# Department of Veterans Affairs Community Living Center Survey Report

This document or report and the information contained herein, which resulted from the Community Living Center Unannounced Survey, has been de-identified to remove individually identifiable health information (also known as protected health information) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule and other federal and state laws. De-Identification was completed in accordance with guidance published by the Office for Civil Rights to protect the privacy of the Community Living Center's residents.

**General Information:**

Location: Central Texas Veterans Health Care System - Waco VA Medical Center (Waco, TX)

Dates of Survey: 6/19/2019 to 6/21/2019

Total Available Beds: 94

Census on First Day of Survey: 79

| F-Tag | Findings |
|---|---|
| F311<br><br>483.25(a)(2) *A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section;*<br><br>**Level of Harm** - Actual harm that is not immediate jeopardy<br><br>**Residents Affected** - Few | Based on observation, interview and record review, the CLC did not ensure a resident was given the appropriate treatment and services to maintain or improve the resident's ability to ambulate. Findings include:<br><br>On 06/20/19 quality management staff provided the CLC's policy titled, Department of Veterans Affairs Central Texas Veterans Health Care System (CTVHCS) Austin-Temple-Waco Community-Based Outpatient Clinics (CBOCs) Memorandum 117-007 titled, "PHYSICAL MEDICINE & REHABILITATION SERVICE (PM&RS) FITNESS REHABILITATION PROGRAM," and dated 05/05/16. The policy indicated, "PM&RS KT [kinesiotherapy] Therapy Staff will incorporate the most current medical and rehabilitative knowledge and technology in patient care management with the ultimate goal of enhancing functional status and quality of life by maximizing each patient's physical fitness level including strength, endurance, flexibility, coordination, and mobility….d. A comprehensive assessment will be completed on all patients enrolled in the PM&RS Fitness Program. This assessment will include a brief medical and family history including activity level, cognitive functioning, diagnoses, precautions, range of motion, strength, endurance, and mobility."<br><br>On 06/20/19 the nurse manager of [LOCATION] provided the Department of Veterans Affairs Central Texas Veterans Health Care System Austin-Temple-Waco Memorandum 002-006 titled, "COMMUNITY LIVING CENTER (CLC) RESTORATIVE CARE PROGRAM," and dated 06/22/15. Under the section titled policy the document read, "Geriatrics and Extended Care Services (GEC) in collaboration with Physical Medicine and Rehabilitation will provide services to facilitate and maintain resident's mobility, enhance and sustain function….All treatment and care provided is based on the comprehensive assessment of the resident ensuring that they receive treatment and care to honor their choices, preferences, goals, concerns and needs." The restorative care program guidelines indicated, "Walking: activity to improve or maintain self-performance in walking with or without assistive device....restorative care is less intensive than rehabilitative care and is coordinated by nursing service. Restorative care nursing programs can also be initiated when a resident is discharged from Physical Medicine and Rehabilitation Service as a coordination between PM&RS and nursing service."<br><br>Resident #204, [LOCATION]<br>• According to documentation reviewed, Resident #204 was admitted to the CLC on [DATE]; the resident's diagnoses include psychosis, Parkinson's disease, Alzheimer's dementia, abnormal gait and muscle wasting.<br>• The resident's comprehensive Minimum Data Set (MDS) assessment dated 02/05/19 was coded to indicate the resident had a Brief Interview for Mental Status (BIMS) score of 6 suggesting severely impaired cognition; the resident had physical behavioral symptoms directed toward others and rejected care 1- 3 days during the assessment period. According to the MDS, the resident required limited assistance with all activities of daily living [ADLs] including walking; balance during walking was coded as not steady, but able to stabilize with staff assistance; no mobility devices were coded on |

the MDS. A quarterly MDS dated 04/29/19 was coded to indicate the resident had short term memory problems based on staff assessment; a BIMS was not completed. According to the quarterly MDS, the resident had physical behavioral symptoms directed toward others 4-6 days during the assessment period and rejected care 1-3 days during the assessment period; the resident required limited assistance for bed mobility and supervision during walking. Balance during walking was coded as not steady, but able to stabilize without staff assistance. The comprehensive and quarterly MDS assessments did not indicate the resident received physical or occupational therapy or participated in restorative nursing programs.

- The resident's plan of care dated 02/13/19 included a statement addressing ADL functional/rehabilitation potential with the following approaches: "I would like staff to give me choices and simple, one-step directions. Remind, redirect, make eye contact, use comforting words and touch, and try negotiating or offering rewards for tasks completed. Watch for negative behaviors, when I'm manageable try back later." An additional care plan dated 02/19/19 addressed falls with the following approach, "Encourage resident to be as active as possible." The care plan did not include approaches to maintain the resident's ability to ambulate (e.g., a restorative walking program, kinesiotherapy, specialized rehabilitation).
- During the initial tour on 06/19/19 at 10:00 a.m., a registered nurse (RN) stated Resident #204 received "one to one for safety; [the resident] can be assaultive…. He [Resident #204] has dementia, Parkinson's and schizophrenia. He is fed [by staff], total care with some ADLs."
- During an interview on 06/20/19 at 12:45 p.m., the kinesiotherapist indicated, "Physical therapy (PT) is not available in Waco at this time. PT will come back in July [2019] but only for skilled rehab [rehabilitation]….We don't do strengthening and maintenance, that is for restorative care [to perform]." During a follow-up interview on 06/21/19 at 8:40 a.m., the kinesiotherapist stated, "The consult for [Resident #204] was declined in April because he wasn't [in need of] skilled rehab anymore....When he finished KT last time he no longer had a skilled need and we only provide skilled rehab services….He also has notes about him being combative….he has dementia."
- A PM&RS KT initial assessment consult dated 02/07/19 indicated the resident was assessed for strength, balance, range of motion (ROM), and mobility. The note indicated, "[Resident #204] with Parkinson's disease with recurrent falls. Please evaluate for gait/balance training and adaptive equipment...Required constant cuing to move upper and lower extremities even at times needing active assistance in ROM to bilateral upper and lower extremities but eventually completing ROM independently….Treatment plan: 1. Transfer training 2. Gait training 3. Therapeutic exercises for strengthening."
- A PM&RS KT reassessment note dated 03/18/19 indicated, "Discharge Planning: Veteran will be discharged from KT in 1 week as he has reached all goals set." Short term goals in the note stated, "Able to tolerate 3 sessions KT on a weekly basis without complications….resident will be able to stand and complete standing and functional transfers requiring only minimal assistance." Long term goals in the note stated, "Resident will be able to ambulate in parallel bars for at least 60 ft [feet]. Requiring moderate assistance before needing to sit and rest. Resident will be able to ambulate for at least 50 ft using least restrictive mobility and requiring moderate assist [assistance]. Resident has been able to ambulate for > [greater than] 150 ft without the use of mobility aid but does require standby to CGA [contact guard assistance]." The kinesiotherapist who wrote the 03/18/19 note left employment between 03/18/19 and 04/16/19.
- A KT consult written on 04/16/19 stated, "Gait balance training….Resident with Parkinson's has declined since discharge from KT….Please resume gait/balance training KT asap [as soon as possible]."
- A PM&RS electronic consult results note dated 04/16/19 indicated, "No contact with the patient [resident] has been performed. Findings: Veteran [resident] was seen in KT therapy from Feb [February] to March [2019] with no progress being made….Resident was discharged from KT. Recommendation: Resident is not indicated for KT rehab therapy."
- A restorative care nursing assessment dated 05/03/19 indicated, "Quarterly – Previous assessment remains unchanged, resident requires assistance with ADL's and is currently on 1:1 [one-to-one] for safety – frequent falls from unsteady gait….per chart review resident has had several documented episodes of assaultive behavior towards staff. At this time resident is not a candidate for restorative care."
- An additional consult was requested during an interdisciplinary meeting on 06/11/19 due to the resident falling; the PM&RS KT general note stated, "Resident [#204] has a hx [history] of falls and hx of being combative. Resident is alert….Due to resident's cognitive state he is unable to safely use a mobility device....He should continue to require stand by assist [assistance] during ambulation for the remainder of his time in the Waco CLC due to safety concerns. There is nothing to offer resident from KT, no skilled therapy is required and resident will continue with restorative nursing and

1:1 safety." (As confirmed during interview with the restorative care RN on 06/20/19 at 2:15 p.m., Resident #204 had not been enrolled in a restorative nursing program since admission to the CLC.)

- Nursing notes regarding Resident #204's ambulation indicated the following:
  - 04/18/19 – "The resident is ambulatory [assisted to ambulate] regularly with assistance and is assisted to sit down intermittently to prevent falls when his gait becomes unsteady."
  - 05/30/19 – "Resident ambulated on unit [neighborhood] several times this tour with a steady gait."
  - 06/14/19 and 06/15/19 – "He [Resident #204] was unable to walk, gait unsteady."
  - 06/16/19 – "Remains on 1:1 staffing for safety…moving about in w/c [wheelchair] with staff. He does attempt to stand up but is unsteady, leaning back."
- On 06/19/19, the resident's spouse requested to speak with a surveyor and stated, "[Resident #204] has declined in his ability to walk. He needs some kind of therapy; we came into Waco to strengthen [the resident's functional abilities] and he did [when he was receiving therapy] and now it has gotten worse…since April….I've talked to staff, and I'm told he [Resident #204] is not a candidate for therapy, but he did it before with the guys [former KT staff member] and it helped."
- Resident #204 was not observed to walk during the survey and was observed each day in a wheelchair. During a brief interview on 06/21/19 at 10:00 a.m. with the 1:1 NA assisting Resident #204, the NA stated, "He hasn't been walking. Today we needed two staff to assist in walking, he is weak. He had three teeth extracted the other day [06/19/19]."
- During an interview on 06/20/19 at 2:15 p.m., the restorative care RN stated, "If a resident's gait is unsteady or safety issue is a concern, we don't work with them. Gait training is a PT [physical therapy] function….[Resident #204] is not on restorative care. We have done quarterly assessments and watched him walk."
- During an interview on 06/20/19, an RN indicated, "He [Resident #204] is walking less now because of his gait, it's unsteady. I sent him down to KT this month – they couldn't work with him although they worked with him in the past when [a former KT staff member] was here."
- During interviews on 06/21/19 at 8:30 a.m. with nursing assistants (NA) who routinely provided care for Resident #204, one NA stated, "He [Resident #204] walks [with staff] quite often, he is a little wobbly. His ability decreased a little since KT....He has not been combative when walking with me." Another NA stated, "He can be fairly safe when walking. He has never hurt me when walking." A third NA indicated, "He gets ROM [range of motion] like everyone else, but he is capable of more."
- In summary, a PM&RS KT reassessment note dated 03/18/19 indicated, "…Veteran will be discharged from KT in 1 week as he has reached all goals set." Short term goals in the note stated, "Able to tolerate 3 sessions KT on a weekly basis without complications….resident will be able to stand and complete standing and functional transfers requiring only minimal assistance." Long term goals in the note stated, "….Resident has been able to ambulate for > [greater than] 150 ft without the use of mobility aid but does require standby to CGA [contact guard assistance]." The kinesiotherapist who wrote the 03/18/19 note left employment between 03/18/19 and 04/16/19. The resident was not provided restorative nursing care to maintain his ability to ambulate following discontinuation of KT services. Additional consults were placed for KT on 04/16/19 and 06/11/19; however, no reassessments were conducted and KT and restorative nursing were not provided. On 06/19/19, the resident's spouse requested to speak with a surveyor and stated, "[Resident #204] has declined in his ability to walk. He needs some kind of therapy; we came into Waco to strengthen [the resident's functional abilities] and he did [when he was receiving therapy] and now it has gotten worse…since April….I've talked to staff, and I'm told he [Resident #204] is not a candidate for therapy, but he did it before with the guys [former KT staff member] and it helped." The resident was not observed to ambulate during the survey. During interviews on 06/21/19 at 8:30 a.m. with nursing assistants (NA) who routinely provided care for Resident #204, one NA stated, "He [Resident #204] walks [with staff] quite often, he is a little wobbly. His ability decreased a little since KT...." Another NA indicated, "He gets ROM [range of motion] like everyone else, but he is capable of more."

---

F329

483.25(l)(1) *Unnecessary Drugs. General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug*

Based on observation, interview and record review, the CLC did not ensure a resident's drug regimen was free of unnecessary drugs. Findings include:

Resident #103, [LOCATION]

- Resident #103 was admitted to the CLC on [DATE]. According to the [DATE] history

*when used: (i) In excessive dose (including duplicate therapy); or (ii) For excessive duration; or (iii) Without adequate monitoring; or (iv) Without adequate indications for its use; or (v) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or (vi) Any combinations of the reasons above.*

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

**Residents Affected** - Few

and physical note the resident's diagnoses included "age-related physical disability," pain, dementia, depression, and hepatic encephalopathy.

- Resident #103's comprehensive MDS assessment dated 04/18/18 indicated the resident had clear speech that was understood, and the resident could understand others; the resident scored 12 on the Brief Interview for Mental Status (BIMS) suggesting moderately impaired cognition. According to the MDS, the resident was not assessed as having any indicators of delirium, depression or potential indicators of psychosis such as hallucinations or delusions; the resident was independent with all activities of daily living (ADLs), except dressing for which the resident required supervision and set up assistance and bathing for which the resident required limited assistance of one staff member. The MDS documented the resident had non-Alzheimer's dementia and received no psychoactive medications. The MDS dated 04/18/18 did not indicate the resident experienced behavioral symptoms of potential distress.
- The resident's most recent quarterly MDS assessment dated 06/05/19 was coded to indicate the resident had clear speech that was understood and the resident understood others; the resident's cognitive skills for daily decision making were independent based on staff assessment; no delirium was coded. According to the quarterly MDS, the resident did not have potential indicators of psychosis including hallucinations or delirium. The quarterly MDS indicated the resident was independent with all activities of daily living except bathing, for which the resident required supervision and set up assistance. The MDS documented the resident had non-Alzheimer's dementia, depression, schizophrenia, and posttraumatic stress disorder (PTSD). The MDS dated 06/05/19 did not indicate the resident had any behavioral symptoms.
- The MDS was coded to indicate the resident received antipsychotic and antidepressant medications.
- The resident's care plan included a statement dated 05/18/19 that read, "I have been diagnosed with schizoaffective disorder, PTSD, and depression. I receive risperidone for my mental disorder and sertraline to help with my mood/depression." The goal was identified as, "I want to be free from side effects of my psychotropic medications daily. I will feel better measured by: engaged in activities/socializing/stating I feel better." The approaches dated 05/18/19 read, "MD [medical doctor] examine, order antidepressant or antipsychotic medications, licensed staff to administer. MD, NSG [nursing], and RPh [registered pharmacist] monitor effectiveness and side effects of medications by monthly assessment and report to provider if they occur. Provide education to resident/family about condition, treatment and symptoms to report." The care plan did not describe the behavioral symptoms of potential distress that the resident exhibited or staff approaches to ease the behavioral symptoms.
- Resident #103 had current provider orders dated 06/11/19 for the following psychoactive medications: sertraline 50 milligrams (mg) at bedtime for depression, risperidone (antipsychotic medication) 1.0 mg at bedtime for schizoaffective disorder, and prazosin 1.0 mg at bedtime for nightmares.
- Resident #103's medical record included the following pertinent notes:
    - On 01/19/19 at 12:32 a.m., a nursing note documented, "Resident called the nurse's station and stated that a [C]aucasian lady and a man in white clothes came to his room asking questions. He then stated that the man in white came to his room 2 weeks ago and hit him in the kidneys. Resident is having vivid hallucinations…."
    - On 01/24/19 at 2:07 p.m., a nursing note documented, "Resident's son called nurses station, stating, 'I received a call from my father. My father says in the middle of the night a man and a woman in all white came to my room and punched me in the kidneys, rummaged through my belongings and took pictures of my armband.' The son states 'I understand these are hallucinations I just wanted to let the staff know.'…I reassured the son that we are familiar with the resident's hallucinations and we will continue to monitor the residnt [resident]…."
    - A 01/27/19 at 1:11 p.m. nursing note stated, "Resident called nurse's station stating that two women, one in all white and one with a flower dress came into his room then told him that they were going to give him a shot. Staff reassured resident that there were no women in there [the resident's room] and they would notify the doctor…." An addendum to this note written at 01/28/19 at 8:25 a.m. by the provider stated, "These delusions have not subsided and appear to bother the resident. Will get formal psych [psychiatric] consult."
    - A 01/28/19 geropsychiatric consult documented, "…I was asked to see him [Resident #103] due to paranoia and VH [visual hallucinations]….He also reports nightmars [nightmares] and flashbacks and says he has trouble sleeping. He denies hearing voices…." "Impression: PTSD Major Neurocognitive Disorder with beh [behavioral] disturbance Schizoaffective Disorder." This was the date the resident was initially diagnosed with schizoaffective disorder.
- Resident #103 began receiving the antipsychotic medication risperidone 0.5 milligrams

(mg) following the 01/28/19 geropsychiatric consult. The resident's record documented the dose was increased to 1.0 mg on 02/14/19 based on the psychiatrist's recommendation.

- The resident's 04/25/19 pharmacist's assessment note documented the resident scored 0 (zero) on an Abnormal Involuntary Movement Scale (AIMS) assessment dated 03/01/19. A 05/01/19 nursing long term care note documented a score of 7 on the AIMS assessment, indicating early potentially irreversible side effects of antipsychotic medications.
- A 06/11/19 geriatric medicine inpatient consult note documented, "RISPERIDONE [emphasis not added] 0.5 mg TAB [tablet]. Indication for antipsychotic drug is: Schizoaffective disorder. If dementia is the indication is consent done: not applicable. If the indication for the antipsychotic use is dementia is the veteran on lowest possible drug dose: Not applicable – indication is schizoaffective disorder."
- On 06/19/19 at 12:50 p.m., Resident #103 was interviewed as he sat in his new power wheelchair in the nursing staff conference room. The resident was observed to be neatly groomed. Resident #103 reported, "I am really sleepy. The medications they give me make me really sleepy. I like staff to wake me up 30 minutes before breakfast." When asked if he reported the medication made him sleepy, the resident responded, "I told the nurses, who told the doctor." According to the resident, the medications had not been changed. The resident stated, "I think maybe the good [benefits] outweighs the bad [sleepiness].
- On 06/20/19 at 1:05 p.m., the pharmacist was interviewed about how psychoactive medications were reviewed for dose reduction. The pharmacist was not the pharmacist who reviewed the medications for Resident #103 on 04/25/19; the pharmacist said there had been a recent pharmacist change for Building 91. The pharmacist reported, "If a resident has a psychiatric diagnosis and is stable, we may not recommend a dose reduction. We usually don't mention gradual dose reduction if a resident has a psychiatric diagnosis. Since he [Resident #103] has schizoaffective disorder, we don't recommend [a dose reduction]." The resident's reports of sleepiness and the change in the AIMS score were reviewed with the pharmacist, who stated being unaware of these issues. The nurse manager, who was present during the discussion, reported the resident's record did not contain notes indicating the resident "was overly drowsy."
- On 06/21/19 at 8:35 a.m., the charge nurse stated, "I am not aware of any recent allegations of people coming into his room." When asked why the resident's care plan did not address the resident's behavioral symptoms of potential distress including hallucinations, the nurse manager responded, "Care plans are driven by the resident. If the resident's hallucinations are his reality, [the hallucinations] would not be in the care plan." The charge nurse was asked if there were any recent nursing notes indicating the resident was experiencing behavioral symptoms of potential distress. The charge nurse provided a note dated 06/01/19 at 5:12 a.m. that stated, "Resident has been restless tonight, resident has been awake several hours saying he needs to catch the bus. I redirected the resident to this room and informed him that it was early in the morning and that it was time to rest. A few minutes later the resident returned and said he was ready to eat breakfast. I redirected the resident back to his room and informed him that it was 04:00 [a.m.] and breakfast was at 07:00 [a.m.]...."
- In summary, a 01/28/19 geropsychiatric consult documented, "…Impression: PTSD Major Neurocognitive Disorder with beh [behavioral] disturbance Schizoaffective Disorder." Resident #103 began receiving the antipsychotic medication risperidone 0.5 milligrams following the 01/28/19 geropsychiatric consult. The resident's record documented the dose was increased to 1.0 mg on 02/14/19 based on the psychiatrist's recommendation. A 05/01/19 nursing long term care note documented a score of 7 on the AIMS assessment, indicating early potentially irreversible side effects of antipsychotic medications; during interview with the resident on 06/19/19, the resident reported that he was "really sleepy." The resident's use of an antipsychotic drug was not reviewed for a potential dose reduction in consideration of these side effects because the resident had the diagnosis of schizoaffective disorder. The resident's care plan did not include any nonpharmacologic approaches to ease behavioral symptoms of potential distress including hallucinations.

---

F428

483.60(c) *Drug Regimen Review. (1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. (2) The pharmacist must report any irregularities to the attending*

Based on interview and record review, the CLC did not ensure irregularities identified in the monthly drug regimen review were acted upon. Findings include:

Resident #102, [LOCATION]

- Resident #102 was admitted to the CLC on [DATE]. According to the admission history and physical note, the resident's diagnoses included chronic acute schizophrenia, depression and insomnia.
- The resident's 04/23/19 pharmacist assessment note stated, "Medications prescribed

*physician, and the director of nursing, and these reports must be acted upon*

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

**Residents Affected** - Few

without apparent indication? Yes, PRN [as needed] melatonin, ondansetron, and benzocaine not used in past 6 mos [months]. PRN ibuprofen for tooth pain last given 01/24/19, PRN docusate last given 01/24/19, PRN loperamide last given 02/10/19. The physician was copied/provided the note and acknowledged receipt of the note.

- The 05/17/19 pharmacist's assessment note documented, "Medications prescribed without apparent indication? No, PRN melatonin, ondansetron, benzocaine not used in past 6 mos….Recommendations: May consider discontinuation of PRN medications without recent use: ibuprofen, benzocaine/menthol lozenge, benzocaine gel, docusate, loperamide, melatonin, ondansetron." The physician was copied/provided the note and acknowledged receipt of the note.
- The 06/14/19 pharmacist's assessment note documented, "Recommendations: The following PRNs have not been used or needed. Consider discontinuing the following benzocaine/menthol lozenge, benzocaine gel, docusate, loperamide, melatonin, and ondansetron." The physician was copied/provided the note and acknowledged receipt of the note.
- On 06/20/19, the resident's current medications orders were reviewed with a nurse manager. According to the resident's record, the resident requested ibuprofen on 05/22/19, 05/23/19, 06/07/19, 06/08/19 and 06/11/19. The provider discontinued the benzocaine/menthol lozenge, benzocaine gel, loperamide, melatonin, and ondansetron. The medications were discontinued following the 06/14/19 pharmacist assessment note. Docusate 100 milligrams (mg) twice a day PRN constipation and ibuprofen 600 mg every eight hours as needed for tooth pain were reordered on 06/05/19. No provider notes were provided indicating the provider's response to the pharmacist's recommendations documented on 04/23/19, 05/17/19 or 06/14/19.

Resident #103, [LOCATION]

- Resident #103 was admitted to the CLC on [DATE]. According to the [DATE] history and physical note, the resident's diagnoses included "age-related physical disability," pain, dementia, depression, and hepatic encephalopathy.
- A 04/25/19 pharmacist's assessment note documented, "All other PRN medications, benzocaine/menthol, camphor/menthol, trolamine, albuterol and trazodone for sleep have not been used this past review. Please DC [discontinue] PRN meds [medications] no longer needed…" The physician was copied/provided the note and acknowledged receipt of the note.
- The 05/15/19 and 06/14/19 pharmacist's assessment note contained the same requests to discontinue PRN medications no longer needed. The physician was copied/provided the notes and acknowledged receipt of the notes.
- On 06/20/19 Resident #103's medication records were reviewed with the nurse manager. The records documented the trazodone had been discontinued following the 05/15/19 pharmacist's assessment note, the camphor/menthol and trolamine were renewed on 06/11/19 and the albuterol was renewed on 06/14/19. No provider notes were provided indicating the provider responded to the pharmacy recommendations documented on 04/25/19, 05/15/19 and 06/14/19.

Systems-level Review

- On 06/20/19 at 1:00 p.m., the pharmacist was interviewed regarding provider response to pharmacy drug regimen reviews. The pharmacist stated, "We try to get the [number of prescribed] medications below nine by our recommendations. We make the same recommendations from month to month." The pharmacist was not aware of a process used by providers to respond to pharmacy recommendations.

---

F441

483.65 *Infection Control. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.*

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

**Residents Affected** - Few

Based on observation, interview and record review, the CLC did not maintain an infection prevention and control program designed to help prevent the development and transmission of disease and infection. Findings include:

Hand Hygiene

On 06/20/19 at 10:50 a.m., a quality management staff member provided the Department of Veterans Affairs, Central Texas Veterans Health Care System (CTVHCS), Austin-Temple-Waco, Community-Based Outpatient Clinics (CBOCs) Memorandum 111-002 titled, "HAND HYGIENE." In section 3, subsection l, staff were directed to, "Perform hand hygiene at the following times…(2) Before donning sterile or nonsterile gloves and after removing gloves. (3) If moving from a contaminated body site to another body site….(6) After touching inanimate surfaces and objects (e.g., medical equipment, furniture, etc.) in a patient's room. (7) After touching body fluids and substances, mucous membranes, and/or non-intact skin."

*Resident #305, [LOCATION]*

- According to documentation in Resident #305's record, the resident was admitted on

[DATE] for hospice care. The resident had provider orders dated 04/26/19 for a dressing change that read, “Change Prophylactic skin care dressing. Prophylactic skin care dressing to sacrum. Change PRN [as needed].” A second physician order dated 06/14/19 included a dressing change as follows; “To right groin: for uncontrolled sanguineous exudate, may cover with calcium alginate dressing to control bleeding. Once controlled, may resort to ABD pad, per Veteran preference.”

- On 06/20/19 at 10:00 a.m., a licensed vocational nurse (LVN) was observed providing a dressing change for Resident #305. The LVN entered the room and performed hand hygiene. The LVN created a barrier for the dressing supplies at the foot of the resident’s bed using an absorbent pad, and placed the dressing supplies and a tube of ointment on the pad. The LVN washed her hands, donned gloves and performed perineal care. The LVN doffed the gloves and donned clean gloves without first performing hand hygiene. The LVN removed the soiled dressing from the resident’s sacrum, and doffed gloves and donned clean gloves without performing hand hygiene. The LVN cleansed the resident’s sacrum, dried the area, applied barrier cream with her gloved right hand. The LVN placed the lid on the tube with the right gloved hand that was used to apply the barrier cream to the sacrum. The LVN doffed gloves and washed her hands. The LVN donned clean gloves and applied a protective dressing to the resident’s sacrum. Without doffing gloves, conducting hand hygiene and donning new gloves, the LVN opened the resident’s closet door for additional supplies; the LVN removed the soiled dressing from the resident's right groin while wearing the same gloves. The LVN doffed gloves, washed hands, donned clean gloves, cleansed the right groin wound and applied an ABD dressing. The LVN then adjusted the resident’s bed linens, touched the bed controls to raise the head of the bed, and placed pillows under the resident’s knees before removing the gloves and performing hand hygiene.

*Resident #104, [LOCATION]*

- On 06/20/19 at 9:30 a.m., an LVN was observed administering 11 oral medications, an eye cleansing wipe, eye drops, and a nasal spray for Resident #104.
- The LVN performed hand hygiene, donned gloves, administered the resident’s oral medications, used the eye cleansing wipe to clean the resident’s eyes, and administered the eye drops. The LVN then doffed gloves, and without performing hand hygiene, donned new gloves to administer the resident’s nasal spray.