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: Wilkes-Barre VA Medical Center (Wilkes-Barre, PA)

Dates of Survey: 9/11/2018 to 9/12/2018

Total Available Beds: 84

Census on First Day of Survey: 75

F-Tag	Findings

F323
 	
483.25(h)(1) *Accidents. The facility must ensure that: The resident environment remains as free of accident hazards as is possible;*
 	
Level of Harm - No actual harm with potential for more than minimal harm that is not immediate jeopardy
 	
Residents Affected - Few
	Based on observation, interview and record review, the CLC did not ensure a resident received adequate supervision to prevent accidents. Findings include:
	
	Resident #302, [LOCATION]
	
	• Resident #302 was originally admitted to the CLC on [DATE]. The resident's diagnoses included dysphagia and Parkinson's disease with related cognitive disorders, and an impulse control disorder.
	• During the initial tour on 09/11/18 at 10:30 a.m., a nurse manager (NM) stated, "[Resident #302] had a brain stimulator battery infection and he went out to the [acute care] hospital and returned on a tube feeding and he was in a wheelchair. [The resident] would take food from other residents and from the dining room [when the resident had orders for nothing by mouth]….He had pneumonia a month ago [07/18], now he is eating orally." It was indicated that previously the resident was walking with a walker and eating a regular diet.
	• The resident's comprehensive Minimum Data Set (MDS) dated 03/29/18 was coded to indicate the resident had a Brief Interview for Mental Status (BIMS) score of 11 suggesting moderately impaired cognition; the resident was independent with eating and did not have functional limitations in range of motion. No nutritional approaches or swallowing problems were identified on the MDS. A significant change MDS dated 07/15/18 was coded to indicate the resident had a BIMS score of 12 suggesting moderately impaired cognition; the resident required supervision with eating and had functional limitations in range of motion of the bilateral upper extremities. According to the MDS, the resident had a diagnosis of dysphagia and received nutrition through a feeding tube.
	• The resident's care plan dated 06/29/18 included a statement dated 06/30/18 that read, "Functional swallowing difficulty related to mechanical causes as evidenced by conditions associated with a diagnosis (dysphagia)/necessity of an enteral feeding." An addendum dated 07/04/18 stated, "[Resident #302] at risk for infection/aspiration r/t [related/to] tube feeding. Vet [resident] is NPO [nothing by mouth]." An additional addendum dated 09/05/18 stated, "Resident not consuming adequate oral calories, swallowing difficulty related to dysphagia as evidenced by need for tube feeding and mechanically altered diet texture." Approaches included:
	  ○ "Nutrition prescription: CLC dysphagia pureed honey thick liquid."
	  ○ "Snacks available on unit [neighborhood] at all times within nutrition prescription."
	• The plan of care did not address concerns or approaches related to the resident actively seeking food while the resident remained on NPO status from 06/29/18 until 09/04/18. The care plan did not include compensatory strategies or guidelines for safe eating/feeding assistance since the resident started eating (orally) on 09/04/18 (e.g., alternating bites and sips, sitting upright, chin tuck).
	• Provider orders included:
	  ○ 03/23/18: "Regular diet/regular liquids."
	  ○ 06/29/18: "NPO."
	• A nursing note dated 07/06/18 indicated, "Resident found in dining room eating a

cookie. Resident remains NPO at time….Plan: Will monitor….Reminded at each check o nothing by mouth status. Reinforced risks of taking food or drink po [orally] including aspiration risks."

- A history and physical note dated [DATE] indicated the resident was sent to the acute care hospital after a rapid response was called for a high fever and rapid heart rate. The note indicated, "Resident receives PEG [percutaneous endoscopic gastrostomy] tube feedings and the suture became loose." Results of a chest x-ray dated 07/19/18 stated, "Patchy opacity in the right lower lung."
- A transfer acceptance note dated [DATE] indicated, "This veteran [Resident #302] was transferred back to…CLC from [LOCATION] where he had been admitted for a right sided probable aspiration pneumonia."
- A speech pathology note dated 07/25/18 stated, "Several empty food containers were found bedside, and hidden in his [Resident #302's] area. I [speech-language pathologist] discussed this risk with nursing staff and they are aware. Later in the afternoon, nursing expressed concern that resident had been observed taking food from common areas to eat. He was provided education not to consume food, however, I do question his ability to comprehend risk at this time. I also expressed concern about him remaining in his current room, as his roommate has much food/drink items available." The resident was moved to another room on 07/28/18, according to the nurse manager on 09/12/18 at 9:00 a.m.
- A nursing note dated 08/13/18 stated, "He [Resident #302] frequently verbalizes his wishes to be able to again eat by mouth and expressions [expresses] sadness regarding same which [with] PCP [personal care provider] aware of [the resident's wishes]."
- A speech pathology general note dated 08/24/18 indicated, "Patient [Resident #302] evaluated with modified barium swallow [MBS] examination in radiology on 08/24/18….Evaluation requested by patient, family and nursing staff. Resident currently NPO with alternate means of nutrition and hydration via tube feedings. Resident known to be non-compliant, consuming variety of solids and thin liquids. Nursing continues to report 'Resident eats fine, no coughing'….Resident observed with mod [moderate]-severe oral dysphagia and severe pharyngeal dysphagia. Due to aspiration of thick material under fluoroscopic examination, recommend continue with NPO and [alternate] means of nutrition and hydration."
- A nursing note dated 08/24/18 indicated, "Resident self-propelled into dining room where CNA [certified nursing assistant] observed resident eating a cookie. Food product found on hands and face. Resident educated on importance of remaining NPO, due to risk of aspiration. Resident acknowledged risks, but states 'I don't care. I want to eat.' Supervisor aware."
- Results of a chest x-ray dated 08/29/18 stated, "Residual ill-defined opacity involving the lateral aspect of the lower lung zone, which may represent residual pneumonia."
- A provider's order dated 09/04/18 read, "Pureed Honey thick liquid diet." The resident had an order for NPO status from 06/29/18 to 09/04/18.
- During observations and an interview on 09/11/18 at 4:30 p.m. with Resident #302, the resident smiled when asked how his meal was and if he enjoyed eating again. Although the resident did not cough or show signs or symptoms of swallowing difficulties while eating, the resident was served nectar-thick apple juice and not a honey-thick liquid as indicated in the provider's order.
- On 09/11/18 (during the survey), an additional care plan statement was written that read, "I want to eat food and increase in quality of life by eating and tasting food even though I had some difficulty swallowing." Interventions included:
    - "I will participate in swallow study."
    - "I will comply with feeding orders as my swallowing status changes per medical and nursing orders to maintain safety and avoid complications."
    - "Staff will assist me to an upright position in wheelchair or in bed."
    - "Staff will monitor temperature of the food before I begin my meal."
    - "I will be allowed to eat slowly and swallow appropriately."
- During an interview on 09/12/18 at 9:00 a.m., the NM of [LOCATION] stated, "[Resident #302] has an impulse [control] disorder….We [The CLC] contemplated bringing in locks for the food cabinets but that wasn't fair to the other residents. We provided education to…[Resident #302] and family. Staff tried to stay on top of him [monitoring the resident]. He was not on one-to-one [observation for swallowing safety]. He is able to self-propel [the wheelchair] to the dining room." The nurse manager indicated the resident received one-to-one observation for falls at times when deemed necessary by nursing staff; the one-to-one supervision was not provided to monitor the resident for oral intake based on the provider's order for NPO status.
- In summary, a provider's order dated 06/29/18 read, "NPO [nothing by mouth]." A nursing note dated 07/06/18 indicated, "Resident found in dining room eating a cookie. Resident remains NPO at time….Plan: Will monitor….Reminded at each check o nothing by mouth status. Reinforced risks of taking food or drink po [orally] including aspiration risks." On [DATE] a transfer acceptance note indicated, "This veteran

[Resident #302] was transferred back to…CLC from [LOCATION] where he had been admitted for a right sided probable aspiration pneumonia." A speech pathology note dated 07/25/18 stated, "Several empty food containers were found bedside, and hidden in his [Resident #302's] area….Later in the afternoon, nursing expressed concern that resident had been observed taking food from common areas to eat. He was provided education not to consume food, however, I do question his ability to comprehend risk at this time." A nursing note dated 08/24/18 indicated, "Resident self-propelled into dining room where…observed resident eating a cookie. Food product found on hands and face. Resident educated on importance of remaining NPO, due to risk of aspiration. Resident acknowledged risks, but states 'I don't care. I want to eat….'" The resident's plan of care dated 06/29/18 was not updated to address concerns or approaches (based on the resident's cognitive limitations and documented "impulse control disorder") related to the resident actively seeking food while the resident remained on NPO status from 06/29/18 until 09/04/18. On 09/04/18, a provider's order stated, "Pureed Honey thick liquid diet." During observations on 09/11/18 at 4:30 p.m., the resident was served nectar-thick apple juice and not a honey-thick liquid according to the provider's order. Although it was determined the resident wanted to eat (orally), it was not evident the CLC identified and implemented approaches to minimize the resident's risk for aspiration or swallowing difficulties. The care plan did not include compensatory strategies or guidelines for safe eating/feeding assistance since the resident started eating on 09/04/18 (e.g., alternating bites and sips, sitting upright, use of chin tuck).

F332

483.25(m)(1) *The facility must ensure that: It is free of medication error rates of 5 percent or greater.*

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 a medication error rate of less than 5 percent. Thirty-six (36) opportunities were observed with three errors identified for a medication error rate of 8.3 percent. Findings include:

Medication Administration, Percutaneous Endoscopic Gastrostomy (PEG) Tube
Resident #104, [LOCATION]

- Resident #104 was admitted to the CLC on [DATE] with diagnoses that included a stroke; the resident's oral medications were administered by way of a PEG tube.
- On 09/11/18 at 1:35 p.m., LPN #1 was observed administering medications for Resident #104. A provider's order dated 09/02/18 indicated the resident was to receive "simethicone 1.2 milliliters (ml), 80 milligrams (mg), to be administered twice daily, by way of PEG tube, [for] gas." LPN #1 diluted 1.2 ml of liquid simethicone with 30 ml of normal saline in a medicine cup. After flushing the PEG tube with 30 ml of normal saline, LPN #1 poured the simethicone into the PEG tube using a funnel to administer the medication using gravity. LPN #1 did not ensure that all of the medication in the medicine cup emptied into the funnel. When asked if there was residual medication left in the medicine cup, LPN #1 acknowledged that she "should have rinsed it [diluted and administered the remaining medication]." The resident did not receive the entire dose of simethicone as ordered.

Medication Administration, Metered-dose Inhalers (MDI)
Resident #105, [LOCATION]

- Resident #105 was admitted to the CLC on 0[DATE] with diagnoses that included dementia, deconditioning, and chronic obstructive pulmonary disease (COPD).
- On 09/11/18 at 4:24 p.m., LPN #2 was observed administering medications for Resident #105. The resident had a provider's order dated 07/19/18 for "fluticasone 230 mcg (micrograms)/21 mcg of salmeterol [Advair® HFA] 230/21," inhaler, 2 puffs (rinse mouth with water and spit) oral, twice daily, severe COPD." Manufacturer's instructions obtained on-line on 09/19/18 were revised in October 2017 and titled, "How to use your Advair® HFA" stated, "3. Shake inhaler for 5-10 seconds. 4. Breathe out fully (in preparation to breathe in medication). 5. Put the mouthpiece in your mouth and close your lips around it. Do not block the mouthpiece with your teeth or tongue. 6. Push the top of the canister all the way down one time while breathing in deeply and slowly through your mouth. 7. Hold your breath for 5-10 seconds, and then breathe out. 8. If your doctor has prescribed more than one dose (puff), wait 30 seconds and repeat above."
- LPN #2 was observed to shake the MDI and hand it to the resident who inserted the MDI into his mouth and depressed the inhaler with two puffs in rapid succession without completely exhaling before inhaling the second puff of medication. The LPN did not prompt the resident to follow the manufacturer's instructions to ensure the complete and accurate dose was administered as indicated by the provider. LPN #2 was interviewed immediately following the observation and indicated that she did not prompt or provide guidance to the resident. LPN #2 was asked if a spacer device was ever utilized to assist the resident to take the correct dose and the LPN replied, "No,

that's a good idea…he doesn't understand how to take it [medication] right."

- On 09/12/18 at approximately 3:00 p.m., the CLC chief nurse was interviewed and indicated the CLC would meet with providers, pharmacy, and respiratory therapy to discuss the use of spacer devices for residents who may require assistance with the use of an MDI to increase the chances of an accurate dose.

Resident #107, [LOCATION]

- Resident #107 was admitted to the CLC with diabetes mellitus and COPD.
- On 09/12/18 at 10:04 a.m., LPN #3 was observed administering medications for Resident #107. The resident had a provider's order dated 08/31/18 that read, "Budesonide 160 mcg/4.5 mcg formoterol [SYMBICORT®] inhaler, 2 puffs, (rinse mouth with water and spit), oral inhaled, every 12 hours."
- Manufacturer's instructions for Symbicort obtained on-line on 09/19/18 and updated in June 2018 stated, "Shake your inhaler well for 5 seconds....Breathe out fully (exhale)....Breathe in (inhale) deeply and slowly through your mouth....Continue to breathe in (inhale) and then hold your breath for about 10 seconds, or for as long as it is comfortable....Shake your inhaler again for 5 seconds and repeat steps 2 to 4."
- After shaking the MDI, LPN #3 inserted the MDI mouthpiece into the resident's mouth and depressed the MDI medication twice in rapid succession without shaking the inhaler again for 5 seconds and prompting the resident to exhale before the next puff of medication was administered, as indicated in the manufacturer's instructions.