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: James H. Quillen VA Medical Center (Mountain Home, TN)

Dates of Survey: 6/26/2018 to 6/28/2018

Total Available Beds: 70

Census on First Day of Survey: 57

F-Tag	Findings
F225 483.13(c)(4) *The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.* **Level of Harm** - Actual harm that is not immediate jeopardy **Residents Affected** - Few	Based on observation, interview and record review, the CLC did not ensure that all alleged violations were thoroughly investigated. Findings include: On 06/28/18 at approximately 8:20 a.m., quality management staff provided the Mountain Home VA Healthcare System Clinical Memorandum 122-17-01 dated November 17, 2017 and titled, “Reporting and Treatment of Abuse, Neglect or Exploitation.” The policy read, “4. Definitions….c. Physical Assault…Neglect or Injuries of Unknown Origin…..(5) Injuries of unknown origin are defined as an “injury of unknown source” when both of the following conditions are met: (a) The source of the injury was not observed by any persons or the source of the injury could not be explained by the Veteran patient/resident, and (b) The injury is suspicious because the extent of the injury or the location of the injury (e.g. the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.” The policy further indicated, “In all instances of alleged patient abuse, the first employee who becomes aware of the incident will immediately notify their supervisor and complete an incident report (VA Form 10-2633, Report of Special Incident Involving a Beneficiary) with detailed information…the supervisor will notify the proper Service Chief, who will then notify the appropriate Executive Leadership Team member.” Resident #104 • As determined through record review, Resident #104 was admitted to the CLC on [DATE] with diagnoses that included dementia. • During an initial interview with the RN charge nurse on 06/26/18 beginning at 10:15 a.m., the RN charge nurse reported that Resident #104 was “totally dependent on [staff for] ADLs [activities of daily living]…and has contractures of his right arm.” • The resident’s annual Minimum Data Set (MDS) assessment dated 08/07/17 indicated Resident #104 had short and long-term memory problems and severely impaired cognitive skills based on staff assessment; the resident did not have mood or behavioral symptoms. According to the MDS, the resident was totally dependent on staff for all activities of daily living, had functional limitations in range of motion of the upper extremity (one side only) and the lower extremities (both sides), was at risk of developing pressure ulcers and did not have pressure ulcers. The MDS indicated the resident had skin tears and skin and ulcer treatments included a pressure reducing device for the chair and bed, a turning and repositioning program and application of ointments other than to feet. The quarterly MDS assessment dated 05/03/18 indicated the resident had short-term and long-term memory problems and moderately impaired cognitive skills based on staff assessment. The resident did not have mood or behavioral symptoms, was totally dependent on staff for all activities of daily living, had functional limitations in range of motion of the upper extremity (one side only) and of the lower extremities (both sides), was at risk of developing pressure ulcers, did not have pressure ulcers, and skin and ulcer treatments included a pressure reducing device for the bed, turning and repositioning, and applications of ointments other than

to feet.

- The provider order sheet included the following:
  - "12/27/17 Change Nurse – brace to right elbow BID [twice daily] as recommended by OT [occupational therapy] to Nurse – brace to right elbow as recommended by OT, as tolerated by the resident."
  - "06/22/18 Location – Right Elbow: Cleanse with normal saline. Use normal saline moistened cotton tipped applicator to reposition torn skin into original position. Cover with non-adherent dressing (e.g., adaptic touch silicone, oil emulsion or Vaseline gauze). Cover with dry gauze dressing and secure with Stretch Net or paper net. Change dressing every 2-3 days and as needed for compromised dressing."
- The resident's comprehensive care plan with a review date of 05/08/18 was reviewed with the CLC medical director on 06/27/18 at approximately 3:30 p.m. The resident's comprehensive care plan did not address the resident's recurrent skin tears. A statement in the comprehensive plan of care dated 01/25/18 and reviewed on 05/08/18 stated the resident "wants to work with the restorative nursing Active Range of Motion Program." The care plan goal indicated the resident would maintain full range of motion while in the CLC. The care plan approaches did not reflect use of the brace on the right arm; however, the use of the brace was included as an approach in another statement addressing the resident's "overall preferences" during his stay at the CLC.
- Resident #104 was observed in the main dining room during the noon meal on 06/26/18; the resident was noted with flexion contractures of the right elbow and contractures of the right hand and fingers. The resident was not wearing a brace or positioning device on the right elbow, arm or hand; the resident's right elbow was observed with the dressing secured with net as indicated in the provider's order. At approximately 4:40 p.m., Resident #104 was observed in the shared gathering area in front of the nursing station seated in a Broda chair. At the time of the observation, the resident had what appeared to be the same dressing on the right elbow.
- In the presence of the quality management staff, the RN consistently assigned to Resident #104's care was interviewed on 06/26/18 at approximately 4:50 p.m. During the interview, the RN stated the resident was "totally dependent on staff with care." When asked about the dressing on the resident's right elbow, the RN said, "He struck his [right] elbow on the bed [side] rail on 06/21/18 when he was being rolled [repositioned] in bed. He was just placed back to bed after lunch and the staff provided care. They rolled him to his side and his [right] elbow hit the bed rail. He's dependent on staff for his care and the right arm is pretty contracted." When asked if the resident had a history of skin tears on the right arm, hand and elbow, the RN stated, "His [the resident's] skin is fragile and he always has something on his skin." The RN reviewed the resident's clinical record including documentation in the nursing progress notes and wound care notes; the RN stated the resident had recurrent skin tears "at least on 08/06/17, 09/25/17 and 04/09/18."
- On 06/27/18 at 11:09 a.m., the following information was obtained during further review of the resident's clinical record to include the wound care treatment notes and nursing progress notes.; the review was conducted with quality management staff and the same RN charge nurse interviewed on 06/26/18 and included the following:
  - The wound care treatment note dated 07/29/17 indicated the resident had a "small skin tear on the right elbow that was covered by Tegaderm, unknown how skin tear was obtained and who placed Tegaderm over wound." The RN charge nurse stated the resident received wound care for the right elbow skin tear from 07/29/17 through 08/12/17. The RN charge nurse confirmed the CLC was did not conduct an investigation to determine what caused the skin tear over the resident's right elbow.
  - The nursing note dated 08/04/17 read, "While the CNA [certified nursing assistant] was putting the resident to bed for the evening, the CNA staff noticed a skin tear to the right outer forearm. Origin unknown. The skin tear was cleansed with NS [normal saline] and applied a bandaid." The RN charge nurse confirmed the CLC did not conduct an investigation to determine what caused the skin tear over the right outer forearm. During follow-up record review with one of the nurse managers on 06/28/18 at 9:25 a.m., the nurse manager stated she found documents titled, "Nursing Assistant Note" that were dated 08/04/17 and 08/05/17 and indicated the use of elbow protectors. The nurse manager indicated being unable to find documentation explaining how the resident sustained the skin tear to the right outer forearm.
  - The nursing note dated 09/23/17 stated that "during rounds, the staff noted small amount [of] dried blood on right hand, below knuckles and upon closer inspection, appears to be from older skin tear." The RN charge nurse stated Resident #104 received wound care for the skin tear and the area was healed

as of 11/01/17. The RN charge nurse said, “There was nothing in the notes that indicated he [Resident #104] had an old skin tear around this time. I don’t know if the nurse who wrote the progress notes assumed the resident had an older skin tear.”

- The nursing note dated 11/28/17 stated, “Upon providing incontinence care to resident [Resident #104], the resident was noted to have swelling, redness, and warmth to left upper arm and the resident appears to be grimacing when site was assessed by the RN.” The cause or etiology of the left upper arm swelling and redness was not indicated in the resident’s clinical record.
- The nursing note date 01/07/18 stated, “While performing PM [p.m.] care for the resident, the nurse found a skin tear to the right elbow. The skin tear had dried blood around it and the origin of the skin tear was unknown.” The RN charge nurse indicated the resident received wound care from 01/07/18 until 01/13/18 when the wound healed. The RN charge nurse confirmed there was nothing documented in the resident’s clinical record indicating what caused the skin tear to the resident’s right elbow.
- The nursing note dated 02/26/18 documented Resident #104 was noted to have what appeared to be an “abraided [abraded] area” to the right forearm. According to the nursing note, the etiology of the abraded area was unclear but the area could have been caused by the arm brace that was applied to the right elbow for contracture management. The nursing note stated, “A recommendation was given by the OT [occupational therapist] to adjust or discontinue the use of the elbow brace ‘if issue with the right forearm persisted.’” During follow-up review with another RN charge nurse on 06/28/18 beginning at 8:20 a.m., the RN charge nurse stated she did not find any documentation indicating a thorough review and investigation into what caused or contributed to the abraded area to the resident’s right forearm.
- The wound care treatment note dated 04/09/18 documented the resident was “turned and repositioned every 2 hours…[skin tear] cleansed [on] right elbow with NS, placed adaptic touch [non-adherent dressing] to affected area and placed dry gauze and secured with tape and stretch net.” The RN charge nurse indicated she was unable to find documentation indicating what caused or contributed to the skin tear to the resident’s right elbow.
- The nursing note dated 06/21/18 stated, “While the resident was being placed back in bed after lunch, he was rolled to change his brief and his right elbow struck the rail on the bed causing a small skin tear approximately 1/2 - 1 cm [centimeter]; wound care was performed.”
- The nursing note dated 06/22/18 stated, “Due to the skin tear on patient’s right elbow, LPN [name] spoke with a member of restorative [and] asked him to pass on not to utilize patient’s brace for a few days to or until further notice to prevent worsening of the wound.”
- The nursing weekly summary dated 06/24/18 stated, “Side rails x 2 [two side rails raised]” were part of the environmental precautions for the resident related to falls.

- On 06/27/18 at approximately 1:30 p.m., the RN interviewed on 06/26/18 and the nursing assistant (NA) who was consistently assigned to provide the resident’s care, were observed assisting the resident to transfer from a chair to bed. During the observation, the resident was observed with a wound dressing over the right elbow; the wound dressing was dated 06/26/18. When asked about the wound dressing on the resident’s right elbow, the RN staff said, “As I told you yesterday, he had a skin tear when he struck the bed rail during care [on 06/21/18]. I changed his [wound] dressing yesterday and the order requires every 2-3 day dressing changes. I was not working when he had the skin tear.” The NA who assisted with the transfer said, “I was working with him [Resident #104] at the time he had the skin tear. We [NA and another NA] were changing his briefs. We always place a pillow by his right side to protect his right arm whenever we roll him in bed. He’s contracted on the right [elbow, arm and hand]. On that day [06/21/18], the pillow must have slipped or dropped to the floor and when we rolled him to his right side, he hit his [right] elbow against the side rail and sustained the skin tear.” When asked if the NA had information about the other instances when the resident sustained skin tears to the right elbow and/or hand, the NA said, “I don’t really know what’s causing the skin tears, except for this recent skin tear [on 06/21/18].”
- On 06/28/18 at approximately 7:30 a.m., Resident #104 was observed in the main dining room receiving assistance from the restorative nursing assistant (RNA). The RNA reported the resident “was initially resistive to the application of the elbow brace but has been cooperative and progressing well with the use of the brace.” The RNA stated, “The nurses told me to stop using the brace for now because of the skin tear on

his right elbow."

- On 06/28/18 at approximately 9:10 a.m., the recurrent skin tears on the resident's right elbow and hand, the consistent documentation by staff that the origin of the skin tear was "unknown" (except the skin tear to the right elbow on 06/21/18) and the lack of a thorough review to determine causative or contributing factors was discussed with the CLC medical director. The lack of a comprehensive care plan to prevent further skin tears and injury to the resident was also discussed with the medical director. The CLC medical director stated, "We recently trained the staff on the CMS [Centers for Medicare and Medicaid Services] definition [of abuse] and the tracers [record review] that are necessary [to determine cause of the injury]. I guess we take it for granted because we know the resident very well. It is not that we are abusing the resident, but we didn't dig enough to determine the cause of the injury. With this latest skin tear on his right elbow that appeared to be where he rolled over and hit his elbow on the bed rail, we could consider padding the right rail or perhaps both rails."
- In summary, Resident #104 was observed during the survey with a flexion contracture of the right elbow and contractures of the right hand and fingers; the resident's right elbow was observed with a dressing. As determined through observation, staff interviews and record review, Resident #104 had recurrent skin tears to the right elbow and/or right hand. With the exception of the skin tear sustained on 06/21/18 when it was determined the resident hit the right elbow against the bed rail, the CLC documented the skin tears on 07/29/17, 08/04/17, 09/23/17, 01/07/18, 02/26/18 and 04/09/18 as skin tears of "unknown origin." Resident #104 was admitted to the CLC with diagnoses that included dementia. The comprehensive and quarterly MDS assessments indicated the resident was totally dependent on staff for ADL care needs. The CLC did not conduct a thorough review of the skin tears to determine causative or contributing factors. The CLC did not develop and implement a comprehensive plan of care to prevent the recurrence of the skin tears.

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 care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include:

Non-pressure Related Ulcers/Wounds

Resident #103

- As determined through review of the clinical record, Resident #103 was admitted to the CLC on [DATE] with diagnoses that included "severe aortic stenosis…restless legs, peripheral neuropathy, peripheral nerve disease, atrial fibrillation…arthralgia (joint pain), and coronary arteriosclerosis."
- During an initial interview with the RN charge nurse on 06/26/18 at approximately 10:15 a.m., the RN charge nurse reported Resident #103 had a "chronic non-healing wound to his left foot." The RN charge nurse commented, "The wound is not pressure related. The etiology is unknown."
- The resident's admission Minimum Data Set (MDS) assessment dated [DATE] documented the resident scored 15 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition; the resident required limited assistance with most activities of daily living (ADLs) including bed mobility, transfers, ambulation, and toileting; and had no functional limitations in range of motion in the upper or lower extremities. Section M (Skin Condition) of the admission MDS documented the resident had skin tears; the resident received skin and ulcer treatments including a pressure reducing device in bed, a turning and repositioning program, and application of nonsurgical dressings other than to the feet. The quarterly MDS assessment dated 05/18/18 was coded to indicate the resident had modified independence with cognitive skills for daily decision making based on staff assessment; the resident required limited assistance with most ADLs including bed mobility, transfers, locomotion on and off the unit (neighborhood), and toileting and had functional limitations in range of motion in the lower extremities. Section M of the quarterly MDS indicated the resident had lesions on the foot, and skin and ulcer treatments included pressure reducing devices in the bed and chair, applications of dressings to the feet and application of nonsurgical dressings other than to the feet.
- A statement in the resident's interdisciplinary care plan dated 03/22/18 and reviewed on 05/22/18 stated the resident "has wound to his medial left great toe." Approaches included but were not limited to the following:
    - "Cleanse and dress left medial toe wound per provider."

- "Notify providers and wound care nurse for any changes or deterioration to the wound, such as erythema, foul drainage, changes in wound base color."
- "Apply Rooke boot to left foot for protection."
- "Consult appropriate disciplines such as podiatry…[regarding] plan of care for resident."

- On 06/27/18 at approximately 8:00 a.m. the surveyor, with the resident's consent, observed the RN charge nurse (who was interviewed on 06/26/18) and the associate chief nurse of wound care and research provide wound care for Resident #103. The resident was observed lying supine in bed at the beginning of the observation; there was a pressure redistribution device (Synergy® Air Elite low air loss mattress) on the resident's bed. The resident's left foot was not covered and the wound on the medial left great toe was observed (the visibly soiled dressing was removed prior to the surveyor's observation at the resident's bedside). The left second toe was covered with a dressing and a Copa™ foam dressing was observed between the left great toe and the left second toe. (See Pressure Ulcers) The associate chief nurse for wound care and research described the wound bed on the medial left great toe as "clean without recurrence of fibrin film, but with minimal yellow slough on the peripheral sidewalls." The associate chief nurse for wound care and research said, "You can see where the bone is visible. The periwound skin is intact with faintly pink coloration that is blanching." When asked about the etiology of the wound, the associate chief nurse for wound care and research said, "I started getting involved in March [2018]. The wound was not pressure related, but it tested positive for MRSA [methicillin-resistant *Staphylococcus aureus*]. He [Resident #103] was treated with the vancomycin [antibiotic]. He was seen by the podiatrist who agreed with the wound care and the use of the Rooke boot. The wound was initially healing, but at some point, he [Resident #103] started complaining of pain in the foot and the wound was not showing progress so he was referred to ID [infectious disease]. The vancomycin was changed to daptomycin because of suspicion of osteomyelitis….I've been putting a thick abdominal pad [on the foot] to protect the wound. I secure the abdominal pad with the silicon tape to keep the pad in place. He [Resident #103] has restless legs and he said the dressings come off at night." At the request of the surveyor, the associate chief nurse for wound care and research removed the gripper sock on the right foot and assessed the right foot. It was noted during observation of the right foot that there appeared to be dead skin cells and accumulation of dark debris in the interdigital spaces of the right foot; the observation was confirmed by the associate chief nurse for wound care and research and RN charge nurse. As the associate chief nurse for wound care and research cleaned the interdigital spaces, the RN charge nurse remarked, "I wonder if that is accumulation of the ointment or moisturizer that they [direct-care staff] may have been applying. They just missed cleaning the skin between his toes." The right foot toenails (most notably the right great toe) were thick and discolored; the skin on the dorsal aspect of the right foot beginning from the toes extending proximally up to the ankle area was reddish/purplish in color. The associate chief nurse for wound care and research said, "There is clinical indication of tinea pedis [athlete's foot]. I'm looking at the color and thickness of the toenails and it looks like he's [Resident #103 has] got some fungal infection. I will have to review his record to see if he had history of tinea pedis before I recommend any treatment. If the provider agrees, I will recommend either miconazole cream twice daily or clotrimazole daily. The [right] foot is cold to touch and I'm detecting very faint DP [dorsalis pedis (pedal pulses)] and PT [posterior tibial] pulses." The RN charge nurse and the associate chief nurse for wound care and research indicated they had not observed the right foot or assessed the right foot previously; the RN charge nurse also indicated she had not been informed by direct-care staff of the appearance of the resident's right foot. During an interview with another RN charge nurse on 06/28/18 at 8:30 a.m., the second RN charge nurse indicated an order was written on 06/27/18 for use of an antifungal cream for the resident's right foot.
- On 06/27/18 beginning at 10:10 a.m., the resident's clinical record was reviewed with the same RN charge nurse interviewed on 06/26/18 and a quality management staff member. The following pertinent information described the left foot wound:
  - The extended care CLC medical note dated 03/02/18 read, "Asked to evaluate patient [Resident #103] due to area of callus on the left foot earlier this morning. Reports that the area yesterday may have been draining. Patient is also noted to have been having increasing anxiety. No fever or chills…."There was no subsequent note written by the provider documenting a comprehensive assessment, interventions or plan of care related to the "area of callus on the left foot;" this was confirmed by the RN charge nurse during review of the record on 06/27/18. When asked what caused the callus on the resident's left foot, the RN charge nurse said, "Probably just from constant friction when he wheels himself

[propels the wheelchair]. He wears the gripper socks mostly."

- The next entry in the medical record that addressed the left foot wound was a wound care treatment note written by an RN on 03/11/18 at 12:52 p.m. The note documented the resident was using a low air loss [mattress] overlay in bed. The treatment notes also read, "Yesterday, resident had a dry, crusty, callused area on the medial side of the ball of his left foot near the base of his great toe with some blanchable redness around it. He complained of tenderness and received pain medication and moisturizer was applied to dry, reddened areas of both feet. Today, the callused area on the left foot is gone and there is an open wound measuring 3.2 cm [centimeters] x 2 cm in its place, with redness extending throughout the great toe and down the medial side of his foot to the base of his great toe. The wound was cleansed with normal saline and patted dry with gauze. Upon applying gentle pressure, serosanguineous drainage appeared and was swabbed for culture. The site and periwound tissue were then painted with betadine…a new pair of non-slip socks and prevalon boots were applied…on-call physician [name] has been apprised of the situation via the telephone and is placing the order for wound culture."
- The culture and sensitivity test report dated 03/13/18 showed MRSA in the left foot wound. The RN charge nurse said, "It looked like the wound had been draining and the nurse reported it to the provider and…[the medical provider] ordered the C/S [culture and sensitivity] [on 03/11/18]. I remember he [Resident #103] was complaining of pain in his [left] foot."
- A podiatry consult dated 03/21/18 documented the following related to the resident's left foot wound, "Ulceration to medial aspect of left hallux, states that he [Resident #103] has had the area for a while but relates that it has worsened over the last few weeks…states that it is painful, denies any other pedal complaints…edema: present to medial aspect of left hallux to periwound…ulceration noted to the medial aspect of the 1st MPJ [metatarsophalangeal joint], left foot. 100% moist fibrotic base with active serous drainage vs [versus] synovial joint fluid. Base well adhered. Patient relates pain when attempting to debride the area. Probes to capsule. Erythema noted to periwound. No edema noted. No malodor…Impression: ulceration to medial 1st met [metatarsal] head, left foot, PVD [peripheral vascular disease]…."
- A provider note dated 05/02/18 documented the wound on the left foot deteriorated with "worsening erythema and exudate" and the resident was referred to infectious disease for further evaluation.
- The infectious disease consult dated 05/03/18 documented the resident had a "nonhealing wound to the right medial aspect of hallux on left foot which has been present for some time now…[Resident #103] was seen by Podiatry in March [2018] and felt no surgical intervention was needed at that time due to his various disease processes. He has had multiple cultures (04/18[18], 3/23[18], 3/11[18]) all showing MRSA and has had multiple rounds of IV [intravenous] vancomycin. Initially the wound did improve but after stopping [vancomycin] and another culture growing MRSA, he has now been on vancomycin again for about 2 weeks with minimal improvement to the wound. Prior imaging studies showing erosions to the area which could be osteomyelitis or from gout and exposed bone was noted in wound care notes….chronic ischemic left foot wound infection with likely underlying osteomyelitis. Wound culture grew MRSA. The patient has been on vancomycin therapy since 04/18/18 with modest improvement and trend up of serum creatinine. Peripheral vascular disease…recommendations: discontinue Vancomycin, start Daptomycin 400 mg [milligrams] IV [intravenously] daily…continue wound care."
- The podiatry outpatient progress note dated 05/25/18 documented the resident was a "poor candidate for surgical intervention of the left foot wound" due to "poor vasculature."
- The most recent wound assessment/reassessment dated 06/19/18 documented the following: "…overall wound base is much cleaner and without a fibrinous film and there is less wound drainage since BlastX antimicrobial ointment was started, additionally the circumferential periwound blanching erythema is significantly less. Wound measurements have not changed from June 5th, 3.1 (l [length]) x 2.1 (w [width]) x 0.25 (d [depth]) cm: 0.5 cm undermining from approximately the 1-4 o'clock positions; + [positive for] visible bone; there is minimal yellow slough from approximately the 10-4 o'clock positions; hx [history] of probing to joint capsule; hx of MRSA wound c/s. Scanty nonodiferous drainage serous (most of staining on prior dressing was the BlastX ointment). No crepitus, no fluctuance…full-thickness left foot wound – not a pressure injury."

- Current provider orders included the following treatment orders:
    - "06/05/18 Nurse – Left Foot Wound: Cleanse with normal saline, blot dry with gauze. Apply 3M no-sting barrier to peri-wound skin. Apply BlastX ointment to wound base. Cover with a dry gauze followed by a folded abdominal [ABD] pad, secure skin with 3M silicone tape. Secure with Kerlex [Kerlix], followed by stretch net. Change dressing daily. BlastX ointment has been left in the Veteran's room in the lock box."
- On 06/27/18 at approximately 2:00 p.m. during record review with the chief nurse executive (CNE) and the quality management staff member present, additional clinical records (e.g. nursing assistant notes, wound care notes, nursing progress notes) documented between the time the resident was initially referred to the provider on 03/02/18 until the documented assessment of the resident's left foot wound on 03/11/18 were reviewed with the staff. Although the clinical record showed documentation of wound care provided to the resident (i.e., sacral wound care, care for skin tears), records reviewed did not include assessment of the medial aspect of the left hallux until 03/11/18. On 03/11/18, the medial aspect of the left hallux wound was described as an open wound measuring 3.2 cm in length and 2.0 cm in width, with redness extending throughout the great toe down to the medial side of the foot to the base of the great toe; the wound was documented with serosanguineous drainage that was swabbed for a culture and tested positive for MRSA.
- During the status meeting on 06/27/18 beginning at 3:00 p.m., the lack of a comprehensive skin assessment following the referral of Resident #103 to the provider on 03/02/18 for evaluation of the callus area on the left hallux, which according to the medical note on 03/02/18, may have been draining the day prior to the provider examining the resident was discussed with staff. On 06/28/18 at approximately 8:40 a.m., the CLC medical director stated the medical director reviewed the resident's clinical record and spoke with the provider who evaluated the resident on 03/02/18. The CLC medical director stated that the provider indicated the resident's primary complaint on 03/02/18 was anxiety and shortness of breath. The CLC medical director said, "He [Resident #103] immediately zoned in on his anxiety and shortness of breath and the provider did not look at the resident's foot. He [the resident] told [name of provider] not to bother with his foot because his primary concern was his shortness of breath." The CLC medical director also commented that once nursing staff identified the open area on the resident's left foot on 03/11/18, the resident was referred to the provider and the associate chief nurse for wound care and research and "aggressive treatment had been implemented including repeated cultures, antibiotic therapy, podiatry and infectious disease consultations."
- In summary, during wound care on 06/27/18, Resident #103's wound on the medial left great toe was observed. The associate chief nurse for wound care and research described the wound bed on the medial left great toe as "clean without recurrence of fibrin film, but with minimal yellow slough on the peripheral sidewalls." The associate chief nurse for wound care and research said, "You can see where the bone is visible. The periwound skin is intact with faintly pink coloration that is blanching." When asked about the etiology of the wound, the associate chief nurse for wound care and research said, "I started getting involved in March [2018]. The wound was not pressure related, but it tested positive for MRSA. He [Resident #103] was treated with the vancomycin [antibiotic]…The wound was initially healing, but at some point, he [Resident #103] started complaining of pain in the foot and the wound was not showing progress so he was referred to ID [infectious disease]. The vancomycin was changed to daptomycin because of suspicion of osteomyelitis. On 03/02/18, the resident was referred to the provider for evaluation of a callus on the resident's left foot. The extended care CLC medical note dated 03/02/18 read, "Asked to evaluate patient [Resident #103] due to area of callus on the left foot earlier this morning. Reports that the area yesterday may have been draining. Patient is also noted to have been having increasing anxiety. No fever or chills…." There was no subsequent note written by the provider documenting a comprehensive assessment, interventions or plan of care related to the "area of callus on the left foot;" this was confirmed by the RN charge nurse during review of the medical record on 06/27/18. Although the clinical record showed documentation of wound care provided for the resident (i.e., sacral wound care, care for skin tears), records reviewed did not include an assessment of the medial aspect of the left hallux until 03/11/18. On 03/11/18, the medial aspect of the left hallux wound was described as an open wound measuring 3.2 cm in length and 2.0 cm in width, with redness extending throughout the great toe down to the medial side of the foot to the base of the great toe; the wound had serosanguineous drainage, which when swabbed for culture tested positive for MRSA. The resident's care plan was not updated to include approaches related to the left foot wound until 03/22/18. The resident's right foot was observed on 06/27/18 with clinical indications of tinea pedis. The RN charge nurse and

the associate chief nurse for wound care and research indicated they had not been informed previously of the changes in the resident's right foot. A provider order was written on 06/27/18 for use of an antifungal cream to the resident's right foot.

F314

483.25(c) *Pressure Sores. Based on the comprehensive Assessment of a resident, the facility must ensure that (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure that residents who entered the CLC without pressure ulcers did not develop pressure ulcers unless they were unavoidable. Findings include:

Resident #103

- Resident #103 was admitted to the CLC on [DATE] with diagnoses that included "restless legs, peripheral neuropathy, peripheral nerve disease, atrial fibrillation…arthralgia, and coronary arteriosclerosis."
- The resident's admission MDS assessment dated [DATE] documented the resident scored 15 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition; the resident required limited assistance with most activities of daily living including bed mobility, transfers, ambulation, and toileting; and had no functional limitations in range of motion in the upper or lower extremities. Section M (Skin Conditions) of the admission MDS documented the resident was at risk of developing pressure ulcers and did not have pressure ulcers; skin and ulcer treatments coded on the MDS included a pressure reducing device in bed, a turning and repositioning program and application of nonsurgical dressings other than to the feet. The resident's quarterly MDS assessment dated 05/18/18 documented the resident had modified independence with cognitive skills for daily decision making based on staff assessment; the resident required limited assistance with most activities of daily living including bed mobility, transfers, locomotion on and off the neighborhood, and toileting and the resident had functional limitations in range of motion in the lower extremities. Section M of the quarterly MDS documented the resident was at risk of developing pressure ulcers, did not have pressure ulcers but had other lesions on the foot, and skin and ulcer treatments included pressure reducing devices in the bed and chair, applications of dressings to the feet and application of nonsurgical dressings other than to the feet.
- A statement in the CLC interdisciplinary care plan dated 01/18/18 and reviewed on 05/22/18 stated the resident had a "low pressure injury risk per [pursuant to] my [Resident #103's] Braden scale score." The care plan approaches included but were not limited to the following:
    - "Provide general skin care at routine intervals by approved skin care cleanser and minimize force and friction."
    - "Avoid or minimize dryness of skin by using moisturizer to dry skin avoiding between toes."
    - "Minimize exposure to cold."
    - "Keep linen clean, dry, and wrinkle free."
    - "Use friction and shearing strategies. Use draw sheet and assist/turn every 2 hours and PRN."
    - "Float heels off mattress with pillow."
    - The care plan did not address prevention of friction or pressure between the resident's toes.
- Provider's orders included the following:
    - "06/25/18 Charge Nurse – left foot – 2nd toe: cleanse with normal saline, blot dry with gauze. Apply a small piece of Mepilex Ag and secure with silicone tape. Apply a piece of Copa foam between 1st and 2nd toe. Change dressing daily to Nurse: left foot – 2nd toe: Cleanse with normal saline, blot dry with gauze. Apply BlastX to wound, cover with a small piece of plain Mepilex and secure with silicone tape. Apply a piece of Copa Foam between 1st and 2nd toe. Change dressing daily and more often if leaking."
- During record review on 06/27/18 beginning at 10:10 a.m., the RN charge nurse said, "They [staff] did the Braden on 02/27/18 and it showed score of 19 [no risk]." The Braden scale score dated 04/29/18 was 16 suggesting the resident was at mild risk for pressure ulcer development. The 04/29/18 note documented the resident had an "abrasion/laceration on the left hallux [and] wound measures 2.5 cm [centimeters] in length, 1.5 cm in width and 0.1 cm in depth; and wound has yellow slough covering it." The pressure ulcer protocol included but was not limited to use of a specialty bed, frequent position changes, elevate heels using pillows or foam blocks, and encourage

activity as tolerated.

- The most recent Braden Scale for Predicting Pressure Ulcer Risk score documented in the nursing weekly summary dated 06/19/18 was 17 suggesting the resident was at mild risk for pressure ulcer development. Risk factors included slightly limited sensory perception, chairfast, slightly limited mobility and potential problem with friction. Under "skin problems" the following was noted: "left great hallux [toe] foot wound has pinkish/red tissue in wound bed and there has been no change in previous interventions…."
- The extended care monthly provider's note dated 06/22/18 read, "New ulcer that has developed between his [Resident #103's] great toe and his 2nd toes on the same foot that is painful to touch and erythematous." The provider notes also indicated the new area was "most likely from pressure of hallux overlapping the 2nd toe."
- On 06/27/18 at approximately 8:00 a.m. the surveyor, with the resident's consent, observed the RN charge nurse (who was interviewed on 06/26/18) and the associate chief nurse of wound care and research provide wound care for Resident #103. The resident was observed lying supine in bed at the beginning of the observation; there was a pressure redistribution device (Synergy® Air Elite low air loss mattress) on the resident's bed. The resident's left foot was not covered and the wound on the medial left great toe was observed (the dressing was removed prior to the surveyor's observation at the resident's bedside). The left second toe was covered with a dressing and a Copa™ foam dressing was observed between the left great toe and the left second toe. Further observation of the resident's left foot determined the resident had flexion of the toes (toes bent or curled downward) of the left foot and the left great toe (hallux) was overlying the second toe, causing constant contact between the great toe and the second toe. There was no padding or dressing to prevent contact between the toes of the left foot other than the Copa foam between the great toe and second toe. The associate chief nurse for wound care and research said, "Unfortunately this was a facility [CLC] acquired unstageable pressure ulcer. As you can see, there is crossing of the [left] hallux on the second toe and the wound is caused by the pressure of the left hallux over the second toe. The nurse [LPN] identified the wound last Friday [06/22/18] and I assessed the wound on the same day. We take pride in having very low percentage of facility acquired pressure ulcers, so when I reported on Monday that the wound was pressure related, they [CLC and VAMC leadership staff] were very disappointed." It was noted that following removal of the visibly soiled dressing on the left second toe, the RN charge nurse had to "separate" the left hallux from the second toe so that the associate chief nurse for wound care and research could visualize the wound bed. The associate chief nurse for wound care and research described the wound bed on the left second toe as "an area of thin cream-colored slough over wound base." As the associate chief nurse for wound care and research cleansed the wound bed using normal saline and gauze, she stated, "The slough is starting to lift medially. The [soiled] dressing only had a drop of scant non-odiferous serous drainage. Periwound skin has very mild erythema with brisk blanch response." Following application of the wound treatment and placement of the Copa foam between the left great toe and the second toe, the associate chief nurse for wound care and research said, "Let's put Copa foam in between the other toes, too, for prevention. I will ask podiatry if they can recommend alternatives to the Copa foam since he has restless leg syndrome and the Copa foam may not stay in place. He [Resident #103] told me his restless leg is worst at night."
- Following the wound care observation on 06/27/18, the resident's clinical records was reviewed with the same RN charge nurse and the quality management staff on 06/27/18 beginning at 10:10 a.m. The following information was obtained during record review and follow-up interview with the RN charge nurse:
    - The wound care treatment note completed by the LPN on 06/22/18 at 11:39 a.m. documented the resident was "noted to have an approximately 1/2 cm in diameter lesion on top of 2nd digit to left foot. Great toe noted to overlay 2nd digit. Area was cleansed with normal saline and patted dry. [Associate chief nurse for wound care and research] notified of above findings. Recommended to applied [apply] hydrophilic foam pad between toes. Will follow recommendation. Will also notify wound care/RN/providers via this noted [note]."
    - The wound assessment/reassessment note completed by the associate chief nurse for wound care and research on 06/22/18 at 5:01 p.m. read, "Alerted by Provider and nursing staff of an area of skin breakdown on the left foot, 2nd toe (there is a crossing of the hallux on to the 2nd toe). 2nd toe 0.4 x 0.3 cm area of skin breakdown, base is whitish/cream colored and surrounding skin has mild erythema with blanching, only 1 drop of serous drainage. Veteran denies pain in this area, no edema, no significant warmth. Area cleansed with normal saline, blotted dry with gauze, small piece of Mepilex Ag applied and secured with

silicone tape. A piece of Copa Foam was placed between the toes."
    - The wound assessment/reassessment note completed by the associate chief nurse for wound care and research on 06/25/18 documented the following about the resident's wounds: "left foot, 2nd toe: area of thin cream colored slough over wound base (measurements and digital image were entered in my note on June 22nd), very scant non-odiferous serous drainage, periwound skin slight pinkish coloration, + [positive for] blanching, no verbalization of pain upon palpation, no edema, normothermic… Left foot – 2nd toe – facility acquired unstageable pressure injury caused by hallux (1st toe) anatomically crossing over on to the 2nd toe. Plan: will begin to use BlastX and a small piece of Mepilex Plain Non-bordered dressing. Continue use of Copa Foam placed between the hallux and 2nd toe to prevent further pressure to area."
- During review of the resident's clinical record, the RN charge nurse was about preventive measures implemented to relieve pressure caused by the left great toe overlying the left second toe prior to identification of the pressure ulcer on 06/22/18. The RN charge nurse said, "I thought they [direct-care staff] had been putting dry gauze in between his [Resident #103's] toes, but I could not find any notes that speak to the use of the dry gauze. The way that the left hallux was overlying the second toe, I didn't think the migration [overlapping of 2nd toe] of the left hallux was as prominent as I had seen it today. I'm wondering too when the great toe started migrating." At the request of the surveyor, the RN charge nurse reviewed the photographic wound documentation in the computerized patient record system (CPRS). The RN charge nurse said, "The second toe starts to come under [the left hallux] on the 03/20/18 Vista imaging [photographic wound documentation]. The other images do not capture images of the left hallux and the second toe. The migration of the left hallux is very prominent on the 06/19/18 Vista imaging. You can really see where the left hallux crosses over the second toe." When asked if the resident had been assessed for risk of developing a pressure ulcer over the second toe as a result overlapping of the left hallux, the RN charge nurse said, "They did the Braden on 06/19/18 but the nurse did not identify the risk for pressure ulcer development [on the second toe]." When asked if there was documentation of preventive measures in place such as padding between the toes on the left foot prior to 06/22/18, the RN charge nurse said, "I did not find anything."
- In summary, during a wound care observation on 06/27/18 at approximately 8:00 a.m., Resident #103's left second toe was covered with a dressing and a Copa™ foam dressing (recommended on 06/22/18 and ordered on 06/26/18) was observed between the left great toe and the left second toe. Further observation of the resident's left foot determined the resident had flexion of the toes (toes bent or curled downward) of the left foot and the left great toe (hallux) was overlying the second toe. A Braden Scale was completed on 06/19/18 and the CLC did not identify the risk of pressure ulcer development that could be caused by the constant contact between the great toe and the second toe. Review of the 06/19/18 photographic wound documentation regarding the left foot with the RN charge nurse determined the resident's left great toe was prominently overlying the second toe on 06/19/18. The associate chief nurse for wound care and research reported the resident developed the unstageable pressure ulcer on the left second toe on 06/22/18 and the wound was caused by the pressure of the left great toe overlying the second toe. The extended care monthly provider's note dated 06/22/18 read, "New ulcer that has developed between his [Resident #103's] great toe and his 2nd toe on the same foot that is painful to touch and erythematous." The provider notes also indicated the new area was "most likely from pressure of hallux overlapping the 2nd toe." Interview with the RN charge nurse during the survey confirmed the CLC did not implement pressure ulcer preventive measures and develop a care plan related to the left great toe overlying the left second toe.

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

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

Based on observation, interview and record review, the CLC did not provide supervision to prevent accidents. Findings include:

Resident #204

- Resident #204 was admitted to the [LOCATION] neighborhood on [DATE] with diagnoses that included heart attack, stroke, cerebral edema, pulmonary embolus, depression, anxiety, and "periods of agitation experienced in the hospital prior to admission;" documentation indicated the resident used tobacco. An MDS assessment had not been completed based on the resident's recent admission date.
- The resident's (interim) care plan dated [DATE] did not address smoking safety. The

Residents Affected - Few

[DATE] initial nursing admission assessment completed by a registered nurse (RN) at 10:38 a.m. indicated the resident was determined to be independent when smoking. A 06/20/18 psychology individual therapy note stated, “Tobacco use disorder,” with an addendum dated 06/25/18 at 10:13 a.m. that indicated, “resumed smoking [following admission].”

- On 06/26/18 at 10:15 a.m., the [LOCATION] charge nurse was interviewed while a quality manager was present. The charge nurse indicated that Resident #204 was “confused at times,” had “left-sided weakness,” and required “supervision” while smoking. It was reported that “last night (06/26/18) he [Resident #204] was aggressive, called out” and nursing staff “called a BERT [behavior emergency response team] for assistance since he [the resident] was a threat to himself and others and he [the resident] received Haldol [antipsychotic].” On 06/26/18 at 11:50 a.m., the door to the resident’s room was open to the hallway and the resident was lying in bed; staff reported the resident was sleeping after receiving the Haldol medication during the night. At 1:30 p.m., the resident was observed lying in bed and continued to sleep.
- On 06/26/18 at approximately 1:35 p.m., the CLC medical director was interviewed and indicated the resident had a “severe delirium” episode during the early morning hours of 06/26/18.
- A 06/26/18 nursing note written at 2:36 a.m. stated, “Pt. [patient] up out of bed confused…agitated…found sitting at foot of bed. Asked pt. to turn [put] out cig [cigarette] and pt. became more agitated. This nurse removed cig from pts. hand and turned [put] out cig and pt. became verbally abusive to staff. Attempted to redirect and speak in a soft voice and offered pt. to be taken to smoking porch but pt. was insisting he was not in the hospital…very agitated…code BERT (behavior emergency response team) called. Took pt. [to] smoke porch with 2 staff members [with resident] in wheelchair due to very unsteady gate and multiple falls…prn [as needed] Haldol given with good effect.” It was indicated the resident had not been found smoking in the CLC prior to the observation by staff on 06/26/18.
- A 06/26/18 nursing note written by an RN at 7:30 a.m. stated, “Does resident smoke? Yes. **Note: when answer selected for any question marked with (*) you may stop assessment and indicate resident deemed at-risk and unsafe to smoke. Can resident independently light cigarette without dropping it? Yes. Oriented to person, place, and time? No*. Burn marks? No. Is resident able to consistently find their [way] back to and from the smoking area without cuing [cueing] or assistance? No*. Medically stable to smoke? No*” The note further indicated, “Resident’s cognitive baseline has changed since admission per night shift’s report and charting. Resident is not safe to smoke alone and will need staff supervision to smoke. Night shift staff have taken resident’s cigarettes and lighter and placed at nurse’s station for safety. Staff will accompany resident outside and remain with the resident during this time.”
- On 06/26/18 at 2:40 p.m., Resident #204 was observed seated in the outdoor smoking patio located near the [LOCATION] neighborhood; there was no staff observed in the area. The resident was seated on a patio chair and was smoking a cigarette. The resident was interviewed while holding a lighter in the left hand and a cigarette in the right hand; the resident had a pack of opened cigarettes in his VA provided pajama jacket. The resident stated, “I had a rough night…slept in, trying to wake up.” The resident stated he recently started to smoke again after quitting and indicated smoking “calms me down.” During the interview, no observations were made of unsafe smoking practices. After approximately five minutes, an unidentified CLC staff person came to the patio, and lit and smoked a cigarette. When asked if the staff member was there to “supervise” Resident #204, the staff member stated, “No. I am taking a break. I don’t know this Veteran.”
- A nursing note dated 06/26/18 at 3:00 p.m. (after the observation at 2:40 p.m. was shared with staff) stated, “Reason for assessment: Change in physical, cognitive [status]. Resident has cognitively returned to baseline…was supervised going outside to smoke and demonstrated adequate ability to smoke safely and return to his room without difficulty…will continue and keep cigarette and lighter at nurse’s station.” Although the resident was not observed being supervised by staff at 2:40 p.m., the note suggested supervision was provided after staff was informed about the concern.
- A 06/26/18 psychiatric consultation report written at 4:20 p.m. read, “Attempted to see Veteran earlier in the day, but he was not in his room…outside smoking….Veteran tells me he is confused….” The note further indicated, “Dx [diagnoses]: 1. Acute confusional state, probable delirium. Mild neurocognitive disorder….”
- A provider’s order dated 06/26/18 stated, “Haloperidol 5 mg [milligrams], po [orally], q6 [very 6] hours, prn [as needed] for agitation.”
- On 06/28/18 at approximately 7:20 a.m., the night shift RN and LPN were interviewed and indicated that Resident #204 had not slept most of the night and experienced a fall during the night sustaining an abrasion to the right lower arm. The RN indicated the resident had a recent stroke and visual limitations that resulted in a visual deficit where the resident was unable to see clearly out of his left eye; the resident reported “running into the wall” which caused him to fall during the night. The RN was asked if the

resident went to smoke during the night and she stated, “Yes, once and staff went with him….We told him he has to use a wheelchair when he goes out to smoke since he’s had so many falls.” The RN stated the resident’s cigarettes and lighter were kept at the nursing station. When asked if a care plan had been developed to indicate the resident required safety measures during smoking, the RN acknowledged that a care plan had not been developed.

- On 06/28/18 at approximately 7:45 a.m., a quality manager provided a copy of an updated care plan that stated, “Category: Safety. Problem: Resident is a smoker and is at risk for clothing/skin burns and/or non-adherence to facility smoking policy.” The care plan was initiated on 06/28/18 at 7:26 a.m. and included the following approaches, “Provide a smoking apron and encourage use. Observe for non-adherence to policy and report. Monitor for difficulty storing or maintaining cigarettes/lighter and report. Develop a schedule for smoking with the resident and promote adherence. Accompany the resident at smoking times. Notify physician if decline in smoking ability is noted.”
- During observations on 06/28/18 at approximately 8:30 a.m., Resident #204 was observed in a wheelchair smoking in the outdoor smoking patio with other residents. A staff person was sitting on a patio chair approximately 6 feet away from the resident. The resident was not observed wearing a smoking apron.
- In summary, according to a nursing note dated 06/26/18 at 2:36 a.m., the resident was observed by staff smoking in his room. It was indicated the resident had not been found smoking in the CLC prior to the observation by staff on 06/26/18. A 06/26/18 nursing note written by an RN at 7:30 a.m. stated, “Resident’s cognitive baseline has changed since admission per night shift’s report and charting. Resident is not safe to smoke alone and will need staff supervision to smoke. Night shift staff have taken resident’s cigarettes and lighter and placed at nurse’s station for safety. Staff will accompany resident outside and remain with the resident during this time.” On 06/26/18 at 2:40 p.m., Resident #204 was observed smoking a cigarette while seated in the outdoor smoking patio located near the [LOCATION] neighborhood; there was no staff observed in the area. The resident was holding a lighter in the left hand and a cigarette in the right hand, and had a pack of opened cigarettes in his VA provided pajama jacket. Following discussions with staff on 06/28/18 at 7:20 a.m. about a care plan to indicate the resident required safety measures during smoking, a quality manager provided a copy of an updated care plan that was initiated on 06/28/18 at 7:26 a.m. and stated, “Category: Safety. Problem: Resident is a smoker and is at risk for clothing/skin burns and/or non-adherence to facility smoking policy.” The care plan included the following approaches, “Provide a smoking apron and encourage use. Observe for non-adherence to policy and report. Monitor for difficulty storing or maintaining cigarettes/lighter and report. Develop a schedule for smoking with the resident and promote adherence. Accompany the resident at smoking times….” During observations on 06/28/18 at approximately 8:30 a.m., Resident #204 was observed in a wheelchair smoking in the outdoor smoking patio with other residents; the resident was not wearing a smoking apron. A staff person was sitting on a patio chair approximately 6 feet away from the resident.