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

Dates of Survey: 10/23/2018 to 10/25/2018

Total Available Beds: 221

Census on First Day of Survey: 202

F-Tag	Findings
F241 483.15(a) *Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.* **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 promote care of residents in a manner and in an environment that maintained or enhanced each resident's dignity. Findings include: Resident #405, [LOCATION] • On 10/23/18, during the initial tour of the [LOCATION] neighborhood accompanied by the outpatient coordinator (OC), the nurse manager of the neighborhood indicated that Resident #405 experienced cognitive limitations and "paranoia and agitation." • The resident's most current Minimum Data Set (MDS) dated 07/28/18 indicated that Resident #405 had moderately impaired cognitive skills for daily decision making based on staff assessment; the resident had signs and symptoms of delirium including inattention that occurred continuously and did not fluctuate. • The most recent long-term care provider's note dated 08/30/18 stated, "Nurses report that he [resident] has been in bed refusing breakfast." • According to the 10/24/18 resident data sheet (daily worksheet for shift report for staff review), "Resident #405 is on a dysphasia pureed diet, has paranoia, agitation, and is resistive with care." Triggers for behavioral symptoms were listed as "overstimulation, anxiety, being woke up and having others in my face." Warning signs included, "Wanting to stay in my room, expressing concern about my peers or what they are doing, flushing of my face." • On 10/24/18 at 9:05 a.m., Resident #405 was observed eating independently at a table in the dining room in the [LOCATION] neighborhood. A nursing assistant (NA) approached the resident and stated, "Are you through eating or still eating?" The resident stated, "Still eating." At 9:08 a.m., another NA approached Resident #405 and stated, "Are you still eating or are you done?" The resident stated, "Still eating." At 9:11 a.m., a third NA approached the resident and asked if Resident #405 was still eating. Resident #405's face began to turn pink (flush) in color and the resident frowned. Resident #405 yelled out, "Why does everybody keep asking me that?" The NA then stated, "Well, your tray has been here a while. I'm going to take it. You did a pretty good job." Resident #405 said in a very low voice, "Ok." Staff documented in the intake flow sheet that Resident #405 consumed 75% of the breakfast meal. • At 9:30 a.m. on 10/24/18, during an interview with the OC who also observed the breakfast meal and interactions between the nursing assistants and Resident #405, the OC stated, "I know [meaning three people approached the resident during this time]." • At 4:50 p.m. on 10/24/18, the OC approached the surveyor and inquired if the surveyor heard Resident #405 say, "Ok," when the NA took the tray away. The OC stated, "She [NA] was frustrating him [the resident]." The OC indicated the meal trays were served at 7:45 a.m. on 10/24/18 but did not know when the breakfast meal was served to Resident #405. • At approximately 10:45 a.m. on 10/25/18, the nurse administrator of extended care and rehabilitation (NAECR) confirmed that it was "not known when he [Resident #405] was served his breakfast tray" on 10/24/18.

F272

483.2 *Resident Assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.*

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 conduct an accurate assessment of a resident's weight status. Findings include:

On 10/25/18 at 8:45 a.m., the quality improvement coordinator provided the instruction manual for the Welch Allyn Masted Scales titled, "Directions for Use." According to the document, as part of the "weighing procedure," staff was to "place the patient on the scale and make sure that his or her weight is evenly distributed."

Resident #203, [LOCATION]

- According to records reviewed, Resident #203 had diagnoses including schizophrenia. According to the resident's most recent annual MDS dated 09/16/18, Resident #203 understood and was understood by others; the resident scored a 15 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition. The annual MDS was coded to indicate Resident #203 required supervision and set up assistance with eating, did not display signs or symptoms of a swallowing disorder, and received a mechanically altered and therapeutic diet. The annual MDS was coded to indicate Resident #203 received restorative nursing for eating and/or swallowing seven days during the assessment period.
- Resident #203's recorded weights from 09/04/18 to 10/23/18 were as follows:
    - 09/04/18: 187.0 pounds
    - 09/11/18: 189.9 pounds
    - 09/25/18: 187.8 pounds
    - 10/02/18: 188.8 pounds
    - 10/09/18: 187.6 pounds
    - 10/16/18: 168.9 pounds (18.7 lb. weight loss)
    - 10/19/18: 169.3 pounds
    - 10/23/18: 171.8 pounds
- On 10/24/18 at 2:00 p.m., the dietitian and nurse manager (NM) were interviewed regarding the resident's significant weight loss (18.7 pounds or 9%) between 10/09/18 and 10/16/18 (one week's time). The NM stated the neighborhood received a new standing scale around 10/16/18 and the resident was weighed on the new scale on 10/16/18; prior to 10/16/18, Resident #203 had been weighed using a different standing scale. The dietitian indicated that because Resident #203's oral intake at meals had not changed and the new standing scale was used to obtain Resident #203's weight, the resident had not lost weight. According to the dietitian, the old standing scale was not accurate, as the new scale was more recently calibrated; the dietitian indicated the new weight was Resident #203's actual weight. The NM and dietitian indicated Resident #203 did not appear to have lost almost 20 pounds in one week; the resident's clothes were fitting the same and the resident did not appear thinner.
- A nutrition note dated 10/23/18 and documented by the dietitian read, "Documented loss of 18.7 lbs [pounds], from 10/9/18-10/16/18. Reweight on 10/19/18 was consistent with WT [weight] from 10/16/18, but WT loss of this amount does not seem accurate over the course of a week as veteran continues to eat well/normal at meals (50-100% at meals)."
- Resident #203's meal intake records were reviewed from 09/19/18 to 10/19/18; the resident's intake averaged between 50% and 100%.
- Resident #203 was reweighed on the afternoon of 10/24/18 to compare the two standing scales and the tub scale in the neighborhood. At 3:30 p.m., the NM provided the following weights for Resident #203: 173.7 pounds using the older standing scale that had a handle bar, 173.5 pounds using the new standing scale that did not have a handle bar, and 172 pounds using the tub (sitting) scale. The NM reported that she was unsure which standing scale had been used to weigh Resident #203 on 10/16/18 since the new scale arrived on 10/16/18. The NM reported that Resident #203 was unable to fully bear weight during the reweigh on 10/24/18 because the resident required more assistance with standing than in the past.
- On 10/24/18 at 3:50 p.m., after further review of the weights obtained using the standing scales, the NM reported that if residents leaned forward when standing on the new standing scale (obtained on 10/16/18), the scale read approximately 15 pounds less than what the resident truly weighed. The NM reported being unaware of how many residents could be affected by the concerns related to the scales.
- On 10/25/18 at 8:40 a.m., the associate nurse manager (ANM) reported that Resident #203 was not able to fully bear weight on either standing scale when reweighed on 10/24/18 which could have skewed the weights obtained on 10/24/18.
- On 10/25/18 at 8:45 a.m., the NM reported that the newer standing scale would not be used until the handle bar (as on the older scale) was delivered. The NM indicated that once the handle bar was installed, the scale would be identical to the old standing scale and would not cause a discrepancy in weights including when the resident used or did not use the handle bar.

F315

483.25(d)(2) *Urinary Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that: A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.*

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

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure that a resident who was incontinent of bladder received appropriate treatment and services to prevent urinary tract infections. Findings include:

Resident #102, [LOCATION]

- During the initial tour of the neighborhood on 10/23/18 at approximately 10:05 a.m., the associate nurse manager indicated Resident #102 "had dementia, required nectar-thick fluids and was receiving antibiotic therapy for urinary tract infections."
- The most recent comprehensive MDS assessment dated 07/13/18 indicated Resident #102 scored 2 on the Brief Interview for Mental Status (BIMS) suggesting severely impaired cognition; the resident required extensive assistance with most activities of daily living (ADLs) including bed mobility, transfers, toilet use and locomotion on the unit (in the neighborhood) and required limited assistance with eating. Section H, of the comprehensive MDS was coded to indicate Resident #102 was frequently incontinent of bladder and bowel and was not on a toileting program. The quarterly MDS assessment dated 10/11/18 indicated Resident #102 scored 4 on the BIMS suggesting severely impaired cognition; the resident required extensive assistance with most ADLs including bed mobility, transfers, toilet use and locomotion in the neighborhood and required supervision with eating. Section H of the quarterly MDS was coded to indicate Resident #102 was frequently incontinent of bladder and occasionally incontinent of bowel and was not on a toileting program.
- A statement in the resident's care plan dated 04/16/18 related to bowel and bladder incontinence indicated the resident had "mixed incontinence of bowel and bladder." The care plan goal indicated the resident "will maintain my [the resident's] current level of bowel and bladder function during this quarter." The care plan approach related to urinary incontinence stated, "….Please assist me with adequate peri-care after toileting. Nursing staff to provide me with my choice of incontinent products...." The resident's comprehensive care plan dated 10/18/18 did not address urinary tract infections (UTIs). The care plan approaches related to the resident's hydration included the following:
    - "Please offer me snacks and nectar thick beverages between meals."
    - "Follow the nutrition/hydration Interdisciplinary EOC [expectations of care]." (A separate document titled, "Interdisciplinary Expectations of Care for Nutrition/Hydration" listed approaches related to hydration such as "Sudden onset of confusion…concentrated urine…provide resident with safer eating and drinking [such as] offer fresh water or an alternate beverage each shift; must offer ice in fluids…and thickened liquids, if ordered by provider….Offer residents sufficient fluid/fluid substitute with oral medications.")
- The provider order sheet included the following:
    - "03/14/18 Consistent Carbohydrate, Dysphagia Mechanically Altered, with Nectar-Thk [thick] Liquids Diet."
    - "10/20/18 Change levofloxacin tab [tablet] 250 mg [milligrams] PO [orally] daily for 7 days to levofloxacin tab 250 MG PO daily for 7 days." It was indicated the antibiotic was ordered to treat a urinary tract infection.
- The resident's clinical record was reviewed with the Behavior Recovery Unit (BRU) case manager and nurse manager in [LOCATION] on 10/24/18 at approximately 9:00 a.m. Documentation included (but was not limited to) the following:
    - The nutritional assessment dated 07/12/18 indicated the resident's estimated fluid need was 1920-2100 milliliters of fluid daily.
    - The nursing progress note dated 10/20/18 indicated the resident was "disoriented and diaphoretic" and the provider ordered laboratory studies to include a urinalysis and treatment of the resident with an antibiotic (levofloxacin) for a possible UTI.
    - The laboratory report dated [DATE] indicated the resident had a UTI that was caused by *Escherichia coli* (E coli).
- Documentation in the daily "Food & Fluid Intake Flow sheets" included percentages of fluids consumed at meals; documentation did not indicate whether the resident received the recommended 1920-2100 milliliters of fluid daily.
- Resident #102 was observed on 10/23/18 at 1:10 p.m. and 5:20 p.m. in the main dining room. The resident was independently (without staff assistance) drinking nectar-thick liquids provided on the meal trays. The NA who was observing the resident as he ate on 10/23/18 at 5:20 p.m. stated the resident "was a good eater and drinker most of the time." When asked if the resident could verbalize needs, the NA said, "He can tell you what he wants if he feels like it. Sometimes we have to ask him if he needs to go to the toilet or if he needs to drink."
- Resident #104 was observed on 10/24/18 at approximately 8:25 a.m. eating breakfast in the main dining room. The resident drank the nectar-thick milk and nectar-thick juice that was on the meal tray; the resident was not offered additional fluids by the NA who

was observing the resident. At approximately 8:50 a.m., the resident's room was observed with the BRU case manager; there was no water pitcher noted at the resident's bedside. As confirmed during observations and interviews, the resident could pour water from the water pitcher into a cup independently and drink the water if available. The BRU case manager stated, "Water pitchers are not provided in the neighborhood for infection control and safety reasons." The BRU case manager said staff passed snacks at 10:00 a.m., 2:00 p.m. and 7:00 p.m. during which time, residents would be provided fluids. When asked about access to fluids between meals and snacks, the BRU case manager said, "The staff will get it for the Veterans [residents] if they ask or need fluids."

- On 10/24/18 at 9:55 a.m., two nursing assistants were observed providing toileting assistance for Resident #102 in the bathroom located in [LOCATION], another resident's room. The adjoining bathroom to Resident #102's room was occupied and the NAs used a different resident's room to assist Resident #102 with toileting. The resident was wearing disposable incontinence briefs. One of the NAs was observed using a disposable wipe to provide perineal care to the resident; the NA provided the perineal care by using the wipe to clean from back to front rather than from front to back. At 10:10 a.m., the resident was assisted to the dining room; the resident was not offered snacks or fluids. When asked about the resident not being offered snacks or fluids, the same NA who assisted with the resident's perineal care said, "He finished his breakfast close to 9:00 a.m. He usually says he is still full from breakfast." During a subsequent interview with Resident #102, the resident stated he would drink juice at a later time.
- In summary, Resident #104 was observed on 10/24/18 at approximately 8:25 a.m. in the main dining room drinking nectar-thick milk and nectar-thick juice that had been served on the resident's meal tray; the resident was not offered additional fluids. During observations of perineal care on 10/24/18, an NA did not provide perineal care in a manner to reduce the risk of developing a UTI. It was not evident the CLC was assessing the delivery of incontinence care. There was not a care plan that addressed individualized approaches to prevent further UTIs. As indicated by the nurse manager, there was not a care plan that included individualized approaches and addressed "monitoring the resident for changes in condition, monitoring the resident for decreased fluid intake and approaching the resident to encourage increased fluid intake."

F318

483.25(e)(2) *Range of Motion. Based on the comprehensive assessment of a resident, the facility must ensure that: A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.*

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

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure that a resident with a limited range of motion received appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. Findings include:

Resident #105, [LOCATION]

- As determined through record review, Resident #105 was admitted to the CLC with diagnoses including [DIAGNOSIS].
- The resident's most recent comprehensive MDS assessment dated 08/03/18 was coded to indicate Resident #105 scored 9 on the Brief Interview for Mental Status (BIMS) suggesting moderately impaired cognition. The MDS indicated the resident required extensive to total assistance with most activities of daily living including bed mobility, transfers, dressing, locomotion on the unit [in the neighborhood], toilet use, personal hygiene and eating; had functional limitations in range of motion of both upper and lower extremities; and received passive range of motion exercises 7 days during the assessment period. The most recent quarterly MDS assessment dated 05/07/18 indicated the resident scored 5 on the BIMS suggesting severely impaired cognition; and required extensive to total assistance with most activities of daily living including bed mobility, transfers, dressing, locomotion in the neighborhood, toilet use, personal hygiene and eating. The quarterly MDS also indicated the resident had functional limitations in range of motion of both upper and lower extremities and received passive range of motion exercises 7 days during the assessment period.
- During the initial tour of the neighborhood on 10/23/18 at approximately 11:00 a.m., Resident #105 was observed seated in a wheelchair in his room. The resident was observed with contractures of the right arm, hand and fingers; the resident's arm was permanently flexed at the elbow and wrist and the resident's fingers on the right hand were curled into a fist. The resident did not have splints or a brace on either upper extremity. A pair of white-colored palm protectors and a blue-colored resting hand splint were noted on top of a dresser in the resident's room. The associate nurse manager who accompanied the surveyor during the tour indicated Resident #105 "requires full care [total assistance with activities of daily living]…and has contractures of the upper extremities."
- A statement in the comprehensive plan of care dated 03/28/18 indicated Resident #105

required, “Range of motion (active/passive) R/T [related to] ROM [range of motion] deficit R/T [DIAGNOSIS], contractures, lack of voluntary movement. At risk for negative effects of immobility.” The care plan goal stated the resident “will maintain joint motion this quarter.” The care plan approaches included, “Encourage AROM [active range of motion] in arms, hands and fingers, with staff assisting with slow, gentle PROM [passive range of motion] to assure that adequate ROM is completed. 10 repetitions each joint daily, in pain-free range. Report pain to nurse. Schedule: BID [twice a day]: A.M., HS [morning and hour of sleep].”

- Current provider orders included, “04/19/16….Restorative Nursing Program Type of Program: Range of Motion (active/passive) Related to: ROM deficit R/T [DIAGNOSIS], contractures, lack of voluntary movement. At risk for negative effects of immobility. Goal: Maintain joint motion. Approach: 1. Encourage AROM in arms, hands and fingers with staff assisting with slow, gentle PROM to assure that adequate ROM is completed 2. 10 repetitions each joint daily, in pain free range 3. Report pain to nurse. Schedule: BID: A.M., HS.”
- On 10/24/18 at approximately 10:35 a.m., the resident’s clinical record was reviewed with the quality improvement RN and the following information was noted:
    - The EC (extended care) restorative nursing note dated 08/01/18 indicated the restorative nursing program was consistent with the provider’s order dated 04/19/18 (as above). It was noted that the restorative nursing program documented in the 08/01/18 EC restorative nursing note for Resident #105 was the same program documented in the 04/26/17 and 05/07/18 restorative nursing notes; this was confirmed by the quality improvement RN.
    - The rehabilitation hand-off communication note dated 08/22/18 documented the resident was provided with palm protectors that were “to be worn 2 hours in AM and 2 hours in PM. Palm protectors to be removed for morning care, bathing and ROM/restorative nursing. Veteran should continue to wear resting hand splint on left hand at night for sleeping and right palm protector at night for sleeping…foam [1-inch] inserts are on order for potential use with veteran to help with right thumb contracture.” The use of the palm protectors and a resting hand splint was not reflected in the resident’s restorative nursing plan.
    - The rehab OT (occupational therapy) final note dated 08/31/18 indicated the resident was “seen by OT to address splinting tolerance in order to decrease likelihood of further hand contracture. Veteran has been tolerating the bilateral palm protectors previously issued…[and] discussed with nursing staff the 1” [1-inch] insert added to the Veteran’s right hand palm protector with the recommendation to continue with the current wear schedule of bilateral palm protectors.”
    - The EC restorative weekly note dated 10/04/18 provided the following instructions: “List dates that each of the following were provided at least 15 minutes a day, in last 7-days. Start date: September 27, 2018 End date: October 3, 2018.” Information also reflected in the EC restorative weekly note of 10/04/18 indicated Resident #105 received passive and active range of motion exercises on 09/27/18, 09/28/18, 09/29/18, 09/30/18, 10/01/18, 10/02/18 and 10/03/18; the restorative notes did not indicate which extremity received active and/or passive range of motion, and did not indicate the resident received splint or brace assistance.
    - The EC restorative weekly note dated 10/11/18 indicated Resident #105 received passive range of motion on 10/04/18, 10/05/18, 10/06/18, 10/07/18, 10/08/18, 10/09/18 and 10/10/10; the notes did not indicate which extremity received active and/or passive range of motion and did not indicate the resident received splint or brace assistance.
    - The EC restorative weekly note dated 10/17/18 indicated the resident received passive and active range of motion exercises on 10/11/18, 10/12/18, 10/13/18, 10/14/18, 10/15/18, 10/16/18, and 10/17/18; the notes did not indicate which extremity received active and/or passive range of motion and did not indicate the resident received splint or brace assistance.
- On 10/23/18 at approximately 5:40 p.m., Resident #105 was observed seated in his wheelchair with the quality improvement staff person present. At the time of the observation, a nursing assistant (NA) was at the resident’s bedside and indicated she just “finished brushing the resident’s teeth.” The NA also indicated she was “doing the resident’s range of motion exercises.” With the resident’s consent, the NA was observed providing passive range of motion exercises to the resident’s right upper extremity. The NA extended the resident’s fifth finger six times; the NA did not hold the extension for at least 30 to 60 seconds before releasing. The hold time of 30 to 60 seconds was described by the restorative RN during an interview on 10/24/18 at 12:55 p.m. as a common stretching technique used during passive range of motion. After discussion with the surveyor about the number of repetitions, the NA stretched the resident’s other fingers 10 times. The NA then flexed and extended the wrist and repeated the process 10 times; the NA did not hold the extension for 10 to 30 seconds

before releasing the wrist. Following the range of motion exercises of the right wrist and right fingers, the NA asked the resident if he felt any pain or discomfort. The resident stated, “No, it felt good.” When asked if the resident was receiving ROM exercises to the right shoulder and right elbow as well as the left upper extremity, the NA said, “I am actually finished. I only do the right hand, wrist and fingers. I don’t do the left hand and fingers because he still has movement in his left arm.” The NA began to exit the resident’s room and a second NA who was standing at the resident’s doorway asked the NA for assistance in transferring the resident to bed. With the consent of the resident, the surveyor observed the two NAs assist Resident #105 to transfer from the wheelchair to bed using the overhead lift. While the resident was being transferred to bed, it was noted the resident was not able to fully straighten his knees. The second NA stated the resident’s knees “were too stiff.” When asked if the resident used splints or positioning devices for the upper extremities (the palm protectors and hand splint were observed in the same position on top of the dresser), the second NA said, “He should be using these palm protectors for a couple of hours during the day. He uses the hand splint only at night.”

- On 10/24/18 at approximately 12:55 p.m., the restorative nursing program for Resident #105 was discussed with the [LOCATION] nurse manager, the restorative RN (who authored the EC nursing note dated 08/01/18 as above), and the [LOCATION] case manager. The nurse manager said the resident’s restorative nursing program included only ROM exercises to the resident’s right upper extremity, the use of the palm protectors during the day (times not specified) on both hands, and the use of the resting hand splint on the right hand at bedtime. The restorative RN confirmed the resident had flexion contractures of both lower extremities and should have a restorative nursing plan to address the lower extremities. The restorative RN stated the resident’s restorative nursing plan should include range of motion exercises for both upper extremities. When informed of the observation of the NA providing the ROM exercises for the right hand, wrist and fingers, the restorative RN said, “She [NA] should range all joints.”

Resident #304, [LOCATION]

- Resident #304 was admitted to the CLC with diagnoses including history of a stroke.
- The resident’s annual MDS dated 01/13/18 indicated the resident required extensive assistance for bed mobility, transfers, dressing and toilet use. The resident’s quarterly MDS dated 09/24/18 indicated the resident had severely impaired cognitive skills for daily decision making and short-term and long-term memory problems based on staff assessment. According to the MDS, the resident was totally dependent on staff for bed mobility, transfers, dressing, eating, personal hygiene, toilet use and bathing; the resident had functional limitations in range of motion of the upper extremities on both sides.
- During the initial tour on 01/23/18 at approximately 9:00 a.m., the nurse manager described Resident #304 as having contractures of the upper extremities and needing total assistance with all aspects of care.
- The current care plan for restorative nursing dated 06/22/18 read, “Problem: Passive Range of Motion: related to: muscle spasms, increased pain and swelling in the hands r/t bilateral hand contractures. Goal: Consistent ROM of hands will decrease edema and prevent further contracture. Approach: 1. I am to have staff place a warm blanket or washcloth on hands prior to ROM. 2. I am to be sitting up or lying down. 3. I am to have PROM completed to the bilateral hands and wrists by extending each finger and extending each finger and extending both wrists, one hand at a time, very slowly and holding in position for up to 5 minutes per joint. 4. I am to be monitored for pain before and during PROM. Report pain to RN. 5. I am to have palm shield removed for 2 hrs [hours] in A.M. [morning], have good hand hygiene completed and the palm shields replaced.”
- Provider orders dated 06/22/18 stated, “Restorative Nursing Program. Type of Program: Range of Motion (passive) Related to: muscle spasms, increased pain, and swelling in the hands r/t bilateral hand contractures. Goal: Consistent ROM of hands will decrease edema and prevent further contracture. Approach: 1. Veteran is to have staff place a warm blanket or washcloth on hands prior to ROM. 2. Veteran to be sitting up or lying down. 3. Veteran is to have PROM completed to the bilateral hands and wrists by EXTENDING [emphasis not added] each finger and EXTENDING both wrists one hand at a time, VERY SLOWLY [emphasis not added] and holding the position for up to 5 minutes per joint. 4. Veteran is to be monitored for pain before and during PROM. Report pain noted to the RN. 5. Veteran is to have palm shields removed for 2 hours in the AM, have good hand hygiene completed, and the palm shields replaced. Schedule: Daily: A.M.”
- On 10/24/18 at approximately 1:00 p.m., the resident’s clinical record was reviewed with the survey and compliance coordinator with the following information noted:
    - The occupational therapy (OT) note dated 12/04/17 read, “Problem/complaint: Hands, contractures, he is clenching his hands very hard, needs some

protectors. Duration of present problem: One week. DX [diagnosis]: Contracture unspecified hand. Contacted by nurse who explained veteran having difficulty opening his hands on and off for the last 6 months." The staff "attempted to provide PROM bilateral hands, however he continues to pull hands away." The OT plan stated, "Apply palm protectors."
    - The occupational therapy noted dated 12/05/17 stated, "Palm protectors not effective 1st digit continues to dig in palms." The OT recommendation stated, "Trialing a progressive Palm protector on left hand and cone in right hand."
    - The occupational therapy note dated 12/20/17 indicated, "Contact by nursing staff report increase in edema of right hand which was exacerbated with use of hand cone. Edema down when cone not used. Determined that a washcloth will be trialed to protect veteran right hand as digits are digging into palm."
    - A provider note dated 12/21/17 read, "Noted that braces previously used for hand contractures have been discontinued, he is now using a rolled up washcloth for hand support. Veteran [resident] continues to contract hand, this is involuntary, will continue to use washcloth."
    - The restorative nursing note dated 12/28/17 stated, "Vet [Veteran] to have PROM to bilateral HANDS, Veteran to have rolled up washcloths in hands during the day and removed at night."
    - The occupational therapy note dated 06/21/18 indicated, "Consult request. Problem: reevaluate for ROM program and splinting needs for bilateral hands. Assessment…will trial bilateral palm shields to decrease hand discomfort and improve hand hygiene. Veteran does not tolerate even touching of his hands. Veteran's cognitive status, he is unable to comprehend the reasoning as to why ROM is necessary."
    - A consultation request dated 07/27/18 indicated that another OT consult was requested to reassess for splinting options or suggestions for staff to keep hands dry and infection free; however, the consult request was cancelled on the same date.
- The resident was observed multiple times during the survey with the survey and compliance coordinator who accompanied the surveyor. Observations included:
    - 10/23/18, 10:20 a.m. – Observed in his room lying in bed with a flat (unrolled) washcloth in the palm of each hand. The resident's hands were clenched into fists with fingers curled; the resident's arms were at his sides.
    - 10/23/18, 1:30 p.m. – Observed seated in his wheelchair in the dining room. The resident's fingers were flexed/curled in the palm of each hand with the thumb under the flexed fingers. Unrolled washcloths had been placed in the resident's hands.
    - 10/24/18, 8:33 a.m. – Observed seated in his wheelchair in the dining room during the breakfast meal at a table being assisted by a staff member. The resident's fingers were flexed/curled in the palm of each hand with the thumb under the flexed fingers. Unrolled washcloths had been placed in the resident's hands.
    - 10/24/18, 9:24 a.m. – Observed in the resident's room while staff used a Hoyer lift to transfer the resident from the wheelchair to bed. The resident was noted to grimace and moan when staff moved his arms in order to position the resident in the lift sling. The resident received incontinence care and was positioned in bed on his right side with the head of the bed elevated approximately 45 degrees. The resident was observed to have an unrolled washcloth in the palm of each hand.
    - 10/25/18, 8:31 a.m. – Observed seated in his wheelchair in the dining room facing the television. The resident had a folded washcloth in his right hand and no washcloth in the left hand. The resident's fingers were flexed and the right thumb was flexed and adducted toward the palm.
- On 10/24/18 at approximately 11:00 a.m., the nurse manager and the survey and compliance coordinator were interviewed regarding the hand shields that were not observed in the resident's hands as ordered. The nurse manager stated, "The shields were discontinued because they were cutting into the edema of his hands and his fingernails were digging into his palm." The survey and compliance coordinator, who was previously the restorative nurse in the neighborhood and was familiar with the resident stated, "We have been trialing many different interventions for the resident. I changed the care plan on 06/22/18 from using rolled washcloths to the palm shields when OT recommended them. I didn't change the plan after that as we were trialing different interventions."
- On 10/25/18 at approximately 8:50 a.m. during a discussion with the restorative nurse and the survey and compliance coordinator, the resident's care plan, use of palm shields, and multiple observations of the resident using washcloths that were not rolled were discussed. The survey and compliance coordinator stated, "In July [2018] when the consult request was cancelled, the nurse manager and OT [occupational therapist] spoke with the provider about using splints vs [versus] washcloths and the decision

was to continue using rolled washcloths." The survey and compliance coordinator stated, "No documentation was done [related to the change to rolled washcloths]." The survey and compliance coordinator stated the use of the rolled washcloth was to "help alleviate pain, prevent fingers from digging into the hand and prevent worsening contractures." When asked if the restorative nurse provided education for neighborhood staff regarding how to roll a washcloth or observed staff placing the washcloths in the resident's hands, the restorative nurse stated, "No the staff do the washcloths."
- In summary, Resident #304 was observed during the survey with unrolled wash cloths or no washcloths in his hands; the resident was not observed with palm shields as ordered or with rolled washcloths as indicated by the survey and compliance coordinator to the be current approach.

F323

483.25(h)(1) *Accidents. The facility must ensure that: The resident environment remains as free of accident hazards as is possible;*

Level of Harm - Immediate jeopardy to resident health or safety

Residents Affected - Many

Based on observation, interview and record review, the CLC did not ensure the resident environment remained as free from accident hazards as possible and each resident received adequate supervision to prevent accidents. Findings include:

Accident Prevention Related to Hot Water
On 10/23/18, the director of facility management and engineering services and safety (FMES) provided a copy of the CLC's policy titled, "Health Care System Memorandum CD 11-28-Annual Evaluation plan for the Prevention of Legionella Disease," and dated March 2018. The policy stated, "d. Facilities Management Director: The Chief Engineer or Facility Manager is responsible for: 1) Regular monitoring and maintenance of the facility distribution systems and documenting these activities (HCSM FM-01, section IV, Chapter 7). 2) Maintenance of appropriate water temperatures in the hot and cold potable water distribution system(s) in accordance with VHA Directive 1061, HCSM FM -01, section IV, Chapter 7 Plumbing Systems…."

On 10/23/18, the director of FMES provided a copy of the CLC's policy titled, "HCSM FM Safety Occupational Health and Fire Protection Manual Plumbing Systems Section IV, Chapter 7 November 15." "Appendix A. Hot Water Temperature Limits," stated, "Historically, this Health Care System has not had a problem with Legionnaire's disease. It is not uncommon, however, for the Health Care System to have patients who cannot detect or tolerate hot water because of their medical condition or the medication they are taking. Because of this history and consideration of outpatient population, the following are procedures for the Health Care System….c. Hot water tank and generator temperatures will be checked and documented on a weekly basis. d. All patient care tubs will be equipped with mixing valves capable of holding tap temperatures at or below 110 [degrees Fahrenheit]." The policy did not address handwashing sinks.

On 10/23/18 the director of FMES provided a copy of the VHA Directive 1061 Transmittal Sheet dated August 13, 2014 and titled, "Prevention of Healthcare-Associated Legionella Disease and Scald Injury from Potable Water Distribution Systems." The VHA Directive referenced a section on Legionella growth and "Maintenance of Appropriate Water Temperatures in Building Water Distribution Systems," and indicated that "Water temperatures at 124 degrees Fahrenheit (°F) or higher are necessary to inhibit Legionella growth in hot water systems. For most adult individuals, 110° F at the water outlet (e.g., sink tap, showerhead) will minimize the risk of scalding and is consistent with the plumbing code adopted by the Department of Veterans Affairs (VA) for VHA buildings. At 117 degrees [F] the risk of scalding increases significantly." Appendix A of the VHA Directive under "Hot Water Distribution Systems," stated, "The use of mixing valves and anti-scald devices on all outlets where people access water from the potable hot water distribution system is required in order to prevent scald injury. The water temperature delivered from the outlet must not exceed 110° F…."

Hot Water Temperatures

- During the initial tour of [LOCATION] on 10/23/18 at approximately 9:32 a.m., a surveyor noted that the water in the handwashing sink in the [LOCATION] hallway and the handwashing sink in the [LOCATION] dining room was too hot to hold a hand under for more than one minute. The survey and compliance coordinator accompanying the surveyor was asked to have someone check the water temperature.
- At 10:15 a.m., the "plumbing shop leader" tested three handwashing sinks in [LOCATION] and recorded the following temperatures:
    - [LOCATION] hallway handwashing sink - 118.3 ºF.
    - [LOCATION] hallway handwashing sink - 119.0 ºF.

- [LOCATION] dining room handwashing sink - 114.0 ºF.

- On 10/23/18 at approximately 1:00 p.m., the survey team requested that hot water temperatures be measured in shared areas such as shower rooms, bathrooms, handwashing sinks in hallways and/or dining rooms; and in resident rooms used by residents who were able to independently access the hot water. Beginning at approximately 1:15 p.m., a facility management staff person accompanied by a surveyor measured the hot water temperatures and identified hot water temperatures above 110º Fahrenheit including the following temperatures in [LOCATION] where residents in the neighborhood primarily received long-term and palliative/hospice care and services:
  - Resident room [LOCATION], bathroom handwashing sink - 116.5 ºF.
  - Resident room [LOCATION], bathroom handwashing sink - 117.9 ºF.
  - Hallway handwashing sink outside room [LOCATION] - 112.1 ºF.
  - Hallway handwashing sink outside room [LOCATION] - 116.9 ºF.
  - Hallway handwashing sink outside room [LOCATION] - 117.5 ºF.
  - Shared bathroom next to laundry room [LOCATION] - 116.1 ºF.
  - [LOCATION] dining room handwashing sink - 116.3 ºF.
  - [LOCATION] dining room handwashing sink - 117.4 ºF.
- The following hot water temperatures were obtained in [LOCATION] where residents primarily received long-term and palliative/hospice care and services
  - Resident room [LOCATION], handwashing sink - 115.5 ºF.
  - Resident room [LOCATION], handwashing sink - 112.7 ºF.
  - Resident room [LOCATION], handwashing sink - 116.9 ºF.
  - Hallway handwashing sink near room [LOCATION] - 116.3 ºF.
  - Shared bathroom [LOCATION] handwashing sink - 112 ºF.
  - [LOCATION] dining room handwashing sink - 113.8 ºF.
- The following hot water temperatures were obtained in [LOCATION] where residents primarily received long-term care:
  - Resident room [LOCATION], bathroom handwashing sink - 113.1 ºF.
  - Resident room [LOCATION], bathroom handwashing sink - 113.0 ºF.
  - Resident room [LOCATION], bathroom handwashing sink - 113.3 ºF.
  - Resident room [LOCATION], room handwashing sink - 113.1 ºF.
  - Visitor lounge room [LOCATION] that was accessible to residents, handwashing sink - 111.0 ºF.
  - [LOCATION] shared bathroom sink - 114.4 ºF.
  - [LOCATION] shared bathroom sink - 112.7 ºF.
- The following hot water temperatures were obtained in [LOCATION] where residents primarily received long-term and short-stay skilled care:
  - Resident room [LOCATION], bathroom handwashing sink - 113.5 ºF.
  - Resident room [LOCATION], room handwashing sink - 115.1 ºF.
  - Resident room [LOCATION], bathroom handwashing sink - 114.0 ºF.
  - Resident room [LOCATION], room handwashing sink - 112.3 ºF.
  - Resident room [LOCATION], room handwashing sink - 116.1 ºF.
  - [LOCATION] Shower Room, handwashing sink - 114.7 ºF.
- The following hot water temperatures were obtained in [LOCATION] where residents primarily received dementia-related care:
  - Resident room [LOCATION], room handwashing sink - 111.3 ºF.
  - [LOCATION] resident room [LOCATION], room handwashing sink - 112.5 ºF.
  - [LOCATION] resident room [LOCATION], room handwashing sink - 114.7 ºF.
  - Dining room handwashing sink - 117 ºF.
  - [LOCATION] shower room 119 handwashing sink - 114.1 ºF.
  - [LOCATION] shared area handwashing sink - 113.1 ºF.
- The following hot water temperatures were obtained in [LOCATION] where residents primarily received mental health care and services:
  - Resident room [LOCATION], room handwashing sink - 114.3 ºF.
  - Resident room [LOCATION], room handwashing sink - 113.4 ºF.
  - Resident room [LOCATION], room handwashing sink - 112.2 ºF.
  - Resident room [LOCATION], handwashing sink #1 - 114.3 ºF.
  - Resident room [LOCATION], handwashing sink #2 - 116.1 ºF.
  - Resident room [LOCATION], room handwashing sink - 111.7 ºF.
  - Resident room [LOCATION], handwashing sink - 111.0 ºF.
  - Room [LOCATION] shared bathroom handwashing sink - 115.5 ºF.
- Based on interviews with nurse managers during the initial tour on 10/23/18, residents with cognitive limitations or that may be less sensitive to hot water temperatures or have reduced reaction times that placed the residents at increased risk for injury from exposure to hot water were residing in all neighborhoods; this was confirmed during observations in each neighborhood made during the initial tour.
- On 10/23/18 at 4:00 p.m., CLC leadership staff was notified of an immediate jeopardy

situation related to hot water temperatures and an abatement plan was requested

- On 10/23/18 at the daily meeting at 4:00 p.m., the St. Cloud VA Medical Center including the medical center director, the associate director for patient care services (ADPCS)/nurse executive, CLC medical director, CLC administrator and the director of FMES were notified that the excessive hot water temperatures identified during observations presented an immediate jeopardy to residents. The lack of monitoring of water temperatures was also discussed; the lack of monitoring was confirmed during interview on 10/24/18 at 9:30 a.m. with the assistant chief of engineering and maintenance operation supervisor. (See below)
- On 10/23/18 at 4:55 p.m., the CLC administrator, ADPCS/nurse executive and quality improvement coordination staff indicated the CLC had taken immediate corrective measures that included “turning the hot water temperature at the holding tanks from 130 ºF to 110 ºF to cool down the water at the tap, education of frontline staff by the nurse managers and associate nurse managers to monitor the common [shared] areas in the neighborhoods, and monitoring of resident access to hot water.” The CLC administrator also stated the FMES staff would check 25% of the faucets in the CLC as indicated below and the CLC leadership team discussed the immediate use of mixing valves.
- A written abatement plan was provided and accepted at 6:45 p.m. on 10/23/18. The abatement plan included:
    - “Immediate review by nursing staff of residents at risk and supervision of residents at risk. Nursing to perform continual rounding for sink use until water temperature are validated less than 110 ºF.”
    - “Immediate education of residents to avoid use of sinks without staff assistance.”
    - “Immediately lower overall hot water generation output to 110 ºF.”
    - “Daily monitoring of 25% of CLC taps to ensure water temperature at or below 110 ºF. Once established initiate weekly testing of temperatures until revision of facility policy regarding water monitoring.”
    - “Long term purchase and install temperature limiting devices on all CLC sinks with Veteran accessibility.”
    - “Revise facility policy and procedure to ensure proper monitoring and record keeping of water temperature at point of use in CLC sinks.”
- At 8:05 p.m., the director of FMES reported that all CLC neighborhoods had been monitored for hot water temperatures and the temperatures were currently under 110 ºF.
- On 10/24/18 at 9:30 a.m., the assistant chief of engineering and maintenance operation supervisor were interviewed to review the hot water monitoring procedures that had been in place prior to implementation of the action plan to mitigate the immediate jeopardy situation. The procedures were outlined in “HCSM [Health Care System Memorandum] FM [Facilities Management] Safety Occupational Health and Fire Protection Manual Plumbing Systems Section IV, Chapter 7 [dated] November 15.” Review of the procedures revealed there was no process for monitoring sinks in shared areas or resident rooms. The assistant chief engineer confirmed that the policy lacked a procedure for monitoring sink faucets; the assistant chief engineer stated: “Plumbing staff were not aware that the maximum water temperature at sinks should be 110 ºF. They were using 120 ºF and only monitoring water temperatures on hot water generators and patient care tubs. We never checked the tap temperatures. I can assure you we take this [hot water temperatures] very seriously and have immediately implemented monitoring and will revise our policies and procedures.”

Accident Prevention Related to Aspiration Precautions
Resident #204

- Resident #204 was admitted to the CLC with diagnoses including neurocognitive disorder and dysphagia. According to the resident’s most recent quarterly MDS dated 08/29/18, Resident #204 was understood by and could understand others; the resident scored a 13 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition. The quarterly MDS was coded to indicate Resident #204 required supervision and set up assistance with eating, did not display signs or symptoms of a swallowing disorder, and was to receive a mechanically altered diet.
- A resident teaching note dated 06/29/18 indicated Resident #204 was complaining of food “getting stuck” in the resident’s throat. The document indicated staff reviewed the need to wear dentures, tuck his chin and chew food thoroughly when eating. According to the teaching note, speech therapy recommended a downgrade in diet from dysphagia advanced to dysphagia mechanically altered; the resident agreed to this diet change.
- Resident #204 had the following active provider orders:
    - 06/19/18: “Oral moisturizer (mouthkote [saliva substitute]) 4 sprays PO [by mouth] QID [four times a day] AC [before meals] & HS [at bedtime] dryness at 10-12-17-22 [10:00 a.m.-12:00 p.m.-5:00 p.m.-10:00 p.m.]”
    - 08/08/18: “Dysphagia mechanically altered diet.”

    - 08/08/18: “1. Veteran is to be in upright position with dentures in mouth. 2. Staff to cue Veteran to take small sips of liquids, chew food thoroughly, swallow what is in mouth before taking another bite/sip, avoid distractors and talking when eating. Compensatory Techniques to cue to use Chin tuck, if food/liquid feel stuck-try dry swallow, if that is not effective then take a bite of fruit sauce/yogurt 3. Veteran is to have mouthkote before meals. 4. Staff are to assist if needed with oral care: remove dentures & clean. Toothbrush and 1:1 [one-to-one] solution of water & antiseptic mouthwash, stroke the inside of cheeks between the gums, roof of mouth and tongue; rinsing and dipping the toothbrush in the solution often. 5. Veteran is to remain upright after meal for at least 60 minutes. Schedule: TID [three times a day]: Breakfast, lunch, supper and snacks.”
- Resident #204’s interdisciplinary care plan dated 09/06/18 addressed the resident’s restorative nursing program for eating and/or swallowing. A care plan statement dated 02/26/18 read, “Difficulty swallowing related to subdural hematoma. Rarely eats breakfast, is ordered when desires.” The related goal with a next review date of 12/03/18 read, “I will be free of aspiration and maintain adequate nutrition and hydration while on the least restrictive diet.” Approaches were all dated 02/26/18 and included the same approaches as indicated in the provider order dated 08/08/18 (as above).
- The administration of Mouth Kote was reviewed on the morning of 10/25/18 with the associate nurse manager (ANM); Resident #204 received the Mouth Kote as ordered from 10/11/18 through 10/24/18. On 10/23/18 at approximately 5:00 p.m., Resident #204 was observed receiving four sprays of Mouth Kote from an LPN while in the resident’s room.
- On 10/23/18 at 5:15 p.m., Resident #204 reported he ate in the dining room because the resident had “choking problems” in the past; the resident reported that if he ate or drank too fast, he “chokes a little bit.” Resident #204 reported that he was “fairly independent with most activities of daily living (ADLs).”
- On 10/23/18 from 5:55 p.m. to 6:05 p.m. during the evening meal, Resident #204 was observed while eating in the dining room. The resident had ground meat and gravy, yogurt, and applesauce on his meal tray, along with milk in a cup and another beverage in a mug with a lid and a straw. The resident was not observed performing a chin tuck maneuver during the meal. There were no staff sitting by the resident or cueing the resident during the observation. Resident #204 started coughing multiple times after sipping the beverage from the mug using the straw. When the surveyor approached the resident, Resident #204 stated to the surveyor that he was ok. At that time, an LPN who was sitting at a nearby table and within the line of sight of Resident #204, suggested the resident take a drink. No further cueing was noted during the observation. It was not known if the resident was wearing dentures during the meal.
- On 10/24/18 from 12:37 to 12:45 p.m. and from 1:00 p.m. to 1:05 p.m. during the noon meal, Resident #204 was observed eating in the dining room. The resident had ground beef tips with gravy, macaroni and cheese, pureed peas, yogurt, applesauce and milk. Resident #204 was observed taking small bites and sips and chewing thoroughly before swallowing. The resident was not observed performing a chin tuck during the meal. While the resident was eating, an RN walked over to Resident #204 and asked the resident a question about the meal while the resident had food in his mouth; the resident waited until he swallowed the food to answer the RN. The RN then cued Resident #204 to take small bites and walked away from the resident. Resident #204 did not display overt signs or symptoms of aspiration during the noon meal observation. It was not known if the resident was wearing dentures during the meal.
- On 10/24/18 at 9:40 a.m., a nursing assistant (NA) that regularly provided care for Resident #204 stated the resident was “mostly independent” with activities of daily living (ADLs) and in regards to the resident’s restorative eating and swallowing program, staff were to stay within sight of the resident to make sure Resident #204 was chewing and swallowing food, and taking sips throughout the meal. The NA reported that Resident #204 usually took his time during meals. The nurse manager (NM) who was present during the interview reported that Resident #204 was “pretty independent with chin tuck.”
- On 10/24/18 beginning at 1:05 p.m. according to the “restorative coordinator,” staff did not need to sit with Resident #204 to provide cueing support and restorative services. The coordinator indicated that if Resident #204 was not following the plan independently, staff should provide cueing, as detailed in the care plan and provider orders. The restorative coordinator reported that the individualized instructions for the restorative plan were directed by speech therapy to minimize the risk of aspiration or choking.
- On the afternoon of 10/24/18, the quality improvement coordinator reported that Resident #204 had not had any acute care stay for aspiration pneumonia or any documented choking episodes within the last year.
- On 10/25/18 at 9:10 a.m., a second NA that regularly provided care for Resident #204 reported that staff provided set up assistance for the resident and because the

resident's food was chopped, staff did not have to do much more for the resident regarding cueing. The NA indicated that staff encouraged the resident to take smaller bites at times. The NA stated Resident #204 was usually in his wheelchair and moving around the CLC for (at least) 60 minutes (after meals) as indicated in the restorative plan. When asked about providing oral care after meals, the NA replied, "I haven't been told anything about that;" the NA stated Resident #204 liked to be independent with most ADLs and did not like to wear dentures at meal times.

- According to weekly restorative notes dated 10/19/18 and 10/25/18, Resident #204 received restorative services for at least 15 minutes 7 days of each week. No further comments or description of the restorative services were included in either note.
- Based on review of restorative care flow sheets from 10/11/18 to 10/24/18, Resident #204 received between 15 and 25 minutes of eating and swallowing restorative services at noon meals every day and between 15 and 20 minutes of restorative services for eating and swallowing during evening meals; the flow sheet did not indicate the specific eating and swallowing services provided (e.g., using a toothbrush to stroke the inside of the resident's mouth) by staff. According to staff, Resident #204 did not eat breakfast as the resident preferred to sleep late and did not want breakfast.
- In summary, on 10/23/18 from 5:55 p.m. to 6:05 p.m., Resident #204 was observed eating in the dining room. The resident had a beverage in a mug with a lid and a straw. There were no staff sitting by the resident or cueing the resident during the observation. Resident #204 started coughing multiple times after sipping the beverage from the mug using the straw. When a surveyor walked over to the resident, Resident #204 stated to the surveyor that he was ok. An LPN who was sitting at a nearby table and within the line of sight of Resident #204, suggested the resident take a drink. No further cueing was noted during the observation including encouraging a chin tuck, a dry swallow, or a bite of yogurt. On 10/24/18 from 12:37 to 12:45 p.m. and from 1:00 to 1:05 p.m., Resident #204 was observed taking small bites and sips and chewing thoroughly before swallowing. The resident was not observed performing a chin tuck during the meal. While the resident was eating, an RN asked the resident a question about the meal while the resident had food in his mouth; the resident waited until he swallowed the food to answer the RN. The RN did not "avoid distractors and talking [with the resident] when eating" as indicated in provider's order and resident's plan of care.

Resident #203

- Resident #203 was admitted to the CLC with diagnoses including schizophrenia. According to the resident's most recent annual MDS, dated 09/16/18, Resident #203 was understood by and could understand others; the resident had a BIMS score of 15 suggesting intact cognition. The annual MDS was coded to indicate Resident #203 required supervision and set-up assistance with eating, did not display signs or symptoms of a swallowing disorder, and was to receive a mechanically altered and therapeutic diet. The annual MDS was coded to indicate Resident #203 received restorative nursing for eating and/or swallowing 7 days during the assessment period.
- During the initial tour on 10/23/18 beginning at 9:30 a.m., the NM and ANM stated that Resident #203 received a mechanical diet and had experienced weakness over the last several weeks.
- Resident #203 had the following active provider orders:
    - 03/30/18, "1. Veteran is to receive diet as ordered. 2. Veteran is to sit up for all meals, be cued/reminded to take small bites and sips of liquids, chew food thoroughly and swallow what is in mouth before taking any additional solids or liquids. 3. Veteran is to avoid distractors during meals and not to talk while eating. 4. Veteran is to sit upright for 60 minutes after each meal. 5. Praise for accomplishments. Schedule: TID [three times a day]: breakfast, lunch, supper and snacks."
    - 05/01/18: "Consistent carbohydrate, mechanical diet."
- Resident #203's interdisciplinary care plan dated 09/21/18 included a statement dated 03/01/18 under restorative nursing that read, "Due to my eating habits, I may eat too fast at times and I am at an increased risk for choking or aspiration because of this." The related goal with a next review date of 12/24/18 read, "I will be able to take in adequate nutrition without aspiration on the least restrictive diet." Approaches, all dated 03/01/18 included the same approaches as indicated in the provider's order dated 03/30/18 (as above).
- On 10/24/18 at 9:20 a.m., an NA who regularly provided care for Resident #203 reported that the resident laid down after meals and preferred to stay in bed until the next meal; the resident did not like participating in activities. When asked about restorative services, the NA reported the resident participated in a walking program. When asked if Resident #203 was on a restorative eating and swallowing program, the NA looked at the resident's care plan and read the details of the program out loud.
- On 10/24/18 at 1:05 p.m., the restorative coordinator indicated staff should provide assistance with cueing Resident #203 (as stated in the care plan and provider orders) if

the resident was not following the plan independently. The restorative coordinator reported that in the past, Resident #203 ate at a more rapid pace and required more cueing to slow down; the resident was currently eating at a slower pace and did not require as much cueing. The restorative coordinator reported that the individualized instructions for the restorative plan were directed by speech therapy to minimize the risk of aspiration or choking.

- On 10/24/18 from 8:25 a.m. to 8:45 a.m., Resident #203 was observed eating in the dining room. The resident's meal tray included pieces of French toast that were approximately 1.5 inches in size, oatmeal, milk and juice. The resident was eating very slowly and pausing for long periods of time when the food was inches from the resident's mouth. At 8:45 a.m. while Resident #203 was chewing a piece of French toast, an RN approached the resident and cued the resident to eat in a "slow" manner and then asked the resident, "Did you chew that one [bite] up?" As the resident was chewing, the resident nodded. The resident was observed coughing intermittently during the meal. The RN sat with the resident beginning at 8:45 a.m. and cued the resident to "sit up straighter" and also provided eating assistance for the resident; between 8:25 a.m. and 8:45 a.m., no staff provided cueing. Resident #203 completed the meal at approximately 9:10 a.m. and at 9:20 a.m., Resident #203 was observed lying in bed, 10 minutes after the end of the meal.
- On 10/24/18 from 12:45 p.m. to 12:51 p.m., Resident #203 was observed eating in the dining room. The resident's meal tray included a whole cheeseburger, cooked vegetables, milk and what appeared to be a red-colored juice. During the observation, Resident #203 was holding the cheeseburger (that had one or two bites taken from it); the burger was inches from the resident's mouth. The resident did not take a bite during the observation. At 12:52 p.m., an NA approached Resident #203 and cued the resident to swallow; the resident did so and then took another bite. The NA stayed with Resident #203 for the remainder of the meal and at 12:57 p.m., Resident #203 requested to end the meal. Resident #203 did not display any overt signs or symptoms of aspiration during the observation. Resident #203 was observed in bed at 1:35 p.m., 40 minutes after completing the noon meal.
- On 10/25/18 at 8:25 a.m., Resident #203 was observed eating in the dining room. A different NA than the NA that provided assistance on 10/24/18, provided eating assistance for Resident #203; the NA cued the resident to "slow down" and take "small sips." Resident #203 did not display overt signs or symptoms of aspiration during the observation. Resident #203 finished with the meal at 8:52 a.m. and was observed in bed at 9:03 a.m., 11 minutes after finishing the meal.
- On 10/25/18 at 9:05 a.m., a second NA who regularly provided care for Resident #203 reported that Resident #203 received set-up assistance at the beginning of meals only. The NA reported that Resident #203 required more assistance with eating over the last several days. The NA stated Resident #203 walked after a meal and then laid down after the walk.
- According to weekly restorative notes dated 10/19/18 and 10/25/18, Resident #203 received restorative services for at least 15 minutes every day of each week. No additional information about specific restorative services provided was included in the notes.
- According to restorative care flow sheets from 10/11/18 to 10/24/18, Resident #203 received between 20 and 30 minutes of eating and swallowing restorative services at both the breakfast and noon meals every day and 30 minutes of restorative services for eating and swallowing during each evening meal; the specific restorative services provided were not documented on the flow sheets.
- In summary, Resident #203 was observed eating breakfast in the dining room from 8:25 a.m. to 8:45 a.m.; no staff provided cueing for the resident. The resident ate very slowly, paused for long periods of time, and was observed coughing intermittently during the meal. The RN sat with the resident beginning at 8:45 a.m. and cued the resident to "sit up straighter" and also provided eating assistance for the resident. Resident #203 was observed in bed 10 minutes after completing the meal. On 10/24/18 from 12:45 p.m. to 12:51 p.m., Resident #203 held a cheeseburger (that had one or two bites taken from it); the resident did not take a bite during the observation. At 12:52 p.m., an NA approached Resident #203 and cued the resident to swallow; the resident did so and then took another bite. The NA stayed with Resident #203 for the remainder of the meal. Resident #203 was observed in bed 40 minutes after completing the noon meal. On 10/25/18 at 8:25 a.m., Resident #203 was observed in bed 11 minutes after finishing the meal. As indicated in provider orders and the resident's plan of care, Resident #203 was not consistently cued to take small bites, chew food thoroughly, and swallow the food in the resident's mouth. Staff did not "avoid distractors during meals" including asking the resident a question while the resident had food in his mouth. Staff did not encourage the resident to sit upright for 60 minutes after each meal; the resident was assisted to bed between 10 and 40 minutes after the meals observed.

F327

483.25(j) *Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.*

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 provide each resident with sufficient fluid intake to maintain proper hydration and health. Findings include:

Resident #104, [LOCATION]

- During the initial tour of the neighborhood on 10/23/18 at approximately 10:45 a.m., Resident #104 was observed in the dining room seated in a wheelchair with his eyes closed. The associate nurse manager who accompanied the surveyor during the tour indicated Resident #104 "requires full care [total assistance with activities of daily living]" and was being "treated for urinary tract infections."
- The resident's quarterly MDS assessment dated 05/23/18 indicated Resident #104 had short-term and long-term memory problems and severely impaired cognition based on staff assessment; the resident required extensive to total assistance with most activities of daily living (ADL) including bed mobility, transfers, toilet use, locomotion on the unit [in the neighborhood] and eating. Section H of the quarterly MDS was coded to indicate Resident #104 was always incontinent of bladder and frequently incontinent of bowel; the resident was not on a toileting program. The most recent comprehensive MDS assessment dated 08/20/18 indicated Resident #104 had short and long-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment. The comprehensive MDS assessment documented the resident required extensive to total assistance with most activities of daily living (ADLs) including bed mobility, transfers, toilet use, locomotion on the unit [in the neighborhood] and eating. Section H of the comprehensive MDS was coded to indicate Resident #104 was frequently incontinent of bladder and bowel and was not on a toileting program.
- A statement in the resident's care plan dated 02/27/18 indicated the resident "has chewing and swallowing difficulties and requires a dysphagia mechanically altered diet to help me [the resident] be safe at meals/snacks." The care plan goal indicated the resident "wants to consume foods/fluid as I [the resident] desire for enjoyment and comfort." The care plan approaches did not address hydration in relation to the resident's urinary tract infections; the care plan included the following related to hydration:
    - "Follow the nutrition/hydration Interdisciplinary EOC [expectations of care]." (A separate document titled, "Interdisciplinary Expectations of Care for Nutrition/Hydration" listed approaches related to hydration such as, "Monitor, evaluate, and report signs and symptoms of dehydration to nurse [such as] dry/cracked lips, dry oral mucosa…sudden onset of confusion…concentrated urine…Provide resident with safer eating and drinking [such as] offer fresh water or an alternate beverage each shift; must offer ice in fluids….Offer residents sufficient fluid/fluid substitute with oral medications.")
    - "I appreciate that I get to receive iced water and other thin liquids with all my meals."
- The resident's clinical record was reviewed with the quality initiative coordinator and the associate nurse manager from [LOCATION] on 10/25/18 at approximately 8:10 a.m. Laboratory reports dated 05/10/18 and 10/16/18 indicated the resident had UTIs caused by *Escherichia coli* (E coli). The resident had a provider's order dated 10/17/18 for "Sulfamethoxazole 800/Trimeth [trimethoprim] 160 mg [milligrams] tab [tablet] 800 mg/16 mg PO [orally] BID [twice daily] UTI X [for] 7 days."
- The daily "Food & Fluid Intake Flow sheet" included the following codes for documenting the resident's fluid intake: 100%, 4 = eats/drinks most; 75%, 3 = eats/drinks over half; 50%, 2 = eats/drinks half; 25% ,1 = eats/drinks less than half; 0 = consumes 0%. From 10/17/18 to 10/24/18, the resident's fluid intake for breakfast, lunch and the evening meal was as follows:

10/17/18	1 (25%)	0 (0%)	3 (75%)
10/18/18	3 (75%)	2 (50%)	2 (50%)
10/19/18	4 (100%)	1 (25%)	Blank
10/20/18	2 (50%)	3 (75%)	2 (50%)
10/21/18	2 (50%)	2 (50%)	2 (50%)
10/22/18	2 (50%)	1 (25%)	2 (50%)
10/23/18	1 (25%)	2 (50%)	3 (75%)
10/24/18	2 (50%)	3 (75%)	4 (100%)

- Observations confirmed the fluid intake documentation on 10/23/18 and 10/24/18. The associate nurse manager stated staff in the neighborhood "have never tracked fluid intakes [other than the percentage consumed during meals]."
- The resident's most recent nutrition assessment dated 08/16/18 documented a weight of 161 lbs.; the nutrition notes indicated the resident's "ability to communicate is limited…appetite varies…intake varies greatly from nothing eaten to 100% consumed Magic cup, chocolate milk, ice water, and juice provided due to this inconsistency and overall weight/hydration does not seem to fluctuate greatly with this plan.

Fluid/beverage intake on unit (average): varies at each meal, not readily accepting of fluids offered between meals…estimated fluid [needs] 1825-2190 ml [milliliters]."

- On 10/25/18 at approximately 8:40 a.m., the resident's recurrent UTIs were discussed with the nurse manager and associate nurse manager. The nurse manager and associate nurse manager indicated there should have been further review of the resident's UTIs to identify contributing factors such as insufficient fluid intake. The associate nurse manager said, "The dietitian can probably provide him [the resident] with other forms of liquids."
- Resident #104 was observed on 10/23/18 at 11:00 a.m., 2:30 p.m. and 5:50 p.m. in his room; a water pitcher was not located in the resident's room. The resident was not observed consuming fluids and staff did not offer the resident fluids. The NA consistently assigned to provide the resident's care indicated on 10/23/18 at 5:55 p.m. that the resident "was not much of a drinker and would not take any snacks."
- Resident #104 was observed on 10/24/18 at approximately 10:45 a.m. and 2:00 p.m. in his room; a water pitcher was not available in the room. The resident was not observed consuming fluids and staff did not offer the resident fluids.
- On 10/25/18, Resident #104 was observed asleep in bed at 8:00 a.m.; there was not a water pitcher available in the room. The LPN assigned to provide care for the resident stated the resident "does not get up for breakfast until 8:30 or 9:00 a.m." When asked about the resident's treatment for a urinary tract infection, the LPN said, "He completed the antibiotic treatment 10/23/18. He cannot really express his needs. Staff provides him with incontinence care and changes his briefs. He hasn't complained of any pain."
- In summary, during observations between meals during the survey, staff was not observed offering and Resident #104 was not observed drinking fluids. The NA consistently assigned to provide the resident's care indicated on 10/23/18 at 5:55 p.m. that the resident "was not much of a drinker and would not take any snacks." Documentation indicated the resident's fluid intake during meals was less than 75% for all but 2 (of 24) meals when the resident consumed 100% of beverages offered. Documentation indicated the resident received treatment for urinary tract infections in May 2018 and October 2018. It was not evident a comprehensive assessment had been conducted of the resident's UTIs to identify contributing factors such as insufficient fluid intake and develop approaches to address hydration.

F431

483.60(e) *Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.*

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

Residents Affected - Few

Based on observation and interview, the CLC did not store all drugs in locked compartments. Findings include:

Resident #404, [LOCATION]

- During medication pass observations in the [LOCATION] neighborhood at 11:05 a.m. on 10/24/18, an RN began preparing medication for administration for Resident #404. The RN took a bottle of chlorhexidine and 2 scopolamine patches out of the medication drawer and stated the resident's liquid gabapentin (anti-convulsant medication also used to treat neuropathic pain) was not in the medication cart and needed to be obtained from another storage location.
- The RN placed the chlorhexidine mouthwash bottle and 2 scopolamine patch packages back into the medication cart, locked the cart and left to obtain a bottle of liquid gabapentin. The RN returned with a bottle of liquid gabapentin which the RN placed on top of the medication cart. The RN poured 8 milliliters of the gabapentin into a medicine cup in accordance with the provider's order. The RN removed the 2 scopolamine patches and the bottle of mouthwash from the medication cart. The RN poured a capful of the mouthwash into another medicine cup. The RN conducted hand hygiene, donned gloves, and placed the bottle of mouthwash in the medication cart. The RN left the bottle of liquid gabapentin on top of the medication cart at 11:10 a.m. The RN entered Resident #404's room and administered the resident's medications including administering the liquid gabapentin by way of the resident's gastrostomy tube. The RN's back was turned so that the medication cart was not in the RN's line of sight while administering the medications. The bottle of gabapentin was left unattended on top of the medication cart until the RN returned to the medication cart at 11:16 a.m. (6 minutes later).
- On 10/24/18 at 11:40 a.m., the outpatient coordinator (OC) who accompanied the surveyor was interviewed regarding the above observations. The OC verified that the gabapentin had been left on top of the medication cart unattended for the 6-minute duration and added, "That's why I was standing in the doorway….I did not see anyone go by the cart either."
