# 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: VA Maryland Health Care System - Baltimore VA Medical Center (Baltimore, MD)

Dates of Survey: 12/18/2018 to 12/20/2018

Total Available Beds: 91

Census on First Day of Survey: 80

| F-Tag | Findings |
|---|---|
| F309<br><br>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).*<br><br>**Level of Harm** - Actual harm that is not immediate jeopardy<br><br>**Residents Affected** - Some | 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:<br><br>Pain Management<br>The CLC's policy dated January 2018 and titled, "Nursing Assessment and Reassessment of Pain in the Community Living Center," was provided by a nurse manager on 12/19/18 at 12:30 p.m. The policy/procedure indicated, "It is the policy of GEC [geriatrics and extended are] to ensure that pain is addressed appropriately in the care and services provided to residents in the CLCs. The ultimate objective is for each resident to attain the highest practicable level of pain relief, quality of life, and functional status.<br>• The staff will provide pain management by:<br>o Recognizing Pain (potential and actual in both verbal and non-verbal residents);<br>o Establishing the Resident's Goals and Preferences with regard to pain prevention/management, in order to participate in activities of daily living at their highest functional and comfort level;<br>o Evaluating for Pain (the presence or absence of pain will be evaluated through assessment and re-assessment;<br>o Managing and Preventing Pain; and<br>o Documenting the aforementioned processes.<br>o Educate [residents] and their families/significant other regarding pain management….<br>• Actions: The GEC RN [registered nurse] will assess all residents for pain by evaluating the resident's verbal/non-verbal pain history/report, physiological aspects of pain, physical examination, clinical interview education related to pain interventions and management; and will ensure that documentation is done on the appropriate schedule and utilizing the appropriate…forms…Complete a reassessment of the effectiveness of pain management interventions, including addressing the resident's need for a bowel regimen, and signs and symptoms or other side effects/adverse reactions of their medication regimen. Initiates and updates plan of care by identifying resident priorities, goals, and interventions related to pain management. Complete all documentation…in a timely manner.<br>• The GEC LPN [licensed practical nurse] will perform a focused observation to determine changes in the resident's condition, collecting and reporting data for pain including the resident's response to interventions, problem identification, and evaluation to the RN or appropriate team member."<br><br>*Resident #104, [LOCATION]*<br>• Resident #104 was admitted to the CLC with diagnoses including degenerative joint disease (DJD), chronic pain syndrome, a Stage 4 pressure ulcer on the right elbow, and [DIAGNOSIS] with paraplegia. A significant change in status MDS dated 09/11/18 was coded to indicate the resident had moderately impaired cognitive skills for daily decision making based on staff assessment; the resident had clear speech, and understood and was understood by others. The MDS indicated the resident required |

total assistance with activities of daily living (ADLs) and received PRN pain medication for moderate pain based on staff assessment; a resident interview was not conducted by staff. A significant change in status MDS dated 10/25/18 was coded to indicate the resident had a score of 10 on the Brief Interview for Mental Status (BIMS) suggesting moderately impaired cognition; the resident had clear speech, and usually understood and was understood by others. According to the 10/25/18 MDS, the resident received scheduled pain medication and non-pharmacologic interventions for almost constant, moderate pain.

- The nursing admission assessment dated [DATE] following the resident's discharge on [DATE] and readmission from the acute care setting, indicated the resident had chronic, constant, generalized pain rated at 10/10 (10 out of 10 on a scale of 0 to 10 with 10 representing the worst pain possible) at its worst and 5/10 at its best. The pain was worse with movement and rest; medication, distraction, humor, music, and company made the pain better; pain affected the resident's mood and stress level. According to the nursing assessment, the resident received Tylenol for pain.
- The resident's undated care plan included a problem statement that read, "I have chronic pain." The goal stated, "My pain will be managed and will not interfere with my quality of life, ADLs, sleep or activities in the next 90 days." Approaches dated 05/17/18 included:
    - "I will accept non-pharmacological interventions to relieve my pain such as visualization, music therapy, and repositioning.
    - I will inform staff when I am experiencing pain pain [sic] and inform my provider.
    - I will be observed for non-verbal signs/symptoms of pain."
- The resident had the following pertinent provider's order:
    - 12/03/18: "Renew acetaminophen [Tylenol] oral tab [tablet] 650 mg [milligrams] PO [orally] every 6 hours for pain." The resident did not have an order for PRN [as needed] pain medication.
- Long-term care medication management notes written by the pharmacist indicated the following:
    - 10/31/18: "[Resident #104] with chronic pain was continued on scheduled acetaminophen after hospitalization from [DATE] to [DATE]. Prior to hospitalization, [the resident] requested pain medication 9 times since last review and assessment of pain was documented 5 times out of 9 (55%)….written nursing assessments are required when requesting PRN pain medications. Since the last review, written PRN pain documentation completed < [less than] 80% of the time. Will inform nurse managers to address pain documentation."
    - 11/05/18: "New medications: Oxycodone tab 5 mg PO daily for pain during dressing changes; acetaminophen oral tab 650 mg PO Q6H [every 6 hours] for pain. Pain assessment was completed – [Resident #104] with chronic pain, nursing monthly assessment documented."
    - 12/13/18: Documentation did not indicate oxycodone was ordered prior to wound care. The noted indicated the monthly nursing pain assessment was pending.
- A wound/skin assessment dated 12/17/18 indicated Resident #104 had a "Stage IV pressure injury [ulcer] right elbow measuring 2 cm [centimeters] x [by] 2 cm x 0.2 cm; with circumference undermining of between 0.5 cm to 2 cm; (undermining from 3 to 9 o'clock of 2 cm) periosteum exposed."
- During a wound care observation on 12/18/18 at 1:33 p.m., when the Stage 4 pressure ulcer on the resident's right elbow was touched, the resident verbalized pain stating, "Ow! That's enough!" When the RN and WCN asked the resident about his pain intensity level, the resident rated his pain at 10/10. The RN indicated the resident was given pain medication 30 minutes prior to wound care. The RN and wound care nurse (WCN) did not discontinue the wound care when the resident verbalized pain several times during the treatment. Review of Bar Code Medication Administration (BCMA) records indicated the resident received acetaminophen 650 mg at 12:56 p.m. on 12/18/18.
- The QM confirmed the resident did not have an order for PRN medication for pain and had no pain score documented from 12/13/18 through 12/20/18 at 10:21 a.m.

*Resident #203, [LOCATION]*

- Resident #203 was admitted to the CLC with diagnoses including Alzheimer's disease; the resident had a healing Stage 3 pressure ulcer on the right foot at the time of the survey. The quarterly MDS dated 10/15/18 indicated the resident had moderately impaired cognitive skills for daily decision making based on staff assessment. Based on staff assessment, the resident did not experience pain during the assessment period and did not receive scheduled or PRN pain medication or non-pharmacologic interventions for pain.
- The resident's current care plan dated 05/02/18 stated, "I have benign headaches occasionally. My staff will re-assess me for pain relief. My staff will utilize non-pharm

[pharmacologic] alternatives to redirect my focus from pain such as heat, cold, TV, etc."

- Pertinent provider orders included:
    - 04/25/18: "Acetaminophen oral tab 650 mg po q [every] 6 hours PRN for pain."
    - 04/25/18: "Baclofen oral tab 5 mg po TID [three times a day]."
- The geriatric monthly summary dated 11/19/18 stated, "Chronic generalized pain and sometimes H/A [headache]. Acetaminophen given as prescribed with good results."
- The long term care medication management note dated 11/30/18 stated, "Veteran with occasional pain, requested PRN medication once since last review."
- The monthly nursing summary dated 11/19/18 included Resident #203's most recent pain assessment. According to the summary, Resident #203 was "sometimes" aware of his needs and had "chronic pain, Location - generalized pain and headaches. Type: sharp. Relieving factors: medication, rest/positioning."
- The 12/19/18 nursing pain evaluation note stated, "Location: headache, Quality: aching. The patient's acceptable level of pain: 1 [1/10]. Alternative pain measures offered: [blank]."
- The 12/20/18 nursing pain evaluation note indicated, "Location: right leg, Quality: aching. The patient's acceptable level of pain: 1. Alternative pain measures offered: [blank]."
- According to the BCMA records from 07/01/18 through 12/20/18, PRN acetaminophen was not administered for Resident #203 from July 2018 through October 2018. According to the documentation, PRN acetaminophen was administered on the following days along with documentation about the effectiveness of the medication:
    - 11/18/18 - no pain intensity rating was documented.
    - 12/11/18 - pain level 6.
    - 12/14/18 - pain level 7.
    - 12/15/18 - pain level 7.
    - 12/16/18 - pain level 8.
    - 12/18/18 (2:28 a.m.) pain level 7.
    - 12/19/18 (10:06 a.m.) - pain level 6.
    - 12/20/18 (8:37 a.m.) - pain level 7.
- On 12/18/18 at 12:10 p.m., Resident #203 was observed sitting at a table in the dining room. The restorative care aide (RCA) approached the resident to assist with eating and asked the resident what was wrong. The resident stated he had a headache. The RCA asked if the resident told the nurse and the resident said, "No." The RCA told the resident she would tell the nurse. On 12/19/18 at 8:10 a.m., the nurse specialist reviewed the nursing documentation to determine the sequence of events after the resident reported pain on 12/18/18 at 12:10 p.m. According to the nurse specialist, "The MARS [medication administration records] indicate the PRN Tylenol was given at 2:28 p.m. for complaints of leg pain. There was no prior dose given." The nurse specialist could not locate documentation indicating the RCA reported the resident's complaint of a headache to nursing staff, other than a nursing note dated 12/18/18 at 4:51 p.m. that read, "Comfort level at 10 - throbbing pain." According to the MAR, no additional pain medication was provided.
- According to documents provided, the RCA completed an entry on 12/19/18 at 11:54 a.m. (following inquiry by the surveyor) for the resident's complaint of pain during the noon meal on 12/18/18. The entry read, "Complained of pain to various parts of body from one end to the other. Pain level at a 6, resident was uncomfortable in wheelchair. Pain and complaints reported to nursing staff. Resident declined session (range of motion) today due to pain."
- During an interview on 12/19/18 at approximately 1:00 p.m., the RCA stated, "I reported it to the restorative RN but there were a lot of other nurses in the dining room. Everyone was asking him [the resident] how he was doing. I told his nursing assistant that he looked uncomfortable and should be put into bed…."
- During an interview on 12/19/18 at 3:10 p.m. while Resident #203 was in bed, the resident said, "I have pain. My head aches, my foot and my leg and all over. Right now, the worst pain is in my foot" as he pointed to his right foot with the "healing Stage 3 pressure ulcer."
- On 12/19/18 at 4:30 p.m., the restorative nurse manager said, "[Resident #203] receives scheduled baclofen three times a day at 10:00 a.m., 2:00 p.m., and 6:00 p.m. which also helps with his pain."
- On 12/20/18 at 9:25 a.m., the provider completed a pain assessment/reassessment that stated, "Resident has no complaint of pain now." According to the BCMA, PRN acetaminophen had been given at 8:37 a.m. The assessment further noted, "Slow healing right foot ulcer, etiology of his slow healing foot ulcer may be multifactorial, DM [diabetes mellitus] with diabetic neuropathy. No sign of active infection will refer to high risk podiatry for further evaluation and management. Will repeat ABI [not further clarified] to evaluate the degree of his PAD [peripheral artery disease], x-ray to r/o [rule out] osteomyelitis…may consider restart Neurontin at low dose or possible BKA [below knee amputation] if pt. [patient] and pt's wife interested in, and his pain is persistent."
- In summary, on 12/18/18 at 12:10 p.m., Resident #203 was observed sitting at a table

in the dining room. When asked what was wrong, the resident stated he had a headache; the RCA told the resident that she would tell the nurse. According to the nurse specialist, "The MARS [medication administration records] indicate the PRN Tylenol was given at 2:28 p.m. for complaints of leg pain. There was no prior dose given [in response to the resident's complaint of a headache]." According to the BCMA records from 07/01/18 through 12/20/18, PRN acetaminophen was not administered for Resident #203 from July 2018 through October 2018. PRN acetaminophen was administered once in November 2018 and seven times in December (between 12/11/18 and 12/20/18) for a pain level of 6 to 8. It was not evident the CLC conducted a comprehensive assessment of the resident's pain to determine causal and contributing factors for the increase in pain in December 2018 and to develop applicable approaches for effective pain management.

*Resident #103, [LOCATION]*

- Resident #103 was admitted to the CLC on [DATE], transferred to the acute care setting on [DATE] for a blood transfusion and readmitted to the CLC on [DATE]. The resident's diagnoses included arthritis, degenerative joint disease (DJD), and Stage 4 pressure ulcers over the right ankle and left heel. The resident's significant change in status Minimum Data Set (MDS) dated 08/28/18 was coded to indicate the resident was independent in cognitive skills for daily decision-making based on staff assessment, had clear speech, and understood and was understood by others; a Brief Interview for Mental Status was not conducted. The MDS indicated the resident required extensive to total assistance with activities of daily living (ADLs). According to the 08/28/18 MDS and based on staff assessment, the resident received scheduled and PRN (as needed) pain medication and non-pharmacological interventions for pain; the resident interview for pain was not conducted. The significant change in status MDS dated 10/03/18 indicated the resident had a score of 15 on the BIMS suggesting intact cognition; the resident had clear speech, and understood and was understood by others. According to the MDS dated 10/03/18, the resident received scheduled and PRN pain medication and non-pharmacologic interventions for frequent pain at an intensity of 8/10 (on a scale of 0 to 10, with 10 being the worst pain imaginable).
- The Care Area Assessment (CAA) narrative dated 08/28/18 and completed in conjunction with the significant change in status MDS indicated, "Pain: Resident has history of…pressure ulcers…and osteoarthritis. Resident has shoulder pain fron impingement syndrome [impingement of tendons or bursa in the shoulder]. He takes oxycodone and uses lidocaine patch as scheduled. He has acetaminophen available as needed for pain. He is alert x 4 [to person, place, time and situation] and can make his needs known. The pain medications have been effective."
- Resident #103's undated care plan included a statement that read, "Problem: I have chronic pain related to my hernia, osteoarthritis, headaches, and peripheral neuropathy." The goal stated, "My pain will be managed and will not interfere with my quality of life within the next 90 days." Approaches dated 05/17/18 included:
    - "I will ask for pain medication when I am in pain.
    - I will accept non-pharmacological interventions to relieve my pain such as music therapy, and cold/hot packs.
    - I will be resting in a position of comfort and repositioned as needed."
    - The care plan did not address an acceptable pain level for the resident.
- Long term care medication management notes written by a pharmacist indicated the following:
    - 10/01/18: "Stopped morphine oral liquid 7.5 mg [milligrams] PO [orally] Q4H [every 4 hours] PRN [as needed] pain score 5; Morphine oral liquid 15 mg PO Q4H PRN pain score > [greater than] 5. Was a pain assessment completed during admission assessment and at regular intervals: No. Comments: [Resident #103] with chronic pain with breakthrough PRN medications. Since last review he has requested PRN pain medication on 25/35 [25 of 35] occasions with 0/25 with a completed nursing pain assessment [following administration of medication for pain]. No monthly nursing assessment completed for September [2018]….written nursing assessments are required when requesting PRN pain medications. Since the last review, written PRN pain documentation completed < [less than] 80% of the time. Will inform nurse managers to address pain documentation."
    - 11/05/18: "Was a pain assessment completed during admission assessment and at regular intervals: No. Comments: [Resident #103] with chronic pain with breakthrough PRN medications. Since last review he has requested PRN pain medication on 16/31 [16 of 31] occasions with 8/16 with a completed nursing pain assessment [following administration of medication for pain]. No monthly nursing assessment completed for September or October [2018]….written nursing assessments are required when requesting PRN pain medications. Since the last review, written PRN pain documentation completed < [less than] 80% of the time. Will inform nurse managers to address pain documentation."

    - 12/04/18: "Was a pain assessment completed during admission assessment and at regular intervals: No. Comments: [Resident #103] with chronic pain with breakthrough PRN medications. Since last review he has requested PRN pain medication on 17/29 occasions with 9/17 with a completed nursing pain assessment.…written nursing assessments are required when requesting PRN pain medications. Since the last review, written PRN pain documentation completed < [less than] 80% of the time. Will inform nurse managers to address pain documentation."
- An orthopedic progress note/orthopedic surgical note dated 11/13/18 indicated, "C/O [complains of] bilateral shoulder pain and would like injection in both shoulders. He [Resident #103] reports that prior injection in right shoulder gave about 4 weeks decreased intensity of pain…given cortisone injection 10/18/18. He lives in chronic pain with limited ROM [range of motion]. Noted long term opioids for pain on chart in CPRS [computerized patient record system]. Too soon to receive cortisone injection bilateral shoulders. DJD – glenohumeral arthritis bilateral."
- Resident #103's restorative notes/resident activity notes and treatment flowsheets/nursing flowsheets indicated the resident complained of pain in the shoulders and heels and "all over" on 12/06/18 and 12/10/18; and declined AROM (active range of motion) due to severe pain in shoulders on 12/08/18. According to the notes the resident was "ASIH [absent sick in hospital]" on [DATE] and returned to the CLC on [DATE].
- Resident #103 had the following pertinent provider orders:
    - 12/12/18: "Activity up as tolerated."
    - 12/12/18: "Out of bed to chair as tolerated daily or PRN when [resident] asks."
    - 12/12/18: "…gabapentin oral cap/tab [capsule/tablet] 200 mg PO SU-MO-TU-WE-TH-FR-SA [every day] @ [at] 0600-1200-1700 [6:00 a.m.-12:00 p.m.-5:00 p.m.]."
    - 12/12/18: "Acetaminophen oral tab 500 mg PO every 8 hours PRN pain. Please give with oxycodone."
- The nursing re-admission assessment dated [DATE] indicated Resident #103 reported chronic, dull, aching pain in the left shoulder; movement made the pain worse and rest and medication made the pain better. The assessment indicated the resident's acceptable level of pain was 3. According to the assessment, the resident rated his current pain level a 3 with the worst pain an 8 and pain at its best a 2. The assessment indicated when the resident's pain was 3/10, the pain kept the resident from activities and being comfortable; when pain was 4/10, pain interfered with sleep; when 5/10, pain affected the resident's stress level; and when 7/10, the pain affected the resident's mood.
- Restorative notes/resident activity notes and treatment flowsheets/nursing flowsheets documented after the resident's readmission on [DATE] indicated the resident complained of pain in the "shoulder sites" on 12/13/18 and declined ROM on 12/15/18.
- A pain inventory note dated 12/17/18 at 7:29 a.m. indicated the resident reported generalized aching pain during the shift. The resident's worst pain was 10/10 and 0/10 was the resident's acceptable level of pain. The note indicated the resident's pain interfered with ADLs. Pain relief measures offered included Tylenol 500 mg and oxycodone 5 mg. The note indicated the resident's pain goal was met with the current medication regimen. Non-pharmacologic methods of pain relief administered or utilized included repositioning and therapy/restorative. In addition, education was provided for the resident regarding pain management.
- A pain inventory note dated 12/17/18 at 2:54 p.m. indicated the resident reported generalized aching pain during the shift. The resident's worst pain was 10/10 and the resident's acceptable level of pain was 5/10. The pain interfered with ADLs. Pain relief measures offered included Tylenol 500 mg and oxycodone 5 mg. The note indicated the resident's pain goal was met with the current medication regimen.
- Bar Code Medication Administration (BCMA) records showed the resident received acetaminophen 500 mg and oxycodone 5 mg on 12/17/18, 12/18/18 and 12/19/18 at the following times:
    - 12/17/18 at 12:57 a.m. for a pain intensity rating of 9; the effectiveness of the medication in relieving the resident's pain was not documented.
    - 12/17/18 at 10:16 a.m. for pain score of 10/10. The resident's pain decreased to 5/10 by 11:16 a.m.; no additional interventions were implemented at 11:16 a.m. to address the resident's pain. According to the pain inventory note dated 12/17/18 at 7:29 a.m. (as above), the resident's acceptable level of pain was 0/10.
    - 12/18/18 at 9:13 a.m. for a pain score of 10; pain decreased to 5 by 11:03 a.m. According to the pain inventory note dated 12/17/18 at 2:54 p.m., the resident's acceptable level of pain was 5/10.
    - 12/19/18 at 9:07 a.m. for pain score of 10. Pain decreased to 6 by 1:23 a.m.; no additional interventions were implemented at 1:23 a.m. to address the resident's pain.

- Restorative notes/resident activity notes and treatment flowsheets/nursing flowsheets dated 12/18/18 stated, “AROM upper extremities. PROM lower extremities. Complained of shoulder pain.”
- During an interview on 12/18/18 at 2:22 p.m., Resident #103 stated, “I am in constant pain, usually a 9 to 10. Pain is in my shoulders. I was supposed to go for cortisone injection. The top of my head hurts. I was given two medicines; oxycodone for pain and something to make me sleep at night; it helps some when I can get it. Pain is usually 5 or 6 after getting medication. I have to call for it [medication]. My pain is 9 [currently]. I am supposed to get up every day; I’ve only been out of bed a few times in the past 5 to 6 weeks; it would probably help if they [staff] got me up like the doctor ordered. I believe working my joints more would help with the pain; they [restorative staff] work with me but it’s not long enough.” The resident did not describe his acceptable level of pain during the interview. The resident was not observed out of bed or requesting to get out of bed on 12/18/18 or 12/19/18.
- A provider’s order dated 12/18/18 and written following inquiry by a surveyor read, “…oxycodone oral tab 5 mg PO every 8 hours PRN for pain – please give with Tylenol [acetaminophen].”
- During an observation of wound care performed by an RN and wound care nurse (WCN) on 12/19/18 at 9:55 a.m., Resident #103 expressed concerns about pain in both feet and indicated a pain level of 9/10. The RN told the resident he had been given pain medication (Tylenol and oxycodone) at 9:00 [a.m.]. The resident stated, “It hurts real bad; the bottom of my feet.” The resident indicated, “They [restorative staff] tied an elastic band on the bottom of my feet and pulled [used a TheraBand during restorative care]; it hurts.” The nurse informed the resident that he would not perform wound care for the resident’s feet after the resident indicated experiencing pain in his feet. The quality manager accompanying the surveyor left the room to inform the physician about the resident’s complaints of pain. The physician arrived and evaluated the resident and ordered the following on 12/19/18: change acetaminophen oral 500 mg PO SU-MO-TU-WE-TH-FR-SA @ [at] 0600-2200 [6:00 a.m.-10:00 p.m.] PRN for pain to acetaminophen oral 500 mg PO SU-MO-TU-WE-TH-FR-SA @ 0600-2200 [6:00 a.m.-10:00 p.m.] for pain. 12/19/18: Tramadol HCL (CS) oral tab 50 mg daily PRN. Please give one hour before dressing change.”
- During an interview on 12/19/18 at 2:23 p.m. with the physician, psychologist, and WCN, the physician stated, “I understand the resident’s pain is not well controlled but I am afraid of delirium. He has cortisone shots every three months; the last shot was given on 10/13/18 and his next appointment is 01/11/19. The resident has chronic anemia that requires blood transfusions. The resident is in and out of the hospital and comes back [to CLC] more confused. He gets Tylenol, oxycodone and gabapentin three times a day. I have to be careful with pain medications because of delirium. He has never complained to me about pain in his feet, never ever. He complained about pain in his shoulders. He told me that pain decreases to 5 after receiving medication.” The physician indicated, “Whenever he [the resident] gets out of bed, he feels better.” The WCN indicated, “…diversion works when doing wound care. He used to be on restorative for transfers until he developed wounds on his feet at the hospital. He used to have a bedside commode but can’t pivot transfer because of wounds on his feet.” The psychologist agreed providing diversional activities for the resident would assist with pain management. The psychologist stated, “The resident is hyper-focused on what he can’t do…resisted going to CLC….He has no patience and forgets things were done for him.” The WCN indicated, “We encourage him to get up but the majority of the time he refuses. We try to get him up for lunch but he complains of pain and is uncomfortable. First thing in the morning they try to get him up. He was up on Friday [12/14/18]; ate lunch and was put back to bed.”
- In summary, during an interview on 12/18/18, Resident #103 stated, “I am in constant pain, usually a 9 to 10. Pain is in my shoulders.…The top of my head hurts….Pain is usually 5 or 6 after getting medication. I have to call for it [medication]. My pain is 9 [currently].” Documentation indicated the resident experienced pain with range of motion (e.g., 12/18/18) or declined range of motion related to pain (e.g., 12/08/18). BCMA records showed the resident received acetaminophen 500 mg and oxycodone 5 mg on 12/17/18 at 12:57 a.m. for a pain intensity rating of 9; the effectiveness of the medication in relieving the resident’s pain was not documented. On 12/17/18 at 10:16 a.m., acetaminophen and oxycodone were administered for a pain score of 10/10. The resident’s pain decreased to 5/10 by 11:16 a.m.; no additional interventions were implemented at 11:16 a.m. to address the resident’s pain. According to the pain inventory note dated 12/17/18 at 7:29 a.m., the resident’s acceptable level of pain was 0/10. Acetaminophen and oxycodone were administered on 12/19/18 at 9:07 a.m. for the resident’s pain score of 10. Pain decreased to 6 by 1:23 a.m.; no additional interventions were implemented at 1:23 a.m. to address the resident’s pain. Long term care medication management notes dated 10/01/18, 11/05/18 and 12/04/18 written by a pharmacist indicated a pain assessment was not completed at regular intervals. For example, the note dated 12/04/18 stated, “[Resident #103] with chronic pain with

breakthrough PRN medications. Since last review he has requested PRN pain medication on 17/29 [17 of 29] occasions with 9/17 with a completed nursing pain assessment….written nursing assessments are required when requesting PRN pain medications. Since the last review, written PRN pain documentation completed < [less than] 80% of the time…."The resident's care plan did not address an acceptable pain level for the resident.

Additional Information

- During a meeting with leadership staff on 12/19/18 at 4:00 p.m., leadership staff was informed about pain management concerns for the resident's listed above. Leadership staff indicated CLC staff would provide additional information. Leadership staff was again informed about continuing concerns with managing pain during a meeting held on 12/20/18 at 11:30 a.m.

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

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

**Residents Affected** - Few

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

Transmission-based Precautions

The CLC's policy titled, "Transmission-Based Precautions In Community Living Centers - Attachment C" and dated August 2018 was provided by the acting chief nurse on 12/19/18 at 4:28 p.m. The policy/procedure indicated,

- "Hand Hygiene: Perform hand hygiene with alcohol-based hand rub (ABHR, such as Purell) or soap and water before and after direct contact with residents, after contact with inanimate objects, after contact with blood/body fluids and before and after removing PPE [personal protective equipment].
- Personal Protective Equipment (PPE):
    - Gloves & Gowns: A gown and gloves are required for care interactions that have been shown to be at high risk for clothing contamination. These interactions include:
        - Dressing changes/wound care
        - Handling/caring for devices (i.e. peg [percutaneous endoscopic gastrostomy] tubes, Foley catheters)
        - Assisting/providing resident care with bathing, combing hair, brushing teeth, changing briefs or getting dressed
        - Transferring the resident
        - Changing bed linen.
- For all other resident interactions, Standard Precautions will be followed.
- Based on the risk of exposure to blood or body fluids, PPE may be required."
- "Environmental Cleaning; Routine cleaning and disinfection of environmental surfaces, beds, bedrails, bedside equipment and other frequently touched surfaces with a hospital-approved disinfectant is required. Disposable trays or dishes are unnecessary."

*Resident #105, [LOCATION]*

- On 12/19/18 at 9:21 a.m., an LPN was observed by the quality management staff person and surveyor administering medications through Resident #105's gastrostomy tube in the resident's room. An Enhanced Barrier Precautions sign was posted on the door to the resident's room; the sign indicated staff were to don a gown and gloves when direct contact was anticipated with the resident or the resident's environmental surfaces.
- The LPN performed hand hygiene, donned a gown and gloves, entered the resident's room with a Bar Code Medication Administration (BCMA) scanner, lifted the resident's arm with one gloved hand and scanned the resident's wristband with the other hand; the nurse's gown was observed to come into contact with the resident's bed. The LPN held the scanner with one gloved hand while walking back to the medication cart located in the middle of the doorway to the resident's room. The LPN returned the scanner to the cradle on top of the medication cart without first wiping the scanner with a germicidal wipe; the front of the LPN's gown came into contact with the front of the medication cart. The LPN doffed gloves and performed hand hygiene prior to touching the computer keyboard. The LPN removed medications from the medication drawer, crushed the medications and placed them in separate medicine cups. The LPN obtained a tray and placed the medicine cups, a bottle of eye drops, and topical lidocaine cream in a medicine cup on the tray; carried the tray into the resident's room; and placed the tray on top of bedside table without first placing a barrier. After administering the resident's medication, the LPN returned to the medication cart and placed the tray on top of the cart without first wiping the tray with a germicidal wipe.

The front of the LPN's gown was observed to touch the front of the medication cart. The LPN doffed the gown and gloves, performed hand hygiene and wiped the tray with a germicidal wipe.