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: Southern Arizona VA Health Care System (Tucson, AZ)

Dates of Survey: 8/7/2018 to 8/9/2018

Total Available Beds: 92

Census on First Day of Survey: 71

F-Tag	Findings
F225 483.13(c)(2) *The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).* **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's injuries of unknown source were investigated. Findings include: Resident #201, [LOCATION] • Resident #201 was admitted to the [LOCATION] household on [DATE] with diagnoses including dementia, mixed neurocognitive disorder and stage 3 chronic kidney disease. The resident's comprehensive admission Minimum Data Set (MDS) assessment dated [DATE] was coded to indicate the resident had clear speech, moderate difficulty with hearing, was understood by others, and rarely/never understood others. The MDS indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment; and the resident required extensive assistance of two staff for transfers, dressing, toilet use and personal hygiene; extensive assistance of one person for walking in the room and corridor; and limited assistance for bed mobility. The MDS did not indicate the resident experienced falls since admission to the CLC. • The "Nursing Admission Evaluation Note" dated [DATE] was documented by an RN and stated, "Skin: intact." • The resident's most recent care plan stated, "Problem: Geri [geriatric]-Psychiatric impaired safety r/t [related to] poor vision, history of falls, poor safety awareness, use of mobility device, unsteady gait. Goal: 1) I am a high safety risk. 2) I want to be safe. 3) I do not want [to] sustain new injuries." Approaches included: "1) I want the interdisciplinary team to assess me for safety awareness. 2) I want staff to supervise me. 3) I want to have alarms and/or 4) Wander-guard placed for my improved safety. 5) I want staff to provide verbal cues for my improved safety. 6) I want the interdisciplinary team to assess me for use of safety management devices: helmet, seat belt, hipsters, floor mat, 1:1 [one-to-one] sitter, post-surgical boots/braces or [left blank] 7) I want a psychiatric consultation placed if deemed appropriate. 7) I want my medications at least every 30 days by my providers and pharmacy." A comment on the care plan dated 08/01/18 read, "Cont [continue] POC [plan of care]." • There were no provider order related to safety or fall precautions. • Resident #201 was observed seated in his wheelchair in the dining/activity room in the [LOCATION] neighborhood on 08/08/18 at 9:02 a.m., with a quality management staff member present. The resident was wearing shorts and non-skid socks; multiple scabbed abrasions were observed over the tibial ridges (shins) on both legs, extending from approximately one inch below the resident's knees to approximately three inches above the ankles. When asked if he knew what happened to his legs, Resident #201 replied, "No, I have no idea." A registered nurse (RN) present in the dining/activity room at the time of the observation was asked if she was aware of what caused the abrasions; the RN replied, "No, I don't know." • During an interview with the nurse manager of the [LOCATION] neighborhood on 08/08/18 at 9:10 a.m., with the assistant nurse manager and the quality management staff member present, when asked if the nurse manager was aware of what caused the abrasions on Resident #201's legs, the nurse manager replied, "I don't know, but I know there's documentation that the nurse practitioner looked at them [the abrasions]. It happened since he has been here [since admission to the CLC]. It wasn't a result of

his falls. The nurse manager then reviewed documentation in the computerized patient record system (CPRS) and stated, “The abrasions were first documented on 07/12/18 on the left shin and 07/17/18 on the right shin. They [the abrasions] wouldn’t have been from his falls, as he didn’t have a fall between 07/05/18 and 07/25/18.” When asked if an investigation of the injuries was conducted, the nurse manager replied, “No, we didn’t do an incident report.”

- On 08/08/18 at 9:00 a.m. the surveyor requested the CLC’s policy regarding investigation of injuries of unknown source/origin. During an interview with the CLC chief nurse on 08/09/18 at 5:30 p.m., the chief nurse stated, “We don’t have a policy on investigation of injuries of unknown origin. We weren’t familiar with that terminology. We file reports on incidents and accidents like falls, but not for something like this.”

F278

483.20(g) *Accuracy of Assessment. The assessment must accurately reflect the resident’s status.*

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

Residents Affected - Many

Based on observation, interview and record review, the CLC did not ensure that the comprehensive assessment accurately reflected each resident’s status for 5 of 10 residents selected for review during the survey. Findings include:

Resident #102, [LOCATION]

- Resident #102 was admitted to the CLC on [DATE]. According to the comprehensive admission Minimum Data Set (MDS) dated [DATE], the resident had clear speech, understood and was understood by others. The resident’s short-term and long-term memory were OK and the resident was independent in cognitive skills for daily decision making based on staff assessment. The Brief Interview for Mental Status (BIMS) was not conducted.
- On 08/08/18 at 2:10 p.m., the resident assessment coordinator (RAC) was interviewed regarding the BIMS. The RAC stated, “I did not get over there [the CLC] to do the assessment in time. I completed the staff assessment for cognition [rather than the BIMS].”

Resident #101, [LOCATION]

- Resident #101 was admitted to the CLC on [DATE]. According to the admission MDS assessment dated [DATE], the resident had clear speech, was understood and sometimes understood others. The BIMS was not completed; the staff assessment for cognition was completed by the RAC. The staff assessment indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills for daily decision making.
- On 08/08/18 at 2:10 p.m., the RAC was interviewed regarding completion of the BIMS. The RAC stated, “I did not get over there [the CLC] to do the assessment in time. I completed the staff assessment for cognition.”

Resident #202, [LOCATION]

- Resident #202 was admitted to the [LOCATION] household on [DATE]. The resident’s comprehensive admission MDS assessment dated [DATE] was coded to indicate that the resident had clear speech, adequate hearing, and was understood by and understood others. The MDS indicated the resident scored 15 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition. The Resident Mood Interview (PHQ 9©) and the Staff Assessment of Resident Mood (PHQ-9-OV©) were not completed. The MDS indicated that the resident interview for Daily and Activity Preferences was not completed.
- During an interview with Resident #202 on 08/08/18 at 4:30 p.m., when asked about any concerns about the care he was receiving in the CLC, the resident replied, “Having a schedule is really important to me. I work out every day.”

Resident #203, [LOCATION]

- Resident #203 was admitted to the [LOCATION] household on [DATE]. The “Admission History and Physical,” documented by the physician on [DATE] indicated the resident had diagnoses including a methicillin-resistant *Staphylococcus aureus* upper respiratory infection; this was an active diagnoses in the 7 days prior to completion of the MDS. The resident’s comprehensive admission MDS assessment dated [DATE] did not indicate the presence of a multiple-drug resistant organism (MDRO) as an active diagnoses (active diagnoses in the last 7 days).

Resident #205, [LOCATION]

- Resident #205 was admitted to the CLC on [DATE] and readmitted on [DATE]. During an interview with the resident assessment coordinator on 08/08/18 at 2:20 p.m., when asked if a comprehensive admission assessment had been completed, the RAC replied, “His [Resident #205’s] admission MDS from his [DATE] admission must have

been lost. We didn't realize that it had been lost until you asked for it. We had a lot of trouble with lost MDSs in [DATE] due to a software problem and we fixed any that we realized were lost."

- The resident's most recent quarterly Minimum Data Set (MDS) assessment, dated 07/26/18 was coded to indicate the resident had clear speech, moderate difficulty with hearing, was understood, and understood others. The MDS indicated that the BIMS was not completed; the resident's short-term and long-term memory were OK and the resident had modified independence in cognitive skills for daily decision making decision based on staff assessment. The MDS was coded to indicate that the resident had no pressure ulcers; documentation in the medical record indicated that the resident had a right heel unstageable pressure ulcer and a Stage 2 pressure ulcer on the left gluteal/coccyx at the time the MDS was completed. (See Pressure Ulcers)
- In the "Nursing Skin Assessment Note" dated 06/19/18, the RN documented, "Suspected Deep Tissue Injury. Location: Right heel – present on admission from acute care. Dark purple discoloration measuring 3 x 3 x 0 cm [three by three by zero centimeters]….Stage 2 Location: left gluteal/buttock – fluid filled blister present on admission from acute care measuring 2.0 x 1.5 x 0 cm."
- The CWOCN (certified wound and ostomy care nurse) documented the "Wound Care Note" dated 07/27/18 that stated, "Right heel – unstageable pressure ulcer, present on admission: eschar is stable, black. Wound measurement: 2.5 x 2.9 x 0 cm…left gluteal/coccyx pressure ulcer, documented as stage 2 present on admission. 07/20/18 0.5 x 1.0 x 0.3 cm: 100% red base. 07/27/18 resolved."

Systems-level Review

- During an interview with the RAC on 08/08/18 at 2:20 p.m., when asked why the BIMS was not conducted with several residents and the Mood Interview (PHQ9) was not conducted with one resident, the RAC stated, "We go over [to the neighborhood] to try to interview, but we are busy. If the resident isn't available, we can't do the interview. They [the residents] go to therapy and go out for a lot of tests." When asked if other interdisciplinary team members assisted in completing the BIMS, the RAC replied, "No, it's up to us [referring to herself and the second RAC]." When asked why Resident #205's pressure ulcer and Resident #202's diagnosis of MDRO were not coded on the MDS, the RAC stated, "I must have missed it; I will correct them both."
- During an interview with the resident assessment coordinator, on 08/09/18 at 7:30 a.m., the RAC was asked about completing the resident Interview for Daily and Activity Preferences; the RAC reported that the admitting nurse completed a paper form that was placed in the resident's record and identified the resident's preferences. The RAC stated, "If we [RACs] don't have time to do the interview, we use the information from the checklist that the nurses complete."
- During an interview with the chief nurse executive of the CLC and nurse manager of the Roadrunner household, an example of the checklist was provided to the surveyors. The checklist included items found in Section F of the MDS; however, the checklist did not indicate how important the preferences were to the individual resident (e.g., very important, somewhat important, not important).

F279

483.20(k) *Comprehensive Care Plans. (1) The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the following: (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and (ii) Any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).*

Based on observation, interview and record review, the CLC did not develop or update a comprehensive care plan for 5 of 10 residents selected for review during the survey. Findings include:

Resident #102, [LOCATION]

- Resident #102 was admitted to the CLC on [DATE] with diagnoses including pseudo gout, incomplete paraplegia post L2 (second lumbar vertebrae) fracture with rod placement, bacteremia, neurogenic bladder and chronic right heel ulcer.
- The resident's comprehensive admission Minimum Data Set (MDS) dated [DATE] indicated the resident had clear speech, was understood by and understood others; the resident's short-term and long-term memory were OK and the resident was independent in cognitive skills for daily decision making based on staff assessment.
- The admission assessment dated [DATE] indicated it was very important for the resident to take care of personal belongings or things, have books, magazines and newspapers to read; listen to music that he liked and to be around animals and pets.
- The most recent care plan did not include preferences or address recreational activities.
- According to staff interview the resident was placed on bedrest in April 2018; however, there was no recreational therapy plan for the resident and the care plan did not indicate the resident spent all or most of his time in bed.

Resident #104, [LOCATION]

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

Residents Affected - Many

- Resident #104 was admitted to the CLC on [DATE] with diagnoses that included major neurocognitive disorder, Parkinson's disease, dementia due to Parkinson's disease, posttraumatic stress disorder (PTSD) and anxiety. According to the admission history and physical dated [DATE], the resident was admitted for "safety due to visual hallucinations and making holes in the wall of his home with a hammer."
- Records reviewed dated 06/27/18, indicated the resident had increasing agitation and behavioral symptoms of potential distress, which led to his admission to the acute care setting on [DATE].
- The MDS dated 07/11/18 indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills based on staff assessment. The MDS indicated the resident had physical behavioral symptoms directed toward others that put the resident at significant risk for physical illness or injury, significantly interfered with the resident's care, put other resident's at significant risk for physical injury, significantly intruded on the privacy or activity of others, and significantly disrupted care or the living environment 4-6 days during the review period. The MDS indicated the resident experienced rejection of care and wandering that occurred 4-6 days during the review. According to the MDS dated 07/11/18, it was very important for the resident to choose what clothes to wear; choose between a tub bath, shower, bed bath, or sponge bath; and have snacks available between meals.
- The resident's care plan dated 07/05/18 did not include goals or approaches related to the resident's behavioral symptoms. The care plan not address the resident's preferences as identified on the MDS.
- During an interview on 08/07/18, the chief nurse agreed there was a lack of direction for care on Resident #104's care plan.

Resident #201, [LOCATION]

- Resident #201 was admitted to the [LOCATION] household on [DATE]. The resident's admission comprehensive MDS assessment dated [DATE] was coded to indicate the resident had clear speech, moderate difficulty with hearing, was understood by and rarely/never understood others; staff assessment indicated that the resident had short-term and long-term memory problems, and severely impaired cognitive skills for decision making. Preferences for Customary Routine and Activities as indicated by resident/family interview were identified on the MDS; the MDS indicated it was very important for the resident to choose his bedtime and somewhat important to have family or a close friend involved in discussions about care; to have a place to lock things to keep them safe; to listen to music that he liked; to be around animals such as pets; to do things with groups of people; to do favorite activities; to go outside or get fresh air when the weather was good; and to participate in religious services or practices. None of the preferences were included in the resident's care plan.
- The resident was not involved in any recreational activities during the survey including during the following observations.
    - On 08/07/18 at 1:30 p.m., Resident #201 was observed sitting in a wheelchair in his room with no activity and no other residents or staff in the immediate vicinity.
    - On 08/07/18 at 2:20 p.m., Resident #201 was observed sitting in a wheelchair outside his room with no other residents or staff in the immediate vicinity and no activity provided for the resident.
    - On 08/08/18 at 9:02 a.m., Resident #201 was observed sitting in a wheelchair in the dining/activity room. Staff were present in the room and engaged in talking with other residents. Resident #201 was not involved in an activity.
    - On 08/08/18 at 10:00 a.m., Resident #201 was observed sitting in a wheelchair in his room, with no activity; no other residents or staff were in the immediate vicinity.

Resident #202, [LOCATION]

- Resident #202 was admitted to the [LOCATION] household on [DATE]. The resident's admission comprehensive MDS assessment dated [DATE] was coded to indicate that the resident had clear speech, adequate hearing, and was understood by and understood others. The MDS indicated the resident scored 15 on the Brief Interview for Mental Status (BIMS) suggesting intact cognition. The MDS indicated the resident interview for Preferences for Customary Routine in Section F was not completed. Staff assessment indicated the resident's preferences included caring for personal belongings, receiving showers and participating in favorite activities. None of the preferences were listed in the resident's care plan.
- During an interview with Resident #202 on 08/08/18 at 4:30 p.m., when asked if he had any concerns about the care he was receiving in the CLC, the resident replied, "Having a schedule is really important to me. I work out every day." The resident did not voice concerns regarding the lack of a schedule.

Resident #205, [LOCATION]

- Resident #205 was admitted to the CLC on [DATE]. The resident's most recent quarterly MDS dated 07/26/18 was coded to indicate that the resident had clear speech, moderate difficulty with hearing, and was understood by and understood others. The MDS indicated that the Brief Interview for Mental Status (BIMS) was not conducted; staff assessment indicated that the resident's short-term and long-term memory were OK and the resident had modified independence in cognitive skills for daily decision making. The resident's daily and activity preferences coded on the MDS indicated it was very important for the resident to choose what clothes to wear; choose between a tub bath, shower, bed bath, or sponge bath; choose his bedtime; have books, newspapers and magazines to read; keep up with the news; to do his favorite activities; and to go outside to get fresh air when the weather was good. None of the preferences were listed in the resident's care plan.

Systems-level Review

- During an interview on 08/07/18, the chief nurse stated that the format of resident care plans was changing to an electronic version and the format had already changed in [LOCATION]. It was reported the goal was to have all the households change to the electronic format.

F309

483.25 *Quality of Care. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Use F309 for quality of care deficiencies not covered by §483.25(a)-(m).*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not provide care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. Findings include:

Fracture Care

Resident #204, [LOCATION]

- Resident #204 was admitted to the [LOCATION] neighborhood on [DATE] with diagnoses including chronic obstructive pulmonary disease (COPD), diabetes, and small cell lung cancer; according to record review, on admission the resident had pain and edema to the dorsum of his left foot. The "Nurse Practitioner History and Physical Note" dated [DATE] stated, "Puffiness, warmth, tenderness top of left foot. Foot x-ray impression: great toe MTP [metatarsophalangeal] joint degenerative disease."
- The resident's comprehensive admission MDS assessment dated [DATE] was coded to indicate the resident had clear speech, adequate hearing, and was understood by and understood others. The MDS indicated the resident had a Brief Interview for Mental Status (BIMS) score of 15 suggesting intact cognition. The MDS was coded to indicate that the resident required supervision of one person for bed mobility, transfers, locomotion in and outside of the neighborhood; limited assistance of one person for walking in his room and in the corridor and dressing; and extensive assistance of one person for toilet use. Balance when moving from a seated to standing position, during surface to surface transfers, when walking, when turning around, and when moving on and off the toilet was coded as not steady, but the resident was able to stabilize with staff assistance.
- The "MRI [magnetic resonance imaging] Report" dated 07/17/18 stated, "Reason for study: left foot pain. Pertinent patient history: Patient has diffuse left midfoot pain (mostly dorsally) > 1 month [greater than one month in duration] with erythema and edema extending to knee. X-rays negative. Impression: Multiple non-displaced fractures which could be stress related. Second through fifth metatarsals."
- The provider documented in the "Palliative Physician Note" dated 07/30/18, "Charcot arthropathy, metatarsal fractures left foot, non-weightbearing, follow up with podiatry 08/20/18."
- RN notes in the "CLC Weekly Note" dated 08/05/18 read, "Patient demonstrates poor safety awareness and needs reinforcement. This week has improved with boot. Mostly uses wheelchair on unit [neighborhood] for locomotion. Can ambulate and is aware of pressure to left foot….Pain assessment: Pain to left foot continues….Barriers to learning: none. Activity/Safety: Transfers: Needs assistance….Mental status: Is alert and oriented x 3 [person, place, time]…Specific limits to functioning/ROM [range of motion]: Left foot pain which limits mobility. Now wearing support boot to left foot."
- A provider's order dated 07/20/18 stated, "Elastic/ace wrap to left foot, post-op [post operative] shoe left foot, non-weightbearing."
- A care plan addendum dated 07/29/18 stated, "Category: ADLs [activities of daily living]. Fractured left foot determined with MRI. Non-weightbearing and requires help but is non-compliant with restrictions."
- During an observation of care on 08/07/18 at 2:50 p.m., Resident #204 was seated in a wheelchair in his room, approximately 5 feet from his bed. An RN was observed standing behind the resident's wheelchair, steadying the chair, while the resident

moved from a sitting to standing position, took approximately five steps forward, and turned and sat on the edge of his bed. The resident was observed to be wearing non-skid socks and was not wearing the ankle foot orthosis or ace wrap to the left foot. The orthosis was observed on the floor near the resident's bed. The resident was not observed to use an assistive device, although a walker was present in the resident's room. The RN did not offer to assist the resident in donning the orthosis, offer or provide the resident with the walker, or cue the resident not to bear weight on the left foot. When asked if the resident was experiencing pain, Resident #204 stated: "Yes, my left foot hurts. It's broken." When asked why he wasn't wearing the brace [orthosis], the resident replied, "I was outside smoking. I forget to put it on sometimes."

- During an interview with the RN caring for the resident on 08/07/18 at 3:00 p.m., when asked if Resident #204's weight bearing status remained non-weightbearing on the left foot, the RN reviewed the physician orders in the computerized patient record system (CPRS) and stated: "Yes, he's still non-weightbearing."
- During an interview with Resident #204 on 08/08/18 at 10:20 a.m., when asked about pain, the resident replied: "The only pain I have today is in my left foot."
- During an interview with the nurse manager and patient care coordinator of [LOCATION] on 08/08/18 at 10:30 a.m., when asked about Resident #204's ability to maintain non-weightbearing status for the left foot, the patient care coordinator stated, "He [Resident #204] was keeping the boot on all the time until this week. He uses the wheelchair for mobility. He has always put weight on his foot for transfers." When asked if putting weight on his foot for transfers, with or without the brace complied with the physician's order to be non-weightbearing, the nurse manager and patient care coordinator agreed that it did not. When asked if there had been a referral for physical therapy to teach the resident how to perform transfers while maintaining non-weightbearing to the left foot, the nurse manager reviewed documentation in CPRS and stated, "No, he hasn't had a referral for PT [physical therapy]."
- During an interview with the physician caring for Resident #204, on 08/08/18 at 10:45 a.m., when asked about the resident's foot pain, the physician replied, "The most important thing for him to do to relieve the pain is to wear the boot and keep the foot non-weightbearing." When asked about referring the resident to physical therapy to teach the resident to transfer and walk while maintaining the non-weightbearing status, the physician replied: "No I haven't, but I will right now."

F314

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

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not ensure that residents who entered the CLC without pressure ulcers did not develop pressure ulcers unless they were unavoidable and residents having pressure ulcers received necessary treatment and services to promote healing. Findings include:

The Southern Arizona VA Health Care System Memorandum 03-17-34 titled, "Pressure Ulcer Prevention and Management Program," and dated February 14, 2017 was provided by a quality management staff member on 08/08/18 at 11:30 a.m. The memorandum stated, "4. g. Care planning: An interdisciplinary approach…that develops, implements, and evaluates the plan of care must be used. (1) Those risk factors that increase the Veteran's [resident's] potential for pressure ulcer development must be identified. (2) Whether and to what extent the risk factor(s) can be modified, stabilized and/or eliminated must be decided…(4) The need for pressure redistribution support surfaces or devices by matching a device's potential therapeutic benefit with the Veteran's situation need to be assessed….(7)…Each Veteran's care plan and progress must be documented, evaluated, and altered, as appropriate….h. (b) The interdisciplinary staff is also responsible for including the Veteran…or authorized decision makers in the prevention and management of pressure ulcers."

Resident #205, [LOCATION]

- Resident #205 was admitted to the [LOCATION] household on [DATE] and readmitted on [DATE] and [DATE] with diagnoses including coronary artery disease, diabetes, neuropathic pain and left below knee amputation (BKA). The "Admission History and Physical Examination" dated [DATE], was written by the nurse practitioner and stated, "Returned from ASIH [absent sick in hospital]. On 06/15/18 patient underwent left BKA [below knee amputation]…Skin: has a sore from being in bed up there [acute care hospital] so long. Buttocks: left buttock stage 2 wound. Right lateral heel 3 cm [centimeters] central black with red circumference(sic)…Wound care consult required: Yes."
- The resident's admission comprehensive Minimum Data Set (MDS) assessment was not available. The most recent quarterly MDS, dated 07/26/18 was coded to indicate that the resident had clear speech, adequate hearing, was understood, and understood others. The resident's short-term and long-term memory were OK and the resident had modified independence in cognitive skills for daily decision making based on staff

assessment. The MDS was coded to indicate the resident required extensive assistance of two for bed mobility and transfers, and supervision and set up assistance for locomotion in and out of the unit (neighborhood); the resident had functional limitations in range of motion in one lower extremity. Skin and ulcer treatments coded on the MDS included a pressure reducing device for the bed and chair, turning and repositioning program, nutrition or hydration intervention, ulcer care, surgical wound care, applications of dressings other than to feet, and applications of ointments/medications other than to feet. The MDS was incorrectly coded to indicate the resident had no pressure ulcers.

- The RN's "Skin Assessment" dated 07/02/18 stated, "Braden (Scale for Predicting Pressure Ulcer Risk) Skin Assessment: Sensory Perception: 3 Slightly limited, Moisture: 3 Occasionally moist, Activity: 1 Bedfast, Mobility: 2 Very limited, Nutrition 3 Adequate, Friction: 3 No apparent problem. 15 Mild risk."
- Resident #205's care plan stated, "Problem: 1. Altered skin integrity. [Not dated] 2. Vascular wound infection. [Not dated] 3. 06/18/18: Left BKA incision, right heel DTI [deep tissue injury] 4. 06/18/18 left gluteal/buttock stage 2 continue to heal/stable. 07/27/18 [left gluteal/buttock] resolved. Goal: Wound will improve and I will not develop new open areas. [Not dated] Approach: [no approaches were dated.] 1. Assess wounds weekly and prn [as needed] using 'wound note' template in CPRS [computerized patient record system]. 2. Change dressing as ordered. 3. Turn every 2 hours while in bed (self) using wedges. 4. Specialty mattress: pressure redistribution. 5. Varilite wheelchair cushion. [style/model of cushion not specified.] 6. Evaluate effectiveness of treatment every week and recommend changes as indicated. 7. Heels offloaded with pillows Sage boots [sic]. Comments: 06/15/18 dressings daily bid [twice a day] to buttocks. 08/07/18 No changes."
- Resident #205 had the following provider orders:
    - 07/02/18: "Left knee immobilizer at all times, remove for bathing."
    - 08/06/18: "Bedrest due to multiple skin breakdown to coccyx and gluteals. Right posterior thigh DTI and left upper thigh open wound. Paint with betadine and air dry daily and prn. Do not apply immobilizer for now. Left knee redness – cover with small allevyn dressing and change every 3 days and prn. Right heel eschar – paint with betadine, air dry and cover with dry dressing. Change Monday, Wednesday, Friday."
    - 08/06/18: "Wound care: coccyx, right gluteal and left gluteal ulcers – bed rest due to worsening pressure injury. No diaper [adult brief] while in bed. Nursing to change dressing TID [three times a day] and prn until improved. Cleanse with Caraklenz spray. Pat dry, apply small amount of vitamin A and D ointment first then followed by thin layer of calmoseptine ointment over the top and cover with mepilex transfer."
- The CWOCN (certified wound and ostomy care nurse) documented in the "RN Wound Assessment" dated 07/06/18, "On Arise [low air loss] air mattress. Right heel unstageable pressure ulcer, present on admission, eschar is stable, black dry hard. No redness surrounding. Measurements: 2.5 x 2.5 cm [centimeters] Treatment is betadine three times weekly/ABD/Kerlix, bandnet to secure. Left gluteal/coccyxpressure ulcer, documented by nursing as a stage 2 present on admission. Measurements: 1.5 x 1.5 x 0.1 cm dry yellow fibrin tissue. Treatment is mepilex and allevyn every three days."
- All wound notes for Resident #205 since the most recent admission on [DATE] were requested; no documentation was provided for the time period between 07/06/18 and 08/03/18. There was no indication that skin checks/assessments were conducted between 07/06/18 and 08/03/18 including observation of the skin surrounding and underneath the left knee immobilizer.
- An RN documented in a "General Nursing Note" dated 08/03/18 at 12:18 p.m., "Patient refused dressing change at 10:45 [a.m.] when approached by this RN. He said he will have his dressing changed when he gets back into bed this afternoon."
- In the CLC weekly note dated 08/05/18, the RN documented, "New wound noted on right [left] gluteal."
- In a "General Nursing Note" dated 08/06/18 at 9:55 p.m., the RN documented, "Refused to change his dressing on his coccyx. Explained it to him it's going to be TID [three times a day]. Patient said 'Again? They just changed it this afternoon. Can it be done in the morning?' Will change in a.m. if able."
- The COWCN's "Wound Care Consult" dated 08/06/18 stated, "Consulted to evaluate new skin breakdown to left gluteal area. Reports by staff patient has been declining to go back in bed once he's up in chair. He stayed in chair for long period of time and refused incontinent [incontinence] care every 2 hours reports by staff [sic]. Staff using sling sky [ceiling] lift during transfer. Continue using low air loss mattress and has verilite seat cushion when up in chair for pressure relief. Head to toe skin assessment. Wounds as follows: Coccyx directly to the bony prominences. Stage 3 pressure injury....This is full thickness skin loss with 40% [percent] yellow adherent slough tissue and 60% red base. Wound measurement: 2.0 x 1.5 x 0.2 cm. Right ischium: Stage 3 pressure injury…full thickness skin loss with 40% yellow slough tissue and 60% red

tissue. Wound measurement: 4.0 x 3.5 x 0.2 cm. Right trochanter/hip: Appears to be blister that has ruptured. Stage 2 pressure injury. 100% pink base. Wound measurement 2.0 x 1.0 x 0.1 cm. Right posterior thigh: Deep tissue injury: Appears to be caused by the immobilizer medical device. Intact with dark purple discoloration. Wound measurements: 1.0 x 1.0 x 0 cm. Right lateral heel: Unstageable pressure injury. Dry and stable eschar. Wound measurements: 2.5 x 2.9 x 0 cm…The team educated the patient on the importance of offloading, doing incontinent [incontinence] care every 2 hours and checking his skin to prevent further skin breakdown. Also discussed bedrest until skin issues improve. Patient verbalized understanding and agreeable. Bed rest for now. Use quartet [alternating air pressure] mattress for pressure relief."

- During an interview with Resident #205 on 08/07/18 at 3:00 pm, the resident stated, "I am on bedrest because of my sores [pressure ulcers]….They [nursing staff] said I wouldn't go back to bed, that I said no, but I just kid with them. The nurse told me she only needed to look at my feet, and that was all she did." During the interview the resident was not wearing the pressure reducing boot and pillows were not in place to offload the heel; the resident was on a quartet mattress as indicated in the 08/06/18 COWCN note.
- During an observation on 08/08/18 at 9:30 a.m., the resident was not wearing a pressure reducing boot on his right foot, and pillows were not in place to offload the resident's right heel when the surveyor and RN entered the resident room for wound care. The registered nurse caring for the resident stated, "Your [right] heel looks worse than it did on Friday." The wheelchair cushion in the resident's wheelchair was observed to be a Jay Fusion cushion; according to the manufacturer's specifications, the cushion was appropriate for individuals with pressure ulcers to the buttocks/coccyx. After wound care was completed the RN did not apply the pressure reducing boot.
- During an interview with Resident #205 on 08/08/18 at 10:00 a.m., when asked about his refusal to have a dressing change completed on Friday morning [08/03/18], the resident replied, "They wanted to do a dressing change in the middle of the morning. My hip hurts during transfers so I didn't want to go back to bed to have it done until after lunch. I don't refuse dressing changes, I just want to do them when I'm already in bed." When asked if the nurse had returned to perform the dressing change at a later time on 08/06/18, the resident replied, "I don't remember." When asked about his refusal to have a dressing change completed on 08/06/18 at approximately 10:00 p.m. the resident replied, "I didn't understand that they needed to do them three times a day. I was already asleep." When asked if the resident was in his wheelchair for long periods of time regularly, the resident replied, "I don't want to stay in bed all day." During the interview the resident was not wearing the pressure reducing boot and pillows were not used to offload the heel.
- During an interview with the nurse manager and patient care coordinator (PCC) of [LOCATION] with the quality management staff member present, on 08/08/18 at 4:00 p.m., the PCC reviewed a time line regarding the development of Resident #205's pressure ulcers that had been completed by the PCC and nurse manager. When asked if there was additional documentation in the resident's record of refusals of care including refusals to return to bed, limiting time up in the wheelchair, or refusals for dressing changes, the nurse manager stated that there was no additional documentation. When asked if there was documentation of resident education during the last two weeks regarding the importance of weight shifting while up in the wheelchair, how to perform weight shifting while up in the wheelchair, or the importance of returning to bed during the day to provide pressure relief, the nurse manager indicated that there was no additional documentation. When asked if there was documentation on 08/03/18 or 08/06/18 indicating that the nurse had returned to complete the dressing change at a later time, the nurse manager indicated that there was not. When asked if the interdisciplinary team had discussed the development of a schedule with the resident, to allow the resident to have a voice in determining the times when the dressing changes were conducted and the amount of time each day that the resident would be up in his wheelchair and in bed, the nurse manager indicated that this had not been done. Review of the occupational therapy documentation provided did not indicate the resident had been taught a method of pressure relief while up in his wheelchair, e.g., wheelchair push-ups. In addition, there was no indication that skin checks/assessments were conducted between 07/06/18 and 08/03/18 including observation of the skin surrounding and underneath the left knee immobilizer.

Resident #102, [LOCATION]

- Resident #102 was admitted to the CLC on [DATE] with diagnoses that include pseudo gout, incomplete paraplegia post L2 (second lumbar vertebrae) fracture with rod placement, bacteremia, neurogenic bladder and chronic right heel ulcer. During the initial tour of [LOCATION] on 08/07/18, the resident was identified by the PCC as having pressure ulcers. The PCC indicated the resident had a Stage 4 coccyx ulcer

that was “acquired in-house [in the CLC]” and development of the pressure ulcer “was due to a cushion.”

- The resident’s comprehensive admission Minimum Data Set (MDS) dated [DATE] indicated the resident had clear speech, and was understood by and understood others; the resident’s short-term and long-term memory were OK memory and the resident was independent in cognitive skills for daily decision making based on staff assessment. The MDS indicated the resident required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use, and personal hygiene; the resident was non-ambulatory and used a wheelchair for mobility. According to the MDS, the resident had an external catheter for urinary incontinence. The MDS documented the resident was at risk of developing pressure ulcers and had two Stage 2 pressure ulcers and one unstageable pressure ulcer on admission. The resident’s current care plan with a last review date of 06/07/18 addressed, “Altered Skin Integrity related to SDT [suspected deep tissue injury] L/R [not further specified] foot and buttock PU [pressure ulcer].” The goal read, “Wound will improve and I will not develop new open areas.” Approaches included: “Assess wounds weekly and PRN [as needed] using wound template in CPRS; Change dressing as ordered; Turn every 2 hours when in bed; Specialty mattress; Wheelchair cushion; Evaluate effectiveness of treatment every week and recommend change as indicated; Heels off loaded with [not specified].”
- A [DATE] nursing admission assessment documented a “gluteal crease stage I,” “right heel pressure ulcer unstageable with 90% eschar” and a “right plantar pressure ulcer with 100% eschar.”
- A 03/22/18 wound consult stated, “Gluteal and buttocks friction injury possibly from moisture. Partial thickness skin loss with 100% pink base. No redness to surrounding skin. Measurements from 3/21/18 were – left gluteal 1.5 cm x 0.5 cm x 0.1 cm. Right gluteal 1.0 cm x 0.3 cm x 0.1 cm. Buttock 0.3 cm x 0.3 cm x 0.1 cm. The wound care team recommended Aloe Vesta ointment followed by a thin layer of calmoseptine TID [three times daily] and PRN for barrier.”
- On 04/04/18, an RN wound assessment was completed. The assessment read, “Asked by CLC nursing staff to evaluate patient worsening coccyx ulcer that [is] probably from friction injury related to moisture is now turned into pressure injury. Stage II to Stage III.” The pressure ulcer treatment was changed to Medihoney and Allevyn and the recommendation was to perform mapping to determine pressure redistribution in the wheelchair.
- On 04/06/18, Resident #102 was seen by kinesiotherapy in the wheelchair clinic and the following was noted: “diagnosis paraplegia, stage III pressure sore coccyx - reason for visit pressure mapping mobility devices power chair on loan from CLC. The chair is equipped with van style seating; he also is using a Roho cushion (high profile). Observed client in very poor sitting position. He is sacral sitting with significant dead space at the back of the seating system. No support under thighs and both feet are off or nearly off the front plate….The Roho cushion inflation valve is open and cushion completely deflated. We over inflated the cushion and allowed it to rest. No signs of leaking. Recommendations - Consider limit[ing] use of the current loaner power chair due to limitations outlined above. Educate staff to not attempt to adjust the cushion inflation. Assist client as needed with positioning, repositioning and off-loading.”
- A 04/24/18 wound care consult requested for “worsening coccyx pressure injury” documented the following, “Was on silvadene ointment daily and damp normal saline dry sterile dressing to loosen up non-viable tissue for wound care. Seen by MD [medical doctor] yesterday started full strength Dakin’s Solution BID [twice a day] due to purulent drainage….Currently on bedrest, continue Quartet mattress for pressure relief. Has a Roho cushion and pressure mapping was done. Stage III advanced to Stage IV probed down to the bone with undermining area. No purulent drainage noted at this time.”
- On 08/07/18 at 1:50 p.m., the resident was observed in bed on a pressure redistribution mattress; the resident was wearing blue pressure relieving boots on both feet and had a turning sheet underneath him. During an interview with the resident, the resident stated, “I have a sore on my backside. My cushion did not have enough air in it and it caused the sore. Now I have to stay in bed so it will heal.”
- On 08/08/18 at 9:24 a.m., the occupational therapist was interviewed and stated, “The resident started working with therapy and was making good progress until he had to go on bedrest. He was issued a power wheelchair with a Roho [cushion] that was inflated. When he was in the wheelchair clinic it was observed to be deflated.” The OT did not indicate the exact date the Roho cushion was implemented but stated it was prior to development of the sacral wound.
- The chief nurse stated education was provided for the staff regarding Roho cushions in May 2018.

F323

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

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and clinical record review, the CLC did not ensure that residents received adequate supervision to prevent accidents. Findings include:

The Southern Arizona VA Health Care System Memorandum 03-14-21 titled "Fall Prevention Program," and dated November 14, 2014, was provided by the chief nurse executive on 08/08/18 at 6:00 p.m. The memorandum stated, "2. B. A plan of care will be developed, implemented, evaluated and revised as needed to address the fall risk factors identified for each patient….3. E. High fall risk: Morse Fall Risk Score greater than 50 and/or clinician has identified fall risk factors, in addition to those included in the Morse Fall Risk Scale….5. (4) Patients with a score greater than 50 on the Morse Fall Risk Scale are classified as a High Fall Risk, and will have both Universal Fall Precautions implemented, as well as High Risk Fall Precautions according to the identified fall risk factors."

Resident #201, [LOCATION]

- Resident #201 was admitted to the [LOCATION] neighborhood on [DATE] with diagnoses including dementia, mixed neurocognitive disorder and stage 3 chronic kidney disease. The resident's comprehensive admission MDS dated [DATE] was coded to indicate the resident had clear speech, moderate difficulty with hearing, and was understood by and understood others. The MDS indicated the resident had short-term and long-term memory problems and severely impaired cognitive skills for daily decision making based on staff assessment. The MDS was coded to indicate the resident required extensive assistance of two for transfers, dressing, toilet use and personal hygiene; extensive assistance of one for walking in the room and corridor; and limited assistance for bed mobility. Locomotion inside and outside of the neighborhood was coded as "Activity did not occur." Balance when moving from a seated to standing position; during surface-to-surface transfers; and when walking, turning around, and moving on and off the toilet were coded as not steady, but the resident was able to stabilize with staff assistance. According to the MDS, the resident did not have functional limitations in range of motion in the upper or lower extremities. The MDS was coded to indicate the resident had not experienced any falls since admission to the CLC.
- The RN's "Nursing Admission Evaluation Note" dated [DATE] stated, "Morse Fall Risk Assessment: History of falls: Yes. Secondary diagnoses (two or more medical diagnoses): Yes. Ambulatory aid: Wheelchair. IV [intravenous]/Saline lock: No. Gait/Transferring: Weak. Mental status: Forgets limitations. Total Score: 65 High risk. Action: High fall risk prevention interventions. Bed/chair alarm was placed….Fall Risk Interventions: Patient oriented to surrounding and assigned staff. Adequate lighting at all times. Call bell within reach, visible and patient informed of the location and use. Light cord within reach, visible and patient informed of the location and use. Personal care items within arms [arm's] length. Bed in lowest position with wheels locked. Room free of known environmental hazard. Ambulate as early and frequently as appropriate for the patient's condition. Non-slip footwear. Room placement closer to the nursing station as available. Every two hour comfort and toileting rounds. Personal alarm, chair or bed alarm to be utilized when appropriate. Provide chair and/or bed alarms. Every one hour observation with toileting and comfort rounds. Obtain low bed. Hip protectors. Re-orient the patient as needed. Close observation."
- The resident's care plan stated, "Problem: Geri [geriatric] Psychiatric high fall risk. Unsteady gait. Expressed concern for safety during ambulation; stated history of previous falls. 1) I am at high risk for falls. 2) I do not want to fall. 3) I do not want any new injuries. [Statements not dated.] Goal: I will remain free of falls [Not dated]. Approach [not dated]: 1) Assist unsteady residents with ambulation. 2) I will wear safe footwear when ambulating: non-skid shoes/slippers/socks. 3) Encourage resident to use ambulation aids and glasses. 4) Physical therapy consult. 5) Follow fall protocol. 6) I want staff to use bed and wheelchair alarms if needed to help me stay safe. 7) I want to be assessed to determine if I need to wear a helmet. 8) I want to be assessed to see if I need a floor mat. 9) I want to be assessed to see if I need to wear hipsters." Comments on the care plan included, "08/01/18 Cont [continue] POC [plan of care]."
- Review of Resident #201's physician orders indicated there were no orders related to fall precautions.
- During an interview with the nurse manager and assistant nurse manager on 08/07/18 at 11:00 a.m., the nurse manager stated, "[Resident #201] has a history of falls since he has been here. He had falls on 7/25 [2018], 7/26 [2018] and 7/28 [2018]. The last fall he had on 07/28/18 resulted in an orbital fracture. He is paranoid with staff. He has a bed and chair alarm."
- The following notes described Resident #201's falls:
    - The RN documented in the "Fall Note" dated 07/02/18, "Narrative/Description of Fall: Bed alarm sounded. Patient was found sitting on buttocks next to bed. Hipsters on. Patient had refused treaded socks earlier this shift." There was no further analysis of the circumstances of the fall to determine causal and

contributing factors for the fall. The interventions listed in the “Fall care plan – post-fall” section of the fall note were the same as those listed in the [DATE] “Nursing Admission Evaluation Note.”

- In the “Fall Note” dated 07/05/18, the RN documented, “ Narrative/description of Fall: Patient was pulling up pants after using toilet. Lost balance and fell backward hitting wall and landing on his buttocks.” The document did not indicate whether a staff member was present at the time of the fall. There was no further analysis of the circumstances of the fall to determine causal and contributing factors for the fall. The interventions listed in the “Fall care plan – post-fall” section of the fall note were the same as those listed in the [DATE] “Nursing Admission Evaluation Note .”
- The “Pharmacy Monthly Note” dated 07/17/18 stated, “07/02/18 at 2350 [11:50 p.m.] Fall: bed alarm sounded, patient found sitting on buttocks next to bed, no head injury. 07/05/18 at 1920 [7:20 p.m.] Fall: lost balance pulling up pants after bathroom, no injury to head.”
- In the “Fall Note” dated 07/25/18, the RN documented, “Narrative/description of Fall: Bed alarm went off, when this RN entered into the room, patient was found on the floor laying on his left side.” There was no further analysis of the circumstances of the fall to determine causal and contributing factors for the fall. The interventions listed in the “Fall care plan – post-fall” section of this document were the same as those listed in the [DATE] “Nursing Admission Evaluation Note,” other than the addition of a “Floor mat” in the 07/25/18 document.
- The “Fall Note” dated 07/26/18 was documented by an RN and stated, “Narrative/description of Fall: Bed alarm went off, patient was found on the floor laying [lying] on his left side. There was no further analysis of the circumstances of the fall to determine causal and contributing factors for the fall. The interventions listed in the “Fall care plan – post-fall” section of the fall note were the same as those listed in the 07/25/18 “Fall Note.”
- The RN documented a “Fall Note” dated 07/28/18 that stated, “Narrative/description of Fall: Patient found lying on the floor near the nurses’ station. Lying on left side, stating: “Oh my head! Oh my back!” Fall was unwitnessed. Wheelchair alarm did not activate. There was no root cause analysis to determine causal and contributing factors for the fall. The interventions listed in the “Fall care plan – post-fall” section of the fall note were the same as those listed in the [DATE] “Nursing Admission Evaluation Note.” A floor mat was not included in the post-fall interventions on 07/28/18.
- In the “Restorative/Rehab [rehabilitation] Nursing Note” dated 07/30/18, the kinesiotherapist (KT) documented, “[Resident #201] now with 5 falls while on [LOCATION]. Three falls in three days. One fall with injury (orbital fracture)…07/28/18 6 a.m. Found near nurse’s station. No chair alarm sounded (orbital fracture found)….Recommendations: Place bedside commode to left of his sitting position. Reinforce with all staff that bed [height] should be set at neutral (90 degrees knees and hips) as he can stand, it will be safer than making the bed lower. Move bedside table (wheeled) and bedside brown table (no wheels) away from bedside…Wear shoes at all times when out of bed. When practicing ADLs [activities of daily living], cue [Resident #201] to have one hand on a support rail and one hand doing the ADL. Cue him to have head up and eyes open…No [floor] mats and bed neutral position, as resident can stand and take steps. These can increase fall risk.”

- During an interview with Resident #201 on 08/07/18 at 2:20 p.m., the resident stated, “I can’t walk straight so I use this wheelchair, except when I go to the bathroom. They help me to the bathroom.”
- On 08/07/18 at 1:30 p.m., Resident #201 was observed sitting in a wheelchair in his room. The resident was wearing non-skid socks, rather than shoes, and the overbed table was positioned approximately 18 inches in front of him. The resident’s call light was not observed to be within reach. The bedside table was located immediately adjacent to the resident’s bed. The bed was in the low (and not neutral) position; a bedside commode was not present in the room.
- On 08/07/18 at 2:20 p.m., Resident #201 was observed sitting in a wheelchair outside the resident’s room; there were no other residents or staff in the immediate vicinity. The resident was wearing non-skid socks (and not shoes). A chair alarm was in place and functioning.
- During an observation in the dining/activity room of the [LOCATION] neighborhood on 08/08/18 at 9:02 a.m., with a quality management staff member present, Resident #201 was observed seated in his wheelchair. The resident was wearing non-skid socks rather than shoes. A chair alarm was in place and functioning.
- On 08/08/18 at 10:00 a.m. Resident #201 was observed sitting in a wheelchair in his room. The overbed table was not present in the resident’s room. The bedside table was adjacent to the bed. The bed was in the low position; a bedside commode was not present in the room. The resident’s call light was not observed to be within the

resident's reach.

- During an interview with the nurse manager and assistant nurse manager of the [LOCATION] neighborhood on 08/08/18 at 09:10 a.m., the resident's Kardex was described by the nurse manager as "the method to communicate specific resident needs to all staff, which is updated daily as needed." Resident #201's Kardex stated the following related to fall prevention, "Mobility 1 person assist to wheelchair, 1 person assist with 2 wheeled walker, alarms/safety measures: bed/chair, hipsters, lights on at night, schedule toileting every 4 hours during day and prn [as needed], and hs [at bedtime], 8/3/18: no mattress on floor per [nurse manager]." When asked about implementation of the individualized interventions recommended by the KT on 07/30/18, the nurse manager stated, "The interventions she recommended are really good and I agree with them….there was a disagreement between the nurse caring for the resident and the KT about what interventions would work best [for Resident #201]. Instead of pulling together a huddle to discuss [the resident's falls], the staff just didn't follow the KT's recommendations because they disagreed with them. We have since pulled everyone together, and have agreed, but we haven't gotten them on the Kardex. We reinforce individualized strategies at every change of shift report, but that is only done verbally."
- During an interview with the chief nurse executive of the CLC on 08/08/18 at 4:45 p.m., when asked about the KT being consulted related to individualized fall prevention strategies prior to 07/30/18, the chief nurse replied, "She [KT] was on leave."
- In summary, Resident #201 fell on 07/02/18, 07/07/18, 07/25/18, 07/26/18 and 07/28/18; the fall on 07/28/17 resulted in an orbital fracture. It was not evident the CLC conducted an assessment to determine the causal and contributing factors of the falls (e.g., inappropriate footwear, call light out of reach, postural hypotension or dizziness related to medications) following the falls. Following the falls, approaches implemented were the same as those listed in the [DATE] Nursing Admission Evaluation Note with the exception of the addition of a floor mat on 07/25/18; the floor mat was not included as an approach following the fall on 07/28/18. Following the fall with injury on 07/28/18, the KT recommended approaches on 07/30/18 including keeping the bed in a neutral position, moving the bedside tables (with and without wheel) away from the bed; wearing shoes at all times; no floor mats. On 08/07/18 at 1:30 p.m., Resident #201 was observed wearing non-skid socks rather than shoes, the bedside table was located adjacent to the resident's bed and the bed was in the low (and not neutral) position; a bedside commode was not present in the room. On 08/07/18 at 2:20 p.m., Resident #201 was wearing non-skid socks and not shoes. During an observation in the dining/activity room of the [LOCATION] neighborhood on 08/08/18 at 9:02 a.m., Resident #201 was wearing non-skid socks rather than shoes. On 08/08/18 at 10:00 a.m., Resident #201 was observed sitting in a wheelchair in his room. The bedside table was adjacent to the bed, the bed was in the low position; a bedside commode was not present in the room and the resident's call light was not observed to be within the resident's reach. It was not evident the CLC conducted a comprehensive assessment to determine the causes and contributing factors to the resident's falls and implemented approaches to address the contributing factors. After the resident was assessed by KT on 07/30/18, the CLC did not consistently implement approaches recommended by KT.

F389

483.40(d) *Availability of Physicians for Emergency Care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of emergency.*

Level of Harm - Actual harm that is not immediate jeopardy

Residents Affected - Few

Based on observation, interview and record review, the CLC did not provide or arrange for the provision of physician services 24 hours a day, in case of emergency. Findings include:

Resident #104, [LOCATION]

- Resident #104 was admitted to the CLC on [DATE] with diagnoses that included major neurocognitive disorder, Parkinson's disease, dementia due to Parkinson's disease, posttraumatic stress disorder (PTSD) and anxiety. According to the admission history and physical dated [DATE], the resident was admitted for "safety due to visual hallucinations and making holes in the wall of his home with a hammer." According to the nurse manager who was interviewed on 08/08/18, after the resident was admitted on [DATE] staff completed hourly rounding and the resident was assigned a room that was close to the nursing station.
- Resident #104 had provider orders dated 06/26/18 for the following medications for agitation and anxiety: pimavanserin (antipsychotic) 34 mg [milligrams] QD (each day), quetiapine (antipsychotic) 75 mg at hour of sleep and trazodone (sedative and antidepressant) 25 mg every six hours as needed (PRN).
- On [DATE] at 4:33 a.m., a "Behavioral and Mood Management RN" note documented the following; "2100 [9:00 p.m.] patient a+o [alert and oriented] x1 [to person] and disoriented, was becoming restless, anxious and invasively wandering unit [neighborhood] but re-directable. At this time patient was given 1:1 [one-to-one] supervision. NA [nursing assistant] gave patient a shower to help relax patient and

successfully toilet patient. Patient was cooperative with the shower. 2300 [11:00 p.m.] - PRN [as needed] Trazodone 25 mg [milligrams] given per order for anxiety ineffective. 0000 [12:00 a.m.] - Patient started aggressively moving furniture in the dining room hall and flipping a few tables. At one point moving table down by the television and attempted to push the patient [another resident] in [LOCATION] out of the way. Staff attempted to re-direct patient [Resident #104] to see if he would calm. 0030 [12:30 a.m.] - PRN Olanzapine 2.5 mg IM [intramuscular injection] given after patient refused to take PRN Quetiapine 50 mg. Patient toileted shortly after and patient was cooperative and appeared calm after a while and at rest in recliner. 0220 [2:20 a.m.] Approximately Code Green was called because patient became increasing[ly] aggressive, cursing persistently, angered and kicked NA in the stomach. Patient was responding to internal stimuli and positive for visual hallucinations. (i.e. pt. seeing flying birds) 0240 [2:40 a.m.] - Olanzapine 5 mg IM per [medical provider's name] Hospitalist. Ineffective [and] pt. continued to be severely aggressive. At least five members of the code team needed to assist patient to remain calm. 0320 [3:20 a.m.] - Olanzapine 5 mg IM per [hospitalist] Ineffective patient continued to be severely agitated. 0345 [3:45 a.m.] - Ativan 1 mg IM given per [hospitalist] Ineffective, patient continued to be severely combative and aggressive. 0405 [4:05 a.m.] - Ativan 1 mg IM given per [hospitalist] VS [vital signs] 147/64 [blood pressure] HR [heart rate] - 110, SO 2 [oxygen saturation] 92% and RR [respiratory rate] 16. 0414 [4:14 a.m.] Approximately [hospitalist] on GEC [geriatrics and extended care] [LOCATION]. 0420 [4:20 a.m.] - Patient was transferred to ICU [intensive care unit] per [hospitalist] request.

- Resident #104 was re-admitted to the CLC on [DATE]. According to the [DATE] admission history and physical completed by psychiatry, the following was documented, "Today he [Resident #104] returns to the unit [CLC] following medical [acute care] admission on [DATE] – [DATE], on the day following admission [to the CLC] patient became aggressive resulting in a code green. This resulted in him getting 2x doses of 5 mg Olanzapine IM and 2x doses of 1 mg Ativan IM. The patient was transferred to the ICU following this event due to concern for respiratory depression. His hospital course was complicated by acute hypoxia, respiratory failure and delirium with agitation requiring occasional [physical] restraints. During medical hospitalization medication adjustments [were made] including a decrease in Quetiapine to 25 mg by mouth every six hours."
- The discharge summary dated [DATE] documented the following, "Transfer from geri-psych [geriatric-psychiatric unit] for increased agitation and possible over medication. Initially presented to the hospital [DATE] for increased aggression, which had been escalating for some time and wife did not feel safe caring for him. He was treated appropriately until [DATE] when he was discharged to geri-psych unit but returned two days later on the [DATE] for increased agitation following a code green in which there was some concern for over sedation….During this time, he remained in ICU in soft restraints with medications and feedings via Dobb Hoff tube. Over the last twenty-four hours he has become more awake and conversive although still not oriented."
- On 08/08/18, the nurse manager was interviewed and stated there was confusion on the night when the on-call provider was notified; the nurse manager stated, "On call duties had been re-assigned recently to the hospitalist but the on-call phone number was wrong and it took a while for the hospitalist to respond." The nurse manager said there was no response from psychiatry because the on-call psychiatrist did not feel he was supposed to cover the CLC. The chief nurse stated on 08/09/18, that the case has been escalated for peer review.