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: Lyons Campus of the VA New Jersey Health Care System (Lyons, NJ)

Dates of Survey: 9/11/2018 to 9/13/2018

Total Available Beds: 231

Census on First Day of Survey: 208

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 #301, [LOCATION] • Resident #301 was admitted to the CLC on [DATE] with diagnoses including bipolar disorder according to the annual history and physical dated 10/04/17. • The resident's quarterly Minimum Data Set (MDS) dated 05/09/18 indicated Resident #301 had a Brief Interview for Mental Status (BIMS) score of 12 suggesting moderately impaired cognition. The MDS indicated that Resident #301 required total assistance with all activities of daily living (ADLs), had functional limitations in range of motion of both lower extremities, and used a wheelchair. • On 09/11/18 at 5:07 p.m., a nursing assistant was observed by a surveyor and quality management specialist (QMS) pushing Resident #301 into the resident's room; another nursing assistant came into the room to assist to transfer the resident to bed. The door to Resident #301's room was left open and the resident's roommate was in the room. Without pulling the privacy curtain, the two nursing assistants removed the blanket covering Resident #301 exposing the resident's bare legs and adult brief, and transferred Resident #301 using a lift to bed; the resident was visible by the roommate and from the doorway. The resident was covered after being placed in bed. When the above observations were discussed with the QMS, the QMS stated, "I know. I thought, pull the curtain." Resident #401, [LOCATION] • Resident #401 was admitted to the CLC on [DATE] with diagnoses including spinal stenosis of the lumbar region, arthritis, paranoid schizophrenia, and posttraumatic stress disorder (PTSD). The resident's comprehensive MDS dated 06/20/18 was coded to indicate the resident had clear speech, was understood by and usually understood others, and had a Brief Interview for Mental Status (BIMS) score of 14 suggesting intact cognition. The MDS indicated the resident required extensive assistance of one staff person for bed mobility and extensive assistance of two staff for transfers, did not walk in the room or corridor, and required extensive assistance with locomotion on and off the unit (neighborhood). The Care Area Assessment (CAA) summary completed in conjunction with the most recent MDS dated 06/20/18 indicated the resident was "weak and deconditioned." • During an interview on 09/11/18 at 1:36 p.m. with a quality manager (QM) present, when asked if the resident used the call light and how quickly staff responded, Resident #401 stated, "I have to holler and scream to get people to come [while in bed]; I don't have a call light." The resident said that when staff responded, he was told he would have to wait for assistance. The resident stated that he liked to stay in bed in the morning after breakfast and needed assistance getting up for the noon meal; the noon meal arrived between 11:45 a.m. and 12:00 p.m. The resident stated that (on

09/11/18), he had to wait until 1:30 p.m. for assistance getting out of bed. (See Resident Call System)

F463

483.70(f) *Resident Call System. The nurses' station must be equipped to receive resident calls through a communication system from:(1) Resident rooms; and (2) Toilet and bathing facilities.*

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, [LOCATION] was not equipped to receive resident calls through a communication system from resident rooms; residents did not have a means of directly contacting caregivers. Findings include:

Resident #401, [LOCATION]

- Resident #401 was admitted to the CLC on [DATE] with diagnoses including spinal stenosis of the lumbar region, arthritis, paranoid schizophrenia, and posttraumatic stress disorder (PTSD). The resident's comprehensive MDS dated 06/20/18 was coded to indicate the resident had clear speech, was understood by and usually understood others, and had a Brief Interview for Mental Status (BIMS) score of 14 suggesting intact cognition. The MDS indicated the resident required extensive assistance of one staff person for bed mobility and extensive assistance of two staff for transfers, did not walk in the room or corridor, and required extensive assistance with locomotion on and off the unit (neighborhood). The Care Area Assessment (CAA) summary completed in conjunction with the most recent MDS dated 06/20/18 indicated the resident was "weak and deconditioned."
- During an interview on 09/11/18 at 1:36 p.m. with a quality manager (QM) present, when asked if the resident used the call light and how quickly staff responded, Resident #401 stated, "I have to holler and scream to get people to come [while in bed]; I don't have a call light." The resident said that when staff finally responded, he was told he would have to wait for assistance. The resident stated that he like to stay in bed in the morning after breakfast and needed assistance getting up for the noon meal; the noon meal arrived between 11:45 a.m. and 12:00 p.m. The resident stated that (on 09/11/18) he had to wait until 1:30 p.m. for assistance getting out of bed.
- During an interview on 09/11/18 at 1:56 p.m., the charge nurse stated, "Call lights on this unit [neighborhood] are different; it is a mental health unit. Pull cords are not used here because of the type of residents we have. The call button is located on the wall and the resident [Resident #401] cannot reach it." The nurse supervisor indicated the "call light system has been out [not working] since 08/03/18," when the nursing station was removed. The charge nurse, nurse manager, quality manager, and surveyor went to the resident's room and observed a metal button located on the wall midway between the two resident beds; the button was approximately 5 feet from the floor and approximately 3-4 feet away from the resident's bed and out of the resident's reach. When the button was pressed, a light displayed in the corridor dome light outside the resident's room near the top of the door frame; one light was white, one was green, and the bottom light was red. The white light indicated a call for assistance; the green light indicated a nurse was in the room; a red light indicated a provider was in the room. While the light displayed, the call system no longer sounded since removal of the nursing station. The charge nurse stated, "We round on the unit every 30 minutes or so." It was confirmed during the survey that rounding occurred approximately every 30 minutes.
- During an interview on 09/11/18 at 3:34 p.m., the associate chief of staff (ACOS) and associate chief nurse acknowledged [LOCATION] did not have call lights that were accessible to all residents. The ACOS stated, "We are aware of the call system issue." The ACOS indicated the call system was "high on our priority list" and staff was trying to secure a call light system for the entire CLC but would have to put something in place temporarily in [LOCATION] until a determination was made about which system to purchase. The ACOS stated, "We are aware and are in the process of obtaining a call system."
- During the daily meeting on 09/11/18 at 3:30 p.m., the medical director stated, "The type of residents [with a mental health diagnosis] is the reason for not having a call system with pull cords." The medical director stated the CLC was working on a solution to the call light issue.
- On 09/12/18 at 3:30 p.m., the ACOS provided an electronic mail (email) dated 09/12/18 that indicated service to "install wall plates and connectors for nurse call system" was purchased and was set for delivery on 09/22/18.
- During an interview on 09/13/18 at 9:30 a.m., the associate chief nurse provided a picture of a metal hand bell affixed to Resident #401's bed rail and indicated this was installed for the resident (on 09/13/18). When asked how many residents in [LOCATION] were unable to reach the call light on the wall, the associate chief nurse indicated there were 6 or 7 residents that could not reach the call light; however, the

remaining residents were able to get out of bed independently. The ACOS reiterated that CLC staff was aware of the issue and working on a permanent fix; the ACOS acknowledged that a temporary fix must be instituted until a decision was made to replace the call system in the entire CLC.