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: Minneapolis VA Medical Center (Minneapolis, MN)

Dates of Survey: 1/8/2019 to 1/10/2019

Total Available Beds: 80

Census on First Day of Survey: 57

F-Tag	Findings
F164 483.10(e) *Privacy and Confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident; (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility; (3) The resident's right to refuse release of personal and clinical records does not apply when (i) The resident is transferred to another health care institution; or (ii) Record release is required by law.* **Level of Harm** - No actual harm with potential for more than minimal harm that is not immediate jeopardy **Residents Affected** - Few	Based on observation, interview and record review, the CLC did not ensure personal privacy was provided for a resident during care. Findings include: Resident #202, [LOCATION] • During the initial tour on 01/08/19 at approximately 10:20 a.m., in [LOCATION] with the chief nurse, Resident #202 was observed from the hallway receiving wound care for his leg. The resident was turned slightly on his side facing away from the door and the resident's right leg was uncovered from the thigh to the foot and visible to anyone in the hallway. The resident was lying in the bed closest to the door, the room door was open and the privacy curtain was not pulled around the resident's bed. • Resident #202's roommate entered the room and as the roommate passed the foot of Resident #202's bed, the registered nurse (RN) conducting wound care said, "I'm just doing his wound care here." A nursing assistant entered the room, walked past Resident #202, and spoke with the roommate. The nursing assistant left the room and returned carrying a breakfast meal tray for the roommate, delivered the meal tray, and exited the room. • The chief nurse said, "It would be better if the door was closed or the privacy curtain was pulled." The surveyor and chief nurse entered the room and introduced themselves. The RN continued providing wound care for approximately 10 minutes with no attempt to close the door or pull the privacy curtain. When the surveyor and chief nurse exited the room, the chief nurse closed the door.
F281 483.20(k)(3)(i) *The services provided or arranged by the facility must (i) Meet professional standards of quality;* **Level of Harm** - No actual harm with potential for more than minimal harm that is not immediate	Based on observation, interview and record review, the CLC did not ensure that services provided met professional standards of quality. Findings include: The Department of Veterans Affairs Minneapolis VA Health Care System "Guidelines for Vascular Access Therapy," dated 12/05/17 was provided by the [LOCATION] Way nurse manager (NM) on 01/08/19 at 2:50 p.m. The guidelines stated, "Flushing Catheter: ….Each peripheral line will be flushed every 8 hours with at least 3-5 ml [milliliters] 0.9% normal saline…Confirm blood return from all vascular access devices prior to use….' The undated Elsevier's clinical skill titled, "Peripherally Inserted Central Catheter (PICC):

jeopardy

Residents Affected - Few

Maintenance and Dressing Change," was provided on 01/08/19 at 3:00 p.m. by the [LOCATION] NM. Under "Catheter Flushing and Locking" the clinical skill stated, "Attach a 10-ml syringe filled with 10 ml of preservative-free sodium chloride….Open the clamp and gently aspirate until a blood return is visible in the tubing….Slowly inject the preservative-free 0.9% sodium chloride or alternative flush solution into the port."

Resident #105, [LOCATION]

- Resident #105 had a provider's order that read, "Saline flush 10 ml every 8 hours."
- During a medication administration observation on 01/08/19 at 1:10 p.m. in [LOCATION], an RN was observed preparing to administer the ordered saline flush by way of a peripherally inserted central catheter (PICC) for Resident #105. The RN attached a 10 ml syringe of 0.9 % sodium chloride to the access device port, administered 2-3 ml of sodium chloride, aspirated for blood return and administered the remainder of the sodium chloride. Immediately following the observation, the RN was asked what the CLC procedure was regarding aspiration of a blood return with a PICC line. The RN said "That's how I was taught, to inject a little, then withdraw."
- On 01/08/19 at 1:30 p.m., the NM was asked what the CLC procedure was regarding when to aspirate for blood return when administering a flush. The NM said, "I think the procedure is to aspirate first, then flush, but I'll check and let you know." The NM later provided the above procedures.

F322

483.25(g)(2) *A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.*

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 appropriate treatment and services for a resident with a feeding tube. Findings include:

The undated Elsevier's clinical skill titled, "Feeding Tube: Medication Administration - Quick Sheet," was provided on 01/09/19 by the nurse manager of [LOCATION]. The clinical skill stated, "Step #11. Before administering medications, verify the placement of the feeding tube."

The undated Elsevier's clinical skill titled, "PEG/PEJ [percutaneous endoscopic gastrostomy/percutaneous endoscopic jejunostomy] Procedure-Custom Management of PEG/PEJ and Enteral feedings," was provided by the nurse manager of [LOCATION] on 01/09/19 at 12:40 p.m. The clinical skill stated, "Special Considerations….You can administer most tablets and pills through the tube by crushing and diluting as necessary….Place syringe on the end of the tube…pull back on the syringe piston to aspirate for gastric content….Follow procedure in the administration of medication."

Elsevier's clinical skill titled, "Feeding Tube: Verification of Placement," and dated June 2018, was retrieved online on 01/15/19 and stated, "Verify placement of the enteral feeding tube every 4 hours using observation of gastric aspirate, pH testing of gastric aspirate, or capnography. **Whether the patient has a gastric or small-bowel feeding, a sharp increase in gastric residual volume (GRV) may indicate displacement of a small bowel tube into the stomach** [emphasis not added]….For a patient who is intermittently tube fed, test placement immediately before each feeding and before administering medications.

Observing Gastric Aspirate

- Draw 30 ml of air into a 60-ml enteral syringe, attach the syringe to the proximal end of the enteral feeding tube and inject the air into the tube.
- Draw back on the syringe slowly and obtain a small amount of gastric contents. If necessary, reposition the patient to facilitate withdrawal of fluid from the tube.
- Observe the appearance of the gastric aspirate.
    - Most gastric aspirates are clear or grass-colored.
    - Most intestinal aspirates are stained a distinct yellow by contact with bile.
    - Gastric aspirates from intermittently tube-fed patients are not typically bile stained (unless intestinal fluid has refluxed into the stomach)….
- If after repeated attempts, fluid cannot be aspirated via a tube that was radiographically confirmed as in the desired position, assume that the tube remains correctly placed if these assessment findings are true:
    - There are no risk factors for tube dislodgment.
    - The tube has remained in the original taped position.
    - The patient is not experiencing respiratory distress.
      Flush the tube with 30 ml of water."

Resident #101, [LOCATION]

- On 01/09/19 beginning at 9:00 a.m., an RN in [LOCATION] was observed preparing to

administer medications by way of a PEJ tube for Resident #101. After preparing the medications properly, the RN flushed the PEJ tube with approximately 30 ml of water and administered the medications. The RN did not verify placement by checking for gastric residual volume prior to administering the flush and medications.

Resident #201, [LOCATION]

- On 1/09/19 at 8:40 a.m., an RN in [LOCATION] was observed preparing to administer medications by way of a PEJ tube for Resident #201. After preparing the medication properly, the RN flushed the PEJ tube with 40 ml of water and administered the first medication. The RN did not verify placement by checking for gastric residual volume prior to administering the flush and medication.
- On 01/09/19 during an interview at 1:00 p.m., the nurse manager and chief nurse concurred that the procedure directed that gastric content be checked prior to administering medication.

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 - 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 the environment remained free from accident hazards. Findings include:

[LOCATION]

- During the initial tour of [LOCATION] with a nurse manager and chief nurse on 01/08/19 at 10:05 a.m., an unattended housekeeping cart was observed in the resident hallway outside storage room [LOCATION]. The top of the cart had 4 bottles of cleaning supplies that were accessible to residents including 3M™ Bathroom Cleaner Concentrate, 3M Non-Acid Disinfectant Bathroom Cleaner, Gemini Crème Cleanser and Northland Alive Green Tree Liquid Bacteria. When the cart was discovered, the nurse manager called environmental management services (EMS) staff to ask them to return to the cart and secure it. Just prior to the observation of the unattended housekeeping cart, the nurse manager said, “We have a number of dementia residents [residents with a diagnosis of dementia] on [in] the neighborhood.” From 10:05 a.m. to 10:15 a.m., three residents in wheelchairs unaccompanied by staff were observed to pass by the cart. The nurse manager said she would stay with the cart until EMS staff arrived in the neighborhood. She later reported that it took 25 minutes for the EMS staff member to return to the cart as he was cleaning a bathroom in the neighborhood.
- On 01/08/19 at 12:10 p.m., the chief nurse provided the product safety data sheets (PSDS) obtained from the environmental management services supervisor for the items found on the cart. The PSDS contained the following “Hazard statements:”
    - 3M Bathroom Cleaner Concentrate – “May be corrosive to metals, causes severe skin burns and eye damage….May cause severe respiratory irritation.”
    - 3M Non-Acid Disinfectant Bathroom Cleaner Concentrate – “Harmful if swallowed…causes severe skin burns and eye damage.”
    - Gemini Crème Cleanser – “Causes mild skin irritation…causes eye irritation…causes damage to lungs through prolonged exposure or repeated exposure.”
    - Northland Alive-Green Tree – “Contact may cause eye irritation…Ingestion may cause stomach upset…Inhalation, irritation of mucus membrane.”
- On 01/09/19 at approximately 10:40 a.m., the environmental management services supervisor verified that the cart should not have been left unattended; the chemicals should have been locked in the cart or put in the locked storage room.

F441

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

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

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

The CLC policy dated 04/14/14 and titled, “Hand Hygiene,” was provided by the chief nurse on 01/08/19 at 11:57 a.m. The policy stated, “Use an alcohol-based hand rub or antimicrobial soap and water…after removing sterile or non-sterile gloves…before donning non-sterile gloves used for patient care or contact with environmental surfaces in the immediate vicinity of the patient and after removing those gloves.”

Resident #202, [LOCATION]

- On 01/08/19 at approximately 10:20 a.m. in [LOCATION], the chief nurse and a surveyor observed wound care for Resident #202. When the surveyor and chief nurse

Residents Affected - Few

entered the room, an RN was observed wearing gloves and an old dressing which contained visible serosanguineous drainage had been removed from the resident's right posterior leg stasis ulcer. The wound measured approximately 18 centimeters (cm) by 5 cm and had a beefy red, granular appearance. The RN was cleansing dried Sensi-Care® paste from around the wound. The nurse explained that it took awhile to remove the Sensi-Care paste so the RN sprayed lidocaine topical spray around the wound and cleansed the area around the wound with a gauze pad. Several gauze pads with Sensi-Care and a brown-colored drainage were observed in the trash receptacle next to the bed. The RN cleansed above the wound, doffed gloves and without conducting hand hygiene, donned another pair of gloves. The RN opened a new gauze pad and cleansed the lateral side of the wound. The RN doffed gloves and without conducting hand hygiene, donned another pair of gloves and applied Sensi-Care paste around the wound. The RN doffed gloves and without conducting hand hygiene, donned another pair of gloves. The RN opened a package of Hydrofera Blue® foam, touched both sides of the foam, and pressed the foam over the wound stating, "I do this so I have an outline of the wound from the Sensi-Care and I can cut the foam to fit the wound shape." The RN lifted the foam from the wound, touched both sides of the foam, and cut and placed the foam over the wound. The RN then covered the wound with ABD pads prior to the conclusion of the observation.

Resident #206, [LOCATION]

- During a medication administration observation for Resident #206 on 01/08/19 at 4:45 p.m., an RN performed hand hygiene, donned gloves, and entered the resident's room. After pushing back the privacy curtain and moving the overbed table, the nurse disconnected an intravenous medication from the resident's PICC line and scanned the resident's armband. The RN moved the resident's overbed table next to the bed. The RN doffed gloves and without performing hand hygiene, exited the room; the RN then touched multiple surfaces on the medication cart including the keyboard, Bar Code Medication Administration (BCMA) scanner and medication drawer. The nurse retrieved two medications from the medication drawer, donned gloves and entered the resident's room with the medications. The nurse obtained an esomeprazole capsule from the medicine cup with a gloved hand and attempted to open the capsule. The resident said, "Let me do it; I do this all the time." The nurse handed the resident the capsule by holding the resident's hand and placing the capsule in his hand. The resident sprinkled the medication over the applesauce and took the medication. The resident asked to take the other medication later. The nurse doffed gloves and exited the room without performing hand hygiene, and returned the medication that the resident did not take to the medication cart. The surveyor spoke with the nurse after the observation about not performing hand hygiene when changing gloves. The RN said, "Yes, I should have done hand hygiene." The observation was shared with the nurse manager.