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:

Location: Louis Stokes VA Medical Center (Cleveland, OH)

Dates of Survey: 3/25/2019 to 3/27/2019

Total Available Beds: 135

Census on First Day of Survey: 128

F-Tag	Findings
F157 483.10(b)(11) *Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.12(a) (ii) The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is (A) A change in room or roommate assignment as specified in §483.15(e)(2); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. (iii) The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.* **Level of Harm** - No actual harm with potential for more than minimal harm that is not immediate jeopardy	Based on observation, interview and record review, the CLC did not notify a resident about a room change. Findings include: Resident #106, [LOCATION] • Resident #106 was admitted to the CLC on [DATE] for rehabilitation following an accident. The resident was receiving dialysis three times a week and had diagnoses that included depression and schizophrenia. • The resident's comprehensive Minimum Data Set (MDS) assessment dated 01/14/19 indicated the resident had clear speech, was understood and understood others, and had a Brief Interview for Mental Status (BIMS) score of 3 suggesting severely impaired cognition. According to the MDS, the resident required limited assistance with bed mobility, and extensive assistance with transfers; the resident used a wheelchair for mobility. • On 03/25/19 at 2:25 p.m., Resident #106 was observed in bed in the hallway; the bed had been pushed up against the wall. When asked why the resident was in bed in the hallway, the NM stated, "They are moving him into a different room, so he is closer to the nurses' station. He got back from dialysis and his room was not ready yet; they are almost done cleaning it." An RN approached the resident in the hallway and said, "They are cleaning your room. They want you closer to the nurses' station. They are almost done." After discussions with the surveyor, the resident was noted to be moved into his room and out of the hallway at approximately 2:35 p.m. • On 03/26/19 at 9:30 a.m., Resident #106 was interviewed while sitting in his room in a wheelchair. When asked about the recent room change, and if the resident had been informed about the room change prior to that time, the resident said, "No." The resident spoke in a quiet voice and said, "I came back from dialysis yesterday and didn't know what was going on. I was in my bed and left in the hallway. I thought they forgot about me." • During the daily meeting on 03/25/19 at 4:20 p.m., the chief nurse indicated the resident had known about a room change (that a room change might occur) because he requested a private room at one time. When asked about documentation of discussions with the resident regarding a room change, the chief nurse said, "We don't document room changes."

Residents Affected - Few

F176

483.10(n) *Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe.*

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 interdisciplinary team did not ensure a resident could safely and correctly self-administer medication. Findings include:

Feeding Tube Medication Administration
On 03/26/19 at 2:05 p.m., a quality management nurse reviewer provided the Northeast Ohio VA Healthcare System Community Living Center Standard Operating Procedure dated 01/25/18 and titled, "Feeding Tubes: Nasogastric, Gastrostomy, or Jejunostomy Tube." The procedure directed the administration of medications by way of a gastrostomy tube as follows:

- **"Prior to Tube Feeding of Medication Administration** [emphasis not added]
  - "Placement should be verified by gastric residual volumes. If the enteral tube has numbers, the number placement can assist in verifying placement of the tube, but is not a substitution for checking gastric residual volumes. The black mark is not present on all feeding tubes and there can be variance in the numerical value due to peristalsis."
  - "Draw back on the syringe slowly and aspirate the total amount of gastric contents...Observe gastric contents. This serves as a secondary verification of placement."
- "**Medication Administration** [emphasis not added]"
  - "Check gastric residual volume…."
  - "Flush feeding tube using tap water…with the amount designated in the provider order."
  - "Remove the piston from syringe and attach syringe to the proximal end of the feeding tube."
  - "Administer one medication by pouring it into the syringe."
  - "Clear tube by flushing using tap water…with the amount designated in the provider order."
  - "If administering more than one medication, give each separately and flush between medications with tap water…with amount designated in the provider order."
  - "Follow the last dose of medication with flush using tap water…with amount designated in the provider order."

Resident #305

- On 03/26/19 at 10:35 a.m., an RN was observed preparing medications for Resident #305 to be administered by way of the resident's gastrostomy tube. As the nurse prepared the medication at the medication cart, the resident was observed standing at the sink in the resident's room rinsing a 60 milliliter (ml) syringe and filling a plastic container with water from the tap.
- According to the Bar Code Medication Administration (BCMA) screen, the resident was to receive acetaminophen liquid, docusate tablets, sertraline liquid, gabapentin liquid, and polyethylene glycol powder. The RN poured the liquid medications into separate medicine cups, crushed the docusate and placed it in a separate medicine cup, and placed the polyethylene glycol in a medicine cup and added approximately 120 milliliters (ml) of water. The RN reported Resident #305 self-administered the medications through his gastrostomy tube. The resident's plan of care did not address self-administration of medication.
- While standing at the room sink, the resident removed his gastrostomy tube from under his shirt, drew approximately 50 ml of tap water into a syringe, removed the cap from the gastrostomy tube, attached the syringe, released the clamp on the tube and rapidly pushed 50 ml of water through the gastrostomy tube without first checking for gastric residual volume. The RN did not encourage the resident to first check for gastric residual volume or inquire as to why the resident did not check for gastric residual volume. The resident then clamped the gastrostomy tube.
- The RN handed the resident the cup with the acetaminophen liquid while informing the resident what was in the cup. The resident added tap water to the cup, drew the contents of the cup (approximately 50 ml) into the syringe, unclamped the gastrostomy tube and rapidly pushed the medication into his gastrostomy tube. The resident clamped the tube, drew approximately 50 ml of tap water into the syringe, unclamped his tube, rapidly pushed the tap water through the tube, and clamped the tube. The resident did not administer the acetaminophen by pouring it into the syringe (using gravity) in accordance with CLC policy.
- The RN handed the resident the cup containing the docusate and informed the resident of the cup's contents. The resident added water to the cup and drew the cup's contents

(approximately 50 ml) into the syringe, unclamped the tube, rapidly pushed the medication through the gastrostomy tube and clamped the tube. The resident drew approximately 40 ml of tap water into the syringe, unclamped the tube, and rapidly pushed the tap water into the gastrostomy tube and clamped the tube.

- The same procedure observed for the docusate and acetaminophen liquid (as above) was repeated for the sertraline liquid, gabapentin liquid and polyethylene glycol, although the resident repeatedly drew the contents of the polyethylene glycol into the syringe until all of the medication had been administered. Other than informing the resident of the medications in the medicine cups, the RN did not provide the resident with instructions for administering the medications.
- On 03/26/19 at 12:30 p.m., the associate chief of inpatient pharmacy reported the medical center's self-medication policy did "not reflect the situation observed" by the surveyor because the medications were stored securely in the medication cart, scanned and recorded by nursing staff, and handed to the resident. The nurse educator discussed the procedure for administering medications by way of a gastrostomy tube and reported nurses were expected to administer medications according to the procedure. The nurse educator reported the physician prescribed the amount of fluid to be administered with medications; however, the resident's current provider orders did not contain an order for the amount of tap water flushes before medications were administered, between medications, or after the last medication was administered.
- In summary, the resident did not administer medications into his gastrostomy tube in accordance with the CLC's procedure. The interdisciplinary team did not conduct an assessment to determine if the resident could safely and correctly administer the medication; the care plan did not indicate the resident self-administered medication. During a medication pass observation on 03/26/19, the resident did not assess for gastric residual volume and did not use a gravity flow for administering the medications and tap water flushes. Although the procedure indicated the provider would designate the amount of water flushes to be used, the provider did not order a specific amount of water to use for flushes. The RN who prepared and provided the medications did not instruct the resident to check for gastric residual volume and use gravity flow for administration, or indicate how much water the resident should use for flushing. The CLC did not ensure a resident self-administered medications correctly by way of his gastrostomy tube.

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 #106, [LOCATION]

- Resident #106 was admitted to the CLC on [DATE] for rehabilitation following an accident. The resident was receiving dialysis three times a week and had diagnoses that included depression and schizophrenia.
- The resident's comprehensive MDS dated 01/14/19, indicated the resident had clear speech, was understood and understood others, and had a Brief Interview for Mental Status (BIMS) score of 3 suggesting severely impaired cognition. According to the MDS, the resident required limited assistance with bed mobility, and extensive assistance with transfers; the resident used a wheelchair for mobility.
- On 03/25/19 at 2:25 p.m., Resident #106 was observed in bed in the hallway; the bed had been pushed up against the wall. The resident was covered with a sheet and blanket, with a partially eaten meal tray in front of the resident. When asked why the resident was in bed in the hallway, the NM stated, "They [staff] are moving him into a different room, so he is closer to the nurses' station. He got back from dialysis and his room was not ready yet; they are almost done cleaning it." The nurse manager indicated the resident liked to eat meals in his room and watch television. An RN approached the resident in the hallway and said, "They are cleaning your room. They want you closer to the nurses' station. They are almost done." After discussions with a surveyor, the resident was noted to be moved into his room and out of the hallway at approximately 2:35 p.m. The quality management (QM) nurse reviewer indicated that according to the dialysis record, the resident's dialysis treatment ended at 11:25 a.m. on 03/25/19 and the resident returned to the neighborhood was approximately 1:00 p.m.
- On 03/26/19 at 8:40 a.m., the supervisor of housekeeping was interviewed. When asked if residents should be waiting in a bed in the hallway for a room to be cleaned, the supervisor of housekeeping said, "It's not something that happens daily."
- On 03/26/19 at 9:30 a.m., Resident #106 was interviewed while sitting in his room in a wheelchair. When asked about the recent room change, the resident spoke in a quiet

voice and said, “I came back from dialysis yesterday and didn’t know what was going on. I was in my bed and left in the hallway. I thought they forgot about me.”
- During the daily meeting on 03/25/19 at 4:20 p.m., the chief nurse indicated the resident returned from dialysis and stated he was hungry, so he was given a meal tray. The resident returned from dialysis at approximately 1:00 p.m. and remained in his bed in the hallway until approximately 2:35 p.m.

F272

483.2 *Resident Assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.*

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 conduct a comprehensive assessment related to safe use of side rails. Findings include:

Side Rail Assessments
On 03/26/19 at 12:30 p.m., the quality management nurse reviewer provided the Northeast Ohio VA Healthcare System Community Living Center Standard Operating Procedure dated 02/01/19 and titled, “Side Rail Utilization in the Community Living Center (CLC).” According to the procedure:

- “Upon admission to the CLC, the admitting RN [registered nurse] will complete a side rail monitor as part of the CLC Nursing Admission documentation.
- Side rail utilization will be reviewed quarterly during the Interdisciplinary Team Conference.
- Side rail utilization and preference may be added to the plan of care and/or discussed in shift huddle.”
- The Side Rail Use Monitor contained the following questions with yes and no responses:
    - Is the resident non-ambulatory?
    - Does the resident have alteration in cognitive abilities?
    - Does the resident have a history of falls?
    - Has the resident displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed?
    - Does the resident have difficulty with balance or poor trunk control?
    - Has the resident expressed a desire to have side rails raised for bed controls or bed mobility?
    - Is the resident visually challenged?
- Based on the side rail use monitor response (one or more of the following was to be checked):
    - Side rails are indicated per resident preference or need.
    - Side rails do not appear to be indicated at this time, but may be used per veteran preference.
    - The resident is unable to provide a side rail preference.
    - The patient/family was educated on the use of side rails. Level of Understanding: (to be documented).

The CLC side rail use monitor did not include the number of side rails to be raised and which rails were to be raised as part of the assessment for side rail use; instead, focusing on resident preference as the primary consideration for side rail use. The monitor sometimes indicated residents had alterations in cognitive abilities, poor bed mobility, or poor trunk control placing the resident at risk for safety concerns when the side rails were used. When used for bed mobility, the monitor did not assist staff to determine if side rails were a safe approach for residents to use. Rationale for side rail use other than resident preference was not documented on the monitor.

[LOCATION]
An initial tour of the [LOCATION] neighborhood was conducted on 03/25/19 beginning at 9:15 a.m. During the tour, six residents were observed with the right and left side rails near the head of the bed in the raised position. The CLC used Carroll CHG beds. The side rails had a solid base and three openings along the top of the rail; the opening near the head of the bed measured 9.5 inches in length and 4 inches in height, the middle opening was 14 inches in length and 4 inches in height, and the opening closest to the foot of the bed was 9.75 inches long and 4 inches high. The height of the entire side rail was 13 inches and the length was 43 inches. The length of the mattress was 78 inches. When raised, the side rails extended more than half the length of the mattress. The standard mattress that came with the bed fit tightly against the raised side rails. The nurse call button and buttons to raise the head and foot of the bed were on the inside of the side rails (near the resident). On 03/25/19 at 10:15 a.m. following a review of residents with the charge nurse, the charge nurse stated, “We have a side rail assessment. Pretty much everyone has one [side rail] up for mobility.”

Resident #301, [LOCATION]

- Resident #301 was admitted to the CLC on [DATE]. According to the 03/19/19 CLC inpatient progress note. the resident had an aortic valve replacement and was in the CLC for rehabilitation.
- The resident's [DATE] nursing admission assessment included a section titled, "Side Rail Use Monitor." According to information documented in this section, the resident was ambulatory, had no altered cognition, had a history of falls, had no problems with bed mobility or balance, and did not express a desire to have the side rails raised. The monitor concluded, "Side rails do not appear to be indicated at this time, but may be used per veteran preference." The resident was educated on the use of side rails and his level of understanding was documented as, "Good."
- The resident's comprehensive MDS dated 01/23/19 documented the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition. The MDS indicated the resident required supervision for bed mobility, transfers, and walking; and supervision with assistance of one staff person for toilet use and personal hygiene. The resident used a walker or wheelchair for mobility and had no falls during the assessment review period.
- The resident's care plan did not address side rail use.
- During the initial tour on 03/25/19 beginning at 9:15 a.m., Resident #301 was observed in bed with the right and left side rails raised on the bed.
- On 03/26/19 at 1:05 p.m., Resident #301 was interviewed while in bed. The right and left side rails on the resident's bed were raised. When asked if the resident requested use of the side rails, the resident responded, "No, they [staff] just put them up. Usually there is one up and one down."
- An assessment had not been conducted to determine if side rails were a safe approach for the resident; the 01/17/19 Side Rail Use Monitor stated, "Side rails do not appear to be indicated at this time, but may be used per veteran preference." During an interview, the resident did not indicate that he preferred the side rails be raised.

Resident #302, [LOCATION]

- Resident #302 was admitted to the CLC on [DATE]. According to the 03/21/19 CLC inpatient progress note, the resident's diagnoses included end stage renal disease (ESRD), atrial fibrillation, and a history of cerebrovascular accidents (CVAs).
- The resident's comprehensive MDS dated 08/08/18 indicated the resident had a BIMS score of 13 suggesting intact cognition. The MDS indicated the resident required limited assistance for bed mobility and toilet use and extensive assistance for transfers. The resident had functional limitations in range of motion of both lower extremities and used a walker or wheelchair for mobility. According to the MDS, the resident had one fall without injury during the assessment review period. The most recent 02/18/19 quarterly MDS indicated the resident's cognition was moderately impaired based on staff assessment; a Brief Interview for Mental Status (BIMS) score was not documented. The quarterly MDS indicated the resident required extensive assistance for bed mobility, total assistance for transfers and limited assistance with toilet use. The resident had functional limitations in range of motion of one upper extremity and one lower extremity and used a walker or wheelchair for mobility. According to the quarterly MDS, the resident had no falls during the assessment review period.
- Resident #302's care plan included a statement dated 08/09/18 that read, "I was brought o [to] the ED [emergency department] by my family r/t [related to] a fall that night. I ahve [have] a history of recurrent falls in past 6 months but unsure of timeline. I have PMH [past medical history] of multiple strokes and I am admitted for short stay rehab [rehabilitation]…." A handwritten note dated 10/25/18 read, "Resident prefers to keep his side rails up to assist with mobility."
- The resident's 10/25/18 nursing assessment included a section titled, "Side Rail Use Monitor." According to information documented in this section, the resident was non-ambulatory, had no alteration in cognition, had poor bed mobility and trunk control, did not have visual limitations and expressed a desire to use side rails. Documentation indicated, "Side rails are indicated per resident preference or need." The resident was educated on the use of side rails and his understanding was documented as, "Good."
- The resident experienced a fall on 03/08/19. According to the post fall assessment note, "Vet [Veteran] was sleeping in his wheelchair with head on bed and slipped out of chair." The position of the side rails was not documented in the note.
- The resident had a fall on 03/13/19. The post fall assessment note stated, "Transferring self….sitting on floor between bed and wheelchair." The position of the side rails was not documented in the note.
- On 03/25/19 at 1:30 p.m., a nursing assistant familiar with the resident indicated being aware the resident had fallen. The nursing assistant stated, "He transfers bed to wheelchair and wheelchair to toilet….He uses two side rails. He uses them to pull up in bed…."
- An assessment had not been conducted to determine if side rails were a safe approach for the resident; the Side Rail Use Monitor dated 10/25/18 did not indicate an evaluation was conducted regarding the resident's ability to lower the side rails and

transfer from the bed to the wheelchair; side rail use was not reassessed following falls on 03/08/19 and 03/13/19.

Resident #304, [LOCATION]

- Resident #304 was admitted to the CLC on [DATE]. According to the CLC history and physical, the resident's diagnoses included dementia, "dizziness," and recurrent falls.
- The resident's most recent 01/29/19 quarterly MDS assessment indicated the resident's BIMS score was 15 suggesting intact cognition. The MDS indicated the resident required supervision for all ADLs except walking which did not occur during the assessment review period. The resident had no functional limitations in range of motion, used a wheelchair for mobility, and experienced more than two falls without injury during the assessment review period.
- The resident's [DATE] nursing admission assessment included a section titled, "Side Rail Use Monitor." According to information documented in this section, the resident was ambulatory, had no alteration in cognition, had a history of falls, did not have poor bed mobility or difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control, and had visual limitations. The side rail use monitor indicated the resident expressed a desire to have the side rails raised for bed controls or mobility, and that the "side rails are indicated per resident preference or need." The resident was educated on side rail use and his level of understanding was documented as, "Good."
- Resident #304's care plan included a statement dated 11/09/18 that read, "My staff note that I am at high risk for falls. I have had multiple falls in the past and I am unsteady now due to deconditioning and large wound to my right thigh…." An approach dated 11/09/18 stated, "Vet prefers to have 2 side rails up to make bed mobility easier and for use of controls located on bed rails."
- A 01/08/19 post fall assessment note indicated the resident stated, "I was in pain and I was going to get the nurse to ask for pain medication, when I stood up I couldn't keep my balance I ran [rang] my call light for help. The nursing assistant lowered me to the floor because she could not hold me." The note did not indicate whether the resident stood from the bed or identify causal and contributing factors for the fall. A preventive measure listed in place at the time of the fall was "Bed siderails – up on both sides."
- On 03/25/19 at 2:30 p.m., a nursing assistant familiar with the resident stated, "He uses two side rails. He can move side to side. He has mobility issues."
- An assessment had not been conducted to determine if side rails were a safe approach for the resident; the Side Rail Use Monitor dated 10/31/18 did not indicate an evaluation was conducted regarding the resident's ability to lower the side rails and stand from bed or transfer in consideration of the resident's dementia, "dizziness," and recurring falls; side rail use was not reassessed following the resident's fall on 01/08/19.

F323

483.25(h)(1) *Accidents. The facility must ensure that: The resident environment remains as free of accident hazards as is possible;*

Level of Harm - Immediate jeopardy to resident health or safety

Resident Affected - Few

Based on observation, interview and record review, the CLC did not ensure the resident environment remained as free of accident hazards as possible. Findings include:

Side Rail Use

Resident #303, [LOCATION]

- Resident #303 was admitted to the CLC on [DATE]. According to the 03/22/19 CLC inpatient progress note, the resident's diagnoses included "severe Alzheimer's dementia." The [DATE] CLC nursing admission assessment included a section titled, "Side Rail Use Monitor." According to information documented in this section, the resident was non-ambulatory, had an alteration in cognitive abilities, did not have a history of falls, displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control, was unable to express a desire to use side rails, did not have visual limitations, and was unable to provide a side rail preference. Documentation indicated the resident's family was educated on the use of side rails.
- The resident's most recent quarterly MDS assessment dated 03/21/19 indicated that based on staff assessment, the resident's cognition was severely impaired. The MDS indicated the resident had indicators of delirium including inattention and an altered level of consciousness that fluctuated, and disorganized thinking that was constant. The resident required extensive assistance for bed mobility and total assistance for all other activities of daily living (ADLs). The resident did not walk during the assessment review period and used a wheelchair for mobility. The resident did not experience functional limitations in range of motion and had more than two falls without injury during the assessment review period. The resident's weight was documented as 96 pounds.

- The resident's care plan included a statement dated 12/28/18 that read, "Resident is at risk for falls related to history of dementia and may overestimate or forget limitations. [Resident #303] has been non-ambulatory since admission however per his daughter prior to admission he was ambulating with no assisted device (with mild gait/balance difficulty)." A handwritten note dated 03/24/19 stated "Vet [Veteran] has history of Dementia and delirium at night…." The goal with a review date of 04/03/19 stated, "Resident's risk for falls will be minimized." One of the approaches dated 12/28/18 read, "2 side rails are up for vet to use for mobility and for easy access to room controls."
- A post fall assessment note dated 02/14/19 indicated, "Pt [patient] was found wedged between the mattress and the bed rail," was reviewed with the chief nurse of the CLC and the quality management nurse reviewer. The chief nurse stated the resident had not fallen on 02/14/19; however, because the resident sustained an injury staff documented the injury in a post fall assessment note. A 02/14/19 provider note following this event stated, "Pt [patient] was found wedged between the mattress and the bed rail." Resident #303 was found to have erythema over the left hip and "ecchymosis on left forearm." After the resident was found "wedged between the mattress and the bed rail" and found with an erythema over the left hip and "ecchymosis on left forearm," a comprehensive assessment was not conducted (as confirmed by the chief nurse and quality management nurse reviewer) to determine the safe use of side rails for the resident.
- On 02/15/19, a post fall assessment note stated, "Vet is on far sided [side of] bed/floor." The resident reported he "scooted out of the chair (bed). I slid down." Preventive measures in place at the time of this fall were documented as "bed rails." The note did not indicate if the resident's side rails were in the raised position when the resident fell.
- A 03/12/19 post fall assessment note stated, "Attempting to exit bed, feet on floor, torso on bed, pushed call light for assistance."
- On 03/24/19, a post fall assessment note stated, "Staff found veteran lying on the left side of his bed on the floor mat with his head on a pillow." The note did not indicate if the side rails were raised or how the resident got out of bed.
- On 03/25/19 at 1:25 p.m., Resident #303 was observed lying on his back in bed with one side rail on the right side of the bed and one side rail on the left side of the bed in the raised position. The side rails extended from the headboard to more than half the length of the mattress when the side rails were raised. The resident had a Dolphin® replacement mattress on the Carroll bed; the Dolphin mattress was not the mattress supplied with the Carroll bed. The bed was in the lowest position and fall mats were in place on the right and left sides of the bed. The resident was not observed attempting to get out of bed during the observation.
- On 03/26/19 a 8:55 a.m., the resident was observed in bed with side rails raised on both sides of the bed. Fall mats were on the right and left sides of the resident's bed and the bed was in the lowest position. During the observation, the resident was not observed attempting to get out of bed.
- On 03/25/19 at 1:45 p.m., a nursing assistant familiar with the resident stated, "He [Resident #303] is total care. We use a Hoyer to move [the resident] in and out of bed….He just had a fall out of bed on night shift [on 03/24/19]. He has an alarm. He does not use his side rail for positioning."
- On 03/26/19 at 4:45 p.m., the configuration of the resident's bed, side rails and mattress was reviewed with the chief nurse of the CLC, quality management nurse reviewer, and head nurse of the spinal cord injury and disorder center. The Dolphin mattress was 78 inches in length. The side rails extended 43 inches from the head of the mattress when the rails were in the raised position; the raised height of the side rails was 9 inches above the mattress. On the left side of the mattress there was a 1-inch gap between the mattress and the side rail and on the right side of the mattress there was a 2.5 to 3-inch gap between the mattress and the side rail. When the resident was in bed, there was a gap of less than 3-inches between the mattress and the side rail. There was a 4.5-inch gap between the headboard and mattress and a 1.5-inch gap between the footboard and the mattress. Concerns were discussed regarding the resident's risk for entrapment and/or injury from falls while side rails were in use. (See Systems-level Review)
- On 03/27/19 at 8:50 a.m., Resident #303 was observed in bed prior to a dressing change. The resident's bed was in the lowest position. The side rails were down, and fall mats were in place on both sides of the resident's bed. The Dolphin® mattress had been replaced with the standard Carroll mattress, and a staff member was providing one-to-one observations of the resident. When asked about pressure reducing qualities of the Carroll mattress, the chief stated she was "comfortable" with the resident using the standard Carroll mattress.

Resident #105, [LOCATION]

- Resident #105 was admitted to the CLC on [DATE] with diagnosis that included non-Alzheimer's dementia; the resident was readmitted on [DATE] with bilateral above

knee amputations (AKA).

- The resident's quarterly MDS dated 12/31/18 indicated the resident was understood and understood others, and had a Brief Interview for Mental Status (BIMS) score of 2 suggesting severely impaired cognition. According to the MDS, the resident required extensive assistance with bed mobility, transfers, and personal hygiene; had a fall in the last month without injury; used a bed alarm daily and did not use bed (side) rails.
- The nursing admission note dated [DATE] indicated the resident was at high risk for falls with a Morse Fall Scale score of 50. The nursing assessment did not address the use of side rails and no side rail assessment was completed at that time. The nursing admission note did not include the Side Rail Use Monitor.
- The care plan dated 10/10/18 addressed falls and stated, "I am at risk for falls related to my confusion, decreased left eye vision, decreased hearing, decreased range of motion to my left hip and both knees (bilat [bilateral] AKA 12/27[/18])…my staff note that I have a need for medication which may increase my risk of falling (opioid pain meds [medications], sleep meds, diuretic medication...)." Approaches dated 10/09/18 stated, "Frequent nursing rounds. Place bed in lowest position with brakes locked." The resident's care plan included a handwritten note dated 10/29/18 that stated, "I prefer to have my siderails up." There was no other information included in the care plan that addressed the use of side rails.
- The interdisciplinary team (IDT) note dated 12/27/18 indicated the resident had a Morse Fall Scale score of 50 suggesting a high fall risk; the note stated, "….had no falls this review period." A Side Rail Use Monitor assessment was completed at this time and indicated the resident was non-ambulatory, had alterations in cognitive abilities, displayed poor bed mobility or difficulty moving to a sitting position on the side of the bed, had difficulty with balance or poor trunk control, expressed a desire to have side rails raised for bed controls or bed mobility, and was visually challenged. Although risk factors were identified in the side rail monitor assessment (e.g., poor bed mobility, difficulty with balance), the assessment conclusion stated, "Based upon the side rail use monitor responses: siderails are indicated per resident preference or need."
- Additional care plan entries read: 01/02/19, "s/p [status post] fall out of bed found on floor next to bed. No apparent injury. Will continue current fall interventions;" 01/03/19, "Vet is noted to have fallen thinking he was attempting to feed dog. Will attempt to move vets room close to nurse station. Vet tolerating alarm well;" 01/03/19, "Ensure that I have an intact and functional bed alarm-remind me to call don't fall;" 02/28/19, "s/p fall found on floor next to bed. Small open area right groin area;" 03/07/19, "Assist me to be located near staff for close supervision."
- The IDT note dated 02/28/19 was completed following a fall and indicated the resident had a Morse Fall Scale score of 55 suggesting a high risk for falls. The note stated, "Vet sitting upright on buttocks on mat @ [at] bedside holding onto side rail….Preventative measures in place at the time of the fall: bed siderails, bed alarm, floor mat." The Side Rail Use Monitor assessment included the same responses and conclusions as indicated in the IDT note dated 12/27/18.
- The pharmacy note dated 02/28/19 stated, "Pt [patient] had an unwitnessed fall on 02/28/19 at 4:50 a.m. Pt could not remember and said he did not fall. Pt was found by staff lying on his left side on the floor mat adjacent to the low bed. Environmental factors identified was dolphin mattress (slipper) [slippery]. Pt is on the following med [medications] that increase risk of falls: Enoxaparin (increases risk of bleeding), Finasteride, Melatonin, Tamsulosin, Torsemide, Tramadol, Warfarin (increases risk of bleeding)."
- According to post fall assessments, the resident had falls from bed while the side rails were in the raised position on 01/02/19 at 1:10 a.m., 02/28/19 at 4:50 a.m., and 02/28/19 at 7:20 p.m. The post fall notes did not indicate how the resident fell from bed while the side rails were raised; the notes indicated side rails were used as a fall prevention intervention. The post fall assessments did not indicate how many side rails or which side rails were raised when the resident was found following the falls.
- The resident was observed lying in his bed with a side rail raised on both sides of the bed on 03/25/19 and 03/26/19. The resident had a Dolphin mattress and the side rails extended to more than half the length of the mattress; the rails extended approximately eight inches above the top of the mattress.
- On 03/26/19 at 9:00 a.m. during an interview, when asked about falls from bed, the resident did not recall the falls but stated that he "probably crawled down and around the rail near the end of the bed trying to get out," adding, "without my legs that's pretty hard to do." The resident was not sure why the side rails were raised and indicated that he did not use the rails; the resident stated, "They [the side rails] have just always been there."

System-level Review

- A meeting was held on 03/26/19 at 5:35 p.m. with CLC and medical center leadership staff including the medical center director, chief nurse executive, chief nurse of the CLC, and quality management nurse reviewer. The serious nature of the findings

related to side rail use and the determination of immediate jeopardy were discussed.
- On 03/26/19 at 7:30 p.m., the CLC provided a corrective action plan and implemented remedies to abate the immediate jeopardy findings. The plan included action to be taken for prevention of accidents for the identified residents including providing one-to-one observation until the nursing side rail assessment could be conducted. The action plan included lowering of the side rails, maintaining the beds in the lowest position, placing floor mats at the sides of the beds, removing therapy mattresses with a slick surface, and replacing the mattresses with a "regular" mattress. According to the action plan, the chief nurse and nurse managers were to discuss findings and future actions, provide education on the new assessment tool (as below). In addition, RNs were to document the results of the new assessment both in the computerized patient record system (CPRS) and the resident's care plan. The quality management staff person and chief nurse were to monitor the use of side rails during rounds and chart the observations. The policy for side rails was to be revised to include when to reassess a resident and a new side rail assessment was developed that included the following questions: Is the resident non-ambulatory? Does the resident have a history of falls this admission related to getting in or out of bed? Does the resident have difficulty getting to the side of the bed and sitting independently at the side of the bed? (Have veteran demonstrate if needed.) Veteran does not have the cognitive ability to use bed controls on the rail independently? If all above questions are answered with a no response the side rail may be left up only if that is the veteran's preference; otherwise, side rails are to be lowered.
- On 03/26/19 at 7:45 p.m., the CLC's corrective action plan was accepted and the CLC leadership team was notified the immediate jeopardy was abated.

F328

483.25(k)(6) *Standard: Respiratory Care*

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 ensure a resident received proper respiratory care and treatment. Findings include:

On 03/25/19 at 4:00 p.m., the CLC chief nurse provided the NORTHEAST OHIO, HEALTHCARE SYSTEM ..MEDICAL CENTER POLICY 111-011 dated January 7, 2019 and titled, "RESPIRATORY CARE SERVICES." According to the policy, "It is the responsibility of the nursing management staff to: 1) Ensure the delivery of quality respiratory care to patients being served by the nursing staff at the Medical Center with respect to respiratory modalities. 2) Ensure the nursing staff providing respiratory care modalities have demonstrated competency for the procedures in which they have been entrusted." Attachment A identified the available respiratory modalities to include "CPAP/BiPAP [continuous positive airway pressure/bilevel positive airway pressure]: Administration - nocturnal use for Long Term Care; PRIMARY PERSONNEL RESPONSIBLE FOR THERAPY [emphasis not added] – nursing staff."

Resident #204, [LOCATION]

- According to Resident #204's history and physical dated [DATE], the resident was admitted to the CLC with a history of obstructive sleep apnea (OSA), pneumonia, congestive heart failure and dementia. The history and physical stated, "OSA – has own CPAP – continue CPAP." Resident #204's comprehensive MDS dated 01/21/19 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 14 suggesting intact cognition. The MDS indicated the resident required extensive assistance with bed mobility, dressing, toilet use and personal hygiene. Section O of the MDS indicated the resident used oxygen therapy and BiPAP/CPAP.
- A provider order dated 01/15/19 at 2:35 p.m. stated, "CPAP at hs [hour of sleep] and during naps…Start 01/15/19 stop 03/08/19."
- A nursing admission note dated [DATE] indicated the resident snored while asleep; the note did not address use of a CPAP machine.
- Resident #204's care plan dated 01/24/19 included information related to special needs for the use of a CPAP but did not include specific information about when the resident used the CPAP or how to administer the CPAP.
- On [DATE], the resident had a change in condition and was transferred to the acute care setting. The resident returned to the CLC on [DATE] with a provider's order that read, "CPAP at hs and during naps. Start [DATE], Stop 03/15/19: Current Status: Orders that have a stop date which has expired. e.g. Unit Dose orders expire at some sites 14 days after the order is created but may be renewed within a hospital designated time after the expiration date. Stop Date 3/15/19 at 8:19 p.m."
- The surveyor and quality management nurse reviewer observed the resident on 03/25/19 at 2:05 p.m. while the resident was asleep in bed; the resident was not wearing the CPAP that was on the resident's bedside table. The tubing and mask were attached to the CPAP and the mask was placed in a clear undated respiratory bag.
- During an interview with Resident #204 on 03/25/19 at approximately 5:30 p.m., the

resident said, “The CPAP was brought from home; I used it every night and my daughter cared for it.”

- On 03/26/19 at 9:40 a.m., the nurse manager (NM) in [LOCATION] stated, “The order for the CPAP should have been renewed on 03/15/19 but wasn’t. A new order was written last evening.” Review of the new order that was written on 03/25/19 after discussions with the surveyor read, “CPAP at hs and during naps: Stop date 06/25/19.” The order did not include settings for the CPAP. When asked if nursing or respiratory services ensured administration of the CPAP to the resident, the NM responded that nursing staff provided CPAP services in the CLC and the CPAP machines were brought from home because a resident’s sleep studies were performed outside the acute care hospital setting. When asked if the CPAP settings were known and if Resident #204’s CPAP had been checked to ensure it was working properly, the NM was unaware of the settings for Resident #204’s CPAP and unsure if the CPAP machine was working because the resident brought the machine from home. The NM was unable to locate documentation to indicate when the CPAP tubing and mask were last cleaned. The NM provided information that indicated the mask and tubing were issued to the resident in January 2019. When asked how many residents in [LOCATION] had CPAP machines that were brought into the CLC from home, the NM was unaware of the number of residents in [LOCATION] that had CPAP machines.
- Documentation was requested regarding nursing treatment notes related to the CPAP machine. Three treatment notes were provided. The first note was dated 03/20/19 and stated, “With encouragement and assistance veteran compliant/donned CPAP at hs this shift.” A second note was dated 03/22/19 and stated, “Veteran encouraged and compliant with CPAP order at hs.” The third note dated 03/25/19 stated, “Respiratory Continuous Positive air pressure refused.” There was no documentation related to nursing staff cleaning the resident’s CPAP mask, filter or tubing.
- During an interview with the CLC nurse educator on 03/26/19 at 2:45 p.m., it was reported the CLC did not provide education for nursing staff related to administration and management of the CPAP equipment to include cleaning of the filter, mask or tubing.
- In summary, Resident #204’s history and physical dated [DATE] stated the resident had a history of obstructive sleep apnea and “[the resident] has own CPAP – continue CPAP.” Provider orders for CPAP written on 01/15/19 did not include settings for the CPAP machine or instructions for cleaning the CPAP machine. The provider order for CPAP was discontinued due to an automatic stop date on 03/15/19; a new order was written on 03/25/19 following inquiry by a surveyor. The order read, “CPAP at hs and during naps: Stop date 06/25/19.” Documentation in the resident’s record did not indicate the CPAP machine was consistently used by the resident at night or during naps and there was no documentation indicating the CPAP machine, tubing and mask were cleaned according to manufacturer's instructions.