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: Salisbury - W.G. (Bill) Hefner VA Medical Center (Salisbury, NC)

Dates of Survey: 10/16/2018 to 10/18/2018

Total Available Beds: 125

Census on First Day of Survey: 97

F-Tag	Findings

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 interview and record review, the CLC did not provide services that met professional standards of quality. Findings include:
	
	Resident #103, [LOCATION]
	• Resident #103 was admitted to the CLC on [DATE] with diagnoses including dementia, right hip fracture, a Stage 2 sacral pressure ulcer and diabetes. According to a wound care nursing note dated [DATE] a discolored abrasion was noted over the resident's right malleolus "possibly from striking his ankle on his broda chair."
	• The resident's quarterly MDS dated 09/11/18 stated the resident sometimes understood and was sometimes understood by others, had severely impaired cognition based on staff assessment, required extensive assistance with activities of daily living (ADLs) including bed mobility, had functional limitations in range of motion of both lower extremities, was at risk for developing a pressure ulcer, did not have a pressure ulcer, and had an open lesion on the foot.
	• Resident #103's care plan dated 09/18/18 read, "Stage II to buttocks that was present on admission-healed June 29th. Dark brown scab to right malleolus, no drainage noted on old dressing. Prevalan [Prevalon] boots BLE [bilateral lower extremities]. Skin problems: Right ankle abrasion same since last assessment scabbed over without signs of infection. Prevalon boots worn all shift interventions: limit sitting out of bed to less than 2 hours at a time, apply heel/elbow pad. Positioning: wheelchair bound: feet should touch the floor or footplates."
	• Current provider orders included
	  ○ "06/29/18 dressing changes: MWF [Monday, Wednesday, Friday] to right ankle with polymem [PolyMem dressing] and kerlix wrap, must wear prevalon boots 24/7."
	  ○ "08/30/18 RT [right] ankle: Clean with normal saline. Apply Polymem foam to right lateral malleolus. Wrap with kerlix. Change daily."
	• The wound care RN's weekly rounds note dated 09/28/18 stated, "Recommendations per wound care nurse: continue current treatment of polymem. Scab is intact. Change Polymem back to Monday, Wednesday, Friday or if gets wet…drainage: small amount of sanguineous drainage…Interventions: Prevalon boots." The wound care nurse's recommendation related to changing the dressing change frequency from daily to Monday, Wednesday and Friday was not addressed in a provider's order. The wound care RN did not document a weekly assessment after 09/28/18.
	• Dressing changes were reviewed between 09/24/18 and 10/17/18. During that time, the dressing was changed on 09/24/18 (Monday), 09/25/18 (Tuesday), 09/27/18 (Thursday), 09/28/18 (Friday), 10/01/18 (Monday), 10/03/18 (Wednesday), 10/09/18 (Tuesday), 10/12/18 (Friday), 10/15/18 (Monday), and 10/17/18 (Wednesday). Dressing changes were not completed daily as ordered (08/30/18) or on Monday, Wednesday and Friday (three times a week) as indicated in the wound care RN's recommendations (09/28/18).
	• On 10/17/18 at 9:04 a.m. during an interview, a nurse manager (NM) stated, "The wound care nurse will evaluate upon admission and if there is a wound, a plan will be developed." The NM confirmed that the provider's order indicated the dressing changes

to the right ankle were to be completed daily and that staff were not following the 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 provide the necessary care and services to attain or maintain a resident's highest practicable physical, mental, and psychosocial well-being. Findings include:

Pain Management
The CLC policy dated September 29, 2017, and titled, "Pain Management Plan" was provided by quality management staff on 10/17/18. According to the policy, "Alternate Rating Scale: A set of observations that estimates the patient's [resident's] pain level when the patient is unable to self report verbally due to sedation, cognitive, or speech impairment. If the alternate rating scale is used, a '99' will be entered in the pain rating in the medical record….Patients who cannot report their perception of pain using the NRS (Numeric Rating Scale) will be given a pain score of 99 and will be assessed non-verbally using the PAINAD [Pain Assessment in Advanced Dementia] scale."

Resident #103, [LOCATION]

- Resident #103 was admitted to the CLC on [DATE] with diagnoses including dementia and right hip fracture.
- The resident's quarterly Minimum Data Set (MDS) dated 09/11/18 indicated the resident sometimes understood and was sometimes understood by others, had severely impaired cognition based on staff assessment, required extensive assistance with activities of daily living (ADLs) including bed mobility, had functional limitations in range of motion of both lower extremities, received scheduled pain medication and no as needed (PRN) pain medication or non-medication approaches for pain. Based on staff assessment for pain, the resident was not observed with indicators of pain or possible pain.
- Resident #103's care plan dated 09/18/18 stated, "Because of my Alzheimer's disease and advanced dementia, [I] sometimes refuse medications or yell out and grab staff during bed mobility, ADL [activities of daily living] care….I recently had a hip fracture and sometimes this causes me pain….Veteran [Resident #103] noted to yell out during reposition [repositioning] due to fear of falling. No pain documented since on [LOCATION]. Sometime will yell when repositioned from fear of falling." The care plan stated, "Team noted Veteran can be combative with care at times. Family shared this is new behavior that has occurred since the Veteran's fall. Family shared that they believe the Veteran has a fear of falling. Staff to give Scheduled Tylenol [acetaminophen] as ordered. Veteran sometimes moans and per Daughter not due to pain but fear of falling." The pain section of the care plan read, "Non-Verbal. Yells out with position change fear of falling." The care plan approach to address fear of falling was identified as, "Staff to reassure safety and allow Veteran to hold on to Trapeze bar."
- The restorative note dated 09/27/18, "He continues to call out and 'yell' when he is touched or has personal care performed, but it is difficult to discern why he does this. When there is no touching involved, he seems happy with no problem."
- A provider's order renewed on 10/09/18 read, "Renew Acetaminophen 650 mg/20.3 ML [650 milligrams per 20.3 milliliters]…SOLN [solution]…PO QID [orally four times a day for generalized pain, fever greater than 100.3 F [Fahrenheit], headache; do not exceed 3000 mg acetaminophen/24 hour from all medication sources."
- On 10/17/18 at 1:01 p.m., a dressing change for Resident #103's right malleolus was observed while a quality manager and nurse manager were present. An LPN was observed to remove the old dressing, cleanse the area, and apply a clean dressing. During the procedure, the resident called out, "Ow," three times while grimacing and holding tightly to a raised side rail. The LPN asked the resident after each vocalization of discomfort if the resident was okay; each time the resident stated that he was okay and the LPN continued with the dressing change. According to the Bar Code Medication Administration (BCMA) record, scheduled acetaminophen was administered at 8:20 a.m. and 1:42 p.m. (after the wound care). The wound care note dated 10/17/18 at 4:21 p.m. stated, "No indication of pain noted."
- During an interview on 10/18/18 at 8:25 a.m. regarding the observations of the dressing change on 10/17/18 and the resident's vocalizations and grimacing, the NM stated, "If a resident is unable to express pain we use 99 such as facial grimaces. We do not feel that he has pain. He will always do that [call out]. The daughter says he has a fear of falling." The NM stated that if staff thought the resident was having pain, the procedure should have been stopped and the provider contacted for a PRN (pain medication).
- The wound care RN was interviewed on 10/18/18 at 10:20 a.m. The RN stated that Resident #103's dressing changes were not "purposefully timed around the medication administration" because he did not have pain with the dressing changes. The RN stated, "He has a fear of falling. A spatial fear. He has a trapeze bar to hold onto when

needed….[it may be] behavioral [meaning the resident calling out].” The CLC had not attempted to rule out pain as the cause of the resident’s behavioral symptoms including the resident stating, “Ow” during wound care. Staff did not indicate that pain medication had been administered prior to wound care to determine if pain relief resulted in less calling out.

- In summary, on 10/17/18, a dressing change for Resident #103’s right malleolus was observed being provided by an LPN. During the procedure, the resident called out, “Ow,” three times while grimacing and holding tightly to a raised side rail. The LPN asked the resident after each vocalization of discomfort if the resident was okay; each time the resident stated that he was okay and the LPN continued with the dressing change. According to the Bar Code Medication Administration (BCMA) record, scheduled Tylenol was administered on 10/17/18 at 8:20 a.m. and 1:42 p.m. (after the wound care). The wound care note dated 10/17/18 at 4:21 p.m. stated, “No indication of pain noted.” Staff indicated during the survey that the Resident #103’s dressing changes were not “purposefully timed around the medication administration” because the resident did not have pain with the dressing changes. The RN stated, “He has a fear of falling. A spatial fear. He has a trapeze bar to hold onto when needed….” It was not evident the CLC attempted to provided pain medication prior to wound treatment in an effort to determine if medication would address the resident’s nonverbal indicators such as grimacing and vocalizations including stating, “Ow” during wound care.

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 that a resident who entered the CLC without a pressure ulcer did not develop a pressure ulcer and a resident having a pressure ulcer received necessary treatment and services to promote healing, prevent infection and prevent new ulcers from developing. Findings include:

The CLC policy dated January 19, 2017, and titled, “Skin Integrity and Wound Care Management,” was provided by quality management staff on 10/17/18 at 9:50 a.m. According to the policy, pressure ulcer interventions may include, “elevate heel using pillow or foam blocks, apply heel/elbow pads, and limit sitting out of bed to less than two hours at a time.”

Resident #103, [LOCATION]

- Resident #103 was admitted to the CLC on [DATE] with diagnoses including dementia, right hip fracture, a Stage 2 sacral pressure ulcer and diabetes. According to a wound care nursing note dated [DATE] a discolored abrasion was noted over the resident’s right malleolus “possibly from striking his ankle on his broda chair.”
- The resident’s quarterly MDS dated 09/11/18 stated the resident sometimes understood and was sometimes understood by others, had severely impaired cognition based on staff assessment, required extensive assistance with activities of daily living (ADLs) including bed mobility, had functional limitations in range of motion of both lower extremities, was at risk for developing a pressure ulcer, did not have a pressure ulcer, and had an open lesion on the foot.
- Resident #103’s care plan dated 09/18/18 read, “Stage II to buttocks that was present on admission-healed June 29th. Dark brown scab to right malleolus, no drainage noted on old dressing. Prevalan [Prevalon] boots BLE [bilateral lower extremities]. Skin problems: Right ankle abrasion same since last assessment scabbed over without signs of infection. Prevalon boots worn all shift, interventions: limit sitting out of bed to less than 2 hours at a time, apply heel/elbow pad. Positioning: wheelchair bound: feet should touch the floor or footplates.”
- A provider’s order dated 06/29/18 stated, “Prevalon boots to be worn 24/7 [24 hours a day] while in bed and in chair.”
- The wound care RN’s note dated 06/29/18 stated, “Right malleolus: 0.3 cm [centimeter] irregular dark discolored area that is blanching. More an abrasion that has bled from trauma, possible striking the ankle from his brodo [Broda] chair. Does not wear the boots when in the chair but now will start. Must wear prevalon boots 24/7 both in bed and in chair.”
- Current provider orders included,
    - “06/29/18 dressing changes: MWF [Monday, Wednesday, Friday] to right ankle with polymem [PolyMem dressing] and kerlix wrap, must wear prevalon boots 24/7.”
    - “08/30/18 RT [right] ankle: Clean with normal saline. Apply Polymem foam to right lateral malleolus. Wrap with kerlix. Change daily.”
- The wound care RN’s weekly rounds note dated 09/28/18 stated, “Recommendations per wound care nurse: continue current treatment of polymem. Scab is intact. Change Polymem back to Monday, Wednesday, Friday or if gets wet…drainage: small amount

of sanguineous drainage…Interventions: Prevalon boots." The wound care nurse's recommendation related to changing the dressing change frequency from daily to Monday, Wednesday and Friday was not addressed in a provider's order. The wound care RN did not document a weekly assessment after 09/28/18.

- Dressing changes were reviewed for a four-week time period between 09/24/18 and 10/17/18. During that time, the dressing was changed on 09/24/18 (Monday), 09/25/18 (Tuesday), 09/27/18 (Thursday), 09/28/18 (Friday), 10/01/18 (Monday), 10/03/18 (Wednesday), 10/09/18 (Tuesday), 10/12/18 (Friday), 10/15/18 (Monday), and 10/17/18 (Wednesday). The nursing notes related to the dressing changes indicated a "scant amount of drainage" until 10/09/18, 10/12/18, and 10/15/18 when "a small amount of bleeding" was documented. Dressing changes were not completed daily as ordered (08/30/18) or on Monday, Wednesday and Friday (three times a week) as indicated in the wound care RN's recommendations (09/28/18).
- On 10/16/18 at 12:35 p.m., Resident #103 was observed seated in a Broda chair eating lunch at a dining room table. The resident was wearing a pair of black slippers with Velcro across the top and was not wearing Prevalon boots. The resident's feet were resting on the footrest with the back of his legs against the padding of the chair. On 10/16/18 at 1:35 p.m., the resident was seated at a 90 degree angle in his chair in the living room wearing the Velcro slippers with his feet on the footrest. On 10/16/18 at 4:30 p.m., an NA provided care and assisted the resident into bed; the NA stated, "Yes, he is in bed for the night, unless he requests to get up." The resident was wearing Prevalon boots.
- A skin assessment dated 10/17/18 at 5:25 a.m. stated, "Braden 16=mild risk. Right ankle abrasion appears unchanged from last assessment. Brown scab noted, scant drainage noted in old dressing. Left heel noted to be boggy."
- On 10/17/18 at 7:30 a.m., Resident #103 was observed eating breakfast at a dining room table. An NA stated, "The night shift [staff] gets him up, so he is up and dressed by the time I get here." During the observation, the resident was wearing the Velcro slippers but the footrest was not lowered; as a result, the resident's feet were in a dependent position and hanging approximately three inches above the floor. The resident's feet remained in the dependent position and did not touch the floor until an NA brought the resident to his room at 8:15 a.m. and placed the footrest down and the resident's feet on the footrest. Wearing the slippers, the resident attended an outing and returned to the neighborhood around 11:45 a.m. The resident remained in the chair until care was provided at 12:45 p.m. when staff assisted the resident to bed.
- On 10/17/18 at 9:04 a.m. during an interview, a nurse manager (NM) stated, "The wound care nurse will evaluate upon admission and if there is a wound, a plan will be developed." The NM confirmed that the provider's order indicated the dressing changes to the right ankle were to be completed daily and that staff were not following the order. The NM said, "The boots are only for bed, not in his chair, it would be an odd order if he was to wear them in his chair." The NM reviewed the provider's order and said she would contact the provider for an order change. After speaking with the provider, the NM stated the order was correct as written and "he [Resident #103] is to wear the boots in his chair and bed."
- On 10/17/18 at 1:01 p.m., the dressing change was observed for the resident's right malleolus. The LPN removed the old dressing, cleansed the area, and applied a clean dressing. The LPN was asked to inspect the resident's right heel. The LPN examined the area including palpating the heel and stated, "It's [the right heel is] slightly boggy." The heel was observed by the surveyor to be pink, mottled, and appeared fluid filled [boggy]. According to the LPN's nursing note on 10/17/18 at 4:25 p.m., "This nurse attempted to contact wound care staff regarding veteran's heels."
- In summary, on 10/17/18 at 1:01 p.m., during observations of a dressing change for Resident #103's right malleolus, the LPN examined the resident's right heel and stated, "It's [the right heel] slightly boggy." The heel was observed by the surveyor to be pink, mottled, and appeared fluid filled (boggy). During observations on 10/16/18 and 10/17/18, Resident #103 was observed seated in a Broda chair wearing a pair of black slippers with Velcro across the top; the resident was not wearing Prevalon boots as ordered, while sitting in the chair. On 10/17/18 at 7:30 a.m., the resident was sitting in the Broda chair wearing Velcro slippers and the footrest was not lowered; as a result, the resident's feet were in a dependent position and hanging approximately three inches above the floor; the feet did not touch the floor or footplate as indicated in the plan of care. The resident's feet remained in the dependent position until 8:15 a.m. when an NA placed the footrest down and the resident's feet on the footrest. The resident attended an outing while wearing the Velcro slippers and returned to the neighborhood around 11:45 a.m.. The resident remained in the chair until care was provided at 12:45 p.m. when staff assisted the resident to bed. Based on record review between 09/24/18 and 10/17/18, dressing changes were not completed daily as ordered (08/30/18) or on Monday, Wednesday and Friday (three times a week) as indicated in the wound care RN's recommendations (09/28/18).