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: VA Black Hills Health Care System - Fort Meade Campus (Fort Meade, SD)

Dates of Survey: 8/28/2018 to 8/29/2018

Total Available Beds: 57

Census on First Day of Survey: 46

F-Tag	Findings
F164 483.10(e) *Privacy and Confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident; (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when (i) The resident is transferred to another health care institution; or (ii) Record release is required by law.* **Level of Harm** - No actual harm with potential for more than minimal harm that is not immediate jeopardy **Residents Affected** - Few	Based on observation and interview, the CLC did not ensure a resident's right to personal privacy during care. Findings include: Resident #201 • On 08/28/18 at 11:58 a.m. a licensed practical nurse was observed during medication administration in [LOCATION] near the dining area used for residents requiring assistance with meals. The LPN scanned Resident #201's name band and the resident's medication and personal health information was displayed on the Bar Code Medication Administration (BCMA) screen. After the LPN scanned the resident's wristband, checked blood glucose results, and checked the provider orders, the LPN drew the resident's insulin into a syringe and had the insulin dose verified by another nurse. The LPN lifted the resident's shirt and injected insulin into the left side of the resident's abdomen; the resident was seated in the hallway next to the dining area. The LPN did not offer to take the resident to his room or another area to provide privacy during the insulin administration. • During the daily meeting with leadership staff on 08/29/18 at 3:30 p.m., leadership staff acknowledged the observation and did not provide additional information.
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	Based on observation, interview and record review, the CLC did not provide services that met professional standards of quality. Findings include: Peripherally Inserted Central Catheter (PICC) The CLC's policy titled, "Administration of IV [Intravenous] Fluids & Medications," was provided by the assistant nurse manager on 08/28/18 at 2:17 p.m. The policy indicated, "The RN/LPN will follow facility [CLC] policy and current approved nursing procedure manual for the initiation, administration, and maintenance of IV medications and solutions." Elsevier's Clinical Skills (formerly Mosby's) was provided by the assistant nurse manager on

jeopardy

Residents Affected - Few

08/28/18 at 2:17 p.m. The policy dated February 2017 and titled, “Peripherally Inserted Central Catheter: Maintenance and Dressing Change,” stated, “Attach a 10-ml [milliliter] syringe filled with preservative-free 0.9% sodium chloride to the appropriate port on the catheter….Open the clamp and gently aspirate until a blood return is visible in the tubing. Each time aspiration occurs during a flush, gently apply pressure against the syringe plunger to avoid catheter or vein damage. Slowly inject the flushing solution into the port, noting any resistance or sluggishness of flow. Never inject against resistance….”

The Infusion Nursing Standards of Practice revised 2016, Standard 57, Practice Criteria I stated, “Assess vascular access device (VAD) function and patency prior to administration of parenteral solutions and medications (refer to Standard 40, Flushing and Locking).” Standard 40.1 states, “Vascular access devices (VADs) are flushed and aspirated for a blood return prior to each infusion to assess catheter function and prevent complications.”

Resident #205, [LOCATION]

- Resident #205 had a provider’s order that stated, “A release hold of Ampicillin NA [sodium] 2 GM [gram]/NS [in normal saline] 100 ml [milliliters] IVPB [IV piggyback] infuse over 30 minutes Q4H [every four hours] bacteremia with enterococcus species for total of 6 weeks of treatment….Start 08/17/18.”
- During an observation on 08/28/18 at 12:31 p.m., a licensed practical nurse (LPN) administered intravenous ampicillin 2 grams in 100 ml normal saline through a PICC line for Resident #205. The LPN did not aspirate for blood return before flushing the PICC line with 10 ml of normal saline prior to administering the intravenous ampicillin. When asked about the observation, the LPN stated, “We were taught that we don’t have to do that [aspirate for blood return] anymore because of new PICCs.” Training information on the new PICC line procedure or literature regarding the new PICC lines was requested by a surveyor; no additional information was provided by staff.
- During the daily meeting with leadership staff on 08/28/18 at 3:30 p.m., leadership staff was informed about the LPN not aspirating for blood return prior to administering a flush through a PICC line. Leadership staff acknowledged the concerns and did not provide additional information.

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

The CLC’s policy titled, “Pain Management,” and dated February 2018 was provided by the assistant nurse manager on 08/29/18 at 11:26 a.m. The policy stated, “The VA BHHCS [Black Hills Health Care System] recognizes and supports the patient’s [resident’s] right to timely and effective pain management through accurate screening, assessment, treatment planning, interventions and evaluation of the effectiveness of pain interventions….

- Re-Screening and Re-assessment: Veterans will be re-screened for pain and any pain not previously reported: when taking vital signs, following PRN [as needed] Medication per BCMA [Bar Code Medication Administration] policy and at a suitable interval following other pain control interventions.
    - Veteran will be re-assessed for worsening pain or when pain has not responded to treatment interventions….”
- The CLC policy did not specify a timeframe regarding how much time should elapse before the effectiveness of the medication was assessed.

Resident #204

- Resident #204 was admitted to the CLC on [DATE] with diagnoses including patella and ankle fracture (08/02/2018), bilateral knee replacement, gout, peripheral vascular disease, diabetic neuropathy, and Parkinson’s disease. The nursing admission assessment dated [DATE] stated, “Pain Assessment: pain [intensity] score 8 [on a scale of 0 to 10, with 10 being the worst pain possible], pain goal 6 or less, pain description: dull continuous, aching, constant; repositioning and analgesic medications make it better; affects functioning, decreases quality of life, and physical activity. Plan: continue present treatment regimen.”
- The resident’s admission Minimum Data Set (MDS) dated [DATE] was coded to indicate the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition; the resident had clear speech, understood and was understood by others, and required extensive assistance with activities of daily living (except eating). The admission MDS indicated the resident received scheduled and

PRN pain medication for almost constant pain at an intensity of 9 that interfered with the resident's sleep at night and limited day-to-day activities. The Care Area Assessment (CAA) summary completed in conjunction with the most recent MDS dated 08/14/18 stated, "[Resident] is noted to have fracture of the left patella and ankle on the pain assessment dated 08/14/18. [Resident] did state pain was almost constant with a 9 being worst pain. [Resident] also has a diagnosis of gout and nerve pain. [Resident] receives allopurinol for gout, baclofen for muscle spasm, pregabalin for nerve pain, and hydrocodone PRN for pain. Will proceed to care plan for pain care at this time."

- The resident's care plan dated 08/08/18 did not address the resident's acceptable level of pain. The care plan included a statement addressing pain with the following approaches:
    - "Provide hydrocodone/acetaminophen and/or pregabalin for pain relief.
    - Allow for periods of rest between activities to avoid pain exacerbations.
    - Notify the provider if pain interventions are ineffective.
    - Offer [the resident] pain medication prior to precipitating factors leading to pain such as physical therapy or occupational therapy or travel.
    - Baclofen for muscle spasms [08/15/18]."
- Provider orders included the following:
    - 08/08/18: "Baclofen tab [tablet] 10 mg [milligrams] PO [orally] TID [three times a day] for muscle spasm."
    - 08/08/18: "Pregabalin Cap [capsule], oral 150 mg PO BID [twice daily] for nerve pain."
    - 08/08/18: "Acetaminophen 975 mg PO Q6H [every six hours] PRN [as needed]. Do not exceed 4 Grams of acetaminophen in 24 hours for pain score of 1 to 4."
    - 08/17/18: "Change hydrocodone 5/acetaminophen 325 mg tab 1 tab PO Q6H PRN for pain 4-7/10 review in one week to hydrocodone 5/acetaminophen 325 mg tab 1 tab PO Q6H PRN for pain 4-7/10 review in 28 days."
    - 08/17/18: "Hydrocodone 5/acetaminophen 325 mg tab 2 tabs PO Q6H PRN for pain above 7. Do not exceed 4000 mg of acetaminophen from all sources in 24 hours."
- During an interview on 08/29/18 at 10:12 a.m. when asked about pain management, Resident #204 stated, "They [CLC staff] are doing the best they can. I broke my knee cap and ankle. I was hurting so bad this morning that I might have been kind of nasty with the nurse. I try to keep myself distracted so not to think about pain." The resident indicated he usually experienced pain of "8 or 9" and 7 was the resident's acceptable pain level. The resident stated, "I try to live with it [the pain]. I hurt all of the time; sometimes the pain is unbearable, but I try to keep going." The resident indicated, "I've had so many surgeries [including] two to three knee replacements [and] elbow surgery. I had cancer on top of my head that went into the bone. I have had it with surgeries...."
- During an interview and record review on 08/29/18 at 10:29 a.m. with a registered nurse (RN) and the readiness coordinator, a pain assessment note dated 08/20/18 was reviewed. The note indicated the resident was not receiving scheduled pain medications; the resident was receiving PRN pain medication and non-pharmacologic interventions for pain. The note did not address the baclofen or pregabalin the resident was receiving on a scheduled basis. According to the note, the resident was "almost constantly hurting…pain effects sleep and day-to-day activities;" and the resident "rates pain at 9 and pain is severe." The pain note stated, "PA [physician assistant] recommended avoiding excess opioids due to excessive use contributing to somnolence. Did not complain of pain at this time when visited earlier."
- A review of the resident's Bar Code Medication Administration records for 08/21/18 through 08/29/18 included the following dates and times when pain medication was administered and was not effective or slightly effective and an assessment was not conducted to determine follow-up approaches such as non-pharmacologic approaches to more effectively address the resident's pain:
    - 08/21/18: Acetaminophen 975 mg was administered at 3:22 p.m. for a pain intensity rating of 8; at 5:02 p.m. the resident's pain score was 8 and documentation indicated the acetaminophen was ineffective. At 5:00 p.m., hydrocodone 5/acetaminophen 325 mg, 2 tablets were administered for a pain intensity rating of 8; the resident's pain score was 7 at 7:04 p.m. and documentation indicated the pain medication was slightly effective. No additional interventions were documented as attempted such as non-pharmacologic approaches. The provider was not notified that the interventions were ineffective in accordance with the care plan.
    - 08/23/18: Hydrocodone 5/acetaminophen 325 mg, 2 tablets were administered at 6:48 p.m. for a pain intensity rating of 8; the resident's pain score was 7 at 7:44 p.m. and documentation indicated the pain medication was slightly effective. No additional interventions were documented as attempted such as non-pharmacologic approaches. The provider was not notified that the interventions were ineffective with the resident's pain score not below the goal of

6 as indicated in the nursing admission assessment and in accordance with the care plan.

- 08/24/18: Hydrocodone 5/acetaminophen 325 mg, 2 tablets were administered at 8:46 a.m. for a pain intensity rating of 8 and documentation indicated the pain medication was slightly effective with distraction. At 11:19 a.m., acetaminophen 975 mg was administered and an ice pack applied for a pain intensity rating of 9; the resident's pain score was 8 at 12:58 p.m. and documentation indicated the pain medication was slightly effective. Additional interventions for pain relief were not documented as attempted such as non-pharmacologic approaches. The provider was not notified that the interventions were ineffective with the resident's pain score not below the goal of 6 as indicated in the nursing admission assessment and in accordance with the care plan.
- 08/24/18: Hydrocodone 5/acetaminophen 325 mg, 2 tablets were administered at 7:57 p.m. for a pain intensity rating of 8; the resident's pain score was 8 at 11:02 p.m. and documentation indicated pain medication was ineffective. Additional interventions for pain relief were not documented as attempted such as non-pharmacologic approaches. The provider was not notified that the interventions were ineffective in accordance with the care plan.
- 08/25/18: Hydrocodone 5/acetaminophen 325 mg, 2 tablets were administered at 3:30 a.m. for a pain intensity rating of 8; the resident's pain score was 8 at 5:38 a.m. and documentation indicated pain medication was ineffective. The provider was not notified that the pain medication was ineffective. Additional interventions for pain relief were not documented as attempted such as non-pharmacologic approaches until 7:40 a.m. when the resident received hydrocodone 5/acetaminophen 325 mg, 2 tablets; the resident's pain score at 8:35 a.m. was 4.
- 08/26/18: Hydrocodone 5/acetaminophen 325 mg, 2 tablets were administered at 5:23 p.m. for a pain intensity rating of 9; the resident's pain score was 8 at 8:29 p.m. and documentation indicated pain medication was slightly effective with distraction. Additional interventions for pain relief were not documented as attempted and the provider was not notified that the interventions were ineffective with the resident's pain score not below the goal of 6 as indicated in the nursing admission assessment and in accordance with the care plan.
- 08/27/18: Hydrocodone 5/acetaminophen 325 mg, 2 tablets were administered at 3:12 a.m. for a pain intensity rating of 7; the resident's pain score was 7 at 5:02 a.m. and documentation indicated the resident refused non-pharmacologic approaches. The provider was not notified that the interventions were ineffective in accordance with the care plan. At 9:40 a.m., hydrocodone 5/acetaminophen 325 mg, 2 tablets were administered for a pain intensity rating of 9; the resident's pain score was 9 at 11:48 a.m. and documentation indicated pain medication was ineffective. Additional interventions for pain relief were not attempted such as non-pharmacologic approaches and the provider was not notified that the pain medication was ineffective in accordance with the care plan.
- 08/28/18: Hydrocodone 5/acetaminophen 325 mg, 2 tablets were administered at 8:24 p.m. for a pain intensity rating of 9; a reassessment of the resident's pain following medication administration was not documented.
- 08/29/18: Hydrocodone 5/acetaminophen 325 mg, 2 tablets were administered at 6:06 a.m. for a pain intensity rating of 8. On 08/29/18 at 10:29 a.m., the registered nurse (RN) assigned to provide care for Resident #204 indicated the resident "requested pain medication an hour later," and the RN informed the resident that "he received pain medication an hour ago" and that she "would notify the doctor about it when the doctor comes in for rounds because it is too soon [to administer additional pain medication]." The RN indicated she had "not seen him [resident] that bad in the morning [in pain]." The RN indicated a physical therapist came in for a regularly scheduled visit (time not provided by the RN) and used a TENS (transcutaneous electrical nerve stimulation) unit for the resident; after the treatment the resident indicated his pain was better. When asked at 10:29 a.m. if the RN notified the provider of the resident's ineffective pain relief after receiving pain medication, the RN stated, "No, I have not seen the doctor make rounds yet." When concerns were discussed with the delay in nursing staff notifying the provider about ineffective pain relief after interventions were provided, the readiness coordinator agreed that nursing should have notified the provider about ineffective pain relief (before 10:29 a.m.).

- During a meeting on 08/29/18 at 3:30 p.m., leadership staff was informed about the concern with ineffective pain management with the resident's current regimen. Leadership acknowledged the concern and did not provide additional information.
- In summary, Resident #204 was admitted to the CLC on [DATE] with diagnoses including patella and ankle fracture (08/02/2018) The nursing admission assessment dated [DATE] indicated the resident had a " pain [intensity] score 8 [on a scale of 0 to

10, with 10 being the worst pain possible], pain goal 6 or less…." Resident #204 indicated during an interview on 08/29/18 at 10:12 a.m. that he usually experienced pain of "8 or 9" and 7 was the resident's acceptable pain level. The resident stated, "I try to live with it [the pain]." Resident #204 stated, "I was hurting so bad this morning that I might have been kind of nasty with the nurse. I try to keep myself distracted so not to think about pain." It was not evident based on documentation in the BCMA record between 08/21/18 and 08/29/18 that staff reassessed the resident's pain following administration of pain medication including when the resident reported pain at a level of 8 or 9, or that staff attempted additional approaches including non-pharmacologic approaches to address the resident's ongoing pain. When interventions including the administration of medication for pain was ineffective, the provider was not notified as indicated in the resident's care plan.

Dementia Care
Resident #102

- Resident #102 was admitted to the CLC on [DATE] and residing in the [LOCATION] neighborhood. According to the [DATE] admission history and physical, the resident's diagnoses included vascular dementia and "inappropriate...behavior." The resident was admitted for short-stay dementia care pending placement in a community facility.
- The resident's [DATE] admission MDS was coded to indicate the resident had clear speech and was understood and usually understood others. The resident had a BIMS score of 0 (zero); indicating severely impaired cognitive skills for daily decision making; Resident #102 had no indicators of delirium or psychosis. The admission MDS indicated the resident required supervision of one staff for bed mobility, transfers, and walking; supervision and set-up assistance for eating; and extensive assistance of one staff for dressing, toilet use, personal hygiene and bathing. According to the MDS, the resident experienced physical behavioral symptoms directed toward others and the behavioral symptom of wandering one to three days during the review period.
- According to the most recent provider orders, the resident was prescribed the following medication to ease behavioral symptoms of potential distress:
    - Medroxyprogesterone for "...behavior suppression."
    - Olanzapine 5 mg at bedtime for delusion/behaviors.
    - Quetiapine as needed for non-directable agitation/aggression.
    - Haloperidol 5 mg/milliliter intramuscularly daily as needed "if refuses to take oral medication for non-directable agitation/aggression."
- The resident's care plan contained a statement dated 06/05/18 related to activities of daily living. One of the approaches read, "If inappropriate comments and/or physical touch by veteran occurs, immediately notify the veteran of its inappropriateness and request it ends." There were no other statements or approaches in the resident's care plan addressing the resident's behavioral symptoms of potential distress.
- The following geriatrics, extended care and rehabilitation (GECR) notes documented Resident #102's behavioral symptoms as follows:
    - 07/10/18 12:56 p.m. "Ill [I'll] scrub you all over [inappropriate language]…writer told vet this is unexceptiable [unacceptable] and I did not like being talked to that way – vet [Veteran] stopped and no more talk like that, pleasant rest of tour."
    - 07/26/18 6:00 p.m. "[Resident #102] proceeded to wheel himself around the table and another Vet had $4 laying on the table. [Resident #102] stopped by the $4 and proceeded to fold it and put it in the left shirt pocket….[Resident #102] claimed he didn't take any money." The note indicated the resident refused to return the money and the police were called; the note stated, "Nothing really settled Vet down." The note indicated, "PRN [as needed] Lorazepam given to calm the veteran and appears to be effective for anxiety." (The lorazepam was a one time provider order; it was not in the resident's list of current medications at the time of survey.)
    - 07/26/18 9:10 p.m. "Veteran was speaking [inappropriately] to staff throughout tour." The note documented staff tried education, redirection, and to "tell vet that speaking like that is not okay." The interventions were noted to be "ineffective."
    - 08/05/18 9:17 a.m. "Lying in bed talking in a native language…refusing to talk to staff and spit out medication."
    - 08/05/18 12:02 p.m. "Veteran was standing by the window trying to walk outside by going through the window. Veteran then started talking in German/Native American. Veteran stated to staff, "Move I don't want to hurt you, but I will." The note documented the charge nurse was notified, staff tried redirecting the resident, offered walking with resident, offered food, called the medical officer of the day, and gave a "now dose of quetiapine;" approaches including the quetiapine were documented as "non effective."
    - 08/05/18 1:56 p.m. "Veteran proceeded to tell writer that he was leaving and no one could stop him. Veteran was telling writer that he could make himself walk through the wall and proceeded to get out of the wheelchair…said there was an accident and his mother was dead….Intervention not effective."Interventions

attempted included offering food and a beverage, toileting and re-direction.

- 08/07/18 9:37 p.m. “Speaking in unknown language – he states it is Swiss – talking and pointing out the window then goes to door and back to window…sat at dining room table looking at a picture of another peer and his wife and begins to talk in unknown language, cry, raise his hands in the air…[staff] moved the picture. [Resident] asked me where the picture was of his wife with another man….Interventions unsuccessful.” Other interventions attempted included offering food and a beverage, toileting and re-direction.
- 08/09/18 6:06 p.m. “Vet then became angry because He couldn’t find His pistol and [resident said] He was holding a 357 rifle and it was pointed at writer. Vet insisted that writer knew where his sliver [silver] pistol with a diamond ring was. Very upset and wasn’t leaving my presence….Staff took Veteran in His wheelchair around CLC unit [neighborhood] and this did calm vet down a bit.”
- 08/16/18 7:18 a.m. “Last evening while assisting with bedtime cares, veteran made [inappropriate] comments to female staff….” The note stated redirection was effective.
- 08/19/18 1:31 a.m. “Talks about getting a machine gun and killing everyone that goes in his room. Very upset at one of the other veterans who is walking in the hallway. Makes statements that he is going to kill that guy either with a machine gun or take a knife and cut his throat….Keeps talking about killing someone….” “Interventions not effective.” Interventions attempted included offering food and a beverage, toileting and re-direction.
- 08/19/18 4:02 p.m. “Vet got upset with another Vet that was walking up and down hallway. Veteran said writer and the other vet stole his money out of his room and it was $25,000 and Veteran had His machine gun loaded and pointed at both of us. Concerned for the other Veteran I stayed between them. Veteran stated that if writer didn’t return it [money] by morning He would, he did a motion of slicing writer’s neck and it won’t be the first time He killed a woman....Intervention not effective.” Interventions attempted included offering food and a beverage, toileting and re-direction.
- 08/19/19:12:00 p.m. “Patient very agitated, yelling profanities, and threats to ‘bomb you all’ and makes gestures of shooting with machine guns. Patient threatening to kill everybody and makes gestures towards other patients….Police unable to control patient…order for Lorazepam and Benadryl injection pending.” The note indicated staff would obtain a urinalysis to evaluate the resident for a urinary tract infection. There was no indication the resident was treated for a urinary tract infection following this incident.
- 08/23/18 9:56 p.m. “Wandered ward [neighborhood] talking to self. Told staff not to place him next to ‘that’ guy again or ‘I will kill him, because I’m not a thief.” The note documented interventions were successful. Interventions attempted included offering food and a beverage, toileting and re-direction.
- 08/25/18 6:35 p.m. “Restless in bed…commenting he is starving, telling stories from his past…talking about killing people…sees animals on the wall, sees farm animals on the floor.” The note indicated the behavioral symptoms were continuous from 10:30 p.m. to 6:15 a.m. and there was “no combative behavior.” Interventions attempted included offering food and a beverage, toileting and re-direction. Staff had not determined if hallucinations were medication related.
- 08/26/18 10:39 p.m. “Approx [approximately] 1750 [5:50 p.m.] vet got up out of wheelchair with no provacation [provocation] started walking towards staff member stating he needs to get out of that area (tv area) and started running toward staff member…vet then stated he was going to kill us and making gun gestures with sound effects…I then saw vet come up from behind staff member while he [resident] was sitting in his wheelchair and kick staff member between the legs….At 2000 [8:00 p.m.] police was [were] present and attempted one last time to get the vet to take meds [medications]. Vet refused and halodal [Haldol] injection was given.” The note documented the resident’s behavioral symptoms lasted approximately two hours and stated, “No intervention helped, vet continued to show agitation and aggression.” Interventions attempted included offering food and a beverage, toileting and re-direction. An addendum to this note written at 12:18 a.m. on 08/27/18 documented, “Vet then proceeded to stand up from his wheelchair and stated that he was absolutely not going to take any medicine. Haldol injection was given at that time. Vet began walking around in between staff stating that he wasn’t going to take anything staff tried to give him. At this time he was standing behind this nurse and told this nurse that he would give this nurse one of these (making a fist with his hand) if this nurse tried to give him any medicine…Vet then made a fist and punched this nurse in the hip…made hand gestures like he was cocking a gun and aimed at this nurse and began making shooting noises….”Interventions attempted included offering food and a beverage, toileting and re-direction.

- On 08/28/18 at 11:30 a.m., the resident was observed in bed with the sheet pulled up

around his head. A staff member stated, “He’s [resident] a sleeper inner [meaning the resident liked to sleep late in the morning].” The nurse manager stated, “He [resident] is having a lot more nonsensical speech, maybe in a foreign language. He has some PTSD [posttraumatic stress disorder]. He talks a lot about bombs and guns. He has really declined and we are considering him for hospice.”

- On 08/28/18 at 12:20 p.m., a chair alarm sounded in Resident #102’s room alerting staff the resident stood from his wheelchair. The resident was observed walking while pushing his wheelchair into the bathroom. A staff member approached the resident and stated, “Why don’t you sit in your wheelchair.” The staff assisted the resident to sit and go into the bathroom. The staff member asked, “Why don’t we get your clothes on and then we can go eat?” The resident responded positively to the staff members instructions and assistance.
- On 08/29/18 at 8:40 a.m., Resident #102 was observed sitting in a chair in the [LOCATION] dining room looking at a newspaper. The resident was dressed in street clothes and nicely groomed. The resident invited the surveyor to sit and visited with the surveyor for approximately 10 minutes. The resident discussed his family and hobbies (fishing and hunting), and very briefly discussed his military service.
- On 08/29/18 at 9:00 a.m., an RN who provided care for Resident #102 since the resident’s admission reported, “He likes to sleep late. I was surprised he was up before breakfast. Sometimes he talks and yells in German. He sometimes tries to escape. He has a Secure Care bracelet now. I heard he was chasing staff trying to hit and pretends he is dead and slumps down. Generally, it is the time of day [that causes behavioral symptoms]. It is always just before or after dinner. Maybe it is PTSD.” When asked what staff did when the resident displayed behavioral symptoms of potential distress, the RN responded, “I try to get him to tell me good stories about his family or tell me what is wrong. I give him a warm blanket. Fifty percent of the time if you talk to him, he comes out of it. Generally, he gets olanzapine [prn] four times a week. We do [document a] challenging behavior note to explain our interventions and if they were effective.”
- On 08/30/18 at 7:50 a.m. the [LOCATION] charge nurse (CN) stated, “He’s [participating in the] STAR VA [program], it [STAR VA care plan] is on the unit [[LOCATION] neighborhood].” Another RN accompanied the surveyor to the neighborhood and looked for a care plan; after looking for the plan for a few minutes, the RN stated, “There is no care plan. He is not [participating in] STAR VA.”
- On 08/30/18 at 8:00 a.m., the RN STAR VA champion reported, “We haven’t come up with a care plan yet. We are working on it. [Psychologist’s name] and I are discussing it. We teamed [had a team meeting about] him [Resident #102] yesterday. He is not on a psychotropic in the morning, maybe he needs something in the morning that will get him through. He has been on our radar. I am going to talk to his nephew [power of attorney] regarding the resident’s life and what has worked [and include the information in the care plan].”
- In summary, during the survey, staff successfully implemented redirection for the resident on 08/28/18 at 12:20 p.m. to encourage the resident to sit down when the resident stood from the wheelchair and was walking in the resident’s room. On 08/29/18 at 9:00 a.m. when asked what staff did when the resident displayed behavioral symptoms of potential distress, an RN that provided care for the resident responded, “I try to get him to tell me good stories about his family or tell me what is wrong. I give him a warm blanket. Fifty percent of the time if you talk to him, he comes out of it...." According to documentation of behavioral occurrences, various approaches used by staff including offering food and a beverage, toileting, redirection, and calling the police, were generally unsuccessful in relieving the resident’s distress; an assessment had not been conducted to address successful approaches depending on specific behavioral symptoms and possible causal and contributing factors (e.g., environmental stimuli, actions of staff or other residents). GECR notes that described the resident’s behavioral symptoms did not consistently include information indicating non-pharmacologic approaches were attempted. The same approaches including offering food and a beverage, toileting and re-direction were routinely attempted although the interventions were found to be ineffective. The RN STAR VA champion indicated a care plan had not been developed to address the resident’s behavioral symptoms of potential distress. The resident’s care plan contained a statement dated 06/05/18 related to activities of daily living. One of the approaches read, “If inappropriate comments and/or physical touch by veteran occurs, immediately notify the veteran of its inappropriateness and request it ends.” There was no additional information in the resident’s care plan addressing the resident’s behavioral symptoms of potential distress. Resident #102 continued to experience episodes of potential distress, including kicking and hitting staff, and threatening staff and other residents.