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 Boston Healthcare System Brockton Campus (Brockton, MA)

Dates of Survey: 6/12/2018 to 6/14/2018

Total Available Beds: 112

Census on First Day of Survey: 84

F-Tag	Findings
F164 483.10(e) *Privacy and Confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident; (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when (i) The resident is transferred to another health care institution; or (ii) Record release is required by law.* **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 had the right to privacy. Findings include: Privacy During Care *Resident #302, [LOCATION] Neighborhood* • Resident #302 was admitted to the [LOCATION] neighborhood on [DATE] with diagnoses including CHF (congestive heart failure) and COPD (chronic obstructive pulmonary disease). The resident's comprehensive admission Minimum Data Set (MDS) dated [DATE] indicated that based on staff assessment, the resident's memory was "OK, [the resident] makes decisions regarding tasks of daily life, and independent, decisions consistent and reasonable;" a Brief Interview for Mental Status was not conducted by staff. The MDS was coded to indicate the resident required extensive assistance of one person for bed mobility and personal hygiene. According to the MDS, the resident had a Stage 2 pressure ulcer. Skin and ulcer treatments included pressure ulcer care, and application of dressings and ointments/medications other than to feet. • A provider's order dated 05/30/18 stated, "Healing Stage 2 pressure injury sacrum/coccyx: NS [normal saline] wash, pat dry. Apply Mepilex sacrum border (use 9.2 x 9.2 size) upside down. Leave in place up to 3 days. Peel back daily to inspect skin." • During an observation of a dressing change on 06/13/18 at 9:30 am, an LPN entered the resident's room, left the door to the hallway open, and did not draw the privacy curtain between the door and the resident's bed. The LPN prepared materials for the dressing change and assisted the resident in turning onto his left side so that the resident was facing away from the door to the hallway. The LPN moved the sheet and blanket to below the resident's buttocks and moved the hospital gown leaving the resident's back and buttocks uncovered while the LPN removed the dressing to the sacrum/coccyx. Although no staff or residents were observed in the hallway outside the resident's room, the resident was visible from the hallway. When asked about closing the door, the LPN replied, "Yes, I forgot;" the door was subsequently closed. *Resident #105, [LOCATION] Neighborhood* • On 06/12/18 at 4:43 p.m. a registered nurse (RN) was observed entering the day room in the [LOCATION] neighborhood and approached Resident #105 who was seated near two other residents. The RN assisted Resident #105 to tilt his head back and administered one drop of Artificial Tears eye drops into each eye. The RN did not assist Resident #105 to a more private area prior to administration of the eye drops. *Additional Observations, [LOCATION] Neighborhood* • On 06/12/18 at 4:20 p.m., 7 residents were seated in the day room watching television, including Resident #202. An RN entered the day room with a glucose meter, scanner,

supplies and a computer on a rolling cart. The RN obtained fingersticks for blood glucose for four of the seven residents without providing privacy for the residents.

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 - Some

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:

Assistance with Dining

- On 06/12/18 at 4:43 p.m., the evening meal was observed. A nursing assistant stood next to Resident #202 to assist the resident with the meal; the NA did not sit next to the resident or otherwise engage with the resident during the meal.
- On 06/13/18 at 7:25 a.m. during the breakfast meal, a nursing assistant was observed assisting Resident #202, Resident #204 and other residents. While providing dining assistance, the nursing assistant stood next to the residents and did not otherwise engage with the residents.

Resident #204, [LOCATION] Neighborhood

- Resident #204 was admitted to the CLC on [DATE] with diagnoses including dementia. The resident's current care plan dated 04/13/18 indicated the resident required assistance with eating. A nursing note dated 06/03/18 stated, "Dependent on staff for all ADLs [activities of daily living], 1:1 [one-to-one] supervision with meals, and is a high risk for aspiration."
- During the breakfast meal on 06/13/18 at 7:25 a.m., Resident #204 was observed seated at a dining room table with two other residents. The resident was observed with excessive nasal discharge. The nursing assistant (NA #1) assisting the resident was not seated, and as NA #1 walked away and turned her back to Resident #204, a thick nasal discharge extended from the resident's nose and onto his plate. While the discharge was present, the resident picked up a cup of orange juice and drank it with some of the discharge entering his mouth. Another nursing assistant (NA #2) was present in the dining room during the observation but did not respond to the resident. NA #1 returned to the table approximately four minutes later and cleaned the resident's nose with a Kleenex. (See Infection Control)

F272

483.20(b)(1) *Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: (i) Indentification and demographic information; (ii) Customary routine; (iii) Cognitive patterns; (iv) Communication; (v) Vision; (vi) Mood and behavior patterns; (vii) Psychological well-being; (viii) Physical functioning and structural problems; (ix) Continence; (x) Disease diagnosis and health conditions.; (xi) Dental and nutritional status; (xii) Skin Conditions; (xiii) Activity pursuit; (xiv) Medications; (xv) Special treatments and procedures; (xvi) Discharge potential; (xvii) Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and (xviii) Documentation of participation in assessment.*

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

Based on observation, interview and record review, the CLC did not conduct comprehensive assessments prior to seat belt use or for residents who smoke. Findings include:

Smoking Assessments

The VA Boston Healthcare System Medical Center Memorandum 11-027-LM dated September 2016 and titled, "Reducing the Fire Hazard of Smoking When Oxygen Treatment is Expected," was provided on 06/13/18 at 1:45 p.m. by a quality management staff person. The policy stated, "1. Purpose: To establish policy and procedure regarding patients who smoke while using supplemental oxygen and to ensure their safety and the safety of those around them….5. Procedures....d. Nursing Service….(5) During the Admissior Assessment/Initial Nursing Assessment, it will be determined if the patient is an active smoker and uses oxygen. If so, a consult to Respiratory therapy for O_2 [oxygen] safety assessment will be completed."

On 06/13/18 at 5:00 p.m., the associate chief of nursing services (ACNS) provided a template described as the smoking assessment portion of the nursing admission assessment and stated, "This assessment should be completed for each resident who is identified as a smoker as part of the nursing admission assessment." The template included the following possible choices to be checked as applicable to an individual resident: "Additional Comments.…This patient cannot participate in screening due to cognitive impairment." "Patient refused tobacco use screening." "Patient is a LTC/SCI [long-term care/spinal cord injury] resident and is a smoker." "Resident is able to smoke independently if answers to all statements below are yes: [1] Resident can verbalize location of designated smoking areas. [2] Resident can independently access smoking locations. [3] Resident is able to hold a cigarette, matches/lighter, light and extinguish cigarette and dispose in appropriate receptable [sic]. [4] Resident does not have any condition/take medications that affects ability to smoke safely. Resident does not have a history of unsafe smoking behavior (falling asleep while smoking,

minimal harm that is not immediate jeopardy

Residents Affected - Some

visible burns to self or clothes)." "Resident unable to smoke independently as indicated below: [text box for narrative]" "Recommendation: Supervised Smoker or Unsupervised Smoker." "Provider has been notified to write order for smoking status."

Resident #302, [LOCATION] Neighborhood

- Resident #302 was admitted to the [LOCATION] neighborhood on [DATE] with diagnoses including CHF (congestive heart failure), COPD (chronic obstructive pulmonary disease), and dyspnea (difficult breathing).
- The resident's comprehensive admission MDS dated [DATE] indicated that based on staff assessment, the resident's memory was "OK, [the resident] makes decisions regarding tasks of daily life, and independent, decisions consistent and reasonable;" a Brief Interview for Mental Status (BIMS) was not conducted by staff. The MDS was coded to indicate the resident was totally dependent on the assistance of one person for transfers and was independent for locomotion on and off the unit (neighborhood). Walking in the resident's room and the hallway, and balance when moving from a seated to standing position, surface-to-surface transfers, and turning around were coded as "activity did not occur." According to the MDS, the resident had functional limitations in range of motion in both lower extremities and no limitations in range of motion of in the upper extremities.
- The "Nursing Admission Assessment" dated [DATE] was written by an RN and stated, "Smoking: Patient reports use of tobacco in the past 30 days. Moderate/heavy use. Patient was offered and declined smoking cessation counseling. Is the patient an active smoker and uses oxygen? Yes. Send a consult to respiratory therapy for O_2 [oxygen] safety assessment."
- Resident #302's care plan dated 05/01/18 stated, "Problem/Need: I need to be supervised while smoking d/t [due to] use of oxygen. I am allowed to smoke with family only (but can be taken by staff when needed if family is unavailable, otherwise I am allowed off the unit [neighborhood] after I check with nursing staff). This problem/need is ongoing. Goal: I will smoke in designated areas with adequate supervision per policy through next review. Approaches: No cigarettes or lighters at bedside, to be left at nursing station. Provide safe environment for smoking. Smoking breaks will be arranged with me. Monitor me at all times while I am smoking. Monitor me while lighting and extinguishing cigarettes."
- A provider's order dated 05/02/18 stated, "[Resident #302] can only go out to smoke with family and his oxygen needs to be turned off prior to smoking. He can otherwise leave the unit independently in his wheelchair after checking in with staff."
- A provider's order dated 05/07/18 stated: "Discontinue [Resident #302] can only go out to smoke with family and his oxygen needs to be turned off prior to smoking. He can otherwise leave the unit independently in his wheelchair after checking in with staff."
- A "Hospice Progress Note" dated 06/07/18 stated, "[Resident #302] continues to smoke and wears oxygen only intermittently for comfort."
- During a tour of the CLC on 06/12/18 at 1:50 p.m. with the quality management staff person present, Resident #302 was observed in the designated smoking area in the courtyard of the CLC smoking a cigarette. There were no staff in the smoking area observing the resident. The resident was not observed smoking unsafely, was not using oxygen and did not have an oxygen tank present.
- During an interview with the nurse manager of the [LOCATION] neighborhood on 06/13/18 at 1:00 p.m., when asked about the oxygen safety assessment performed by respiratory therapy for residents who use oxygen and smoke as indicated in Resident #302's nursing admission assessment, the nurse manager stated, "Respiratory therapy doesn't document a safety assessment. If a resident is on oxygen and wants to smoke, the respiratory therapist inserts a valve in their oxygen tubing that has a sensor. If the sensor senses any smoke, it shuts off the flow of oxygen." The nurse manager reviewed the "Respiratory Therapy Progress Notes" for Resident #302 and stated, "There's nothing here about a safety assessment." When asked if the care plan had been updated, the nurse manager stated, "No, it needs to be updated. The physician discontinued the order for supervision about 3 weeks ago." When asked if other CLC staff performed smoking safety assessments including an assessment of the resident's cognition and functional limitations, the nurse manager stated, "No, we don't have an assessment like that."
- None of the items in the smoking assessment template were addressed in Resident #302's nursing admission assessment.

Resident #304, [LOCATION] Neighborhood

- Resident #304 was admitted to the [LOCATION] neighborhood on [DATE] with diagnoses including diabetes, heart failure, peripheral vascular disease, and chronic

kidney failure. The resident's comprehensive admission MDS dated [DATE] indicated the resident scored 15 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition. The MDS was coded to indicate the resident was independent in transfers and locomotion inside and outside of the neighborhood. According to the MDS, moving from a seated to standing position, surface-to-surface transfers, walking, and turning around were coded as "activity did not occur." The MDS indicated the resident had functional limitations in range of motion in both lower extremities and no limitations in the upper extremities.

- The "History and Physical" dated [DATE] stated, "[Resident #302 has a] closed fracture of the metacarpal [finger] bone….Smoker."
- The "Nursing Admission Assessment" dated [DATE] was documented by an RN and stated, "Smoking: Patient reports use of tobacco in the past 30 days. Light use. Patient was offered and declined smoking cessation counseling. Is the patient an active smoker and uses oxygen? No."
- There were no current provider orders provided by staff related to smoking.
- Resident #304's care plan dated 04/24/18 did not address the resident's smoking.
- During a tour of the CLC on 06/12/18 at 1:50 p.m. with the quality management staff person present, Resident #304 was observed in the designated smoking area in the courtyard of the CLC safely smoking a cigarette.
- During an interview with the assistant nurse manager of the [LOCATION] neighborhood on 06/13/18 at 1:45 p.m., when asked if CLC staff performed smoking safety assessments for residents who smoked including an assessment of the resident's cognitive and functional limitations, the assistant nurse manager stated, "We don't have anything like that. We don't look at all the individual parts of the smoking process or watch each resident smoke to make sure they are safe."
- None of the items in the smoking assessment template were addressed in Resident #304's nursing admission assessment.

Seat Belt Use

Resident #202, [LOCATION] Neighborhood

- Resident #202 was admitted to the CLC on [DATE] with diagnoses including dementia and a cerebrovascular accident (CVA).
- The resident's annual comprehensive Minimum Data Set (MDS) dated 12/03/17 indicated the resident had unclear speech, and sometimes was understood by and understood others. The Brief Interview for Mental Status (BIMS) was not conducted; based on staff assessment, the resident's cognition was severely impaired. The MDS indicated the resident needed total assistance with transfers, walking in the corridor (hallway) did not occur, and the resident had functional limitations in range of motion of one upper extremity. According to the MDS, the resident did not use physical restraints. The resident's quarterly MDS dated 05/30/18 indicated the resident had a BIMS score of 3 suggesting severely impaired cognition, had unclear speech, and sometimes was understood by and understood others. The MDS indicated the resident needed total assistance with transfers, walking in the hallway did not occur, and the resident had no functional limitations in range of motion. According to the MDS, the resident did not use physical restraints.
- The resident's care plan dated 06/07/18 indicated the resident was at high risk for falls; use of a seat belt was not addressed in the plan of care.
- On 06/12/18 at approximately 10:00 a.m., Resident #202 was observed across from the nursing station. The resident was seated in a tilt-in-space wheelchair that was not reclined; a seat belt with a red button for opening the belt was observed across the resident's lap. The resident's right hand appeared contracted with the fist clenched. On 06/12/18 from 1:00 p.m. until 4:40 p.m., the resident was observed in the "day room." The resident was sitting in the same wheelchair observed on 06/12/18 at 10:00 a.m.; the wheelchair was reclined and a seat belt with a red button was across the resident's lap. The resident was observed attempting to sit up and reposition but did not appear to be attempting to get out of the wheelchair; the wheelchair was in a reclined position. The resident's left leg remained crossed over the top of the right arm of the wheelchair from 1:00 p.m. until 4:40 p.m. and the resident appeared to be attempting to sit up and reposition. At approximately 2:15 p.m., while still in this position, the resident's right foot became lodged between the foot rests. (See Pressure Ulcers) Multiple staff were observed coming and going from the day room and walking by the resident, including an RN who was conducting blood sugar checks at 4:25 p.m. The resident remained with the left leg over the right wheelchair armrest and the right foot lodged between the foot rests until the resident was taken to the dining room for the evening meal at approximately 4:40 p.m. In the dining room, the resident was repositioned to an upright position with the wheelchair placed in an approximate 90-degree angle. On 06/12/18 at

5:20 p.m. following the evening meal, the resident was removed from the dining room table by a nursing assistant (NA); the resident's seat belt was released during the meal. As the resident was moved away from the dining room table, the NA reapplied the seat belt and said to the resident, "I will take you back to the day room." The NA said to surveyor, "I release his [seat] belt when he eats, he doesn't."

- On 06/13/18 at 7:40 a.m., Resident #202 was observed in the dining room eating breakfast; the resident was seated in the wheelchair with the seat belt applied. At 8:05 a.m., the resident was taken from the dining room, the wheelchair placed into the reclined position, and the resident placed across the hall from the nursing station.
- On 06/13/18 at 8:07 a.m., a different NA than the NA observed assisting the resident on 06/12/18 at 5:20 p.m. was interviewed regarding use of the seat belt. The NA said, "He always has to have it on. We don't ever take it off. He is a fall risk. If he becomes really agitated, he tries to take it off. I think he can remove it, maybe not right now."
- On 06/13/18 at 8:37 a.m., the nurse manager (NM) was interviewed regarding the seat belt. The NM stated, "He [Resident #202] is a high fall risk and the belt is to remind him. We put it on when he is up in the chair and when he is not in the chair we will take it off. My understanding is that he can take it off."
- There were no provider orders related to use of a seat belt and use of the seat belt was not addressed in nursing monthly or weekly summaries. Although an assessment of the seat belt was requested from the QM staff person on 06/12/18 and 06/13/18, an assessment was not provided. 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. The seat belt was not addressed in the resident's plan of care.

F281

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

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

Residents Affected - Few

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

Resident #202, [LOCATION] Neighborhood

- Resident #202 was admitted to the CLC on [DATE] with diagnoses including dementia, cerebrovascular accident (CVA) and diabetes type 2.
- The resident's comprehensive annual MDS dated 12/03/17 indicated the resident had unclear speech, and sometimes was understood by and understood others. The MDS indicated the resident needed total assistance with transfers, walking in the corridor (hallway) did not occur, and the resident had functional limitations in range of motion of one upper extremity. The Brief Interview for Mental Status (BIMS) was not conducted; based on staff assessment, the resident's cognition was severely impaired. The resident's quarterly MDS dated 05/30/18 indicated the resident had a BIMS score of 3 suggesting severely impaired cognition, had unclear speech, and sometimes was understood by and understood others. The MDS indicated the resident needed total assistance with transfers, walking in the hallway did not occur, and the resident had no functional limitations in range of motion. According to the MDS, the resident did not experience pain.
- The resident's current care plan dated 06/07/18 stated, "I have episodes of pain due to "Edema to Right Lower extremity." Approaches included, "Ted [TED, thrombo-embolic-deterrent] stocking RLE [right lower extremity] on in AM off in HS [hour of sleep]. Monitor for pain Q [every] Shift."
- Current provider orders stated, "06/06/18 TEDS RLE on in AM off at HS."
- The resident was observed on multiple occasions throughout the survey on 06/12/18 and 06/13/18. The resident was wearing white crew socks and tennis shoes; a TED stocking was not in place on the right lower extremity.
- On 06/13/18 at 8:07 a.m., a nursing assistant (NA) assigned to care for the resident stated she provided hygiene care and dressed the resident for the day. The resident was observed wearing crew socks and tennis shoes; a TED stocking was not in place on the right lower extremity. When asked about being in pain when TED stockings were applied, the NA state, "He doesn't have any special stockings. He only wears regular socks."
- The CLC did not ensure TED stockings were applied as indicated in the provider's order.

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 ensure a resident received the necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being. Findings include:

Pain Management

The CLC's policy dated November 2016 and titled, "Pain Management Program," was provided by a quality management staff person on 06/13/18. According to the policy, a comprehensive pain assessment was to be completed "once pain symptoms that are unacceptable or intolerable to the patient are recognized."

Resident #202, [LOCATION] Neighborhood

- Resident #202 was admitted to the CLC on 1[DATE] with diagnoses including dementia, cerebrovascular accident (CVA) and diabetes type 2. During the initial tour on 06/12/18 at 10:00 a.m., an RN indicated that Resident #202 did not experience pain.
- The resident's comprehensive annual MDS dated 12/03/17 indicated the resident had unclear speech, and sometimes was understood by and understood others. The MDS indicated the resident needed total assistance with transfers, walking in the corridor (hallway) did not occur, and the resident had functional limitations in range of motion of one upper extremity. The Brief Interview for Mental Status (BIMS) was not conducted; based on staff assessment, the resident's cognition was severely impaired. The resident's quarterly MDS dated 05/30/18 indicated the resident had a BIMS score of 3 suggesting severely impaired cognition, had unclear speech, and sometimes was understood by and understood others. The MDS indicated the resident needed total assistance with transfers, walking in the hallway did not occur, and the resident had no functional limitations in range of motion. According to the MDS, the resident did not experience pain.
- The resident's current care plan dated 06/07/18 stated, "Episodes of physically abusive behavior as demonstrated by physically [physical] and verbally [verbal] abuse during care. Approaches read, "if appropriate stop giving care when resident is hostile and try later." The care plan also included a statement that read, "I have episodes of pain due to "Edema to Right Lower extremity." Approaches included, "Ted [TED, thrombo-embolic-deterrent] stocking RLE [right lower extremity] on in AM [morning] off in HS [hour of sleep]. Monitor for pain Q [every] Shift."
- Current provider orders included the following:
    - 03/23/18 Gabapentin capsule orally, 100 milligrams (mg) twice daily for "anxiety/agitation."
    - 06/06/18 TEDS RLE on in AM off at HS.
- The most recent occupational therapy consult dated 05/02/16 (no additional assessments provided) stated, "Pt [patient, Resident #202] unable to quantify pain, however, verbalized pain and jumped when writer attempted ROM [range of motion] to R [right] hand. No pain at rest."
- Nursing summaries dated 05/30/18, 06/06/18 and 06/11/18 included pain assessments that stated, "Pain control is effective." The NM stated on 06/13/18 at 3:30 p.m. that nursing assistants were to verbally report pain to the nurses. The NM stated, "The NAs don't document pain anywhere."
- The resident was observed on multiple occasions throughout the survey on 06/12/18 and 06/13/18. The resident was not observed experiencing pain when at rest.
- On 06/13/18 at 8:07 a.m., a nursing assistant (NA) assigned to care for the resident stated she provided hygiene care and dressed the resident for the day. The NA said, "The [resident's] right hand is difficult to open. I can place a small towel in there but it is painful to open and he screams when it is opened. I can put a towel in there now." The NA left the room, returned with a towel and folded the towel; the NA stated, "This [folded towel] would be put in there [the resident's hand] to keep the hand from closing, sometimes he screams [when the towel is placed in the hand]." As the NA attempted to open the resident's hand, the resident cried out loudly in pain and the procedure was stopped. When the NA removed the resident's shoes and crew socks, the resident again loudly yelled. When asked about pain medication provided prior to care, the NA said, "I'm not a nurse so I don't know about that. This is how he is all the time."
- A nurse manager (NM) was interviewed on 06/13/18 at 8:37 a.m., regarding Resident #202's right hand contracture. The NM said, "Sometimes we put a towel inside it [the hand] to keep it open, but it is too painful and he becomes combative." When asked about pain management and pain medication prior to care and treatment, the NM stated, "He doesn't have any pain medications ordered, but he is on Gabapentin which can help with pain."

- A different NA than the NA interviewed at 8:07 a.m., was interviewed on 06/13/18 at 10:20 a.m. The NA stated, “No, I don’t touch that hand. He screams so I just leave it alone. I [have] seen him scream out when others have touched it.”
- A third NA familiar with the resident was interviewed on 06/13/18 at 10:35 a.m. The NA stated, “No I don’t touch it [the right hand]. It must be very painful as he keeps it tight and will be combative if you try and touch it. Yes, it hurts when you move his legs, when putting on his shoes and socks. He yells.”
- Following discussion with the NM at 8:37 a.m. (as above) regarding the resident’s pain, a provider’s order was written on 06/13/18 at 10:21 a.m. that read, “Acetaminophen tab [tablet] 500 mg po [orally] tid [three times a day] prn [as needed] pain.”
- Resident #202 was observed experiencing pain during care during the survey. Three NAs familiar with the resident indicated the resident "yells" and would "scream out" when staff touched the resident’s right hand or when "putting on his shoes and socks." A comprehensive pain assessment had not been completed for Resident #202 to address pain relief.

F314

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

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure a resident did not develop a pressure ulcer. Findings include:

Resident #202, [LOCATION] Neighborhood

- Resident #202 was admitted to the CLC on [DATE] with diagnoses including dementia, cerebrovascular accident (CVA) and diabetes type 2.
- The resident’s comprehensive annual MDS dated 12/03/17 indicated the resident had unclear speech, and sometimes was understood by and understood others. The MDS indicated the resident needed total assistance with transfers and had functional limitations in range of motion of one upper extremity; walking in the corridor (hallway) did not occur. According to the annual MDS, the resident did not have any pressure ulcers. The Brief Interview for Mental Status (BIMS) was not conducted; based on staff assessment, the resident’s cognition was severely impaired. The resident’s quarterly MDS dated 05/30/18 indicated the resident had a BIMS score of 3 suggesting severely impaired cognition, had unclear speech, and sometimes was understood by and understood others. The MDS indicated the resident needed total assistance with transfers, had no functional limitations in range of motion and did not have a pressure ulcer. No skin or wound treatments were identified on the MDS.
- The resident’s care plan dated 06/07/18 stated, “I am at risk for skin breakdown d/t [due to] impaired mobility and incontinence of bowel and bladder.” Care plan approaches read, “Educate resident/caregiver regarding causes and prevention of pressure ulcers and the importance of changing position frequently for pressure ulcer prevention, encourage small frequent position changes if resident is independent.”
- The 06/06/18 weekly nursing assessment indicated the resident had a Braden Scale score of 13 suggesting moderate risk for pressure ulcer development; approaches included, “Encourage small frequent position changes.”
- On 06/12/18 at approximately 10:00 a.m., Resident #202 was observed seated in a tilt-in-space wheelchair across from the nursing station; the wheelchair was not reclined and a seat belt was observed across the resident’s lap. On 06/12/18 from 1:00 p.m. until 4:40 p.m., the resident was continuously observed in the day room. The resident was in the same wheelchair as observed at 10:00 a.m. and the chair was reclined with a seat belt across the resident’s lap. The resident was observed with the left leg crossed over the right and over the top of the right arm of the wheelchair. At approximately 2:15 p.m. while in the wheelchair in a reclined position, the resident’s right foot was observed between the foot rests with the edge of the left foot rest against the bottom of the resident’s right foot. The resident remained in this position until a NA approached the resident at 4:40 p.m., removed the resident’s right foot from between the foot rests, uncrossed the resident’s left leg, and took the resident to the dining room. From 1:00 p.m. until 4:40 p.m., nursing staff was continuously present in the day room.
- On 06/13/18 at 8:07 a.m., a NA indicated she provided care for Resident #202 earlier in the morning; the NA stated she provided hygiene care for and dressed the resident. With the surveyor present, the NA removed the resident’s white crew socks to inspect the bottom of his feet. An area that resembled a blood blister was observed on the bottom of the resident’s right foot. The NA stated, “That is a new.” On 06/13/18 at 8:37 a.m. after the NM was informed of the blister, a wound care consult was requested by the NM. The consult was completed on 06/13/18 at 9:33 a.m. The assessment stated, “Reason for Consult: newly identified right plantar foot wound. Wound assessment:

Right Plantar Foot Deep Tissue Pressure Injury (DTPI); 1.5 x 1 cm [centimeter]; intact non blanchable deep purple skin; no odor….” On 06/13/18 at 10:06 a.m. during an interview, the wound and ostomy nurse specialist stated, “It [the area on the bottom of the right foot] definitely is from pressure, a deep tissue injury, a small blood blister. He has a history of edema and is supposed to wear TEDs [thrombo-embolic-deterrent] [stockings].” When observations of the resident’s right foot resting between the foot rests was shared with the wound and ostomy nurse specialist, the specialist stated, “Yes, that could be the potential cause.”

F318

483.25(e)(2) *Range of Motion. Based on the comprehensive assessment of a resident, the facility must ensure that: A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

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

Resident #202, [LOCATION] Neighborhood

- Resident #202 was admitted to the CLC on [DATE] with diagnoses including dementia and cerebrovascular accident (CVA).
- The resident’s comprehensive annual MDS dated 12/03/17 indicated the resident had unclear speech, and sometimes was understood by and understood others. The MDS indicated the resident needed total assistance with transfers and had functional limitations in range of motion of one upper extremity. The Brief Interview for Mental Status (BIMS) was not conducted; based on staff assessment, the resident’s cognition was severely impaired. The resident’s quarterly MDS dated 05/30/18 indicated the resident had a BIMS score of 3 suggesting severely impaired cognition, had unclear speech, and sometimes was understood by and understood others. The MDS indicated the resident needed total assistance with transfers and had no functional limitations in range of motion.
- The resident’s current care plan dated 06/07/18 stated, “I have impaired mobility r/t [related to] H/o [history of] right side CVA with Ataxia [loss of control of bodily movements].” A care plan approach read, “PROM [passive range of motion].” The care plan did not identify specific approaches or care to be provide related to the resident’s contracted right hand.
- The most recent occupational therapy evaluation was completed on 05/02/16 (no additional evaluations provided) and stated, “Evaluate and treat as indicated for upper extremity splinting needed right hand contracture. Objective: consult received for Right hand contractuire [sic] and need for splinting. Pt [patient, Resident #202] unable to tolerate PROM to right hand to assess the severity of contracture. Per nursing report, pt’s right hand has gotten worse since admission. At this time, pt will not be able to tolerate splint d/t pain. Lambswool palm protector placed to right hand with additional padding of ABD. Pt tolerated well and did not report pain. Encouraged pt to wear at all times. Nurse verbalized understanding of plan.”
- On 06/12/18 at approximately 10:00 a.m., Resident #202 was observed seated in a tilt-in-space wheelchair across from the nursing station. The resident was observed with what appeared to be a right hand contracture with no protection inside the hand. On 06/12/18 from 1:00 p.m. until 4:40 p.m., the resident was observed in the day room. The resident was in a tilt-in-space wheelchair and the right hand remained clenched; there was no protection in the right hand.
- On 06/12/18 at 5:20 p.m., the resident was observed in the dining room eating the evening meal. The resident’s right hand remained clenched as the resident ate with the left hand; there was no protection in the right hand.
- On 06/13/18 at 7:40 a.m., the resident was observed in the dining room eating breakfast. The resident’s right hand was clenched and he was holding the fork with his left hand; there was no protection in the right hand.
- On 06/13/18 at 8:07 a.m., the nursing assistant (NA) assigned to provide care for the resident stated that she provided hygiene care and dressed the resident for the day. The NA said, “The right hand is difficult to open. I can place a small towel in there but it is painful to open and he screams when it is opened. I can put a towel in there now.” The NA left the room and returned with a folded towel; the NA stated, “This [the folded towel] would be put in there [the resident’s hand] to keep the hand from closing, sometimes he screams.” As the NA attempted to open the hand, the resident cried out in pain and the procedure was stopped.
- The NM was interviewed on 06/13/18 at 8:37 a.m. regarding Resident #202’s right hand contracture. The NM said, “Sometimes we put a towel inside it [the hand] to keep it open. But it is too painful and he becomes combative.”
- A different NA than the NA interviewed on 06/13/18 at 8:37 a.m. was interviewed on

06/13/18 at 10:20 a.m. The NA stated, “No, I don’t touch that hand. He screams so I just leave it alone.”
- A third NA familiar with the resident was interviewed on 06/13/18 at 10:35 a.m. The NA stated, “No I don’t touch it [the right hand]. It must be very painful as he keeps it tight and will be combative if you try and touch it.”
- During the survey, a lambswool palm protector was not observed in place in Resident #202’s hand as indicated in the most recent occupational therapy consult dated 05/02/16. Staff stated placement of a towel in the resident’s hand was painful. It was not evident an appropriate approach to address the contracture of the right hand had been identified and implemented.

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 - Many

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

Transmission-based Precautions
The VA Boston Healthcare System Medical Center Memorandum 11-035-LM dated September 2017 and titled, “Control of Infectious Agents in the Healthcare Setting,” was provided on 06/13/18 at 2:30 p.m. by a quality management staff person. The policy stated, “Attachment 1. Transmission Based Precautions….4. Barrier (Contact) Precautions. A. Barrier Precautions are the Community Living Center’s version of Contact Precautions….Barrier Precautions are designed to reduce the risk of transmission of epidemiological important pathogens that may be spread by direct or indirect contact with the resident or the resident’s environment. Such infectious diseases/pathogens include: 1. Methicillin Resistant Staphylococcus aureus (MRSA)….C. Requirements for Barrier Precautions: 1. Gloves and gowns are required for any contact with resident and/or the immediate resident environment. Some examples include passing medication, assisting with activities of daily living, bathing, repositioning and dressing changes….3. A “Barrier Precaution” sign is affixed to entrance of room. D. Other Considerations…. 2. Resident care items are to be dedicated to the individual patient and remain in the resident’s room

Resident #304, [LOCATION] Neighborhood

- Resident #304 was admitted to the [LOCATION] neighborhood on [DATE] with diagnoses including diabetes, chronic kidney failure and chronic foot wounds. The resident’s comprehensive admission MDS dated [DATE] indicated the resident scored 15 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition. According to the MDS, the resident had functional limitations in range of motion of both lower extremities. Other skin problems were coded on the MDS as a diabetic foot ulcer.
- On 06/14/18 at 9:15 a.m., the “infection prevention nurse” stated Resident #304 had “MRSA Right heel wound and nares. Most recently positive [for MRSA on] 06/10/18.”
- The “Nursing Admission Assessment” dated [DATE] was written by an RN and stated, “Reason for admission: Diabetic foot ulcers. Skin problems: Wound location, type description: Diabetic foot ulcers on bilateral feet. Right heel a 4 cm [centimeters] x [by] 1 cm opening. Left foot plantar wound that is 2 cm x 1.5 cm and a heel wound that is 1 cm x 1 cm. All wounds have beefy red wound beds and appear to be recently debrided.”
- A provider’s order dated 06/01/18 stated, “Dressing change for bilateral feet daily. Apply betadine dampened gauze over remaining wound on right and left foot, wrap with Kerlix.”
- During an observation of care in the [LOCATION] neighborhood on 06/13/18 at 9:20 a.m., an RN was observed using hand sanitizer and entering Resident #304’s room without donning a gown and gloves. A sign posted above the door to the resident’s room stated, “Barrier [Contact] Precautions: Staff and visitors to don gowns and gloves before entering room if coming into contact with the resident or environment.” Resident #304 was in bed and while the RN spoke with the resident, she placed both ungloved hands on the footboard of the resident’s bed. Upon leaving the resident’s room, the RN used hand sanitizer.
- During an observation of dressing changes for Resident #304’s feet on 06/13/18 at 10:10 a.m., the nursing assistant who was performing the dressing change used hand sanitizer and donned a gown and gloves prior to entering the room. The resident transferred independently from a wheelchair to bed and positioned himself in bed with the head of the bed raised to approximately 85 degrees; the plantar surfaces of the resident’s feet were against the footboard of the bed. The nursing assistant removed Kerlix™ and gauze from the resident’s feet, and rested the resident’s feet against the surface of the footboard with the open wounds on the plantar aspect of both feet directly against the surface of the footboard. The nursing assistant lifted each foot and

poured normal saline across the plantar surfaces of both feet, then patted each foot dry with gauze. After each foot was cleansed with normal saline and dried, the nursing assistant returned each foot to the previous position, with the plantar surface of each foot directly against the surface of the footboard of the bed. The nursing assistant completed the dressing change as ordered by the provider; there were no other observations of infection prevention and control concerns.

Resident #204, [LOCATION] Neighborhood

- Resident #204 was admitted to the CLC on [DATE] with diagnoses including dementia. The resident's current care plan dated 04/13/18 indicated the resident required assistance with eating and staff was to implement Contact Precautions due to MRSA in the nares. The nursing note dated 06/03/18 stated, "Dependent on staff for all ADLs [activities of daily living], 1:1 [one-to-one] supervision with meals…"
- During observations of the evening meal on 06/12/18 at 4:43 p.m., a NA entered the dining area and donned gloves without first performing hand hygiene. The NA sat next to Resident #204 and as the NA began to assist the resident to eat, the resident was observed with a large amount of nasal discharge. The NA used a Kleenex to clean the discharge and placed the used Kleenex into a plate cover that was sitting upside down on the table between two other residents seated at the table. Without changing gloves and performing hand hygiene, the NA continued to feed the resident. The NA cleaned discharge from the resident's nose four more times placing used Kleenex into the plate cover on the table. The NA doffed gloves, disposed of the gloves, performed hand hygiene and donned another pair of gloves before continuing to assist the resident. Resident #204 continued to experience discharge from the nose and the NA assisted to clean the resident's nose, placing used Kleenex into the plate cover on the table. At 5:15 p.m., the NA removed the resident's tray from the table, scraped food the resident had not eaten into a trash receptacle and doffed gloves. Without performing hand hygiene, the NA obtained a can of soda for a different resident than Resident #204, opened the can, poured it into a glass and donned gloves without first performing hand hygiene.
- During observations of the breakfast meal on 06/13/18 at 7:25 a.m., Resident #204 was sitting at a dining room table with two other residents. The resident frequently experienced a nasal discharge that was excessive. A NA assisting Resident #204 had a used Kleenex in one hand used to clean the resident's nose while assisting the resident to eat with the other hand. After assisting Resident #204 to eat, the NA was observed to doff gloves, perform hand hygiene, lift the edge of a trash receptacle with a hand to dispose of the gloves and reapply clean gloves.

Resident #101, [LOCATION] Neighborhood

- Resident #101 was admitted to the CLC on [DATE] and readmitted to the CLC on [DATE] with diagnoses including peripheral neuropathy, cellulitis of the right ankle, MRSA in a right ankle wound, and right foot osteomyelitis.
- On 06/13/18 at 9:40 a.m., a Contact Precautions sign was observed posted outside the resident's room. A nursing assistant (NA) in Resident #101's room was wearing a gown and gloves. When Resident #101 indicated he would like a fresh pitcher of ice water, the NA doffed the gown and gloves and without performing hand hygiene picked up the water pitcher from the overbed table and exited the room to obtain a fresh pitcher of water. The NA returned to Resident #101's room wearing a gown and gloves and carrying the water pitcher. The NA informed Resident #101 she had filled the pitcher with fresh ice water.
- On 06/13/18 at 1:25 p.m. during an interview, the nurse manager (NM) and assistant NM (ANM) indicated the NA should have washed hands after doffing the gown and gloves. The NM and ANM indicated the NA should not have removed the water pitcher from Resident #101's room and taken the pitcher to the nourishment room where the ice machine was located; the NM stated a clean water pitcher should have been obtained for the ice water.

Resident's #107

- Resident #107 was admitted to the CLC on [DATE] with diagnoses including non-small cell lung cancer and a groin/upper thigh wound. On 05/31/18, Resident #107 was diagnosed with MRSA of the nares; a Contact Precautions sign was posted outside the resident's room.
- On 06/13/18 at 2:04 p.m., an individual identified as a night shift RN (by another RN standing at a computer on wheels) was observed sitting near the foot of the bed next to Resident #107. The night shift RN was not wearing a gown or gloves. At 2:05 p.m., the night shift RN stood and exited the room without performing hand hygiene, spoke with the RN who was standing at the computer on wheels, and left the area without performing hand hygiene. The RN standing at the computer on wheels stated anytime a staff member entered a room with a Contact Precautions sign they were to wash their hands, and don gloves and a gown; staff was not to sit on a resident's bed. The RN

stated the night shift RN should have worn a gown and gloves while in Resident #107's room and should have washed hands prior to exiting the room. The RN stated staff was to implement Contact Precautions for MRSA for Resident #107.

Resident #106, [LOCATION] Neighborhood

- Resident #106 was admitted to the CLC on [DATE] with diagnoses including dementia; the resident had a gastrostomy tube due to dysphagia.
- On 06/13/18 at 12:40 p.m., an RN was observed preparing to administer Resident #106's gastrostomy tube feeding. The RN washed hands, reached into her right uniform pocket, removed two gloves, donned the gloves and checked placement of the gastrostomy tube.
- On 06/13/18 at 1:25 p.m. during an interview, a nurse manager (NM) and assistant nurse manager (ANM) from the [LOCATION] neighborhood stated staff was not to carry gloves in their pockets to don after performing hand hygiene; gloves were available in resident rooms for use by staff. Note that the nurse manager for the [LOCATION] neighborhood was not available for interview following the observation.

Resident #104, [LOCATION] Neighborhood

- Resident #104 was admitted to the CLC on [DATE] with diagnoses including a femoral neck fracture and chronic pain. Resident #104 was diagnosed with MRSA of the nares on 01/23/18. A Contact Precautions sign was posted outside the resident's room.
- On 06/13/18 at 8:10 a.m., a respiratory therapist (RT) was observed entering Resident #104's room without washing hands or donning a gown and gloves. With ungloved hands, the RT held Resident #104's arm, scanned the resident's arm band, exited the room and placed the scanner on the RT cart without first cleansing the scanner. The RT returned to Resident #104's bedside to obtain an oxygen saturation level after placing a portable pulse oximeter on the resident's finger; the RT removed a stethoscope from her neck, leaned against the upper side rail and bed linens with the RT's clothing in direct contact with the side rails and bedding, completed a lung assessment placing the stethoscope on the resident's chest, and placed the stethoscope around her neck without first cleansing the stethoscope. The RT opened a unit dose package of albuterol inhalation solution 0.083%, obtained a nebulizer from the resident's bedside stand, placed the albuterol solution in the nebulizer chamber, placed the oxygen mask over Resident #104's face and turned on the nebulizer. The RT performed hand hygiene prior to exiting the room, and proceeded down the hallway with the treatment cart.
- On 06/13/18 at 8:21 a.m., the RT returned to Resident #104's room. Without washing hands, the RT obtained gloves from inside Resident #104's room, exited the room, went across the hallway to obtain personal protective equipment, obtained a gown, and donned the gown and gloves. The RT returned to Resident #104's room, removed the resident's oxygen mask and placed the mask on the bedside stand without first placing a barrier. The RT removed the stethoscope from her neck and performed lung assessments placing the stethoscope on the resident's chest. Upon completion of the assessment, the RT placed the stethoscope around her neck without first cleansing the stethoscope, doffed the gown and gloves, and washed hands prior to exiting the room.
- On 06/13/18 at 3:00 p.m., the above observations were discussed at the daily meeting.

Systems-level Review

- On 06/14/18 at 8:40 a.m., the infection prevention nurse (infection preventionist) stated she was "very surprised" with the findings of hand hygiene as staff was monitored while performing hand hygiene by a staff person in the infection control section. It was indicated that CLC nursing staff attended annual training on hand washing, glove use and the different types of precautions utilized at the CLC. The infection preventionist stated that staff knew they were not to sit on a resident's bed even when wearing a gown as this was not an acceptable practice. Reportedly, respiratory staff was also trained regarding Contact Precautions at a mandatory annual review.