheduled medication was administered 82 minutes before wound care and was ineffective in addressing the resident's pain.

F314 483.25(c) *Pressure Sores. Based on*	Based on observation, interview and record review, the CLC did not ensure that a resident who entered the CLC without pressure ulcers did not develop pressure ulcers unless the

the comprehensive Assessment of a resident, the facility must ensure that (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

individual's clinical condition demonstrated that they were unavoidable. Findings include:

The CLC policy dated May 29, 2018 and titled, "Prevention and Management of Pressure Ulcers," was provided by the quality manager on 07/24/18 at 9:30 a.m. According to the policy, a Braden Scale for Predicting Pressure Ulcer Risk score of 15-18 indicated a resident was at mild risk for pressure ulcer development. Approaches for pressure ulcer prevention included, "Protect heels, support entire leg with pillows to allow heels to suspend above the mattress or consult PT [physical therapy] for special heel protectors. Turn every two hours…may place pillow under one hip at a time if patient cannot tolerate full turning."

Resident #201, [LOCATION]

- Resident #201 was admitted to the CLC on [DATE] with diagnoses including Alzheimer's disease. During the initial tour on 07/23/18 at 10:30 a.m., the charge nurse stated that Resident #201 "has a Stage 4 pressure ulcer on his coccyx that he was not admitted with. He uses a seat belt for positioning and posture [in the wheelchair]." The charge nurse said the pressure ulcer developed as a result of the resident "slouching in his wheelchair." The charge nurse also said, "He cannot be up for very long [in the wheelchair]…his positioning is monitored very carefully and he is followed by wound care."
- Resident #201's quarterly MDS dated 02/12/18 indicated the resident was at risk of pressure ulcers; however, the resident did not have any pressure ulcers. The annual MDS dated 05/12/18 indicated the resident had severely impaired cognitive skills for daily decision making, required total assistance for all activities of daily living, and was incontinent of bowel and bladder. According to the annual MDS, the resident was at risk for pressure ulcers and had an unstageable ulcer that measured 2.5 cm (centimeters) x (by) 1 cm x 1.4 cm. Skin and ulcer treatments included pressure reducing devices in the chair and bed, pressure ulcer care, and applications of ointments/medications other than to feet. The Care Area Assessment (CAA) Summary completed in conjunction with the 05/12/18 MDS stated, "Veteran has an unstageable PU [pressure ulcer] to his coccyx. He is incontinent, does not ambulate, and is a full assist transfer via mechanical lift and has diagnosis of dementia. Interventions are in place such as the veteran is not sitting up for more than 1 hour at a time except for Sundays when he attends church services, he offloads the area of the wound when not sitting in his chair and is repositioned regularly."
- The resident's current care plan dated 06/21/18 included the following approaches: "[Resident #201] is up for Breakfast every day, out of bed for all meals no more than one hour at time….At risk for skin breakdown. Incontinent of bowel and bladder. Moderate [risk], score 15 Braden [mild risk according to CLC policy, as above]. Unstageable pressure ulcer to his gluteal cleft….[Resident] is OOB [out of bed] for 1 hour max [maximum] for meals." The care plan did not include approaches for repositioning the resident in bed including use of positioning wedges or use of heel protection.
- Resident #201 had the following pertinent provider orders:
  - 04/05/18: "Up in WC [wheelchair] for 1 hour only for meals otherwise in bed, off loading coccyx. Positional change q 2 hours [every 2 hours]."
  - 07/11/18: "Wound care clarification: sacral wound: if EpiCord visible in base of wound (appears similar to Aquacel AG but firmer texture) then continue to cover w/ Aquacel Ag/Mepilex. If wound base clearly visable [visible] w/o [without] evidence of EpiCord then irrigate wound bed, place Prisma, moistened w/ [with] small amt [amount] wound gel in wound bed. Fill any dead space w [with]/Aquacel AG. Cover with Mepilex border M-W-F [Monday-Wednesday-Friday] & prn [as needed]."
  - 07/20/18: "EpiCord again placed in wound bed as new epithelium continues to form over wound bed. Continue with same dressing change orders….Goal is to keep EpiCord in place, undisturbed until next clinic visit in 1 week."
- The most recent nursing skin assessment dated 07/16/18 indicated the resident had a Braden Scale for Predicting Pressure Ulcer Risk score of 15 suggesting mild risk for skin breakdown. Approaches included, "Use specialty bed (air), encourage small frequent [position] changes, turn and reposition q [every] 2 hours while in bed using pillows to separate pressure areas, use wheelchair cushion while in wheelchair, apply heel/elbow pads, maintain clean dry skin, and apply protective barrier ointment."
- The wound care provider note dated 07/11/18 stated, "Primary issues that impact wound healing….prolonged pressure and urinary fecal contamination. Wound: Superior gluteal cleft overlying coccyx; Current [measurements]: 2.0 cm x 1.0 cm x 0.05 cm: Prior [measurements]: 1.8 cm x 1.0 cm x 0.5 cm; Undermining @ [at] 12:00 [o'clock position]: Current [measurement of undermining] 1.0 cm; Prior [measurement of undermining]: 0.8 cm."

- The certified wound specialist (CWS) was interviewed on 07/24/18 at 8:35 a.m. and stated that Resident #201 had “a slow to heal wound due to exposure to moisture and exasperated by pressure.” The CWS said the resident had been seen in the wheelchair clinic and had pressure mapping completed with the wheelchair cushion. The CWS stated the resident had a pressure reducing air bed that the resident had for “at least two years.” The CWS said, “Staff are strict that he [the resident] is up in the wheelchair for no more than 1 hour at a time and when he is in bed he is repositioned every two hours. He has wedges that keep him at a 30 degree angle and his heels are off-loaded with pillows. Despite all the best [efforts], I haven’t seen progress and it’s not getting better.” When asked about other interventions, the CWS said, “The number one most important [intervention] is off-loading [pressure].”
- On 07/23/18 at 1:30 p.m., Resident #201 was observed with the charge nurse. The resident was lying in bed on a pressure reducing mattress. The charge nurse removed the resident’s blanket. The resident was lying on his left side with knees in a flexed position. The resident’s bare legs and knees were touching each other and there were no pillows between pressure points. The resident was wearing socks with the left ankle resting directly on the mattress. The resident was not supported with wedges, pillows, or other positioning devices. When asked about positioning devices, the charge nurse said, “No, he [Resident #201] doesn’t have any. It depends on the veteran [resident] and their preferences [as to whether positioning devices are used].”
- On 07/23/18 at 2:55 p.m., an NA exited Resident #201’s room stating, “He will stay in bed until dinner time.” The resident’s positioning in bed was again observed with the charge RN. The resident was positioned on his back wearing only an incontinence brief, a shirt and socks. The resident’s legs were adjacent to one another and the resident’s knees were touching. There were no pillows or wedges used for positioning or placed between pressure points; the resident’s heels rested directly on the mattress. The resident was again observed on 07/23/18 at 4:15 p.m. The resident remained on his back with two positioning wedges against the raised upper side rails; the positioning wedges were not used to position the resident.
- On 07/23/18 at 4:25 p.m., two NAs entered the resident’s room to transfer the resident to his wheelchair for the evening meal. The NAs placed the ceiling lift sling underneath the resident and transferred the resident to his wheelchair, leaving the sling in place on top of the pressure reducing cushion in the wheelchair. The resident was taken to the dining room and assisted with the evening meal. At 5:30 p.m., the NA said to the resident, “I’m going to take you into the TV room for a while.” The LPN stated, “All of the residents go into the TV room after they eat, until it’s time to put them into bed.” An NA who routinely provided care for Resident #201 said she assisted the resident to bed around 6:30 p.m. each evening. The NA said, “Tonight it may be later because some of the guys [residents] are not feeling well and so they will go [be assisted to bed] before him [Resident #201].”
- On 07/24/18 at 11:00 a.m., Resident #201 was observed lying in bed on his back with his heels resting directly on the mattress. Two NAs entered the resident’s room to transfer the resident to his wheelchair for the noon meal. The NAs placed the ceiling lift sling underneath the resident and transferred the resident to his wheelchair, leaving the sling in place on top of the pressure reducing cushion in the wheelchair. After eating the noon meal, the resident was taken into the TV room in his wheelchair. At 12:30 p.m., the resident was taken to his room and assisted into bed.
- On 07/24/18 at 12:45 p.m., the nurse manager was informed of the observations of the resident including concerns with positioning, lack of heel and bony prominence protection, length of time spent in the wheelchair and the observations of the sling left in the wheelchair. The nurse manager stated, “We tend to leave it [sling] under him” because the resident may experience more shearing if the sling is removed each time the resident is placed in the wheelchair. The nurse manager stated, "We are pretty proactive in getting him back to bed except on Sundays when he attends church service."

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

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:

<u>Transmission-based Precautions</u>

The CLC’s policy titled, “Guidelines for Isolation Precautions in the Healthcare Setting” and dated 04/16/18, was provided by the assistant service line manager on 07/24/18 at 9:29 a.m. The policy for Contact Precautions stated:

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

Residents Affected - Some

- "Wear gloves upon room entry of a patient/resident on Contact Precautions and for duration of time spent in room. If gloves become soiled with blood/body fluids while in the room, they must be changed. An isolation gown must also be worn when entering the room."

  In regard to "Enhanced Barrier Precautions" the policy stated:

- Despite the relaxed precautions for socialization, persons who will be having contact with the resident's skin or the resident's environment should adhere to Contact Precautions when performing resident bathing, wound care or other interventions which may cause exposure of MRSA [methicillin-resistant *Staphylococcus aureus*]."

A policy titled, "Methicillin Resistant Staphylococcus Aureus Prevention Policy" and dated 12/31/13, was provided by the assistant service line manager on 07/24/18 at 9:29 a.m. The policy indicated, "In the resident's bedroom, gloves and gowns should be worn by staff to prevent contamination of the healthcare worker's skin and clothing during procedures and resident care activity when contact with the resident's skin, body fluids, blood secretions or devices is anticipated. Gloves and gowns should be worn when doing wound care or providing assistance with activities of daily living (such as transfers, dressing, bathing, grooming and toileting), eating (if in resident bedroom) or during Physical or Occupational Therapy. For medication passes, if no anticipation of contact with blood or body fluids, patient or patient environment (i.e. patient bed or g-tube), then no PPE [personal protective equipment] is required. However, hand hygiene is still necessary before and after medication pass. Gowns should be worn whenever anticipating that clothing will have contact with potentially contaminated environmental surfaces or equipment in the resident's room….Reusable Medical Equipment (RME) is to be cleaned and disinfected before use on another patient according to RME policy. Staff are provided with, and educated about, the proper use of sanitizing wipes and /or other cleaning solutions, which they can use on non-critical equipment and environmental surfaces."

Resident #106, [LOCATION]

- On 07/23/18 at 4:48 p.m., a registered nurse was observed administering insulin for Resident #106 in the resident's room; the assistant service line manager accompanied the surveyor during the observation. A Contact Precautions sign was posted on the PPE caddy hanging on the resident's room door; the resident had an MRSA infection. The sign indicated staff must don a gown and gloves prior to entering the resident's room. The RN performed hand hygiene and entered the resident's room with the Bar Code Medication Administration (BCMA) scanner; the RN did not don a gown or gloves. The RN lifted the resident's arm with one ungloved hand and scanned the resident's name band holding the scanner in the other ungloved hand; the RN's clothing was observed to come into contact with the resident's bed. The RN held the scanner with ungloved hands, including the hand used to lift the resident's arm and walked to the computer located inside the resident's room to check the resident's medication orders. The nurse's clothing came in contact with the computer terminal and the nurse's fingers came in contact with the keyboard and mouse. The nurse exited the resident's room and drew up the insulin at the medication cart located outside the resident's room; the nurse did not conduct hand hygiene prior to or after preparing the insulin. The RN donned gloves but no gown, re-entered the resident's room and administered insulin into the resident's left arm; the RN's clothing was observed to come in contact with the resident's bed. The RN disposed of the insulin needle in the Sharps container in the resident's room, doffed gloves, performed hand hygiene and used the computer in the resident's room. At the conclusion of the medication administration, the RN placed the scanner on top of the medication cart without first placing a barrier and disinfecting the scanner with a germicidal wipe. After the RN completed the medication pass at 5:10 p.m., the surveyor asked the RN about the Contact Precautions sign posted on the door to the resident's room. The RN stated, "He [Resident] has MRSA in his foot; his infection is contained in the dressing."

Resident #105, [LOCATION]

- On 07/23/18 at 5:21 p.m. an RN was observed administering oral medication and medication administered through a gastrostomy tube for Resident #105; the assistant service line manager accompanied the surveyor. An Enhance Barrier Precautions (EBP) sign was posted on the PPE caddy hanging on the resident's room door. It was indicated staff was to implement EBP for a positive culture of MRSA of the resident's nares. The sign indicated staff was to don a gown and gloves when coming in contact with the resident or the resident's environment. The RN performed hand hygiene and entered the resident's room with a BCMA scanner; the RN did not don a gown or

gloves. When the RN scanned the resident's name band, the RN's gown was observed to come in contact with the resident's bed. The RN walked back to the medication cart located in the middle of doorway to the resident's room and placed the scanner on top of the medication cart without first placing a barrier and/or disinfecting the scanner with a germicidal wipe. The front of the RN's clothing came in contact with the front of the medication cart. The nurse prepared the resident's medications, performed hand hygiene, and donned a gown and gloves before re-entering the resident's room to administer medications.

Resident #104, [LOCATION]

- On 07/24/18 at 10:38 a.m. during wound care for Resident #104, a different RN than the RN that administered medications for Resident #105 was observed bringing a medication cart into Resident #104's room; the assistant service line manager accompanied the surveyor. An Enhanced Barrier Precautions (EBP) sign was posted on the PPE caddy hanging on the resident's room door. The sign indicated staff was to don a gown and gloves when coming in contact with the resident or the resident's environment. During wound care, the RN conducted hand hygiene, and donned and doffed gowns and gloves in accordance with CLC policy. At the conclusion of wound care, the RN wheeled the medication cart into the hallway outside of the resident's room. When asked by the surveyor if it was appropriate to bring the medication cart into the room if EBP was to be implemented for the resident, the RN stated, "Probably not."

Hand Hygiene

The CLC policy titled, "Hand Hygiene," and dated October 5, 2016, was provided by the nurse manager on 07/26/18 at 9:30 a.m. According to the policy, "If gloves become visibly soiled or if performing patient care on a contaminated site, remove or change gloves before moving to another body site on the same patient, a device, or the environment." Indications for hand hygiene included, "Before and after patient contact, before donning and after removing sterile or non-sterile gloves, [and] when moving from a contaminated body site to another body site during the episode of care."

Resident #205, [LOCATION]

- On 07/23/18 at approximately 4:40 p.m., the evening meal trays arrived in the neighborhood. Without first performing hand hygiene, the sitter/caregiver assigned to provide dining assistance for Resident #205 donned gloves at the direction of the LPN, and began to assist the resident to eat.

Resident #201, [LOCATION]

- On 07/24/18 at 11:00 a.m., two NAs entered Resident #201's room to assist the resident with transferring from the bed into his wheelchair for lunch. After performing hand hygiene, the NAs donned gloves and provided incontinence care. Without doffing gloves, conducting hand hygiene, and donning new gloves, one of the NAs applied an adult brief, sweatpants and shoes for the resident, and used the ceiling lift to transfer the resident into the wheelchair. After the resident was transferred into the wheelchair, the same NA applied the resident's seat belt and adjusted the resident's clothing; the NA doffed gloves, opened the door into the hallway and performed hand hygiene at the sink in the resident's room.