# 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: New Mexico VA Health Care System (Albuquerque, NM)

Dates of Survey: 8/21/2018 to 8/23/2018

Total Available Beds: 16 (usually capped at 15)

Census on First Day of Survey: 16

| F-Tag | Findings |
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| F241<br><br>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.*<br><br>**Level of Harm** - No actual harm with potential for more than minimal harm that is not immediate jeopardy<br><br>**Residents Affected** - Some | Based on observation and interview, the CLC did not ensure promote care for residents in a manner and in an environment that enhanced each resident's dignity and respect in recognition of their individuality. Findings include:<br><br>Resident #101<br>• According to Resident #101's admission history and physical dated [DATE], the resident was admitted from an acute-care hospital to the CLC on [DATE], used a feeding tube, and had visual limitations.<br>• Resident #101's admission Minimum Data Set (MDS) assessment dated [DATE] indicated the resident had a Brief Interview for Mental Status (BIMS) score of 13 suggesting intact cognition. The MDS indicated the resident was visually impaired and used a feeding tube. An MDS dated 08/07/18 indicated the resident was independent with all activities of daily living with the exception of eating; the resident had a feeding tube.<br>• During the initial tour of the CLC on 08/21/18 at 10:00 a.m., Resident #101 had signs posted outside the resident's room around the door frame at a height of 5 feet and above. One sign stated N.P.O. (nothing by mouth), a second sign stated, "Visually Impaired: Identify Yourself-Give clear directions - Patient may require assistance with medication intake, eating, reading and mobility - Ask if and when assistance is needed. Contact the Visual Impaired Services Team (VIST) coordinator ext. 2…or Social Work Services." A third sign stated, "Fall Risk."<br>• During an interview with the resident on 08/21/18 at 5:00 a.m., the resident stated he was unaware of the signs at the door to the resident's room; the resident expressed no concerns regarding the signage. During observations of the resident walking from his room on 08/22/18 at 9:40 a.m., the resident had difficulty raising his head and it appeared the resident could not see the signs. Although the resident did not have concerns related to the sign, the sign posted provided personal information that could be seen by others.<br><br>Resident #103<br>• Resident #103's admission history and physical dated [DATE] indicated the resident was admitted from an acute-care hospital to the CLC on [DATE]. The resident's diagnoses included, retinopathy (with visual limitations).<br>• Resident #103 had a sign posted outside his room and located above the hand sanitizer dispenser. The sign read, "Visually Impaired: Identify yourself - Give clear directions - Patient may require assistance with medication intake, eating, reading and mobility - Ask if and when assistance is needed. Contact the Visual Impaired Services Team (VIST) coordinator ext. 2…or Social Work Services."<br>• During observation and interview on 08/22/18 at 10:30 a.m., the resident was unable to see the signs and was unaware the sign was posted outside the door. Although the resident had no concerns related to the sign, the sign posted provided personal information that could be seen by others.<br><br>Resident #202 |

- Resident #202 was admitted to the CLC on [DATE] with diagnoses including cervical spinal fusion with neurologic deficits. The resident's admission comprehensive Minimum Data Set (MDS) assessment dated [DATE] was coded to indicate that the resident had a BIMS score of 12 suggesting moderately impaired cognition. The MDS was coded to indicate that the resident required extensive assistance of two for transfers, dressing, locomotion outside of the neighborhood and toilet use. The MDS was coded to indicate that the resident was dependent on the assistance of two for locomotion in the neighborhood. Walking in the room and corridor and balance while turning around were coded as "Activity did not occur." The resident's balance from a seated to standing position, when walking, when moving on and off toilet, and during surface-to-surface transfers was coded as not steady but the resident was able to stabilize with assistance. The MDS was coded to indicate that the resident had a fall prior to admission to the CLC but no falls since admission to the CLC.
- The "Nursing Inpatient Admission Assessment" dated [DATE], the RN documented, "Fall risk level: High."
- The "Interim Care Plan" dated 08/10/18 stated, "Fall risk high."
- During the initial tour of the CLC with the nurse manager on 08/21/18 at 10:00 a.m. and throughout the survey, a magnetic sign that stated, "Fall Risk," was observed on the door frame of Resident #202's private room.
- During an interview with Resident #202 and his wife on 08/22/18 at 10:15 a.m., when asked if the resident and his wife were aware of the "Fall Risk" sign posted outside the resident's room, the resident replied, "Yes." Although the resident stated, "I don't care one way or the other" about the presence of the sign, the sign provided personal information.

Systems-level Review

- During an interview with the CLC nurse manager (NM) on 08/22/18 at 9:45 a.m., the NM was asked about the signs posted outside resident rooms. The NM stated the signs were used to assist staff in providing care for residents. The NM indicated, for example, that the signs regarding the resident's NPO status were posted "so that food service knows not to give the resident food or drink."

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F441

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

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

**Residents Affected** - Few

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

When asked if the CLC had a policy and procedure related to the operation of wound VAC [vacuum-assisted closure] pump systems, on 08/22/18 at 9:30 a.m. the nurse manager provided the manufacturer's operations manual titled, "VAC Therapy KCI Healing by Design Clinical Guidelines." Page 24 of the manual included a section titled, "Changing the Canister" that stated, "The V.A.C. Canister should be changed when full (the alarm will sound). 1. Follow standard precautions as the system may contain bodily fluids. 2. Close clamps on both the canister and dressing tubing."

The New Mexico VA Healthcare System Memorandum 111-54, dated July 17, 2018 and titled, "Standard Precautions." The policy stated, "1. Policy: The New Mexico Veteran Affairs Healthcare System considers blood and body fluids to be potentially infections and requires all Healthcare Workers (HCW) to use Standard Precautions (SP), as recommended by the Center for Disease Control, while caring for all patients in all patient care settings…b. The most utilized SP practices are: Applied through the assessment of HCW-Patient interactions or the task which includes the anticipated contact of blood, body fluid or pathogen exposure. (1) Hand hygiene. (2) Personal Protective equipment (PPE)....(4) Handling medical equipment….d. The type of PPE used shall be appropriate for the procedure and type of exposure anticipated. No PPE is ever reused even for the same patient….Approved PPE includes gloves….(1) Gloves (a) Worn to protect both the HCW and patient from exposure to: Actual or potentially infectious agents. (b) Are worn when the HCW anticipates exposure to actual or potentially infectious agents."

On 08/22/18 at 10:45 a.m., the CLC nurse manager provided the New Mexico VA Healthcare System Memorandum 111-2, dated August 3, 2018 and titled, "Hand Hygiene." The procedure stated, 3. Procedure: a. The minimum required standard for performing hand hygiene shall be immediately upon entry and exit of a patient care room or treatment area. b. Other indications for hand hygiene include: (1) Before and after any direct contact with patients including before donning clean or sterile gloves or…after removing gloves. (2) Before and after contact with the patient's environment. (3) After contact with body fluids. (4) When moving from a

contaminated body site to a clean body site during patient care. (5) Before any 'clean' activity like preparing medications or handling supplies. (6) After contact with contaminated surfaces or waste."

Resident #201

- Resident #201 was admitted to the CLC on [DATE]. The resident's admission comprehensive MDS assessment dated [DATE] was coded to indicate that the resident had active diagnoses including a multiple-drug resistant organism (MDRO) and wound infection. The MDS was coded to indicate the resident had a surgical wound and was to receive surgical wound care.
- The history and physical dated [DATE] documented by a physician assistant stated, "[Resident #201] went ASIH [absent sick in hospital] and found to have c. diff [Clostridium difficile] started on oral vanc [vancomycin] (EOT [end of therapy] 9/1[/18]). He then went ASIH again and was found to have UTI [urinary tract infection], now being treated with ceftriaxone and flagyl EDT [end date of therapy] 8/25[/18]…Medicine found patient to have acute cystitis with hematuria, growing MDRO Klebsiella and started flagyl and ceftriaxone."
- The resident's "Interim Care Plan" dated 08/20/18 stated, "Infection Potential: Antibiotic medications per physician order…."
- During observations of care for Resident #201 on 08/22/18 at 8:45 a.m., the RN caring for the resident used hand sanitizer, donned gloves and entered the resident's room. Upon entering the room, the resident's wound VAC pump was alarming. The RN looked at the pump and stated, "The cartridge is full, I need to change it;" the cartridge on the pump was observed to be full of pink-tinged fluid. The RN reached into a cabinet in the resident's room and extracted a new cartridge wrapped in the manufacturer's packaging. The RN clamped the wound VAC tubing between the wound and the tubing connection with her right hand, disconnected the tubing with her left hand, and touched the tip of the tubing connected to the used cartridge. With the tubing in the RN's left hand, the RN disconnected the cartridge from the pump with her left hand. The RN was not observed to close the clamp between the connection and the full cannister during this procedure as indicated in the CLC policy. While holding the used cartridge and tubing in her left hand, the RN picked up the new cartridge and tubing and brought the two (used and new) cartridges and the attached tubing together, allowing the tubing of the two cartridges to come into contact with each other. The RN placed the used cartridge and tubing on the floor next to the resident's bed; the RN's hand did not come into contact with the floor. Without changing gloves and performing hand hygiene, the RN connected the new tubing to the wound VAC using both hands and inserted the new cartridge into the pump with her left hand. The RN unclamped the tubing between the wound and the connection; droplets of pink-tinged fluid were observed on the floor under the tubing connection. The RN wiped the fluid off the floor with paper towels, picked up the used cartridge and tubing from the floor, and inserted the items into the packaging from the new cartridge. The RN stated, "I am going to dispose of this." The RN was then observed to leave the resident's room with the used cartridge and tubing.