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: St. Cloud VA Medical Center (St. Cloud, MN)

Dates of Survey: 10/8/2019 to 10/10/2019

Total Available Beds: 221

Census on First Day of Survey: 203

F-Tag	Findings
F697 483.25(k) *483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents??? goals and preferences.* **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 pain management was provided to a resident who required such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences. Findings include: The CLC's St. Cloud VA Health Care System (HCS) Memorandum titled, "Pain Management," and dated March 2019 was provided by a quality manager on 10/09/19 at 4:48 p.m. The memorandum indicated, "It is the policy of St. Cloud VA HCS to recognize and appropriately treat pain conditions through a comprehensive, multidisciplinary, integrated, system-wide approach that maintains or improves the functional status and quality of life for Veterans experiencing acute and chronic pain. This systematic approach employs a stepped-care model of pain care that provides for management of most pain conditions in the primary care setting and promotes inclusion of patient [resident] and family as active participants in pain management. This is supported by timely access to secondary consultation from pain medicine, behavioral health, physical medicine and rehabilitation, rheumatology, orthopedics, neurology or anesthesiology and care by coordination with palliative care, tertiary care, advanced diagnostic and medical management, and rehabilitation services for complex cases involving comorbidities such as mental health disorders and traumatic brain injury (TBI). PROCEDURES: • Pain Screening - Patients will be screened for the presence of pain using the 5th Vital Sign concept when a full set of vital signs (temperature, pulse, respirations [TPR], and blood pressure [BP]) are taken as appropriate to the care setting. Pain screening scores are to be documented in BCMA [Bar Code Medication Administration]/Vital Sign Package… • Pain Assessment - Patients with a positive pain score of 4 or greater will be queried as to whether the pain level is acceptable or whether they would like further evaluation of the pain. Non-communicative patients will be routinely assessed for pain by a range of methods including direct observation by staff, input from family members and close monitoring of the effects of pain management interventions….(2) Treatment of the pain will be determined by the patient's perception that the pain is problematic, and by provider judgment. (3) The pain assessment will be performed by members of the care team…. • Pain Reassessment: Reassessment will be individualized to the patient, care setting, type of pain, and interventions provided. Patients will be asked about their pain intensity when a full set of vital signs are taken and after interventions to assess effectiveness. Documentation of the patient's response to treatment will include side effects and patient function when indicated. • Pain Management and Care Planning: (1) An interdisciplinary, multi-modal approach will be taken for effective pain management throughout the patient's continuum of care. Pain management will emphasize optimal pain control, improved function, and quality of life. Both nonpharmacological and pharmacological interventions will be offered, with consideration of the patient's cultural, physical, and psychological characteristics." The CLC's policy titled, "Pain Management," and dated August 2018 was provided by a

quality manager on 10/09/19 at 4:48 p.m. The policy/procedure indicated, “The interventions to these Interdisciplinary Expectations of Care are as indicated, needed, appropriate, or as ordered for the resident. GOAL: Effective ongoing pain assessment and pain management. Pain management problems, goals, and interventions will be documented on the interdisciplinary treatment plan for all residents with a positive pain screening and for all residents receiving pain interventions. ASSESSSMENTS….

- When screening a resident using any pain scale besides numerical, staff are to enter the corresponding numeric number from the scale into the vital signs package in CPRS/BCMA, and a note describing pain symptoms and pain scale used.
- An LPN may complete a focused pain assessment including: pain scale, signs and symptoms of pain, alleviating and exacerbating factors. RN will determine individualized interventions….
- An assessment will be completed with a new positive pain score. Based on this assessment, the RN will determine the individualized plan of care and notify the provider. Reassess pain symptoms ongoing, when there is a change in pain status, and when the current pain management interventions are ineffective.
- The effectiveness of PRN pain medication will be documented before and after administration. This will be documented in the BCMA PRN effectiveness log within 2 hours after administering medication(s).”

Resident #101, [LOCATION]

- Resident #101’s current diagnoses included an infection of the left hand resulting from moisture associated skin damage (MASD), a scrotal mass, arthritis, degeneration of lumbar spine, dementia, posttraumatic stress disorder (PTSD), and anxiety disorder. The resident’s comprehensive Minimum Data Set (MDS) dated 10/12/18 was coded to indicate the resident had clear speech, sometimes understood and was sometimes understood by others; the resident’s cognitive skills for daily decision making were severely impaired based on staff assessment. According to the MDS, the resident received a scheduled pain medication regimen and non-medication intervention for pain, and was unable to complete the pain assessment interview; the staff assessment for pain indicated the resident had no indicators of pain or possible pain. The quarterly MDS dated 07/03/19 was coded to indicate the resident had clear speech, usually understood and was sometimes understood by others; the resident’s cognitively skills for daily decision making were severely impaired. According to the quarterly MDS, the resident received a scheduled pain medication regimen and non-medication interventions for pain, and was unable to complete the pain assessment interview; staff assessment for pain identified non-verbal sounds (e.g., crying, whining, gasping, moaning, or groaning) as indicators of pain or possible pain that occurred one to two days during the review period.
- The resident’s care plan dated 05/18/19 included a statement addressing pain that read, “I have a history of lower back and knee pain, stiffness r/t [related to] arthritis.” The care plan did not address the resident’s left hand pain. The goal stated, “My pain will not interfere with my daily activities or sleep. My pain is 3 out of 10 on a daily basis.” Approaches included the following:
  - “Follow IEOC [Interdisciplinary Expectation of Care] for pain management.
  - Please offer me a warm blanket and/or turn on the radio if I am having back pain.
  - If I have verbal or non-verbal concerns of increased pain, please help me to rest in my bed.
  - Please assist me with making small frequent movements to assist with decreasing pain.
  - RN will complete weekly/PRN [as needed] pain assessment using a non verbal pain assessment; update provider with unmet pain needs.
  - Offer PRN analgesic medications as ordered.
  - Aromatherapy helps with pain distractions at times.”
- Provider orders included the following:
  - 09/05/19: “ACETAMINOPHEN TAB [tablet] 500 MG [milligrams] PO [orally] 500 MG PO BID [twice a day] PRN Pain.”
  - 09/05/19: “Renew ACETAMINOPHENOPHEN TAB 650 MG PO 1200-1600-2000 [12:00 p.m. - 4:00 p.m. – 8:00 p.m.] dx [diagnosis]: OA [osteoarthritis] with pain-TOTAL ACETAMINOPHEN NOT TO EXCEED 4000 MG/24 HRS ALL ORDERS COMBINED [emphasis not added].”
  - 09/05/19: “Renew ACETAMINOPHEN TAB 1000 MG PO 0600 [6:00 a.m.] dx: OA with pain-Increased am [morning] dose on 9/14 [*sic*] - TOTAL ACETAMINOPHEN NOT TO EXCEED 4000 MG/24 HRS….”
  - 10/01/19: “WOUND CARE NURSING PROGRAM Type of Dressing: GUAZE [gauze]. Wound Care Instructions: Left hand…Cleanse with a cleansing cloth, Carra-Klenz or saline and dry thoroughly, place rolled gauze in palm of hand for wound dressing, drainage collection, padding/protection and moisture wicking

management. May hold in place using band net. Change daily and PRN."

- Skin assessment/skin integrity notes and pain assessment/reassessment notes for the period of 09/21/19 through 10/09/19 were reviewed with the assistant nurse manager on 10/10/19 at 8:30 a.m. and included the following:
    - A skin assessment/nursing skin assessment note dated 09/21/19 indicated (but was not limited to) the following:
        - "Other (list): skin breakdown r/t [related to] moisture secondary to hand splint usage [the wound was first identified on 09/21/19].
        - Number of wounds: 1 Location(s): left hand 3rd digit.
        - Odor (if none, say so): yes, foul smelling 'cheese like' smell
        - Pain score: 6
        - Plan: Cleansed the area with betadine, placed adaptic (cut down) over the open area and wrapped kerlix in between the digits of the fingers as well as the palm of his hand."
    - A skin integrity nurse note/nursing skin assessment note dated 09/24/19 stated, "Focused skin assessment to left hand completed with unit [neighborhood] RN. Staff…report Veteran was given a different style hand splint (cone with terry cloth) 9/3/19. OT [occupational therapy] was consulted for revaluation due [to] nursing report that the previous palm protector with red foam roller was not adequately staying in place. [Resident] has a long history of hand contractures with left ring finger distal joint hyperextension. Staff noticed moisture, maceration, foul odor, and skin breakdown, to left hand and ring finger on 9/21/19, splint was discontinued at that time and a wound dressing applied….Signs & Symptoms of Local Infection: suspect moisture/fungal component. Wound pain: absent of non-verbal signs of pain during assessment."
    - A pain assessment/reassessment/nursing note/extended care and rehabilitation pain assessment dated 10/02/19 indicated the resident experienced the following indicators of pain or possible pain - Emotion: smiling (0), anxious/irritable (1); Verbal Cues: whining, whimpering, moaning (1); Facial Cues, drawn around mouth and eyes (1); Positioning/Guarding: guarding/tense (1); for a total score of 4. The indicators of pain or possible pain were observed three to four days during the review period. Assessment/clinical findings in the note were documented as "Veteran has had recent hand infection and could contribute to his pain. He does scream out with cares on occasion. Plan/Nursing Measures: continue to use nonpharms [nonpharmacologic approaches], explain cares, and talk to veteran during cares to help distract. Notify np [nurse practitioner] of unmet pain needs…."
- During observations on 10/09/19 at 9:23 a.m., Resident #101 loudly cried out "Ahhh!" and pulled his left hand away from the RN after the nurse sprayed the hand wound with CarraKlenz and used gauze to wipe the wound using moderate pressure. The RN asked the resident if the wound care hurt and the resident said, "Yes." The RN indicated she pre-medicated the resident with acetaminophen 500 mg at 8:55 a.m. and stated, "He [resident] was eating breakfast or I would have given it to him sooner." The RN applied a gauze dressing, rolled gauze and DermaSaver™ palm pillow to the resident's left hand and asked the resident if the left hand wound was still painful; the resident responded, "Yes."
- Additional documentation reviewed with the assistant nurse manager on 10/10/19 at 8:30 a.m. included the following:
    - BCMA records indicated 500 mg of acetaminophen (PRN) was administered for Resident #101 on 10/09/19 at 9:01 a.m.; the wound care observation began at 9:23 a.m., 22 minutes after acetaminophen was administered. BCMA records did not indicate the resident received PRN acetaminophen 500 mg prior to wound care on other days since identification of the left hand wound on 09/21/19. The resident received the scheduled 6:00 a.m. 1000 mg dose of acetaminophen on 10/09/19 as confirmed by the QM. The 14-day medication administration record starting from 09/24/19 indicated the resident received PRN pain medication on 10/09/19 only.
    - A skin assessment/nursing skin assessment note addendum dated 10/09/19 read, "Veteran's dressing changed on…digit of left hand. Wound bed appears red. No drainage or odor noted. No signs or symptoms of infection, veteran was premedicated with acetaminophen 35 minutes prior to dressing change. Veteran did holler out when wound bed was being cleansed with the carra cleanse [CarraKlenz]…immediately after dressing change Veteran was a 2/10 [2 out of 10 on a scale of 0 to 10 with 10 representing the worst pain possible] on the non verbal pain scale."
    - An EC (Extended Care) PRN pain note/pain note dated 10/09/19 at 10:18 a.m. indicated the following:
        - "Current pain level: 3 [on a scale of 0 to 10 with 10 representing the worst

pain possible).
- Non-communicative pain scale used.
- Pain locations: left hand, other pain Veteran was grimacing just after eating breakfast and pre-med [pre medicated] for dressing change.
- Quality of pain: Other Veteran unable to verbally communicate type of pain or discomfort.
- Non-pharmacological interventions attempted: Alternate positions, Assistive devices, Brace/Support, Other: elevate hand on pillow. Was not effective.
- PRN Tylenol 500 mg at 9:01 a.m.
- Pain Level: 2
- Veteran went down to OT [occupational therapy] at 1000 [10:00 a.m.]."

- A new order written on 10/10/19 indicated the following change to the current wound care order: "Wound Care Instructions: Left hand daily skin care: cleanse with small amount Baby Shampoo in a warm washcloth; thoroughly dry. Place cotton glove on hand then place DermaSaver Palm Pillow. Remove at HS [bedtime]. MICONAZOLE POWDER, TOP [topical] 2% LIGHT DUSTING TOP [topical] HS [at bedtime] TO left hand. Start 10/10/19."

- During an interview on 10/09/19 at 3:39 p.m., the skin integrity nurse indicated, "The miconazole powder was discontinued on 10/01/19 [and restarted on 10/10/19 as indicated in the updated wound care order]; the resident's whole [left] hand was raw, peeling, pasty, and macerated. The resident was assessed on 09/24/19 and found to have a fungal infection. The resident was started on miconazole to treat it. The [left hand] cone was discontinued [on 09/21/19], and another splint was ordered; this one was made of plastic material and wouldn't stay in place. The resident had a hard cone that didn't stay in place. He…now has [a] DermaSaver palm protector. He has a fungal rash."
- During the daily meeting on 10/09/19 at 4:00 p.m., leadership staff were informed about Resident #101 experiencing pain as indicated by crying out during the wound care observation. Leadership staff offered no questions or feedback.
- A QM provided a document on 10/09/19 at 4:45 p.m. that indicated acetaminophen was effective in 30 to 60 minutes. The QM also indicated the resident received scheduled acetaminophen 1000 mg at 6:00 a.m. and PRN acetaminophen 500 mg at 9:01 a.m. The QM agreed that further assessment of the resident's pain should be conducted. The QM also confirmed the resident had not been pre-medicated for wound care prior to 10/09/19.
- In summary, on 10/09/19 at 9:23 a.m. during wound care, Resident #101 loudly cried out "Ahhh!" and pulled his left hand away from the RN after the nurse sprayed the hand wound with CarraKlenz and used gauze to wipe the wound using moderate pressure. The RN asked the resident if the wound care hurt and the resident said, "Yes." The RN applied a gauze dressing, rolled gauze and DermaSaver palm pillow to the resident's left hand and asked the resident if the left-hand wound was still painful; the resident responded, "Yes." BCMA records indicated 500 mg of acetaminophen (PRN) was administered for Resident #101 on 10/09/19 at 9:01 a.m.; the wound care observation began at 9:23 a.m., 22 minutes after acetaminophen was administered. Documentation first indicated the resident had skin breakdown related to moisture related to hand splint usage on 09/21/19. BCMA records did not indicate the resident received PRN acetaminophen 500 mg prior to wound care since identification of the left hand wound on 09/21/19 other than on 10/09/19. The resident's care plan dated 05/18/19 included a statement addressing pain that read, "I have a history of lower back and knee pain, stiffness r/t [related to] arthritis." The care plan did not address the resident's left hand pain.

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483.80(a)(1)(2)(4)(e)(f) *§483.80 Infection Control. The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control*

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 communicable diseases and infections. Findings include:

Hand Hygiene

The CLC policy titled, "Isolation Precautions Policy," dated October 2017 and updated April 2018, was provided by the nurse manager of the [LOCATION] neighborhood on 10/08/19 at 2:20 p.m. According to the policy, "Contact Precautions: are intended to prevent transmission of infectious agents, including epidemiologically important microorganisms, which are spread by direct or indirect contact with the Patient [resident] or the Patient's environment….(9) Hand Hygiene (HH) and Gloving: (a) Hand decontamination by soap and water or an alcohol-based hand rub also referred to as hand hygiene (HH) is the single most important measure for preventing the spread of infection. HH should be performed promptly before procedures,

program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

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

Residents Affected - Few

articles contaminated with them, and after removing gloves….(c) Non-sterile gloves will be worn for contact with all body substances, mucous membranes, and non-intact skin. They will be donned just prior to use after HH is performed. Gloves will be changed if they become soiled, between procedures or body sites, and between patients.…"

Resident #401, [LOCATION]

- Resident #401 had a provider's order dated 09/13/19 that stated, "Contact Precautions for MRSA [methicillin-resistant *Staphylococcus aureus*]. 1. Private room & bathroom preferred. 2. Strict Hand Hygiene. 3. Gown and glove required upon entering room. 4. Dedicate equipment or disinfect prior to reuse with appropriate disinfectant." The door to the resident's room was observed on 10/09/19 with signage indicating "Contact Precautions" were to be implemented and that gloves, a gown, and hand hygiene were required upon entry to the room.
- On 10/09/19 at approximately 1:30 p.m., the surveyor and nurse manager observed a nursing assistant (NA) and an RN providing care for Resident #401. The RN and NA performed hand hygiene and donned gloves and gowns prior to entering the resident's room. After removing the resident's adult brief and providing peri-care with a disposable wipe, the NA did not doff gloves, perform hand hygiene and don new gloves prior to applying a clean brief. The NA disposed of the disposable wipe and brief. The NA said, "I need to change my gloves." The NA removed the gloves, and without first performing hand hygiene, applied a new pair of gloves, and placed the bed linen over the resident. The RN and NA doffed the gloves and gowns, performed hand hygiene and left the room.