# 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: Dayton VA Medical Center (Dayton, OH)

Dates of Survey: 7/10/2018 to 7/12/2018

Total Available Beds: 157

Census on First Day of Survey: 114

| F-Tag | Findings |
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| F225<br><br>483.13(c)(3) *The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.*<br><br>**Level of Harm** - Actual harm that is not immediate jeopardy<br><br>**Residents Affected** - Few | Based on observation, interview and record review, the CLC did not ensure all alleged violations including injuries of unknown source were thoroughly investigated. Findings include:<br><br>On 07/12/18 at 11:30 a.m., the patient safety manager provided the VA Medical Center, Dayton, Ohio 45428, Medical Center Policy number 00Q-16, dated July 1, 2016 and titled, "Patient Safety Program," with a recertification date of 07/31/19. The "Purpose" of the policy stated, "It [the Patient Safety Program] is an integrated program designed to identify, evaluate, and continuously improve the quality of care delivered to reduce the risk of patient harm. The Patient Safety Program uses a system-based approach, driven by organizational leadership, to promote patient [resident] safety through the proactive identification and management of actual and potential harm to patients by promoting a culture of safety, providing patient centered care, and striving to increase system reliability. A critical element of the program is the prompt identification and review of actual and close call events."<br><br>On 07/12/18 at 11:30 a.m., the patient safety manager provided the VA Medical Center, Dayton, Ohio 45428, Medical Center, Policy No. 00Q-16 titled, "REPORTABLE PATIENT EVENTS [emphasis not added]: Actual or Close Call." The section titled, "Care Management Events," indicated incidents requiring investigation included a "Complication or Iatrogenic event that required transfer to a higher level of care/monitoring, for…treatment to resolve the condition."<br><br>On 07/12/18 at 11:30 a.m., the patient safety manager provided a document titled, "VHA National Patient Safety Improvement Handbook" and dated 03/04/11. Section 7 titled, "Root Cause Analysis (RCA)," stated, "An RCA is a specific type of focused review that is used for all adverse events…requiring analysis." The policy further described an RCA as an "analysis digs deeper by asking "what" and "why" until all aspects of the process are reviewed, and the contributing factors are considered….The analysis identifies changes that could be made in systems and processes through either redesign or development of new processes, and systems that would improve performance and reduce the risk of the adverse event or close call recurrence. To be thorough, an RCA must include…A determination of the human and other factors most directly associated with the event or close call and the processes and systems related to its occurrence. There is rarely only one underlying cause." Adverse Events were defined as, "Events that may be candidates for an RCA are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical facility…or other VHA facility."<br><br>Resident #201, [LOCATION]<br><br>• Resident #201 was admitted to the CLC on [DATE]. According to the resident's history and physical dated 09/29/16, the resident's diagnoses included dementia, rheumatoid arthritis, ankylosing spondylitis and hypothyroidism. The resident's quarterly Minimum Data Set (MDS) completed on 06/06/18 indicated the resident had short-term and long-term memory problems based on staff assessment and experienced verbal |

behavioral symptoms directed toward others. According to the quarterly MDS, the resident was totally dependent for all activities of daily living (ADLs) including bed mobility and transfers. The resident's significant change of condition Minimum Data Set (MDS) assessment dated 03/15/18 indicated the resident had a Brief Interview for Mental Status (BIMS) score of 2 suggesting severely impaired cognition. Based on staff assessment the resident had short-term and long-term memory problems. The MDS indicated the resident was totally dependent on staff for all activities of daily living (ADLs) including bed mobility and transfers. The MDS was not coded to indicate the resident had an "other fracture."

- On 07/10/18 at 1:37 p.m., a nurse manager stated the resident did not get out of bed at the wife's request since the resident had bilateral arm fractures. The nurse manager indicated the wife wanted to wait until "they [the fractures] were totally healed."
- A provider's note dated 03/30/18 indicated the resident had recently been hospitalized for a urinary tract infection (UTI), delirium, and bilateral humerus fractures. The note stated, "Both elbows are less edematous with resolving hematomas. Impaired Bone Strength. Repetitive motion against the wheelchair may contribute. She [wife] thought staff was rough with his [the resident's] care at times especially [during] turning and hands on care."
- An entry in a family meeting note 06/19/18 stated, "Arm fracture - Attending and GEC [geriatrics and extended care] Chief Nurse explained extensive history of osteoporosis…most likely caused unintentional fracture during service delivery." According to Resident #201's plan of care dated 06/19/18 there was one approach related to the bilateral arm fractures that stated, "Staff to transfer resident via mechanical lift to his chair one time per day." There were no documented approaches that addressed the bilateral humerus fractures related to repositioning the resident and moving the resident in bed. The care plan had not been updated to indicate the resident spent most of his time in bed.
- On 07/12/18 at 9:13 a.m. during an interview with the CLC medical director and the chief executive nurse, the CLC medical director indicated an investigation was conducted but the cause of the fractures could not be determined. The medical director stated, "It [fractures] could have been from his [the resident's] repetitive arm movements against the back of his wheelchair. The wife was comfortable enough to bring the resident back to the neighborhood [after the acute care stay related to the bilateral fractures]. I had explained to the wife about the osteoporosis at length." The chief executive nurse stated, "The resident was transferred with a mechanical lift, but the fractures could have occurred when staff lifted him up in bed. He had a draw sheet to use but they [staff] could have put their arms under his [the resident's] to lift him up in bed."
- On 07/12/18 at 11:07 a.m., a summary of the sequence of events in electronic mail (email) format was provided by the patient safety staff member. The document read, "Testing inconclusive for pathologic fracture. DEXA [bone density] scan unremarkable. No clear cause. Regarding the bilateral arm fractures they [not further clarified] do not think he [the resident] was intentionally injured during provision of care, however they wanted to ensure that we tailor his care so that he is comfortable and does not develop skin breakdown now that he is temporarily bed bound." Although requested, documentation was not provided to indicate the date of the fractures.
- On 07/10/18 at 1:37 p.m., Resident #201 was observed in bed, appropriately positioned with a neck pillow around his neck; the resident was lying on an air flotation specialty mattress. The resident was unable to participate in an interview related to his cognitive status.
- In summary, Resident #201 experienced bilateral humerus fractures. A provider's note dated 03/30/18 indicated the resident had recently been hospitalized for bilateral humerus fractures. The note stated, "Both elbows are less edematous with resolving hematomas. Impaired Bone Strength. Repetitive motion against the wheelchair may contribute. She [wife] thought staff was rough with his [the resident's] care at times especially [during] turning and hands on care." It was not evident the CLC conducted a comprehensive investigation to determine how the resident sustained the fractures (e.g., while being lifted in bed, repetitive motion against the back of the wheelchair). The summary of the sequence of events did not indicate a root cause analysis of the fractures occurred according to the national patient handbook including identification of and interviews with staff involved with the care of the resident at the time of the fractures. Documentation in the summary did not indicate when the bilateral humerus fractures (and hematomas) were first discovered and who discovered the fractures. The resident's care plan did not include approaches that addressed the bilateral humerus fractures related to repositioning or moving the resident.

Resident #205, [LOCATION]

- Resident #205 was admitted to the CLC on [DATE]. According to a CLC monthly medical assessment dated 07/10/18, the resident's diagnoses included posttraumatic stress disorder (PTSD), mental health disorder, dementia, head trauma, and hip fracture in February 2018. The resident's most recent quarterly MDS dated 05/30/18 indicated the resident's Brief Interview for Mental Status (BIMS) score was 13 suggesting intact cognition. The MDS indicated the resident required extensive assistance from one to two staff members for walking, dressing, toileting, and personal hygiene; and total assistance for bathing. The MDS indicated the resident was not steady and only able to stabilize with staff assistance for walking and transferring. The MDS indicated the resident used a wheelchair for mobility.
- A podiatry consult dated 07/10/18 stated, "Pt to wear prevalon boot on left foot, cleanse 2nd toe with normal saline, cover 2nd left toe with bacitracin, nonstick dressing, secure with tape."
- The resident's record included a CLC monthly medical assessment dated 07/10/18 that stated, "Assessment - Subungual [between the nail bed and nail] hematoma: Pt [patient] with subungual hematoma [resulting from a direct injury to the nail] without significant pain or persistent bleeding. Likely due to traumatic injury although pt does not remember. Will refer to podiatry for nail care and will continue to keep nail wrapped and foot in a soft boot until pt can be seen."
- On 07/11/18 at 10:15 a.m., Resident #205 was observed in a wheelchair in his semiprivate room. The resident's room appeared cluttered with a variety of items stored on the floor and on furniture in the room. The resident appeared to have difficulty maneuvering the wheelchair in the room. The resident wore a Prevalon boot and the resident's second toe extended past the end of the boot and was unprotected by the boot but was covered by a dressing that appeared to provide some protection. During the observation, an LPN performed a dressing change for the resident's second toe on the left foot; the second toe was noted to be reddened and the toenail was thick, discolored and loose from the nail bed. The second toe was cleansed with normal saline an antibiotic (bacitracin) ointment applied and the second toe dressed with a 4-inch by 4-inch piece of gauze that was taped in place. When asked about the resident's foot and current treatment, the LPN stated, "Podiatry will follow up with him [the resident]." During the observation, Resident #205 was asked how the injury occurred and if he had pain in the second toe. The resident responded, "I don't remember how it happened. I only have pain when I bang it [second toe] sometimes against something."
- Review of the resident's record did not include approaches to ensure the prevention of further injury to the resident's foot; the second toe injury was not addressed in the resident's care plan.
- No documentation was provided to indicate the CLC conducted a comprehensive assessment to identify possible causal and contributing factors to the subungual hematoma to the second toe.
- In summary, on 07/11/18 at 10:15 a.m., Resident #205 was observed in a wheelchair in his semiprivate room. The resident's room appeared cluttered with a variety of items stored on the floor and the resident appeared to have difficulty maneuvering the wheelchair in the room. The resident wore a Prevalon boot and the resident's second toe extended past the end of the boot and was unprotected by the boot but was covered by a dressing that appeared to provide some protection. During the observation, wound care was provided and the resident's second toe was noted to be reddened and the toenail was thick, discolored and loose from the nail bed; the resident indicated he could not recall how the injury occurred. The resident's record included a CLC monthly medical assessment dated 07/10/18 that indicated the area to the second toe was determined to be a "subungual hematoma." It was not evident the CLC conducted a comprehensive assessment to identify possible causal and contributing factors related to the injury and develop approaches to protect the toe from further injury; the second toe injury was not addressed in the resident's care plan.

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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

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 and respect in full recognition of his or her individuality. Findings include:

Resident #103, [LOCATION]

- Resident #103 was admitted to the CLC on [DATE] with diagnoses including urinary tract infection; the resident used an indwelling urinary catheter. During observations on 07/10/18 at 12:00 p.m., 1:45 p.m., and 5:00 p.m., and on 07/11/18 at 8:30 a.m.

with potential for more than minimal harm that is not immediate jeopardy

**Residents Affected** - Few

Resident #103's urinary catheter collection bag which hung on the resident's bed in the resident's room was observed from the hallway; the collection bag was not covered and contained a yellow liquid that appeared to be urine. In addition to the above noted observations, observations were made at 2-hour intervals throughout each day of the survey (07/10/18 through 07/11/18) of signage posted above the head of the bed, on a wall-mounted light that read, "Pt. [patient] needs dentures and hearing aid daily….Pt. legally blind. Needs assistance with food and what is on plate….Liquid nectar diet. Dysphagia mech [mechanically] alt. [altered] likes fruit cups." (See Activities of Daily Living)

Resident #302, [LOCATION]

- Resident #302 was admitted to the [LOCATION] neighborhood on 05/16/18 with diagnoses including treatment-resistant bipolar schizoaffective disorder, congestive heart failure, and chronic kidney disease. The resident's comprehensive admission MDS assessment, dated [DATE] was coded to indicate the resident's short-term memory was "OK," and the resident experienced long-term memory problems and had moderately impaired cognitive skills for daily decision making based on staff assessment.
- In the "CLC Readmission from Away Sick in Hospital" note dated [DATE], the provider documented, "[Resident #302] must have 24/7 [twenty-four hours a day, seven days a week] direct observation for his safety and that of others; on 1:1 [one-to-one] sitter [status]. He continues to demonstrate non-compliance with fluid restriction….Strict I/O [intake/output], fluid restrict < 1500 ml [less than 1500 milliliters] daily."
- A provider's order dated 06/26/18 stated, "Cardiac [diet], 1500 ml fluid restriction." A provider's order dated 07/08/18 stated, "Renew Please provide a therapeutic companion for patient due to inability to control behavior."
- Resident #201's care plan dated 05/16/18 stated, "Nutritional Status: Current Diet: Regular 1500 FR [fluid restriction]; Nutrition diagnosis: Decreased nutrient needs (sodium) r/t [related to] cardiac dysfunction AEB hx CHF [as evidenced by history of congestive heart failure]."
- During an interview on 07/10/18 at 9:15 a.m. with the charge nurse and nurse manager of the [LOCATION] neighborhood, with the patient safety manager present, the charge nurse stated, "[Resident #302] has a one-on-one sitter 24 hours a day….He compulsively drinks a high amount of fluids, so he is on a 1500 milliliter fluid restriction."
- During a tour of the [LOCATION] neighborhood on 07/10/18 at 10:00 a.m. with the nurse manager and patient safety manager, a sign was observed at eye level on the door frame outside the resident's private room. The typed sign was in a large font, bolded, capitalized and underlined. The sign stated, "RM #121A: NO OUTSIDE SNACK AT ANY TIME!! PER DR [doctor's] REQUEST!! THANKS [emphasis not added]."
- During an interview on 07/10/18 at 12:50 p.m. with the nurse manager of the [LOCATION] neighborhood, with the patient safety manager present, when asked about the reason for the sign outside Resident #302's room, the nurse manager stated, "We [CLC staff] were having problems with some of the therapeutic companions giving [Resident #302] salty snacks which resulted in him wanting to drink more. We would come in first thing in the morning and he would have already had 500 [milliliters] of his allowed 1500 [milliliters of fluid allowed per day]. I have more consistent companion staffing during the week, but a lot of different people covering on the weekends. Since we have controlled his fluid intake so closely, he has been much more stable."
- During an interview on 07/11/18 at 9:00 a.m. with the nurse manager of the [LOCATION] neighborhood, with the patient safety manager present, the nurse manager stated, "I understand your concern. We shouldn't have it [signage with personal information] posted outside the door, there are other ways to communicate this information."

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F248

483.15(f)(1) *Activities. The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.*

Based on observation, interview and record review, the CLC did not provide an ongoing program of activities designed to meet the interests and the physical, mental and psychosocial wellbeing of each resident. Findings include:

Resident #204, [LOCATION]

- Resident #204's history and physical dated [DATE] indicated the resident was admitted to the CLC for palliative care on [DATE] with diagnoses including heart disease, diabetes and chronic diabetic ulcer to the left foot. The resident's comprehensive

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

**Residents Affected** - Few

admission MDS dated [DATE] indicated that based on staff assessment of the resident's mental status, the resident had no memory problems. The MDS indicated the resident required limited assistance with transfers; and extensive assistance with locomotion, dressing, toilet use, personal hygiene and bathing; the resident was using a wheelchair. Section F. Preferences for Customary Routine and Activities on the MDS was not completed by staff. A recreational therapy (RT) assessment dated 05/30/18, indicated that animals, news, leisure activities, and fresh air were somewhat important to the resident and that religion was very important. According to the RT assessment, the resident was interested in golf, religious television programs, church and religious music. In the past the resident fished, hunted and played cards. The resident experienced visual limitations and was not interested in reading or group activities. The assessment indicated Resident #204 expressed no interest in activities and was "preoccupied with situation of being at hospice and not home with family;" The resident stated, "I'm too tired. I need to let go of this anger."

- During an interview on 07/10/18 at 1:13 p.m., Resident #204 indicated he was not interested in bingo or group activities and stated, "Bingo and groups; it's not what I want." The resident said he enjoyed playing cards and that, "someone came around and offered card games but he never came back." The resident indicated he enjoyed one-on-one activities.
- The resident's plan of care dated 06/11/18 stated, " Spirituality, Resident experiencing anxiety related to being in Hospice and away from family. Approach-Provide activities that the resident has previously enjoyed, such as listening to radio, contact with pets, religious books and tv. Encourage resident to go to KT [kinesiotherapy], OT [occupational therapy] for physical activities. Provide opportunities for resident to engage in conversation with recreation therapist. Chaplain support."
- Activities were also addressed in the resident's plan of care dated 06/11/18 for approaches to relieve pain. The plan included but was not limited to, "Use of non-medicinal approaches…biofeedback, relaxation, music therapy, recreation therapy….Discipline responsible: Nursing Involve Pt. [patient] in structured leisure activities…every OD [one activity every other day]. Discipline responsible: Therapist."
- Based on record review, recreational therapy documented three contacts with the resident since Resident #204 was admitted to the CLC. A "Recreation Therapy Note" dated 05/29/18 stated, "Individual contact: Recreation therapist met with Veteran [Resident #204] to offer recreational services for initial set up of recreation needs. Veteran said he enjoys listening to religious stations at this time. He said he mostly reads the bible [Bible], but since his vision is poor he does not read bible. CTRS [certified therapeutic recreation specialist] offered bible cd's to listen to but he [the resident] declined at this time. He said he feels he can get a variety of religious content from the tv at this time. He declined any magazines, games or music at this time. Veteran [Resident #204] did accept visit from the therapy dog, Morgan, today. He was alert and smiled. The dog sat up on his bed next to him and Veteran pet [petted] him. Veteran talked about enjoying his pet dog in the past and now his son's dog, lab. Veteran was cooperative and appeared to enjoy the visit. He initiated with dog owner often. Recreation therapist to meet with Veteran again to gather more information of interests to assist with helping Veteran have a sense of control/choice and engagement in interests for expression of feelings/needs and enjoyment.
- A recreational therapy note dated 06/05/18 read, "1:1 [one-to-one] Intervention. Promote socialization, Leisure material distribution. Duration: 15 min [minutes]. Resident seen this afternoon to promote socialization and address leisure needs. Resident bedside reading his bible. Resident politely conversed with this writer throughout intervention. Resident given June bingo calendar as a reminder of alternative activity. Leisure needs are currently being met at this time. Resident appreciative of visit. RT [recreational therapist] will continue to remind Resident of scheduled activities and encourage participation in activities of choice in order to maintain current level of leisure activity."
- A recreational therapy note dated 06/26/18 stated, "Recreation therapist offered Veteran opportunity to visit therapy dog but Veteran declined. Cont [continue] With Plan."
- There were no entries in the record indicating the resident was encouraged to participate in an activity every other day as indicated in the plan of care.
- During an interview on 07/12/18 at 10:19 a.m. with two recreational therapists, it was indicated there were three recreational therapists in the [LOCATION] neighborhood. The therapist responsible for [LOCATION] confirmed there were three events documented related to recreational therapy for Resident #204. The recreational therapist stated that if a contact with a resident was less than 15 minutes it did not meet the criteria for documentation. The recreational therapist did not indicate that contacts of less than 15 minutes occurred for Resident #204. The recreational therapist

stated most activities were provided on a one-to-one basis due to resident needs in [LOCATION] where Resident #204 was residing; the RT indicated working 8:00 a.m. to 4:30 p.m.

- During observations on 07/10/18 at 1:13 p.m. and 5:00 p.m., Resident #204 moved independently in a wheelchair throughout the neighborhood and courtyard. The resident was observed on three occasions sitting alone in the sun with his eyes closed. On 07/11/18 at 7:49 a.m., the resident was in his room and engaged in watching television; the resident stated he was getting ready to leave the neighborhood for a podiatry appointment. During random observations throughout the survey, there were no observations of other residents participating in group or self-directed activities.
- In summary, Resident #204 was observed on 07/10/18 at 1:13 p.m. and 5:00 p.m. moving independently in a wheelchair throughout the neighborhood and courtyard. The resident was observed on three occasions sitting alone in the sun with his eyes closed. On 07/11/18 at 7:49 a.m., the resident was in his room and engaged in watching television; the resident stated he was getting ready to leave the neighborhood for a podiatry appointment. The resident was not otherwise engaged in activities during the survey. The CLC assessed the resident's preferences for activities and developed a plan of care that indicated staff was to offer the resident's preferred activities (e.g., playing cards, pet therapy, religious activities) every other day; the resident did not enjoy group activities. Based on interview with the recreational therapist from [LOCATION] and documentation, there were three events documented related to recreational therapy for Resident #204 since the resident was admitted to the CLC ([DATE]); the CLC did not provide preferred activities for the resident as indicated in the plan of care.

Systems-level Review

- Review of the [LOCATION] July 2018 recreational therapy calendar indicated there were no activities offered after 3:00 p.m. During the survey, there were no observations of group or self-direct activities in [LOCATION]; there was a jigsaw puzzle in the shared gathering area that a volunteer was putting together. Weekend activities included religious services on Sunday at 9:15 a.m. and 3:00 p.m. in the "multipurpose room" that was easily accessible to residents in [LOCATION]. Saturday activities were self-directed and the calendar for Saturdays stated, "Puzzle 1st floor. Share funny memories today! Look for humor. Signs of summer? How high is the corn? Farming memories, fruit picking….Open Leisure. Play a card game or checkers with staff or peer! Just ask! Get some fresh air today. Read or listen to an inspirational book." There were no Saturday activities listed that were staff initiated.
- The [LOCATION] recreational therapy calendar for July 2018 indicated at most, one activity was offered in the [LOCATION] neighborhood including "1:1 recreation therapy visits" on Mondays; and 1:1 Recreation Therapy visits on Tuesdays. On Wednesdays, the calendar indicated, "Brain Games Fun" were offered; and on Thursdays, "Brain Games and Wii Games" were offered; there were no activities offered in [LOCATION] on Fridays, although "Big Movie Cinema" was available in [LOCATION]. The recreational therapists stated that a bingo game was arranged each month by an outside volunteer group and offered during the evening.

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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** - Some

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

Multi-dose Inhalers

On 07/11/18 at approximately 4:00 p.m., a quality manager provided a copy of the Dayton VAMC Policy No. 118E-04, dated 05/05/17 and titled, "Bar Code Medication Administration (BCMA)." with a recertification date of 06/25/20. The policy read, "BCMA: A VISTA software application that will validate medications against active orders prior to being administered to the patient." The policy for respiratory therapy administration of medications included, "(5) Scan the bar code on the patient's wristband and verify that the correct patient is displayed on the screen…back away from the patient's bedside (contaminated area) to the medication cart…scan medications…administer medications.'

*Resident #104, [LOCATION]*

- Resident #104 was admitted to the CLC on [DATE] with diagnoses that included heart

failure and chronic obstructive pulmonary disease (COPD).

- The resident's provider orders dated 05/16/18 stated, "Albuterol/Ipratropium 0.5 ml [milliliters]/3 ml, inhaled, give 1 amp [ampule] prn [as needed]," and "Budesonide/formoterol 4.5 mcg [micrograms], inhaled, give 2 puffs."
- On 07/11/18 at 8:10 a.m., a respiratory therapist (RT) was observed administering multi-dose inhaler (MDI) medications in the [LOCATION] neighborhood. The RT scanned Resident #104's name band and appeared to review the BCMA medication orders on the portable medication cart. The RT did not retrieve albuterol/ipratropium or budesonide/formoterol MDI canisters from the medication cart or scan the medication prior to administration. The RT re-entered the resident's room and obtained a spacer from a bag, located on a shelf in a cabinet. The RT reached into the right pocket of the RT's scrub shirt and removed an unlabeled MDI canister with albuterol/ipratropium, opened the mouth piece capsule and inserted it into one end of the spacer, and instructed the resident to place the other end of the spacer in his mouth. The RT instructed the resident regarding how to inhale/exhale when administering the medication. At the completion of the albuterol/ipratropium MDI medication administration, the RT removed the inhaler from the spacer and reapplied the cap to the mouthpiece. The RT then reached into the same right pocket and removed an unlabeled MDI canister with budesonide/formoterol, removed the cap, and inserted the inhaler into the spacer and the other end into the resident's mouth. The 2 puffs of budesonide/formoterol were administered correctly with no concerns. After the RT removed the budesonide/formoterol inhaler, the RT recapped the inhaler and placed it into the RT's right pocket. The RT performed hand hygiene, returned to the medication cart and scanned each medication as given. When asked if it was practice to use the same inhaler for more than one resident, instead of using a specific inhaler for each resident, the RT stated, "I was taught to do it this way. If someone is in isolation, I access the meds [medications] from the cabinet;" in reference to the cabinet, the RT pointed to a wall-mounted, combination key lock medication cabinet located just outside the entrance to the resident's room. (See Infection Control)
- On 07/11/18 at approximately 10:10 a.m., the chief of respiratory therapy, clinical coordinator, and quality manager were interviewed. The chief of respiratory therapy stated, "It's not ok to scan the medication after it is given."

Mid-line Catheter

On 07/12/18 at approximately 12:00 p.m. a quality manager provided a copy of the Elsevier's procedure dated 07/12/18 and titled, "Medication Administration: Intravenous (IV) Bolus;" the procedure was adapted from Perry, A.G., et. al. (2018). Clinical nursing skills & techniques (9th edition)" and retrieved on-line on 07/12/18 from https://lms.elsevierperformancemanager.com/contentarea/nursingskills. The procedure stated, "If using a disinfecting port protector or cap, remove the protector cap from the needleless connector….Assess and confirm central line patency using, at a minimum, a 10-ml syringe filled with preservative-free 0.9% sodium chloride….Perform a vigorous mechanical scrub before each access of the needleless connector or hub with an antiseptic swab and then allow it to air dry completely."

Elsevier's Clinical Skills titled, "Midline Catheter Maintenance and Dressing Change," with a review date of February 2017 stated, "Disinfect the needleless connector using vigorous mechanical scrubbing for a minimum of 5 seconds with an appropriate disinfecting solution (e.g., 70% isopropyl alcohol, an iodophor such as povidone-iodine, or greater than 0.5% chlorhexidine in alcohol solution) and allow the solution to dry."

*Resident #105, [LOCATION]*

- On 07/11/18 at 12:42 p.m., a registered nurse (RN) was observed administering medication through a mid-line catheter for Resident #105 who lived in the [LOCATION] neighborhood. The resident had a provider order for "Ceftin 2 GM [grams], [give over] 30 minutes, IV [intravenous], Q [every] 8 hours." The RN accessed the resident's right forearm single-lumen, mid-line access device for administration of normal saline to assess for patency prior to administering an intravenous (IV) antibiotic. The RN removed a protective green-colored port from the mid-line port and assessed and confirmed central line patency using the 10-ml syringe filled with the sodium chloride. The RN removed the syringe and left the mid-line port unprotected while it rested against the resident's forearm and bed linens as the resident moved his arm. After the RN primed the IV tubing that contained the antibiotic, the RN did not disinfect the needleless connector and perform a vigorous mechanical scrub of the unprotected mid-line port just prior to attaching the IV tubing. After the medication administration observation was complete, the RN confirmed that she did not protect the mid-line port and did not perform a vigorous mechanical scrub to disinfect the needleless connector.

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 each resident's highest practicable physical, mental, and psychosocial well-being. Findings include:

Pain Management

On 07/11/18 at approximately 4:00 p.m. a quality manager provided a copy of the Dayton VAMC Policy No. 117-08, dated 05/23/16 and titled, "Pain Management Program." The policy stated, "Use of Numeric Rating Scale: The VHA has chosen the Numeric [Pain] Rating Scale (NRS) to assess pain as the fifth (5th) vital sign. The pain score (0-10) will be used based on the patients perception/verbalization and the results recorded in the electronic medical record under vital signs….For patients with cognitive/expressive deficits, nonverbal expression and behavior must be assessed when evaluating pain. The Pain Assessment in Advanced Dementia (PAINAD) scale assesses pain in the cognitively/expressively impaired patient and evaluates the following: breathing, vocalization, facial expression, body language and consolability. For those patient's unable to report their perception of pain due to cognitive/expressive deficits a score of '99' will be recorded in the vital signs package. For those patients unable to report perception of pain due to sleeping, a score of '0' with a comment of 'sleeping' will be recorded. It is not necessary to wake patient to obtain a pain score. Nursing observations that are incongruent with patient's perceived pain score should be documented under comments in BCMA [Bar Code Medication Administration] and/or in a nursing note."

*Resident #103, [LOCATION]*

- Resident #103 was admitted to the CLC on [DATE] with diagnoses including altered mental status, failure to thrive, urinary tract infection and multiple pressure ulcers. The resident's admission MDS dated [DATE] had not been completed based on the resident's recent admission date.
- The initial care plan dated [DATE] included approaches for pressure ulcer prevention and wound care monitoring; the plan did not address pain management during wound care.
- On 07/10/18 at approximately 9:25 a.m., a registered nurse (RN) was interviewed during the initial tour of the [LOCATION] neighborhood while the clinical leader, clinical coordinator, and quality manager were present. During the interview, the RN indicated Resident #103 was "deconditioned" upon admission and had multiple pressure ulcers acquired at home.
- The following information was obtained during review of documentation between 06/27/18 and 07/11/18; there was no documentation in the notes to indicate the level of pain the resident considered to be acceptable.
    - 06/27/18 - a provider's order dated 06/27/18 stated, "Acetaminophen 650 mg [milligrams], po [orally], q8h [every 8 hours], prn [as needed] for fever/pain."
    - 06/28/18 – 1:21 a.m. acetaminophen administered for a pain score of 6 prior to administration of medication, with no follow up pain score.
    - 06/29/18 – no documentation related to pain.
    - 06/30/18 – 10:33 a.m. acetaminophen administered for a pain score of 7 prior to administration of medication, with no follow up pain score.
    - 07/01/18 – 10:22 a.m. acetaminophen administered for a pain score of 7 prior to administration of medication, with no follow up pain score. A pain reassessment note dated 07/01/18 stated, "Pain location [blank], Pts. [patient's] response to pain: current level of pain is acceptable. No interventions required."
    - 07/02/18 and 07/03/18 – no data related to pain.
    - 07/04/18 – 9:02 a.m. acetaminophen administered for a pain score of 6 with no follow-up score. A daily nursing note dated 07/04/18 at 4:20 p.m. indicated, "Pain score 7/1 [07/01/18] at 11:13 a.m. = 3, location back." A pain reassessment note dated 07/04/18 indicated, "Pain location [blank], Pts. [patient's] response to pain: current level of pain is acceptable. No interventions required." A CLC daily nursing note dated 07/04/18 indicated, "Pain assessment, most recent pain score: 3, location of pain: back, frequency: daily, not medicated at this time due to pt./resident declined. Reports pain level acceptable. Pain impacts: sleep."
    - 07/05/18 and 07/06/18 – no acetaminophen was administered. Pain reassessment notes dated 07/05/18 and 07/06/18 stated, "Pain location [blank], Pts. [patient's] response to pain: current level of pain is acceptable. No interventions required."
    - 07/07/18 – 9:48 a.m. acetaminophen administered for a pain score of 6 prior to administration. A pain reassessment note dated 07/10/18 indicated, "Pain location [blank], Pts. [patient's] response to pain: current level of pain is

acceptable. No interventions required."
- 07/08/18 – 9:30 a.m. acetaminophen administered for a pain score of 5 prior to administration, with no follow-up score. A pain reassessment note dated 07/08/18 stated, “Pain location [blank], Pts. [patient’s] response to pain: current level of pain is acceptable. No interventions required."
- 07/09/18 – 9:23 a.m. acetaminophen administered for a pain score of 6, with no follow up score.
- An RN wound and skin note dated 07/09/18 at 7:52 a.m. stated, “Denies pain…most recent pain = 1 on 06/28/18 at 3:07 a.m.” A pain reassessment note dated 07/09/18 at 9:59 a.m. indicated, “Pain location [blank], Pts. [patient’s] response to pain: current level of pain is acceptable. No interventions required.”
- A CLC weekly nursing summary note dated 07/09/18 indicated, “Mental status: alert, confused, changes often, poor memory, oriented to person. Pain assessment: most recent pain score: 6 on 07/09/18 at 9:23 a.m.”
- 07/10/18 – 9:23 a.m. acetaminophen administered for a pain score of 5 prior to administration; there was no follow-up pain score. A pain reassessment note dated 07/10/18 at 9:59 a.m. indicated, “Pain location [blank], Pts. [patient’s] response to pain: current level of pain is acceptable. No interventions required.
- On 07/10/18 at 2:50 p.m., a pain note was documented by an RN; the note read, “Pain Ad [PAINAD] score: 0 Assessment: Resident states pain is gone. Continue prn Tylenol.” No pain medication had been administered since 9:23 a.m.
- The most current provider’s order stated, “07/10/18 Tramadol 50 mg, po, prn, before dressing change;” the order was written after surveyor discussions with staff about the resident’s pain during wound care.
- 07/11/18 – no acetaminophen was documented as being administered as of 12:00 p.m.

- On 07/10/18 at 1:45 p.m. during observations of wound care, the wound treatment LPN was assisted by a nursing assistant (NA). The NA and LPN explained the procedure to the resident and the resident appeared to understand and followed directions during repositioning. When the resident was positioned to the right side, observations were made of multiple wounds on the back, ischium, and right trochanter area. When the LPN removed the dressing from the resident’s midback near the spine, a wound was observed to be approximately 3 to 4 centimeters (cm) round with adherent yellow slough surrounding an approximately 2 to 3 cm wound with brown adherent eschar. When the LPN cleaned the wound, the resident called out, “Ouch! Ouch!” and pulled away from the LPN each time the LPN touched the wound throughout the observation. The resident also called out, “Ouch!” when the wound on the right trochanter was cleansed. When asked if the resident received pain medication prior to wound care, the LPN stated she was “not sure” and stated, “He [Resident #103] has an order for a prn [as needed] Tylenol.” The wound treatment LPN documented a wound and skin progress note on 07/10/18 at 3:10 p.m. that indicated, “Location: multiple areas along back area…all wounds are slightly painful when cleaned. N.O. [new order] for Tramadol with dressing changes.”
- On 07/10/18 at approximately 5:00 p.m., Resident #103 was observed lying in bed and was persistently moaning; there was no staff near the resident’s room at the time. An RN was observed near the resident's room at 5:48 p.m. The RN indicated she just started her shift and was preparing to pass medications. When asked about the resident’s vocalizations of what sounded like moaning, the RN stated, “He does that.” When asked if the resident might be in pain or exhibiting another distressed behavioral symptom, the RN stated, “I don’t think so. If I ask him if he’s in pain, he says no.” The RN was asked which pain assessment tool was utilized to determine if Resident #103 was in pain, and she replied, “He will usually tell us, he gets Tylenol prn.” The RN did not indicate how the resident’s pain was consistently assessed to determine if the resident was experiencing pain.
- On 07/11/18 at approximately 10:10 a.m., the [LOCATION] clinical leader was interviewed while a clinical coordinator and quality manager were present. The clinical leader acknowledged there was not evidence in the clinical record of the resident’s “acceptable pain level” and a comprehensive assessment to determine the resident’s pain response during daily wound care.
- On 07/11/18 at approximately 7:45 a.m., a wound care RN was observed standing outside Resident #103’s room; the RN indicated she was preparing to enter the room to conduct wound care with another RN and the resident’s provider. When asked if the resident had been pre-medicated prior to the wound care that was to be provided, the RN stated, “Not that I know of; we ask him if he wants something.”
- On 07/11/18 at approximately 12:15 p.m., the resident assessment coordinator (RAC) was interviewed regarding the care planning process for Resident #103. The RAC indicated the resident should have had an approach in the initial care plan to address pain during wound care; the RAC confirmed pain management was not addressed in the initial care plan. The RAC stated, “Our interim [initial] care plans are lacking…they should be completed within 24 hours and updated by the interdisciplinary team…this is

an action plan for us [CLC]."

- In summary, on 07/10/18 at 1:45 p.m. during observations of wound care, when an LPN removed the dressing from the resident's midback near the spine, a wound was observed to be approximately 3 to 4 centimeters (cm) round with adherent yellow slough surrounding an approximately 2 to 3 cm wound with brown adherent eschar. When the LPN cleaned the wound, the resident called out, "Ouch! Ouch!" and pulled away from the LPN each time the LPN touched the wound. The resident also called out, "Ouch!" when the wound on the right trochanter was cleansed. When asked if the resident received pain medication prior to wound care, the LPN stated she was "not sure" and stated, "He [Resident #103] has an order for a prn [as needed] Tylenol [acetaminophen]." Medical record documentation indicated acetaminophen was administered on 07/10/18 at 9:23 a.m. (approximately 4 hours prior to wound care) for a pain score of 5; there was no follow-up pain score. On 07/10/18 at 2:50 p.m., a pain note read, "Pain Ad [PAINAD] score: 0 Assessment: Resident states pain is gone. Continue prn Tylenol." No pain medication had been administered since 9:23 a.m. On 07/10/18 at approximately 5:00 p.m., Resident #103 was observed lying in bed and was persistently moaning; there was no staff near the resident's room at the time. When an RN was observed near the resident's room at 5:48 p.m. and asked about the resident's vocalizations of what sounded like moaning, the RN stated, "He does that." When asked if the resident might be in pain or exhibiting another distressed behavioral symptom, the RN stated, "I don't think so. If I ask him if he's in pain, he says no." Documentation reviewed between 06/27/18 and 07/11/18 indicated acetaminophen 650 mg (as ordered) was administered on 06/28/18, 06/30/18, 07/01/18, 07/04/18, 07/07/18, 07/08/18, 07/09/18 and 07/10/18 (8 days) for pain scores between 5 and 8; documentation did not include a follow-up pain score. The documentation did not indicate the resident's acceptable level of pain as confirmed by the [LOCATION] clinical leader. Following observations of wound care on 07/10/18 and after surveyor discussions with staff about the resident's pain during wound care, a provider's order was documented that stated, "07/10/18 Tramadol 50 mg, po, prn, before dressing change." The resident's care plan did not address pain management including the resident's acceptable level of pain; the RAC confirmed the plan did not address pain management.

Non-pressure Related Wound Care

*Resident #204, [LOCATION]*

- On 07/11/18 at 9:30 a.m., the CLC hospice coordinator provided a history and physical dated [DATE]. The report stated Resident #204 was readmitted to the CLC for palliative care on [DATE] with multiple medical conditions including heart disease, diabetes and a chronic diabetic ulcer with cellulitis to the left foot. The wound was described as a "5-centimeter non-healing ulcer underneath left great toe down to muscle-clean no erythema."
- A provider's order for wound care dated 05/22/18 stated, "Cleanse with saline pat dry. Calcium alginate AG-cover AFM foam. Wrap with Kerlix. Tuesday and Friday."
- The resident's admission MDS dated [DATE] indicated that based on staff assessment, the resident experienced no memory problems. The MDS indicated the resident required limited assistance with transfers; and extensive assistance with locomotion, dressing, toilet use, personal hygiene and bathing. The resident used a wheelchair for mobility. Section M Skin Conditions of the MDS indicated the resident had a diabetic foot ulcer; the MDS did not indicate the resident had any pressure ulcers.
- During an interview on 07/10/18 at 1:13 p.m., the resident stated he had a diabetic ulcer on the left foot for about 1.5 years. The resident stated the area had a "burning and throbbing sensation at times." According to the resident, he was to have dressing changes to the foot 2 to 3 times a week and staff performed the dressing changes "at least twice a week and if it [the ulcer] needs it."
- The resident's record indicated an assessment was conducted on 05/18/18 and a consult for the inpatient wound team was requested. The skin assessment stated, "Veteran [Resident #204] is a new admit to unit [neighborhood] with a diabetic ulcer to left lateral foot. Per Veteran's wife, home care nurse has been using Medihoney twice a week to dress wound. Will update MD [medical doctor] for wound care orders until Veteran is seen by wound team. Small scab to left shin. Buttock with blanchable redness, otherwise skin is intact."
- A wound and skin consult dated [DATE] (four days after admission) indicated the resident's Braden Scale for Predicting Pressure Ulcer Risk score was 15 suggesting mild risk for pressure ulcer development. The resident's wounds were described in the consult as follows: "Location: left lateral foot/5th toe amputation site. L [length]: 4 cm [centimeters], W [width]: 3.5 cm, D [depth]: 0.1 cm, Wound bed: Yellow. Slough: 10%. Exudate amount: Moderate. Type: Serosanguinous."
- The wound and skin consult dated [DATE] indicated there was a second wound described as: "Location: left 4th toe lateral. L: 2 cm, W: 1.8 cm, D: ? [unknown] cm.

Wound bed: Yellow slough 80%. Exudate amount: moderate. Type Serosanguinous. Peri ulcer area: Intact."

- The wound and skin consult dated [DATE] indicated there was a third wound described as: "Wound Number 3. Location: Left 4th toe medial. L: 0.5 cm, W: 0.1 cm, D: 0.1 cm. Wound Bed: Pink. Exudate amount: Light. Type: serosanguinous. Peri ulcer area intact. [Resident #204] was seen today in his room for a wound consultation per request related to foot wounds. [Resident #204] was sitting up at the side of the bed upon arrival into the room….RN and I were present for the assessment. We agree with the Braden score of 15. His bilateral elbows and coccyx were intact. Wounds were noted to the left foot including the left lateral 5th toe amputation site, and the medial and lateral sides of the 4th toe. Treatment at home has been medihoney gel sheet. The 5th toe amputation site was only 10% slough, the majority of the wound bed was beefy red. The other two wound beds were almost entirely slough covered, however, he has [been] having a moderate amount of drainage that the medihoney was unable to absorb. The wound team is suggesting use of calcium alginate AG, covered with foam and the foot lightly wrapped with kling or kerlix. We also suggest a podiatry consult. This hospice patient will need podiatry to see him in his room on the hospice unit. [Resident #204] stated antibiotic was making him nauseous and that he was unsure that he wanted to continue. He wanted to speak to his physician about it. [Physician] was informed. The wound team will not follow at this time and highly suggest the involvement of the podiatry team for end of life treatment. Start using calcium alginate AG for drainage containment and control of bacteria. Continue skin precautions. Continue encouragement of repositioning. Please re-consult the wound team with any wound concerns."
- A podiatry consult dated 05/23/18 stated, "The patient was seen at bedside for an ulcer under the 5th metatarsal head region of his left foot. His only complaint is that the antibiotic (doxycycline) is upsetting his stomach. The wound is not painful. The left foot is wrapped with a dry sterile dressing and covering the wound there is medihoney and a foam sheet. The wound itself appears healthy with no signs of infection. The patient is known to have peripheral vascular disease and [provider] suggested a bypass surgery but that he needed to have CABG [coronary artery bypass graft] before she [the provider] would consider doing a bypass in his [the resident's] legs. His circulation is poor and the likelihood of his healing the ulcer is not good….Continue current wound care dressings…antibiotic is necessary to try and suppress the infection. I currently do not see doxycycline on his medication list. Augmentin 875 bid [twice daily] could be used as an alternative. At this point f/u [follow up] will be prn [as needed]. Please re consult if needed."
- The resident's care plan dated 06/11/18 addressed pressure ulcers and stated, "Resident has ulcer on left foot related to Diabetes. Being followed by podiatry. Braden 15. Approach: Follow Podiatry wound care orders. Cleanse left foot wounds with saline, pat dry with gauze, apply calcium alginate and dry dressing. Change twice a week and as needed if dressing becomes loose or soiled. Administer antibiotic to suppress infection."
- Documentation was requested for dressing changes conducted since the resident's admission to the CLC. The hospice coordinator provided the documentation on 07/11/18 at 1:00 p.m. and confirmed that some of the dressing changes were not documented as completed. It was indicated the dates below were the dates the dressing was to be changed; there was no documentation to indicate the dressing was changed on other dates between 05/26/18 and 06/18/18. "Hospice Nursing Note Palliative Care Nursing Notes" included the following:
    - 05/26/18 (Saturday) "dressing to left foot intact." There was no documentation to indicate the dressing was changed.
    - 05/30/18 (Wednesday) "Dressing to left foot is CDI [clean, dry and intact]." There was no documentation to indicate the dressing was changed.
    - 06/08/18 (Friday) "Dressing clean, dry and intact to left foot." There was no documentation to indicate the dressing was changed.
    - 06/13/18 (Wednesday) "Dressing dry and intact to left foot." There was no documentation to indicate the dressing was changed.
    - 06/18/18 (Monday) "Dressing to left lateral foot intact." There was no documentation to indicate the dressing was changed.
- A "Wound and Skin Progress Note" dated 07/07/18 (Saturday) stated, "Dressing changed as ordered, wounds cleansed, patted dry, Ca [Calcium] Alginate in place and wrapped with Kerlix. Wound bed Pink, yellow, moderate exudate. Infectious process. Erythematous."
- The "Hospice Nursing Note Palliative Care Nursing Note" dated 07/07/18 stated, "Dressing to left foot saturated and changed. Noted new black area on left lateral 5th metatarsal with erythema to foot; will notify physician for podiatry consult. He [the resident] reported 5/10 [5 out of 10 on a scale of 0 to 10 with 10 being the worst pain possible] pain to left foot; medicated as ordered PRN [as needed] Vicodin 2 tabs [tablets]."

- On 07/09/18, two days after identification of the “black area on left lateral 5th metatarsal,” a provider assessed the area and documented, “Dressing to the left foot changed, d/t [due to] Doctor’s wanting to assess, a new area noted. Denies any pain. Dressing changed tolerated well.”
- An “IDT [interdisciplinary team] Hospice Palliative Care Team” note dated 07/10/18 (Tuesday) stated, “Podiatry to f/u [follow up] with L [left] foot wound today.” Staff stated the dressing was not changed because the resident was to see the podiatrist for the dressing change on 07/10/17.
- During interviews with the nurse manager on 07/11/18 at 1:00 p.m. and 07/12/18 at 8:00 a.m., the nurse manager stated the resident was seen by podiatry on 07/12/18 and not on 07/10/18 as planned. The nurse manager stated the resident’s dressing changes were to now occur daily as indicated in a podiatry note dated 07/12/18.
- In summary, Resident #204 was admitted with a wound described as a “5-centimeter non-healing ulcer underneath left great toe down to muscle-clean no erythema.” A provider’s order for wound care dated 05/22/18 stated, “Cleanse with saline pat dry. Calcium alginate AG-cover AFM foam. Wrap with Kerlix. Tuesday and Friday.” The resident’s care plan dated 06/11/18 stated, “Cleanse left foot wounds with saline, pat dry with gauze, apply calcium alginate and dry dressing. Change twice a week and as needed if dressing becomes loose or soiled….” Documentation dated 05/26/18 (Saturday), 05/30/18 (Wednesday), 06/08/18 (Friday), 06/13/18 (Wednesday) and 06/18/18 (Monday) indicated the dressing to the left foot was “dry and intact.” There was no documentation to indicate the dressing was changed on these dates or other dates during the weeks that included these dates, as confirmed by the hospice coordinator.
- The “Hospice Nursing Note Palliative Care Nursing Note” dated 07/07/18 stated, “Dressing to left foot saturated and changed. Noted new black area on left lateral 5th metatarsal with erythema to foot; will notify physician for podiatry consult….”On 07/09/18, two days after identification of the “new black area on left lateral 5th metatarsal,” a provider assessed the area. During interviews with the nurse manager on 07/11/18 at 1:00 p.m. and 07/12/18 at 8:00 a.m., the nurse manager stated the resident was seen by podiatry on 07/12/18 and not on 07/10/18 as planned.

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F311

483.25(a)(2) *A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section;*

**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 provide appropriate treatment and services to maintain and/or improve a resident’s ability to eat. Findings include:

Resident #101, [LOCATION]

- Resident #101 was admitted to the CLC on [DATE] with diagnoses that included legal blindness due to glaucoma, debility, and history of syncopal episodes. The resident’s admission MDS dated [DATE] indicated that staff determined the resident was severely cognitively impaired; had highly impaired vision; required extensive assistance of one staff member with eating, transfers, and bed mobility; and had no functional limitations in range of motion. A quarterly assessment had not been completed at the time of the survey. The Care Area Assessment completed in conjunction with the admission MDS dated [DATE] indicated, “ADL [activities of daily living] function/rehabilitation potential: dependent upon others for ADL assistance and has risk for unmet needs…feelings of helplessness, isolation…and being visually impaired.” The note further stated, “Allow to wash face to give resident some gratification of being able to do something for himself.”
- On 07/11/18 at approximately 4:00 p.m., a quality manager provided a copy of a document titled, “Visit Annual Review” dated 04/10/18 that indicated, “Vision loss – end stage glaucoma. Requires moderate assistance with bathing, dressing, grooming;” no information was documented related to the resident’s needed level of assistance with eating.
- The extended care nursing admission note dated [DATE] stated, “Blind in bilateral eyes.”
- On 07/10/18 at approximately 9:30, the RN charge nurse was interviewed during the initial tour of [LOCATION] while a clinical coordinator, clinical leader, and quality manager were present. The RN described Resident #101 as alert, confused at times, legally blind, and able to see “shadows.” When the RN was asked if the resident had been evaluated to determine the extent of his needs during meals, the RN indicated that the staff would “feed him [the resident] or assist with foods.”
- On 07/11/18 at 12:15 p.m., Resident #101 was observed during the lunch meal while seated in a chair; a meal tray was in front of the resident on an overbed table. The resident was not eating when initially observed and was asked if he planned to eat the steamed carrots or slice of apple pie on the meal tray; the resident had eaten other items on the tray. When asked if he needed staff assistance, the resident indicated he needed assistance, depressed the call bell and a staff person spoke over the room intercom system and asked if the resident needed assistance. The resident indicated

he needed someone to come to his room. The resident stated, “I didn’t see the apple pie…where is it? It’s terrible when you can’t see.” The resident used his left hand to feel around the meal tray until he touched the plastic container with the pie. The resident picked up the container, felt around the tray for a utensil and was able to hold the pie container and eat without difficulty. After approximately 5 minutes, a nursing assistant (NA) arrived at Resident #101’s room and asked what the resident needed; the resident indicated he was “okay right now.” Another NA entered the room; when both NAs left the room, the NAs were asked if the resident could locate items on his meal tray or if he required assistance with meals. One NA stated and the other NA agreed that the resident “can find his food, we set him up…he can see shadows.” At the conclusion of the observation, the quality manager was asked for an assessment or plan related to Resident #101’s visual limitations.

- On 07/11/18 at 7:50 a.m., Resident #101 was observed in bed with the head of bed positioned between 45 and 90 degrees with a meal tray on an overbed table in front of the resident. The resident had eaten most of the food items except an unopened bowl of oatmeal. When asked about eating the oatmeal, the resident responded, “Can you open that for me and put some sugar in it?” The surveyor informed a NA who was walking down the hallway that the resident required assistance; the NA entered the room to provide assistance with the meal.
- On 07/12/18 at approximately 9:00 a.m., the resident assessment coordinator (RAC) was interviewed and indicated that the resident’s visual needs were to be determined during the admission assessment by nursing and a plan of care developed to determine the ADL assistance needed by a resident in an effort to assist the resident to maintain as much independence as possible.

Resident #103, [LOCATION]

- Resident #103 was admitted to the CLC on [DATE] with diagnoses that included altered mental status and failure to thrive; the resident was hard of hearing and legally blind. The resident’s admission MDS dated [DATE] had not been completed based on the resident’s recent admission date.
- The initial care plan dated [DATE] did not address the resident’s activities of daily living (ADL) needs or the resident’s visual limitations.
- On 07/20/18 at approximately 9:25 a.m. a registered nurse (RN) was interviewed during the initial tour of the [LOCATION] neighborhood, while the clinical leader, clinical coordinator, and quality manager were present. During the interview, the RN indicated Resident #103 was “deconditioned” upon admission and required “cueing to eat and [was] fed by staff.”
- Observations were made throughout the survey on 07/10/18 and 07/11/18 of signage posted above the head of the resident’s bed, that stated, “Pt. [patient] needs dentures and hearing aid daily,” and “Pt. legally blind. Needs assistance with food and what is on plate.”
- On 07/10/18 at approximately 12:35 p.m., Resident #103 was sitting in bed and a nursing assistant (NA) was observed assisting the resident to eat and at times, feeding the resident. The NA cued the resident at times to hold a cup of juice that the resident was able to drink without difficulty.
- On 07/11/18 at 8:30 a.m., Resident #103 was observed sitting in bed with a meal tray in front of the resident on an overbed table. The resident had eaten approximately 75% of the oatmeal and 100% of the scrambled eggs and was trying to use a spoon to pry off the foil covering on a container of nectar-thick cranberry juice. The resident appeared to have some difficulty seeing the foil covering to remove it; after approximately five [5] to 10 minutes, the resident pulled back the foil and quickly consumed the cranberry juice. When asked about the oatmeal, the resident stated, “I can’t see it…,” and requested assistance from the surveyor. Moments later a NA entered the room and indicated she intended to assist the resident with the meal. The NA stated staff that worked the night shift would have assisted the resident with the meal tray that was likely delivered at approximately 7:00 a.m., before the NA’s shift started. The NA stated, “I will help him eat. He can’t see things on his tray.” The NA further acknowledged that if the resident was aware of where food containers were placed on the tray, the resident could feed himself.
- A speech pathology note dated 07/02/18 stated, “Needs assistance at meals. Feel pt. [patient] would have difficulty cutting up more advanced food and getting it on his fork due to vision difficulties. Pt. seems to enjoy the independence of feeding himself with some set-up guidance.”

Systems-level Review

- On 07/11/18 at approximately 10:10 a.m., the [LOCATION] clinical leader was interviewed while a clinical coordinator and quality manager were present. The clinical leader acknowledged that upon admission a registered nurse was responsible for conducting a comprehensive assessment of the resident’s ability to eat, determine the level of staff assistance required, and develop an initial (interim) care plan to alert staff

regarding how to prepare a resident's meal tray to promote as much independence as possible during meal times. The clinical leader validated that the care delivery card (Kardex) for Resident #101 and for Resident #103 did not include instructions to alert staff as to how to orient the residents to food items on their trays to facilitate independence in dining.

Resident #303, [LOCATION]

- Resident #303 was admitted to the [LOCATION] neighborhood on [DATE] and most recently readmitted on [DATE], with diagnoses including Parkinson's disease, diabetes, hypertension and neuropathy. The resident's most recent quarterly MDS dated 03/27/18 was coded to indicate the resident had adequate vision and hearing, clear speech, was understood, and understood others. The MDS indicated the resident scored 12 on the Brief Interview for Mental Status (BIMS), suggesting moderately impaired cognition. The MDS was coded to indicate the resident required limited assistance of one staff member for eating, The MDS indicated the resident did not have functional limitations in range of motion of the upper extremities. The MDS was coded to indicate the resident had no swallowing problems, received a therapeutic diet and participated in a restorative program for eating. Resident #303's most recent comprehensive significant change MDS dated 06/28/18 was coded the same as the 03/27/18 quarterly MDS (as above), except the 06/28/18 MDS was coded to indicate the resident required extensive assistance of one staff member for eating.
- Resident #303's care plan dated 01/11/18 stated, "Restorative dining: Problem: Resident has a need for…[left blank]. Goal: Resident will dine in a safe pleasant environment to reduce the risk of aspiration. Approach: Staff to assist resident with tray set up; open cartons/packets, season food, cut up meats for each meal."
- The "CLC Readmission from Absent Sick in Hospital" note dated [DATE] stated, "[Resident #303 was] Neuro: + [positive for] tremors to both upper extremities worse with movement."
- The "Nursing Admit Assessment" dated 06/25/18 stated, "Nutrition Info – Feeding Partial Assist [assistance]…Feeding: Needs help cutting, spreading butter, etc."
- A provider's order dated 06/25/18 read, "Renew Restorative Program Dining: Staff will assist [Resident #303] to eat in his room or the dining room, set up; Staff to open cartons/packets, season foods, cutting [cut] meats and set up tray for each meal."
- The "Psychiatry Consult" dated 06/29/18 documented by a psychiatrist stated, "Motor functions, tremor indicative of Parkinson's noted, improved since increased Sinemet."
- The "Extended Care ADL Flowsheet" dated 07/10/18 at 12:58 p.m., documented by a nursing assistant stated, "Dining: Restorative Dining Program completed….Is Resident an aspiration risk? No. Resident received set up care in order to feed self….Nutrition: Limited assist [assistance] (set up, open packets/condiments, cut food). Lunch percent of food taken: 50 [percent]. Patient ate in room."
- Based on record review, an assessment had not been conducted of the resident's ability to eat and applicable approaches; this was confirmed during interview with the nurse manager.
- During an observation of the evening meal on 07/10/18 at 5:20 p.m., a nursing assistant was observed providing set up assistance for Resident #303 including opening a milk carton, inserting a drinking straw in the carton, removing covers from the dishes of food, and ensuring the resident could reach all items on the tray. The resident was observed in bed with the head of the bed raised approximately 85 degrees. The meal consisted of bite-size pieces of barbecued pork, redskin potatoes, mixed vegetables and mandarin orange slices. Resident #303 was observed with significant bilateral upper extremity tremors that increased with purposeful use when the resident fed himself. The resident attempted to push or spear the barbecued pork with a fork six to eight times before successfully picking up each piece of pork; some pieces of pork were pushed off the plate onto the meal tray during these attempts. The resident pierced the potatoes successfully and brought them to his mouth without repeated attempts; he did not attempt to eat the vegetables or oranges. Resident #303 was observed to require use of both hands to pick up and steady the carton of milk. The resident placed the straw in his mouth to drink the milk; however, milk spilled onto the resident's hospital gown while the carton was brought to his mouth. When asked about working with occupational therapy to try adaptive equipment for eating, such as a scoop plate or a handled, covered cup, the resident stated, "No, I'm just working on arm exercises." When asked if he thought these items might be helpful and make eating easier, the resident stated, "Yes, it would be worth a try."
- During an interview with the nurse manager of the [LOCATION] neighborhood with the patient safety manager present on 07/11/18 at 8:30 a.m., when asked how long Resident #303 had been experiencing upper extremity tremors, the nurse manager stated, "The tremors are new since the first time he came back from the hospital in [DATE]." When asked if adaptive equipment for eating had been attempted for the resident since the tremors began, the nurse manager stated adaptive eating equipment had not been trialed for the resident.

- During an observation of the noon meal on 07/11/18 at 11:20 a.m., a nursing assistant was observed setting up the resident's meal, including cutting the barbecued chicken sandwich into bite size pieces, opening a bag of potato chips, opening a can of soda, placing a straw in the can, and ensuring that the resident could reach the items on the meal tray. The resident was observed in bed with the head of the bed raised to approximately 85 degrees. The fork, spoon and knife provided to the resident had built up handles of approximately 1.5 inches in diameter. The resident was observed to have tremors of both upper extremities, which increased when the resident used his upper extremities to eat. The resident was observed to require five to ten attempts to pierce the bite size pieces of the sandwich and independently bring the bites to his mouth. The resident independently picked up the potato chips and brought the can of soda to his mouth; with two to three attempts, the resident inserted the straw in his mouth and the contents of the can did not spill. When asked if the utensils with built up handles were helpful to eat, Resident #303 stated: "No, this was someone's idea, but it doesn't really help." Additional approaches to address the resident's eating ability had not been attempted by staff.
- In summary, during an observation of the evening meal on 07/10/18 at 5:20 p.m., Resident #303 was observed with significant bilateral upper extremity tremors that increased with purposeful use when the resident fed himself. The resident attempted to push or spear the barbecued pork with a fork six to eight times before successfully picking up each piece of pork; some pieces of pork were pushed off the plate onto the meal tray during these attempts. The resident pierced the potatoes successfully and brought them to his mouth without repeated attempts; he did not attempt to eat the vegetables or oranges. Resident #303 was observed to require use of both hands to pick up and steady the carton of milk. The resident placed the straw in his mouth to drink the milk; however, milk spilled onto the resident's hospital gown while the carton was brought to his mouth. When asked about working with occupational therapy to try adaptive equipment for eating, such as a scoop plate or a handled, covered cup, the resident stated, "No, I'm just working on arm exercises." When asked if he thought these items might be helpful and make eating easier, the resident stated, "Yes, it would be worth a try." During an observation of the noon meal on 07/11/18 at 5:20 p.m., the fork, spoon and knife provided to the resident had built up handles of approximately 1.5 inches in diameter. The resident was observed to have tremors of both upper extremities, which increased when the resident used his upper extremities to eat. The resident was observed to require five to ten attempts to pierce the bite size pieces of the sandwich and independently brought the bites to his mouth. The resident independently picked up the potato chips and brought the can of soda to his mouth; with two to three attempts, the resident inserted the straw in his mouth and the contents of the can did not spill. When asked if the utensils with built up handles were helpful to eat, Resident #303 stated: "No, this was someone's idea, but it doesn't really help."
- During an interview with the nurse manager of the [LOCATION] neighborhood with the patient safety manager present on 07/11/18 at 8:30 a.m., when asked how long Resident #303 had been experiencing upper extremity tremors, the nurse manager stated, "The tremors are new since the first time he came back from the hospital in [DATE]." When asked if adaptive equipment for eating had been attempted for the resident since the tremors began, the nurse manager stated adaptive eating equipment had not been trialed for the resident. Based on record review, an assessment had not been conducted of the resident's ability to eat to determine applicable approaches; this was confirmed during interview with the nurse manager.

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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.*

Based on observation, interview and record review, the CLC did not ensure a resident who entered the CLC without a pressure ulcer did not develop a pressure ulcer. Findings include:

On 07/11/18 at 12:30 p.m., an "administrative assistant" provided Medical Center Policy Number 118A-02, dated 04/24/15 and titled, "Assessment and Prevention of Pressure Ulcers." The policy read, "All Interdisciplinary Team (IDT) members are responsible for….Providing a therapeutic environment that promotes pressure ulcer prevention and treatment." The policy indicated members of the IDT included "all Nursing Staff." The policy stated the following regarding the plan of care, "For ulcers/wounds at the ankle, foot, or toes, the physician should consider consult to the PODIATRY TEAM [emphasis not added]….[staff should] Monitor the position of feet and heels; offload heels with heel offloading devices, or offload using pillows…RN's [sic] may treat Stage I and Stage II pressure ulcers initially by using preventative skin interventions (heel boots, air mattress) and dressings."

Resident #403, [LOCATION]

- Resident #403 was admitted to the CLC on [DATE] with diagnoses including

**Level of Harm** - Actual harm that is not immediate jeopardy

**Residents Affected** - Few

non-Alzheimer's dementia and schizophrenia. During the initial tour interview on 07/10/18 at 9:50 a.m., the charge nurse (RN) and nurse manager (NM) stated that Resident #403 had a recent decline in status, was receiving hospice services and developed a blister on the heel while at the CLC; the blister was evaluated by podiatry and treatment orders included a Mepilex® dressing and offloading boots. The RN and NM reported Resident #403 crossed his legs and because of the resident's limited movement and contractures, Resident #403 tended to rest the back of his foot (including the heel) on the other leg.

- Resident #403's most recent comprehensive significant change MDS dated 06/21/18 was coded to indicate the resident had unclear speech, was rarely understood, and rarely understood others based on staff assessment, Resident #403 had both short-term and long-term memory problems and severely impaired decision making skills. The significant change MDS was coded to indicate Resident #403 had functional limitations in range of motion of the upper and lower extremities and was dependent on staff for activities of daily living (ADLs). The significant change MDS indicated Resident #403 was at risk for skin breakdown; the MDS indicated the resident did not have pressure ulcers. Skin and ulcer treatments coded on the MDS included a pressure relieving device for the chair, a turning and repositioning program, and applications of ointments/medications other than to feet. The Care Area Assessment (CAA) summary completed in conjunction with the MDS stated, "Braden Scale Score: 13-Moderate risk for pressure ulcers. Has fluid filled blister to right inner heel….Elevate heels….'
- The resident's care plan dated 07/13/17 and last reviewed on 04/05/18 read, "Skin: Braden Scale Score-17-mild risk for skin breakdown[.] Currently skin is intact[.]" The goal with a review date of 07/05/18 read, "I will be free of skin breakdown/condition by target date[.]" Related approaches stated, "Assess my skin for…blisters….Keep skin clean + [and] dry." Resident #403's care plan dated 07/10/18 stated, "At risk for pressure ulcers related to decreased mobility. [Resident #403] Has a fluid filled blister on right heel that has opened…." The related goal with a next review date of 10/04/18 read, "Skin will be intact without signs of pressure ulcers or other conditions." Approaches related to the heel pressure ulcer were dated 07/10/18 and read, "Place Mepilex to right heel and apply Z-Flex heel boots to offload heels….Keep skin clean and dry. Apply protective barrier ointment as needed."
- A 06/20/18 extended care nursing note first identified Resident #403's right heel wound and stated, "Notified by NA [nursing assistant] of vet [Resident #403] having an open area to right heel and is draining clear liquid. This nurse observed area and applied a mepilex and prevalon [Z-Flex] boots. RN notified."
- According to a 06/21/18 skin assessment note, Resident #403 was at moderate risk for skin breakdown based on a Braden Scale Score of 13. The 06/21/18 note read, "Fluid filled sac to right inner heel. Serous drainage. Provider notified." Interventions in the note included, "Elevate heels using pillows or foam blocks."
- A 07/05/18 extended care nursing note read, "During change of shift report yesterday it was reported that the NA made CN [not specified] aware that veteran's [Resident #403's] right heel was bleeding while removing veteran's sock. Veteran's right heel is open and ulcer is present. CN applied mepilex and wrapped with kerlix. This nurse cleansed area with NS [normal saline] and covered both heels with mepilex. New Z-flex heel protector applied. No s/sx [signs/symptoms] of pain noted at this time." An addendum, written by a nurse practitioner (NP), was added on 07/10/18 at 5:15 p.m.; the addendum read, "Late entry – [Resident #403] was seen on 7/5/18, right heel assessed. Podiatry notified and could not see till Monday [07/09/18] a.m. [morning]. Area was open, covered with Mepilex until seen by Podiatry. Continue to offload the area – he does cross his legs at time."
- The podiatry consult dated 07/09/18 stated, "Pt [patient, Resident #403] presents to clinic…with a right foot heel pressure ulcer…wound on his right heel…Both feet we wearing offloading boots…pressure ulcer site on right heel had pain on palpation. Skin on the pressure ulcer was partly deroofed and had epithelialized skin beneath it." The note further read, "Ulcer [skin] was removed using a sterile pair of nail nippers as the wound was already partly deroofed and the underlying tissue was fully epithelialized…treated with Mepilex heel borders and offloading boots were reapplied to avoid wound development again."
- A 07/10/18 extended care note written by the NP read, "Podiatry note reviewed, orders written for mepilex heel borders and z flex boots. Z flex boots to be removed every shift, wiped down with a damp cloth, and assess skin under boots every shift."
- Resident #403 had the following active orders at the time of survey (there were no previous orders for the boots or heel borders):
    - 07/10/18: "Per podiatry—veteran [Resident #403] to have mepilex heel borders on bilateral heels and off loading boot[s] [Z-Flex] to prevent further breakdown."
    - 07/10/18: "Clean z flex boot[s] every shift with a damp cloth, remove and assess

skin every shift."

- According to a 07/10/18 skin assessment note, Resident #403 was at mild risk for skin breakdown with a Braden Scale Score of 15. The wound was described as a Stage 2, "Heel right." The wound description and treatment included the following: "3 cm [centimeters in] diameter, red wound bed. Area clean and dried, mepilex with border applied." Z-Flex boots were placed on both feet and should be "on at all times. Area to be cleansed and assessed Q shift [each shift]."
- On 07/10/18 at approximately 10:25 a.m. and at 1:10 p.m., Resident #403 was observed sleeping in a specialty "Phoenix" chair while wearing offloading boots on both feet.
- On 07/10/18 from 5:00 p.m. to 5:30 p.m., Resident #403 was observed eating the evening meal in the dining room; a NA was assisting the resident with the meal. Resident #403 was sitting upright in his Phoenix chair; the resident was wearing nonskid socks and not wearing the offloading boots. The resident's heels were resting directly on the padded foot rests of the chair.
- On 07/11/18 at 11:10 a.m., the NP stated podiatry oversaw heel-related pressure ulcers and nursing monitored and provided care for the ulcer. The NP indicated that podiatry had not staged Resident #403's pressure ulcer during the assessment on 07/09/18 and had written orders in the narrative which could not be reviewed by the NP until after the podiatrist signed the assessment on 07/10/18. The NP stated that education was provided for nursing staff after the resident returned from the podiatry appointment regarding recommended treatments including use of the Z-Flex boots. The NP reported that Resident #403 was to wear the "Z-Flex boots…at all times" and the boots should only be removed once each shift to check and clean the resident's skin.
- On 07/11/18 at 1:40 p.m., two NAs that regularly provided care for Resident #403 reported that the resident should wear the offloading boots at all times except when removing the boots once during each shift to check and clean the resident's skin. The NAs reported that Resident #403 had a tendency to cross his legs which may have contributed to the development of the blister; Resident #403 wore either street shoes with socks or nonskid socks prior to development of the blister on 06/20/18.
- On 07/12/18 at 11:30 a.m., the NP reported that Mepilex and Z-Flex offloading boots were initiated "immediately" after the wound was identified on 06/20/18; there was no corresponding order and the NP stated that RNs did not need orders to provide these treatments.
- In summary, on 07/10/18 from 5:00 p.m. until 5:30 p.m., Resident #403 was observed eating the evening meal in the dining room; a NA was assisting the resident with the meal. Resident #403 was sitting upright in his Phoenix chair; the resident was not wearing offloading boots. The resident was wearing nonskid socks and the resident's heels were resting directly on the padded footrests of the chair. Resident #403 developed a Stage 2 right heel pressure ulcer while at the CLC; a 06/20/18 extended care nursing note first identified Resident #403's right heel wound and stated, "Notified by NA [nursing assistant] of vet [Resident #403] having an open area to right heel and is draining clear liquid...." According to the NP during an interview on 07/12/18 at 11:30 a.m., Z-flex offloading boots (and Mepilex) were initiated "immediately" after the (heel) wound was identified on 06/20/18. The podiatry consult dated 07/09/18 stated, "Pt [patient, Resident #403] presents to clinic…with a right foot heel pressure ulcer…wound on his right heel….Skin on the pressure ulcer was partly deroofed and had epithelialized skin beneath it." A 07/10/18 extended care note written by the NP read, "Podiatry note reviewed, orders written for Mepilex heel borders and z flex boots. Z flex boots to be removed every shift, wiped down with a damp cloth, and assess skin under boots every shift." On 07/11/18 at 11:10 a.m., the NP reported that Resident #403 was to wear the "Z-Flex boots…at all times" and the boots should only be removed once each shift to check and clean the resident's skin.

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F323

483.25(h)(2) *The facility must ensure that: Each resident receives adequate supervision and assistance devices to prevent accidents.*

**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 adequate supervision to prevent accidents. Findings include:

Resident #401, [LOCATION]

- Resident #401 was admitted to the CLC on [DATE] and transferred to [LOCATION] on [DATE]; the resident had diagnoses including non-Alzheimer's dementia and Parkinson's disease with auditory and visual hallucinations. According to the most recent quarterly MDS dated 04/26/18, Resident #401 had clear speech, was usually understood and usually understood others, and had a Brief Interview for Mental Status (BIMS) score of 10 suggesting moderately impaired cognition. The quarterly MDS was

coded to indicate Resident #401 experienced delusions and had symptoms of delirium (specifically disorganized thinking) that fluctuated; there were no physical, verbal, or other types of behavioral symptoms directed toward others according to the MDS; however, Resident #401 rejected care four to six days during the assessment period. According to the quarterly MDS, Resident #401 required extensive assistance of one person for activities of daily living (ADLs). The quarterly MDS indicated the resident was unsteady but able to stabilize without assistance when moving from a seated to standing position and while walking and was unsteady and able to stabilize with assistance when transferring from surface-to-surface; turning and moving on and off the toilet did not occur during the assessment period, according to the MDS. The quarterly MDS was coded to indicate the resident had no functional limitations in range of motion of the upper or lower extremities and used a wheelchair as a mobility device. The quarterly MDS indicated Resident #401 received psychoactive medication for seven days during the assessment period.

- During the initial tour on 07/10/18 at 10:30 a.m., the NM and charge nurse (RN) reported that Resident #401 had a VA CLC staff member as a “therapeutic companion” who provided the resident with one-to-one (1:1) supervision 24 hours a day; the supervision had been provided since admission. The staff indicated Resident #401 had Parkinson’s disease, dementia and multiple falls while at the CLC; the resident currently used a “modified ambulation device [that resembled a Merry Walker®]” to increase the resident’s “autonomy” as the resident was unable to ambulate independently (without a device) due to the resident’s “scissor gait.” Resident #401 was described with visual and auditory hallucinations and often had “unpredictable behaviors,” especially during care.
- Resident #401’s care plan was last updated on 05/29/18 and addressed the resident’s risk for falls. The care plan included a statement that read, “Resident is at high risk for falls due to history of falls within previous 3 months, unsteady gait, impulsivity, and medications that increase his risk: diuretics, analgesics, antihypertensives, and psychotropics.” The related goal, dated 02/12/18 read, “Resident’s risk for falls will be minimized.” Approaches stated, “Ensure that the resident wears rubber-soled, heeled shoes, or non-skid slippers.” (02/12/18) “Continue therapeutic companion” (05/09/18). An addendum dated 05/31/18 read, “Veteran currently utilizing a modified walker with order written on 05/30/18. Staff will assess the need for the walker weekly and communicate with the provider….” Another addendum dated 06/07/18 read, “Veteran continues to utilize ambulation assistive device to promote autonomy, enable independent ambulation, prevent falls, and modify behaviors. Nursing staff provides supervision and will assess need for therapeutic companion every shift and communicate findings with provider.” An addendum dated 06/19/18 read, “Falls: June 11, 2018-witnessed fall with visible signs of injuries to torso-back. June 16, 2018-Unwitnessed fall with no visible injuries. Therapeutic companion: Companion is not ordered from 1200-1600 [12:00 p.m. until 4:00 p.m.]. Veteran is utilizing a modified ambulation assistive device to increase independent mobility and promote safety….” An addendum dated 06/24/18 read, “…Veteran fell on 6/23/18. No injuries. Morse Fall Scale completed with a score of 90. This is indicative of high risk for falls. Problem: Resident is at risk for falls due to history of falls (four) this month, unsteady gait, impulsivity, and medications that increase his risk. Goal: Resident risk for falls will be minimized. Approach: Ensure that the resident wears rubber-soled shoes or non-skid slippers. Approach: Reinstate therapeutic companion for safety.”
- A physical therapy administrative note dated 02/09/18 read, “Vet’s [Veteran’s] gait with ataxic movements, tandem gait pattern, and occasional scissoring…makes vet a high fall risk with ambulation unless he has at least moderate levels of assistance…there is no assistive device for walking that is going to correct or compensate for vet’s unsafe gait pattern. Vet [Resident #401] would benefit from walking but should not be attempted unless adequate support can be provided….Gait should only be attempted if adequate staffing is available to provide needed support.”
- The physical therapy administrative note dated 05/29/18 (the day the modified ambulation device was ordered) read, “NH [nursing home] staff to closely monitor vet and his use of the walker to make sure it is meeting his needs. NH staff will need to assist vet as he transitions from sit <----> stand [to and from sitting and standing] with walker wheels (8 total) need to [be] manually locked and unlocked by hand [*sic*].”
- Resident #401’s active orders included orders for medications with side effects including drowsiness and dizziness such as a psychopharmacologic medication (quetiapine), and valproic acid and mirtazapine. Resident #401 had an order for a carbidopa, levodopa, and entacapone combination medication to treat the resident’s Parkinson’s disease symptoms. The following order regarding the use of the ambulation device was active at the time of survey:
    - 07/05/18: “Renew ext [extended] care restraint order…high risk of injury to self,

when: out of bed….This is an oversized walker with 8 casters for stability." The oversized (Merry) walker was first ordered on 05/29/18.

- A follow-up physical therapy administrative note dated 06/28/18 read, "Vet's gait pattern and endurance is much improved since last visit on 5/29/18 when he was issued his new walker. Vet ambulation is more fluid, upright and less scissoring; vet is able to ambulate longer distances before needing to rest."
- On 07/10/18 at 3:50 p.m., the charge nurse stated the device "tipped over" twice when the resident fell while using the device during a trial period (06/07/18 until 06/23/18); during the trial the resident was without a therapeutic companion during parts of each day to determine if Resident #401 could use the device safely without assistance.
- On 07/11/18 at 7:50 a.m., the NM stated that Resident #401 had a therapeutic companion since admission and was trialed without a companion between 06/07/18 and 06/23/18 to determine if Resident #401 could be without the companion while using the "modified ambulation device." The NM reported that the first trial without a therapeutic companion occurred between 06/07/18 until 06/19/18, between the hours of 12:00 p.m. and 4:00 p.m.; the timeframe was deemed appropriate because this was when staff was most available to assist the resident if needed. An additional trial without a therapeutic companion occurred between 06/19/18 until 06/23/18 and was extended to the hours between 8:00 a.m. and 4:00 p.m. The NM stated that during the trial without a therapeutic companion, the resident fell while in the device and, as a result of the fall, a therapeutic companion was reinstated for 24 hours a day on 06/23/18 (at 3:01 p.m.). The trial dates without a therapeutic companion were confirmed by the chief nurse during review of the resident's provider orders on the morning of 07/12/18.
- "Post fall risk assessment notes" were reviewed from 05/29/18 (when the modified ambulation device was issued) until 07/10/18. During all falls, Resident #401 remained at high risk for falls, with a Morse Fall Scale score of 90 as indicated in each note. The resident had not fallen while using the device since the therapeutic companion was reinstated for 24 hours a day on 06/23/18. The post fall assessment notes indicated the following:
    - On 06/11/18 at 9:15 p.m., the resident had a witnessed fall in the lounge/dining room. The fall occurred while Resident #401 "was reaching for something which was not there. He went to reach out, the 'Merry Walker' went sideways, nursing staff attempted to hold the Merry Walker up, but the chair is awkward and big, along with having the appearance and structure of a shower chair." The note indicated Resident #401 had an injury to "torso-back." The note further read, "This Merry Walker is not supportive or structured to fit his body frame….This Merry Walker requires further assessment and revision for safety." According to records provided by staff, it was not evident a review of the device and revision for safety was completed by staff.
    - On 06/16/18 at 4:15 p.m., the resident had an unwitnessed fall in the lounge/dining room. The fall occurred while Resident #401 was "sitting in buddy chair [Merry walker]." The note read, "Vet [Resident #401] slid out of chair unto [onto] the floor." According to the note, there was no injury as a result of the fall. The plan indicated the resident would have "increased monitoring." Although there was a recommendation to increase monitoring, a therapeutic companion was not reinstated.
    - On 06/20/18 at 1:25 p.m., the resident had a witnessed fall without injury in the lounge/dining room. The post fall note read, "Modified ambulation assistive device in upright position with veteran sitting in it….Veteran was reaching forward and the modified ambulation assistive device turned onto the right side…continue to be supervised in the ambulation device."
    - On 06/23/18 at 2:55 p.m., the resident had an unwitnessed fall in the lounge/dining room. The fall occurred "while [Resident #401 was] attempting to reach for an item." The note read, "Veteran and modified walker lying on left side…." According to the note, there was no injury from the fall. The plan read, "Therapeutic companion was reordered for 24/7 until further evaluation from provider."
- The CLC documented Resident #401's time when using the modified ambulation device on flowsheets; the flowsheets allowed for documentation of observations in 15-minute increments, alternatives to the device that were offered, an RN's assessment of comfort, as well as interventions that were provided. The flowsheets were reviewed from 07/03/18 through 07/09/18; the flowsheets for the days corresponding to the resident's falls were unavailable as the flowsheets had been sent out of the CLC to "imaging.". The flowsheets from 07/03/18 to 07/09/18 indicated the resident used the device at varying times 24 hours a day. No alternatives to use of the device, RN assessments or interventions were documented on 07/03/18, 07/04/18,

07/07/18, 07/08/18 and 07/09/18. On 07/05/18 and 07/06/18 interventions included but were not limited to “active listening” and “nutrition/hydration.”

- On 07/11/18 at 10:45 a.m., the NP and NM stated the purpose of the “modified ambulation device” was to increase Resident #401’s “autonomy.” The NP described the device as a “bariatric walker” that was ordered through prosthetics; the device had an enclosed, heavier frame with a wide base and had a number of casters, called “anti-tip outriggers,” for stabilization. The NP and NM reported that Resident #401 was unable to walk without some type of device; several devices had been tried for Resident #401 prior to use of the “modified ambulation device;” however, the other devices were too difficult for the resident to use or not safe for the resident due to Resident #401’s “scissor gait.”
- On 07/10/18 at 1:10 p.m. during the noon meal, Resident #401 was observed wearing street shoes and regular socks; the resident was standing and leaning over the front bar of the ambulation device while reaching towards the dining room floor. An NA was standing next to the resident and supporting the back of the device. Resident #401 stood up and began walking (with uncoordinated movement) in the device; the NA was directly next to or behind the resident. At one point, Resident #401 attempted to move between a couch and the back of another resident’s wheelchair; the resident was directed to back up when Resident #401’s device became stuck. As Resident #401 backed up, the resident lost his footing and fell backwards sitting on the wide seat of the device; the NA was supporting the device during the backward movement and the device did not tip over.
- On 07/10/18 at 3:45 p.m., Resident #401 was in the dining room while a recreational therapist led a group activity; the resident was using the modified ambulation device. A different NA than the NA observed during the noon meal on 07/10/18 was next to the resident during the activity.
- On 07/11/18 at 7:45 a.m., Resident #401 was sitting in a standard wheelchair while a NA was sitting next to the resident in the dining room. The charge nurse reported that a screw “backed out” of the modified ambulation device “last night” and physical therapy was repairing the device.
- On 07/11/18 at 10:25 a.m., the same NA who was observed with Resident #401 during the noon meal on 07/10/18 was interviewed; the NA was a therapeutic companion who regularly provided care for Resident #401. The NA reported that Resident #401 had a therapeutic companion at all times and staff rotated throughout the day. The NA reported that she assisted the resident with toileting and all other ADLs including during meals. The NA reported that Resident #401 often bent over and tried to touch the wheels of the ambulation device as the resident thought he was working on a car; the NA indicated always standing and supporting the chair during times when the resident leaned forward. The NA further explained that supporting the device kept the device stable and safe. When asked if there was a diversional activity for the resident (e.g., a table height activity that would simulate car repair), the NA stated there were puzzle type activities that would interest the resident; there were no observations of the resident participating in puzzle activities on 07/10/18 or 07/11/18.
- In summary, Resident #401 was observed during the survey ambulating in a modified ambulation device (also referenced as a Merry walker). On 07/10/18 at 1:10 p.m. during the noon meal, Resident #401 was observed standing and leaning over the front bar of the ambulation device while reaching towards the dining room floor. An NA was standing next to the resident and supporting the back of the device. Resident #401 stood up and began walking (with uncoordinated movement) in the device; the NA was directly next to or behind the resident. At one point, Resident #401 attempted to move between a couch and the back of another resident’s wheelchair; the resident was directed to back up when Resident #401’s device became stuck. As Resident #401 backed up, the resident lost his footing and fell backwards sitting on the wide seat of the device; the NA was supporting the device during the backward movement and the device did not tip over. On 06/11/18 at 9:15 p.m., the resident had a witnessed fall in the lounge/dining room. The fall occurred while Resident #401 “was reaching for something which was not there. He went to reach out, the ‘Merry Walker’ went sideways, nursing staff attempted to hold the Merry Walker up, but the chair is awkward and big….” The note indicated Resident #401 had an injury to “torso-back.” The note further read, “This Merry Walker is not supportive or structured to fit his body frame….This Merry Walker requires further assessment and revision for safety.” On 07/11/18 at 7:50 a.m., the NM stated that a (therapeutic) companion was not provided for Resident #401 between 06/07/18 and 06/23/18 to determine if Resident #401 could be without the companion while using the ambulation device. The NM reported that the first trial without a therapeutic companion occurred between 06/07/18 until 06/19/18, between the hours of 12:00 p.m. and 4:00 p.m. An additional trial without a therapeutic companion occurred between 06/19/18 until 06/23/18 and was extended to the hours

between 8:00 a.m. and 4:00 p.m.; on 06/23/18, the therapeutic companion was reinstated 24 hours a day. While using the device and without a therapeutic companion, Resident #401 fell three times. On 06/16/18 at 4:15 p.m., the resident had an unwitnessed fall without injury in the lounge/dining room when the resident "slid out of chair unto [onto] the floor." On 06/20/18 at 1:25 p.m., the resident had a witnessed fall without injury in the lounge/dining room when the resident "was reaching forward and the modified ambulation assistive device turned onto the right side…." On 06/23/18 at 2:55 p.m., the resident had an unwitnessed fall without injury in the lounge/dining room "while [Resident #401 was] attempting to reach for an item." The note read, "Veteran and modified walker lying on left side…." The plan read, "Therapeutic companion was reordered for 24/7 until further evaluation from provider." It was not evident a comprehensive assessment was conducted after each fall to determine why the resident was falling (e.g., need to use the toilet, length of time in the device, lack of diversional activities [e.g., puzzles]). Recommendations following the falls were not always implemented (e.g., following the fall on 06/11/18, documentation indicated, "This Merry Walker is not supportive or structured to fit his body frame….This Merry Walker requires further assessment and revision for safety)." According to documentation provided by staff, it was not evident further assessment had been conducted by staff.

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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** - Some

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 disease and infection. Findings include:

The Dayton VAMC policy dated 02/11/16 and titled, "Respiratory Therapy MDI -metered-dose inhaler] Administration," indicated, "Clean MDI canister and mouthpiece with alcohol wipe, allow to dry. Connect MDI to appropriate spacer device….Wipe MDI canister and mouthpiece with alcohol pad and place in locked Respiratory medication cart…3.0 References: AARC [American Association of Respiratory Care] clinical practice guidelines, APIC (Association for Professionals in Infection Control and Epidemiology) Text of Infection Control Epidemiology."

Resident #104, [LOCATION]

- Resident #104 was admitted to the CLC on [DATE] with diagnoses that included heart failure and chronic obstructive pulmonary disease (COPD).
- The resident's provider orders dated 05/16/18 stated, "Albuterol/Ipratropium 0.5 ml [milliliters]/3 ml, inhaled, give 1 amp [ampule] prn [as needed]," and "Budesonide/formoterol 4.5 mcg [micrograms], inhaled, give 2 puffs."
- On 07/11/18 at 8:10 a.m., a respiratory therapist (RT) was observed administering multi-dose inhaler (MDI) medications in the [LOCATION] neighborhood. The RT scanned Resident #104's name band and appeared to review the BCMA medication orders on the portable medication cart. The RT did not retrieve albuterol/ipratropium or budesonide/formoterol MDI canisters from the medication cart. The RT re-entered the resident's room and obtained a spacer from a bag, located on a cabinet shelf. The RT reached into the right pocket of the RT's scrub shirt and removed an unlabeled MDI canister with albuterol/ipratropium, opened the mouth piece capsule and inserted it into one end of the spacer, and instructed the resident to place the other end of the spacer in his mouth. The RT instructed the resident regarding how to inhale/exhale when administering the medication. At the completion of the albuterol/ipratropium MDI medication administration, the RT removed the inhaler from the spacer and reapplied the cap to the mouthpiece, without first disinfecting the mouthpiece. The RT then reached into the same right pocket and removed an unlabeled MDI canister with budesonide/formoterol, removed the cap, and inserted the inhaler into the spacer and the other end into the resident's mouth. The RT administered 2 puffs of budesonide/formoterol. After the RT removed the budesonide/formoterol inhaler, the RT recapped the medication and placed it into the RT's right pocket without disinfecting the mouthpiece. Before leaving the resident's room, the RT sanitized his hands, returned to the medication cart and scanned each medication as given; the RT did not return the inhalers to the medication cart or a medication cabinet in the resident's room. When asked if it was practice to use the same inhaler for more than one resident, instead of using a specific inhaler for each resident, the RT stated, "I was taught to do it this way. If someone is in isolation, I access the meds [medications] from the cabinet," as he pointed to the wall-mounted, combination key lock medication cabinet, located on the wall just outside the entrance to the resident's room. When asked about cleansing the mouthpiece of the MDI before or after use including before use by another resident, the

RT stated, “I should have done that…forgot.”

- On 07/11/18 at approximately 4:15 p.m., following the daily meeting, the chief of respiratory therapy was interviewed and acknowledged that the RT “should have wiped off the mouthpiece” for each inhaler prior to and after using the MDI devices.