Laguna Honda Hospital & Rehabilitation Center (LHH)

December 2022 Federal Monitoring Survey Root Cause Analysis Findings and Recommendations

Health Services Advisory Group, Inc. (HSAG)

RCA Report #2
January 31, 2023

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Introduction

In October 2022, Laguna Honda Hospital and Rehabilitation Center (LHH) contracted with Health Services Advisory Group, Inc. (HSAG) to serve as the Quality Improvement Expert (QIE) in response to its Settlement and Systems Improvement Agreement with the Centers for Medicare & Medicaid Services (CMS).

On December 1, 2022, the QIE submitted to CMS a root cause analysis (RCA) report (RCA Report #1) that identified factors contributing to LHH's decertification from the Medicare Program. The RCA specifically addressed deficiencies identified during surveys between October 14, 2021, and April 13, 2022, and all deficiencies that were discovered and disclosed to LHH by the California Department of Public Health (CDPH), CMS, or a contract surveyor after those surveys. CMS approved RCA Report #1 on December 12, 2022.

LHH, in consultation with the QIE, developed an Action Plan in response to RCA Report #1, which identified areas that must be addressed to ensure long-term substantial, sustained compliance in the future with Federal participation requirements. LHH submitted the initial Action Plan to CMS on January 6, 2023. The Action Plan with any necessary modifications must be fully implemented by May 13, 2023.

The settlement agreement also requires on-site, Federal monitoring surveys at least once every 90 days to assess LHH's compliance with CMS nursing home care requirements and other Federal requirements. The first health, life safety code, and emergency preparedness monitoring surveys occurred between November 28, 2022, and December 16, 2022. All resulting 2567 report findings were provided to LHH by January 9, 2023.

Under the settlement agreement, for any monitoring survey findings at a scope and severity (SS) of D or higher, LHH must engage the QIE to develop a new RCA report to identify why non-compliance was cited and develop an updated Action Plan to address the survey findings. The recent health, life safety code, and emergency preparedness monitoring surveys identified 66 deficiencies (F-Tags, K-Tags, and E-Tags). Of these, 62 deficiencies were identified to have an SS of level D or higher.

For this RCA (RCA Report #2), the QIE identified and defined problems, investigated monitoring survey deficiencies, and analyzed and identified the root cause of each identified problem. Due to approval timelines, Action Plan outcomes have yet to be realized because milestones have not been fully implemented. Therefore, this review also considered whether systems-level issues from RCA Report #1 continued to be identified in the monitoring survey and whether previous recommendations address the newly identified deficiencies. The findings from RCA Report #2 will inform LHH's updated Action Plan, which will support LHH's certification to the Medicare Program and achieve substantial and sustained compliance.

Report Structure

RCA Report #2 builds upon the foundational root cause categories identified in RCA Report #1. These categories represent the systems-level areas needing significant improvement for LHH to sustain long-term compliance.

This RCA report addresses the following foundational root cause categories:

1. Quality Assurance & Performance Improvement (QAPI)
2. Infection Prevention and Control
3. Medication Management and Administration
4. Resident Rights and Freedom from Harm
5. Comprehensive Care Plans and Quality of Care
6. Competent Staff, Training, and Quality of Care
7. Emergency Preparedness Program
8. Fire and Life Safety
9. Resident Quality of Care
10. Food and Nutrition Services

Each category includes discussion of the following:

- Problem statement that summarizes the overall systems-level problem
- Monitoring survey deficiencies with SS levels associated with each foundational root cause category
- Priority root causes and recommendations
- Monitoring survey analysis and findings

The recommendations outlined in this RCA report will inform the development of an updated Action Plan to respond to the RCA findings and implement the recommendations and necessary improvements. The Action Plan includes a detailed list of milestones and completion dates for each corrective action. All elements of the Action Plan will be incorporated into LHH's QAPI Program and will be implemented by May 13, 2023.

1. Quality Assurance & Performance Improvement

Problem Statement

The QAPI Program and Quality Assessment and Assurance (QAA) Committee lack a consistent approach of systematic analysis, action, and proactive program activities, such as performance improvement projects and strongly documented, good-faith effort initiatives, including identifying and prioritizing problems that reflect high-risk, high-volume, problem-prone areas based on performance indicator data. This results in a program that is ineffective in including direct-care staff members in addressing the full range of complex care and services provided by LHH and is unable to signal deficiencies at an early onset. These issues were evidenced in the monitoring survey with findings that fall interventions, pressure ulcer management, and tracheostomy care were not adequately addressed by the QAPI Program. In addition, LHH's facility assessment was not properly reviewed and updated to reflect the resources needed to provide care and services to the resident, including competent staff.

Monitoring Survey Citation(s) Reviewed

F838 (SS = F): Facility Assessment
F865 (SS = F): QAPI Prgm/Plan, Disclosure/Good Faith Attempt

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: QAPI Program not aligned to skilled nursing facility (SNF) setting

LHH's QAPI Program is currently implementing an updated QAPI structure. It was previously designed to align with LHH's affiliated acute care hospital within the San Francisco Network and acute care processes, resulting in a QAPI Program that is not tailored toward the SNF setting and does not effectively involve direct-care staff, medical staff, or residents. This increases the risk that performance goals are not met and the necessary care to residents related to SNF regulations is not delivered, such as wound and tracheostomy care.

Recommendation: LHH will continue reorganizing its QAPI Program to have subcommittee involvement on all nursing units. These subcommittees will include (1) psychotropic medication and behavior monitoring, (2) restraints and falls, (3) nutrition and wounds, and (4) infection control and antibiotic stewardship. This unit- and department-based structure will take a systematic, interdisciplinary, comprehensive, and data-driven approach to improving and maintaining safety and quality, while involving multi-departmental direct-care staff, medical staff, residents, and families in practical and outcomes-focused problem solving. This puts the resident at the center of the QAPI Program. **(Stronger action)**

Root Cause 2: Lack of strong QAA Committee oversight

The QAA Committee members focus on data reports that are not based on reliable and validated data. In addition, the committee does not identify typical high-risk, problem-prone areas within the nursing home, regardless of the data reported. This results in a committee that focuses on data reporting compliance, rather than analysis, discussion, and follow-up actions to make changes to ensure regulatory compliance and resident safety. Therefore, the program does not

proactively identify issues for performance improvement, safety vulnerabilities, or regulatory compliance. For example, pressure injuries were last discussed at QAA Committee meeting in January 2022.

Recommendation: LHH will continue to follow its most current QAPI plan and restructure the QAA Committee to align with SNF regulations by ensuring:

1. The right participants are included in monthly QAPI meetings;
2. An effective and relevant data dashboard, including data regarding pressure injury, is created and utilized to convey the current status of regulatory compliance and optimal resident outcome to properly inform leadership in the governing body;
3. Committee members are trained and coached regarding data and data analysis;
4. Committee meetings have effective facilitation to drive discussion to connect data findings to immediate actions, such as chartering performance improvement projects (PIPs); and
5. Committee members are trained and coached in order to monitor and support staff and medical staff who are implementing systemic changes into practice. **(Stronger action)**

Root Cause 3: Direct-care staff and medical staff not active in QAPI activities

Direct-care staff and medical staff do not contribute to daily QAPI activities, such as RCAs and PDSA (plan-do-study-act) cycles, due to lack of training on how to raise quality concerns. This results in a culture of silence and indifference, increasing the likelihood that quality concerns, such as wound and tracheostomy care, are not raised and addressed. This places residents at risk for harm.

Recommendation: LHH will provide scheduled training, using adult learning techniques, such as teach-back, to reinforce QAPI principles to direct-care staff and medical staff. This training will be applied daily through the use of unit-based huddle boards, which will include data relevant to the nursing unit as well as mechanisms for staff to raise concerns. In addition, trained middle managers will lead daily huddles using the huddle boards to identify concerns and actively include direct-care staff in RCAs and PDSA cycles to solve issues. To increase unit-based accountability, once training has occurred, supervisors will meet routinely with their middle managers to develop their individual QAPI dashboards to include pressure injury, so they can monitor progress and the effectiveness of their interventions and efforts. On a routine basis, a report of huddle boards and interventions will be reported through the QAA Committee. **(Stronger action)**

Root Cause 4: Facility assessment not properly operationalized

The QAPI governing body fails to properly update its facility assessment to ensure LHH has the resources necessary to provide resident care and services. Specifically, LHH does not address programs, such as wound care, fire safety, abuse investigations, and staff training. This increases the risk that resident programs do not function properly after staff turnover, leading to potential resident harm, such as the worsening of wounds.

Recommendation: LHH will update and maintain the facility assessment, per regulations. Specifically, LHH leadership and quality management (QM) will participate in an education program related to facility-assessment development. LHH will evaluate facility programs across the facility to determine the resources necessary to care for residents during daily operations and

emergencies, e.g., LHH will establish a wound assessment program and update the facility assessment accordingly. Finally, the QAA Committee will provide oversight of the facility assessment revisions to ensure regulatory compliance. **(Stronger action)**

Monitoring Survey Analysis and Findings

Policy and Process Flow

The Pressure Ulcer Committee has been inactive since the Clinical Nurse Specialist (CNS) for wound care retired in December 2021. The last time "pressure injury" was discussed in the QAPI meeting was in January 2022. The current QAPI Calendar does not have pressure injury or tracheostomy care listed as an agenda item. In addition, presentations to address pressure injury have not been made to the Performance Improvement and Patient Safety (PIPS) Committee nor has pressure injury been listed on the agenda.

The facility assessment (FA) was not reviewed and updated for FY 2021–2022 to address (1) staff training for the facility's fire safety plan, (2) pressure injury training for licensed nurses, (3) the lack of replacement of the wound care nurse specialist to provide wound care training, (4) inaccuracies regarding wound care training vs. education, and (5) allegations of abuse.

Staffing & Competencies

Competency and Qualifications

Staff interviews indicated a general lack of understanding of the purpose of the facility assessment and the role of leadership in developing, reviewing, and updating the document.

Staffing Level

LHH posted the position to replace the CNS, who had Wound, Ostomy, and Continence Nurse (WOCN) certification. This position has yet to be filled, and LHH, in the interim, has not identified a point person to lead the wound care program.

2. Infection Prevention and Control

Problem Statement

The Infection Prevention and Control Program (IPCP) does not routinely follow SNF best practice recommendations and regulatory requirements regarding policy and procedure updates, planning, implementation, and corresponding surveillance activities. The approach causes key required elements of an IPCP to be performed unsatisfactorily. These issues were evidenced in the monitoring survey with findings of improper personal protective equipment (PPE) use by staff, biohazard bin clutter in an isolation room, improper hand hygiene, and a pneumococcal vaccine policy that was not updated to reflect current CDC guidelines.

Monitoring Survey Citation(s) Reviewed

F880 (SS = E): Infection Prevention & Control
F883 (SS = E): Influenza and Pneumococcal Immunizations

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Non-compliant policies and procedures

LHH's IPC-related policies and procedures, including the pneumococcal vaccine policy, are not consistently updated to current evidence-based standards, have lapsed, and are non-compliant with annual review cycle expectations. This results in disjointed facility-wide guidance, increasing the likelihood of staff confusion and non-compliant behavior.

Recommendation: LHH will immediately update its pneumococcal vaccine policy to reflect current CDC guidelines. LHH will also create a monthly calendar of activities that includes reviews of policies and procedures, the surveillance program, and education based on any updates. IPCP accountability will occur through monitoring via the QAPI Program. LHH will retain an IP-certified expert consultant or executive coach to support IPCP regulatory compliance. **(Stronger Action)**

Root Cause 2: Insufficient hand hygiene and PPE audits

Hand hygiene and PPE audits are not collected in a volume that meets the size and scope of the facility and/or may be performed ineffectively. This results in an inaccurate picture of overall facility compliance, increasing the potential for non-compliant IPC practices systemwide, including hand hygiene during wound care, tracheostomy care, and tube feeding care.

Recommendation: LHH will conduct observational audits and unit-based rounding and will add audit integrity checks (e.g., secret shopper approaches), at least quarterly, to ensure accuracy of findings. Observations with more specificity will be made to address specific care areas, such as wound care, tracheostomy care, and tube feeding care, to ensure resident safety. Overall compliance will be monitored monthly through QAPI, and feedback will be provided by department leaders to staff (e.g., verbal and/or written feedback, written education, and competency checklists). (**Intermediate Action)**

Root Cause 3: Lack of effective IPC education to all staff

LHH does not effectively organize IPC communication and training to staff members, resulting in confusion, compliance concerns, poor PPE and hand hygiene compliance, isolation room disorganization, and discord between various departments and service lines. This increases the likelihood that IPC practices are not uniformly implemented facility-wide and are non-compliant with regulations.

Recommendation: LHH nursing and IPC staff will partner to create an education calendar, focusing on IP issues specific to SNF IPC needs and using adult learning principles, including teach-back and return demonstration, to fully equip nursing staff to prevent, identify, report, investigate, and control infections and changes in condition. Specific educational topics will include PPE use, hand hygiene, and biohazard bin organization in isolation rooms. **(Intermediate Action)**

Monitoring Survey Analysis and Findings

Policy and Process Flow

LHH failed to revise its pneumococcal vaccine policy to reflect current CDC pneumococcal vaccination guidelines.

Staffing & Competencies

Staff Performance

The following issues were identified during the monitoring survey: (1) Environmental services (EVS) staff walked out of the isolation room to the hallway wearing a disposable isolation gown; (2) Two EVS staff's respirator masks and reusable eye protection were placed on top of the table while they were on break; (3) The red bin (biohazard) in the ante-room of the isolation room in S4 was overflowing and exposing the soiled PPEs; used gloves and paper towels were cluttered on the floor; (4) Two licensed nurses failed to perform hand hygiene and change gloves in between providing wound care, tracheostomy care, and tube feeding care for a resident; (5) A licensed vocational nurse failed to perform proper hand hygiene after providing peri-care to a resident; and (6) One resident's urinary catheter bag was found on the floor.

3. Medication Management and Administration

Problem Statement

LHH medication management and administration policies are inconsistently applied, resulting in resident medication safety issues and non-compliance with Federal regulations. These issues were evidenced in the monitoring survey with findings that assessments for medication self-administration are not completed in a consistent manner. In addition, the medication error rate exceeded the regulatory threshold of 5 percent.

Monitoring Survey Citation(s) Reviewed

F554 (SS = D): Resident Self-Admin Meds-Clinically Approp
F658 (SS = F): Services Provided Meet Professional Standards
F759 (SS = D): Free of Medication Error Rts 5 Prcnt or More

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Medication self-administration policies not routinely followed

LHH policies for self-administration of medications are not consistently followed, including self-administration assessment, secure medication storage, and appropriate documentation (e.g., physician's order, pharmacy reconciliation, drug regimen review, and medication administration record). This results in unsafe medication management and self-administration practices.

Recommendation: LHH nursing, physician, and pharmacy departments will follow the updated self-administration of medication policy in accordance with the regulations. LHH will ensure processes are implemented to validate completion of 1) resident self-administration assessments using objective and consistent criteria; 2) regular re-assessments to determine continued competency; 3) observation of residents performing self-administration; 4) secure storage of self-administered medications; and 5) correlating required documentation including the Medication Administration Record (MAR). Monitoring metrics will be developed and reported to the QAPI Program. **(Stronger action)**

Root Cause 2: Non-compliance with safe medication management practices

LHH licensed nursing staff are not consistently compliant with medication management policies and procedures, such as proper documentation and following physician orders for medication administration. This results in non-compliance with medication administration and increases the potential for medication errors, placing residents at risk of harm.

Recommendation: LHH pharmacy and nursing leadership will collaborate to develop a program that regularly validates effective medication administration. This system will include increased medication pass observations from pharmacy of the licensed nurses that include just-in-time education with accountability actions when non-compliance is identified. LHH will also provide education, at least quarterly, to licensed nurses to include proper medication administration and following physician orders. This training will be scenario-based and include return demonstration to validate comprehension. Medication management and administration

will be monitored through the QAPI Program, and results will be shared with nursing staff administering medications. **(Intermediate action)**

Monitoring Analysis and Findings

Policy and Process Flow

During the monitoring survey, a licensed vocational nurse verified there was not a field on the MAR to document when or if nursing staff asked a resident whether an albuterol inhaler was administered during each shift.

The assessment for the self-administration of medication was to be done at least quarterly; however, surveyors found a resident's most recent assessment for the self-administration of a resident's medication was completed in May 2022.

Staff Performance

A nursing staff member did not scan the medication's bar code and perform the dual cosign as per the facility's policy and procedures before administering oxycodone to a resident. This failure resulted in a medication error by giving the medication too soon and not according to the physician's order.

During the monitoring survey, a nurse confirmed she administered one nasal spray for each of a resident's nasal spray medications, and only one drop of Artificial Tears in each of the resident's eyes. At that time, the nurse reviewed the physician's orders and confirmed they indicated two nasal sprays in each nostril, and two drops in each eye. The nurse verified they were not administered as ordered.

During the monitoring survey, a nurse stated that she mixed PEG 3350 (powder medication) with chocolate pudding and then administered the mix to a resident. She stated that the resident's electronic record indicated that medications should be given with chocolate pudding. During an interview with the medical doctor, it was confirmed that only the pills/tablets/capsules should be administered with chocolate pudding and not the PEG 3350. The PEG 3350 should have been mixed with liquid and dissolved before administering it to the resident.

4. Resident Rights and Freedom from Harm

Problem Statement

LHH daily operations have several characteristics that limit a holistic focus on residents' well-being and freedom from harm. These issues were evidenced in the monitoring survey with findings of an ineffective resident council, poorly implemented interventions after abuse allegations, an ineffective program to address resident range of motion and mobility, and an inconsistent activities program to support residents in their choice of activities. LHH also lacks an effective process for providing written notice to a resident, resident representative, and the ombudsman when an emergent transfer takes place from the facility or a bed hold notification is provided.

Monitoring Survey Citation(s) Reviewed

F550 (SS = D): Resident Rights/Exercise of Rights
F558 (SS = D): Reasonable Accommodations Needs/Preferences
F567 (SS = E): Protection/Management of Personal Funds
F561 (SS = E): Self-Determination
F565 (SS = D): Resident/Family Group and Response
F578 (SS = D): Request/Refuse/Discontinue Trmnt;Formlte Adv Dir
F600 (SS = E): Free from Abuse and Neglect
F623 (SS = E): Notice Requirements Before Transfer/Discharge
F625 (SS = E): Notice of Bed Hold Policy Before/Upon Trnsfr
F676 (SS = D): Activities Daily Living (ADLs)/Mntn Abilities
F679 (SS = E): Activities Meet Interest/Needs Each Resident
F688 (SS = G): Increase/Prevent Decrease in ROM/Mobility

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Lack of regulatory knowledge of bed hold and transfer/discharge

LHH staff lack regulatory knowledge on bed hold and transfer/discharge as well as a proactive monitoring process to ensure regulatory compliance. This results in policies that are not in alignment with the regulations, leading to the likelihood that residents, resident representatives, and the ombudsmen do not receive timely notifications of bed hold and/or transfer discharge notices.

Recommendation: LHH will develop a monitoring process to confirm written notice of bed hold and transfer/discharge is provided to residents, residents' representatives, and ombudsmen when discharged from LHH. Staff will be educated, using adult learning principles, on the new standard work. Education will include required documentation, timeliness, and electronic health record (EHR) compliance. Results will be monitored by the QAPI Program. **(Stronger action)**

Root Cause 2: Resident activities not fully resumed after COVID-19

LHH has not resumed a robust activities program since COVID-19 restrictions were lifted. LHH also has decreased staff numbers. This results in a program that lacks leadership and

accountability. This increases the likelihood of a lack of activities that allow residents to reach their highest practicable physical, mental, and psychosocial well-being.

Recommendation: LHH will develop and implement an updated activities program. It will be based on the comprehensive assessment and care plan and incorporate the preferences of each resident. This program will be designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident to encourage independence and interaction within the facility. LHH will reassess all appropriate activities as well as staffing and volunteer options for the activities program that can be implemented while following COVID-19 protocols. LHH will also ensure activities-related policies and procedures are in place for dementia residents. An updated activities calendar will be created and disseminated to residents. Finally, the facility assessment will be updated, reflecting updates to the activities program. **(Stronger action)**

Root Cause 3: Ineffective resident council meetings

LHH resident council meetings were not held during the COVID-19 pandemic and alternatives to in-person group meetings were ineffective. This resulted in meetings with limited resident attendance when the resident council started meeting in person in July 2022. No discussion or facility follow-up occurred on resident rights, the grievance process, or other resident concerns, increasing the likelihood that residents had limited ability to or could not exercise their rights as residents of the facility.

Recommendation: In partnership with residents, LHH will continue to develop a resident council meeting schedule that includes facility-wide and unit-level monthly meetings to be facilitated by the activities therapy department. Meetings will include an agenda, minutes, review of grievance trends and concerns, resident rights, and other resident concerns. LHH will also actively engage residents to increase meeting attendance. The results of these meetings will be reported during the QAPI meeting. **(Intermediate action)**

Root Cause 4: Lack of proactive intervention to prevent abuse

LHH does not have a strong proactive process to identify early abuse triggers between residents, resulting in a lack of interventions implemented and documented in resident care plans to prevent altercations. This increases the likelihood that residents may experience harm.

Recommendation: LHH will examine the current abuse and neglect investigation process and develop a standardized plan that enhances the abuse investigation process and intervention development (e.g., ensuring unbiased allegation investigators and inter-disciplinary team (IDT) review of care plan interventions). **(Intermediate action)**

Root Cause 5: Lack of formalized restorative nursing program

LHH does not have a formalized restorative nursing program with defined ownership. The current process is not designed to maintain the functional ability of residents, resulting in inconsistent assessments for mobility and care planning and poor implementation of specific interventions. This increases the likelihood that residents could be at increased risk for harm due to declines in range of motion, mobility, and quality of life.

Recommendation: LHH will continue to develop a restorative nursing program in collaboration with nursing and therapy leadership. LHH will utilize industry standards when developing the program to ensure best practices are established. Leadership will review the appropriateness and effectiveness of the program, including the implementation of interventions

at least quarterly in conjunction with the MDS schedule. This will be reported to and monitored through the QAA Committee for compliance and follow-up to gaps in the program. **(Stronger action)**

Monitoring Analysis and Findings

Policy and Process Flow

LHH was not consistently providing notices to residents, resident representatives, or ombudsmen related to acute care transfers and bed holds. In addition, policies and procedures were not in place to provide transfer discharge notification to residents, representatives, and ombudsmen for residents transferring to acute care. A review also indicated that the bed-hold policy was requested and not provided and that the standard work titled, "Notice of Bed Hold Policy and Notice of Proposed Transfer/ Discharge," dated 12/2/22 was provided instead.

Resident interviews revealed that LHH has not opened community activities since before the pandemic, and limited individual activities occur.

LHH has a secured memory care unit and has no policy and procedure in place to support activities for dementia residents. Activities scheduled are not individualized for the residents and are not always happening when scheduled.

Each unit has its own diverse resident population requiring a unique set of activities to meet resident needs. Observations and interviews reveal that staff do not have a clear understanding of current policy and procedures and the operations of the activities department.

Staffing & Competencies

Staff Performance

Transfer/Discharge and Bed Hold deficiencies were identified during a mock survey in June 2022. The notices were not being given prior to that. A process was developed and implemented in September 2022, but compliance rates never reached over 65 percent. Gaps in education and understanding of the process were identified and reported in PIPS meetings. During the 90-day monitoring survey, LHH failed to issue transfer/discharge notices to residents being transferred to acute care. Licensed nurses had not received education or in-services on bed holds and the transfer/discharge policy and procedure and had outdated forms on the units.

Staff Performance

The activities program has not modified the activities currently available post-pandemic, given the updated guidance on COVID-19. Staff are unclear on what activities can and cannot be implemented based on COVID-19 restrictions.

Staffing Level

Staff interviews showed that there has not been a dedicated Director of Activities Therapy since before the pandemic, and the department lost several staff members during the pandemic. The Director of Activities Therapy position is currently open, and there are eight open positions in the department. Additionally, prior to the pandemic, volunteers and contractors strongly supported the department by bringing entertainment and classes to the facility and assisting with operations of the gift shop, library, and computer room. Volunteers have decreased since the

pandemic from 125 to 50. One of the barriers to bringing volunteers/contractors back is the state's requirement to have a COVID-19 booster to interact with residents.

5. Comprehensive Care Plans and Quality of Care

Problem Statement

Resident care plans are not individualized and are not being used effectively as an accessible tool for the IDT to plan and document care and accomplish individualized care goals, healthier outcomes, and overall quality of life for residents. In addition, inaccuracies in MDS coding contribute to LHH not delivering accurate care that meets professional standards of quality. These issues were evidenced in the monitoring survey with findings that care plans were not properly developed, individualized, or revised following changes in condition, and the MDS was not accurately coded to reflect the care needs of the resident. In addition, residents' needs were not routinely accommodated nor were residents consistently treated with dignity and respect.

Monitoring Survey Citation(s) Reviewed

F550 (SS = D): Resident Rights/Exercise of Rights
F558 (SS = D): Reasonable Accommodations Needs/Preferences
F578 (SS = D): Request/Refuse/Discontinue Trmnt;Formlte Adv Dir
F580 (SS = E): Notify of Changes (Injury/Decline/Room, etc.)
F641 (SS = E): Accuracy of Assessments
F656 (SS = E): Develop/Implement Comprehensive Care Plan
F657 (SS = E): Care Plan Timing and Revision

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Ineffective care planning by interdisciplinary team

The IDT, including the medical staff, does not demonstrate an understanding of its role and the appropriate knowledge or training to develop and modify effective SNF resident care plans. This results in care plans that do not consistently include resident preference, have missing advanced directives, have a lack of wound care documentation, and/or are not revised to reflect the current or changing status and interventions needed. This increases the likelihood that the whole care team is limited in working collaboratively toward optimal resident outcomes.

Recommendation: LHH will continue to reorganize interdisciplinary care plan teams by evaluating roles and responsibilities and redefining expectations for each role to ensure active participation in developing and implementing individualized care and creating an accountability structure. LHH will also restructure the current care plan program to include mandatory, in-person education and a coaching program, using a care plan subject matter expert to guide the IDT to achieve resident-centered care. LHH will also implement a standardized process to document and communicate resident preferences and needs for individualized care plans. **(Stronger action)**

Root Cause 2: Lack of MDS Department oversight and accountability

The LHH MDS Department lacks leadership oversight and accountability, resulting in care planning being delegated to charge nurses and direct-care staff who have limited training in MDS coding processes and care planning. This increases the likelihood that resident assessments

are miscoded and care plans are not accurate, resulting in care being provided that is not individualized to the needs of the resident.

Recommendation: LHH will continue to reorganize the MDS Department from a centralized office to a unit-based presence, including office locations on each unit, in order to become part of the unit culture and active member of the unit-based care team. LHH will actively monitor, through the QAPI Program, the accuracy of care plan individualization using standardized assessment tools, such as the critical element pathways, and MDS coding accuracy. The competency of leadership will be reviewed with an executive dashboard that monitors the integrity and individualization of each care plan. (**Stronger action)**

Root Cause 3: LHH not using consistent nursing assignment

Currently, the majority of the nursing staff at LHH are not assigned to a specific unit. Furthermore, consistent nursing assignment is not a widespread practice at LHH, resulting in staff not working with the same residents daily. This increases the likelihood that staff do not have baseline knowledge of behaviors or do not adequately know care plans to be able to quickly identify any deviations or changes in condition among residents.

Recommendation: LHH will continue to establish core staff on each nursing unit who are assigned exclusively to that unit. LHH will also adopt elements of an evidence-based, consistent assignment program on each unit with a goal to have the care team (Registered Nurses [RNs], Licensed Practical Nurses [LPNs], Certified Nursing Assistants [CNAs], Patient Care Assistants [PCAs], EVS, and dietary) consistently care for the same residents through most of their shift to improve staff/resident relationships. **(Stronger action)**

Root Cause 4: Limited care planning participation by nurse leaders

Nurse leaders (e.g., directors and managers) have inconsistent and ineffective participation in the care plan process. This results in activities, such as, 1) not identifying discrepancies between physician orders and the nursing care being delivered; 2) having interventions not customized to the residents' needs; and 3) outdated information about the residents' current conditions and preferences. This increases the likelihood that quality of care (e.g. range of motion, pain management, and respiratory care) for residents does not meet professional standards of care.

Recommendation: LHH will clearly define nurse leaders' roles and responsibilities that include their active participation in developing and implementing individualized care plans. LHH will also require nurse leaders to attend a mandatory, in-person education and coaching program, using a subject matter expert (SME), to guide the IDT to achieve resident-centered care. Observations of their contributions to the care plan process will be made by the SME to provide feedback to the nurse leaders. **(Stronger action)**

Root Cause 5: EHR not optimized for SNF setting and lack of EHR knowledge

The EPIC EHR utilized is not customized for the SNF setting and staff have limited knowledge of full EHR capabilities. This results in increased burden to staff to update and modify care plans, which increases the likelihood that residents have care plans with generic, acute-care–based interventions rather than comprehensive, resident-centered care plans.

Recommendation: LHH will continue to develop and implement a Kardex system to ensure direct-care staff have access to current resident care plan information. Training will occur for all staff on how to use the Kardex for daily resident care and how to update, as needed. In addition,

LHH will develop a business plan with timelines and milestones to customize the current EHR to the SNF setting and LHH's unique population needs. **(Stronger action)**

Root Cause 6: Limited access by direct-care staff to care plan information

CNAs, PCAs, and other non-licensed caregivers do not routinely review or have limited access and training to the care plan and the EHR and do not have a Kardex system as a resource. This results in a lack of up-to-date knowledge of individualized resident needs and preferences.

Recommendation: LHH will train all care staff to understand care plan basics and how to access care plans in the EHR. The training will also address how to obtain, communicate, and implement resident preferences in all aspects of care. LHH will continue implementing a Kardex system to guide daily resident care and interactions. This will become part of new employee orientation and scheduled mandatory training. LHH will also create scenario-based training with return demonstration to ensure staff comprehension and validation of expectations to utilize the care plan/Kardex in their daily work and to update the care plan, as needed, to reflect changes in residents' needs and preferences. **(Intermediate action)**

Root Cause 7: Lack of specialized skills to individualize care plans

LHH staff do not have the specialized knowledge and skills needed to care for the unique needs of behavioral health (BH) and substance use disorder (SUD) residents, resulting in care plans that do not specifically address individualized interventions to meet their psychosocial and physical needs. This gap increases the likelihood that residents are not safe from accidents and hazards.

Recommendation: LHH will expand its Behavioral Emergency Response Team (BERT) program and embed it in the care plan process in order to develop individualized interventions in care plans for residents with BH and SUD needs. **(Intermediate action)**

Monitoring Analysis and Findings

Policy and Process Flow

Care Plan Development

The monitoring survey found that LHH did not develop an individualized care plan (1) for a resident with multiple pressure ulcers/injuries that includes current treatment, preventive measures, and services, (2) for a resident with a new open wound, and (3) for a resident with bowel and bladder needs. In addition, for two residents with pressure ulcers, LHH did not develop a comprehensive care plan that reflected positioning preferences and appropriate wound care. The facility did not develop a care plan for appropriate follow-up care for fall safety when a resident was ordered lorazepam (antianxiety medication) *prn* for dental procedures. Staff also did not implement a care plan for a resident in need of assistance with feeding.

Care Plan Revisions

The monitoring survey found that one resident's pressure injury care plan was not revised after a significant change assessment and development of new pressure injuries. One resident's fall care plan was not revised timely after a recent fall. One resident's behavior care plan was not revised timely after the resident had an episode of agitation and frustration. One resident's tracheostomy care plan was also not properly revised.

Staffing & Competencies

Staff Performance

During an interview with CMS, the Nursing Director who oversees the MDS Coordinator, confirmed a resident's schizoaffective disorder was not placed in the quarterly MDS and unclear as to why it was missed. An MDS Coordinator confirmed that both the annual and quarterly MDS assessments for a resident were not coded with tracheostomy and confirmed that both MDS assessments should have been coded to reflect a tracheostomy. Lastly, an MDS Coordinator stated a significant change in a pressure ulcer was not captured.

The monitoring survey found that LHH failed to ensure residents were consistently treated with dignity and respect and failed to accommodate resident needs. These gaps included a failure to provide residents with personal grooming tools, assist the residents at eye level during meals, ensure personal closets had appropriate wheelchair accommodations, ensure bedside dresser drawers were functional, and include consistent advanced directives in care plans. Staff interviews identified that Resident Care Council (RCC) reviews do not include resident preferences and individualized needs as a standard, nor do they include direct PCA involvement.

6. Competent Staff, Training, and Quality of Care

Problem Statement

Leadership, management, facility staff, and medical staff do not effectively operationalize SNF regulations, validate findings/data and performance issues, and educate staff to ensure sustainable, substantial compliance. In addition, current communication and staff training methods do not fully support ongoing needs for effective knowledge management and skills development, especially in relation to SNF and healthcare facility regulations, to ensure staff are fully competent to provide quality care. These issues were evidenced in the monitoring survey with findings regarding staff performance issues, including staff not properly following fire safety policy and procedures, staff not completing mandatory training, and lapses in resident care regarding catheters, respiratory care, and pain management.

Monitoring Survey Citation(s) Reviewed

F580 (SS = E): Notify of Changes (Injury/Decline/Room, etc.)
F689 (SS = L): Free of Accident Hazards/Supervision/Devices
F690 (SS = D): Bowel/Bladder Incontinence, Catheter, UTI
F695 (SS = D): Respiratory/Tracheostomy Care and Suctioning
F940 (SS = E): Training Requirements

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Lack of care rounds to reinforce training and knowledge

LHH leadership and middle management do not consistently perform routine care rounds at the facility, resulting in staff perceiving leadership as uninvolved at the frontline. Regulations, policies, and training are not reinforced at the unit level; staff do not feel comfortable raising quality concerns; and leadership is unaware of staff performance issues.

Recommendation: LHH will implement an executive leadership and middle-management rounding program that reports through the QAPI Program. An executive dashboard will be utilized to monitor compliance on rounding, and subsequent findings will be addressed immediately to ensure staff are performing according to professional standards of care. Residents' input and feedback will be reviewed regularly. LHH will also develop a plan to use industry expert coaches to consult and support executive leadership and management on improvement in high-vulnerability areas. **(Stronger action)**

Root Cause 2: Lack of accountability for mandatory educational requirements

There are no consequences for employees and medical staff not completing mandatory education, resulting in some staff providing care without the tools and knowledge necessary for optimal resident outcomes.

Recommendation: LHH will monitor, through the QAPI Program, mandatory staff education compliance with an executive dashboard. LHH will also implement policies that include

accountability and progressive disciplinary actions for non-compliance regarding mandatory education and training. **(Stronger action)**

Root Cause 3: Lack of focused scope of work in Department of Education and Training (DET)

The DET's scope of work (SOW) requires many human resource functions, such as validation of licensure, annual vaccine compliance (e.g., flu), and tracking CPR compliance. The DET resources are diverted to HR responsibilities, limiting its ability to develop a robust educational program.

Recommendation: The HR functions should not be part of the DET's SOW. The DET will focus on training instead of HR functions. This will allow the DET to have a robust program that meets the educational needs of staff and improves regulatory compliance. LHH will continue to complete an assessment of DET tasks and responsibilities, review industry standards and best practices, and realign work to the appropriate departments to increase DET bandwidth to meet the educational needs of staff. **(Stronger action)**

Root Cause 4: Adult learning approaches absent in training

Staff training relies heavily on "read and sign." The electronic learning management (ELM) system is in English only without additional adult learning techniques for multi-lingual staff that encounter many barriers to computer accessibility. This results in limited access to and comprehension of educational materials and an inability to ask questions and validate staff comprehension.

Recommendation: LHH will continue to modify its current education program to apply adult learning techniques, such as teach-back, videos, and 24/7 in-person educational rounds, to complement standard staff messaging and verify return demonstration on new policies and/or regulatory-based education. The ELM will have additional languages available to meet the needs of staff. LHH will develop and implement a strategy to overcome barriers to computer accessibility. **(Intermediate action)**

Monitoring Analysis and Findings

Policy and Process Flow

There was no evidence that licensed nurses received training on pressure injury management for the year 2022. A PCA failed to complete 44 required computer-based training courses from 2017 to 2022. One PCA failed to complete the required "Annual 2022 Mandatory Part 2 and 3 Dementia Training."

Staffing & Competencies

Competency and Qualifications

Staff were observed not following the facility's fire response plan policy and procedure, indicating they were not aware of facility policies and procedures for fire safety. Two of the seven staff observed not following the facility's fire response plan policy indicated they understood facility fire policies and procedures but chose to not shelter in place.

A nurse manager stated there was no documented evidence that a nurse had completed an assessment of a resident's response to the nebulizer treatment.

Communication

LHH failed to notify a physician when a resident had his/her catheter clogged multiple times and had to be changed.

7. Emergency Preparedness Program (EPP)

Problem Statement

LHH's EPP does not have elements in place, such as readily available emergency information, resulting in an ineffective program that lacks standardization across the facility. LHH also has gaps in regular training and exercises, contributing to an EPP that is out of compliance with Federal emergency preparedness requirements. This lack of awareness and knowledge of the EPP requirements leads to an overall lack of urgency among staff regarding emergency preparedness. These issues were evidenced in the monitoring survey with the declaration of an immediate jeopardy (IJ) due to LHH not following its fire response plan and a lack of staff knowledge about LHH's fire safety policy and procedure. The IJ was resolved.

Monitoring Survey Citation(s) Reviewed

F689 (SS = L): Free of Accident Hazards/Supervision/Devices
F921 (SS = L): Safe/Functional/Sanitary/Comfortable Environ

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Lack of alternative communication methods during emergencies

Communication methods (e.g., communication radios, mass text messaging) have not been implemented, resulting in continued reliance on an ineffective overhead paging system. This increases the likelihood that staff do not hear emergency announcements and do not respond quickly during an emergency.

Recommendation: LHH will continue to develop processes and communications that focus on urgent, resident-centered responses during an emergency. LHH will update its paging system to ensure it can be easily heard throughout the facility. LHH will also implement and routinely actively test and implement multiple alternative communication methods to ensure communications reach all staff during an emergency. **(Stronger action)**

Root Cause 2: Lack of leadership involvement in the EPP

Leadership has not made emergency preparedness a priority for the facility, which leads to a lack of a sense of urgency or indifference by staff. Staff continue their routine tasks when an alarm or overhead page is activated, which increases the risk of resident and employee harm during an emergency.

Recommendation: LHH will create a calendar of leadership rounds to actively interact with staff members to communicate and reinforce expectations for emergency preparedness. In addition, leadership must be an active participant in EPP drills in resident care areas to set the systemwide standard for emergency response and ensure staff are appropriately responding. Leadership will also actively participate in LHH's local emergency preparedness coalition. Leadership participation will be documented during EPP after-action reports (AARs) and monitored during QAPI meetings. LHH will retain subject matter expert consultants to support its EPP. **(Stronger action)**

Root Cause 3: EPP resources not readily accessible to staff

Vital pieces of emergency preparedness information (such as unit-specific, color-coded binders; appropriate signage; maps for emergency shut-offs; processes to obtain emergency equipment and services; generator information) are not readily accessible on all units within the facility, resulting in a lack of important information available to staff during an emergency. This increases the likelihood that staff do not respond appropriately.

Recommendation: LHH will create and regularly update unit-based emergency guidance manuals accessible in multiple areas per unit to meet staff needs and train staff on the contents of the manuals. The emergency preparedness badge buddies and signage will be reviewed and updated annually, and as needed, to ensure they are current and readable during an emergency. Charge nurses will be responsible on each shift to make sure staff, including registry staff, are wearing their badge buddies. **(Intermediate action)**

Root Cause 4: Staff not adequately trained for emergencies

Annual and at-time-of-hire emergency preparedness training is completed online, which may limit comprehension among staff at LHH who have many learning styles. This increases the likelihood that staff are not able to articulate the meaning of emergency codes on name badges, utilize a fire extinguisher, or execute emergency preparedness procedures.

Recommendation: LHH will continue to develop and implement a more comprehensive and robust EPP training and education program. This training program will be rooted in adult learning principles, such as scenario-based training or teach-back, and incorporate multiple learning modes, e.g., electronic and in-person. Training materials will include table-top exercises with scenarios based on the HVA results, badge-buddy definitions, and security-team collaboration (i.e., the sheriff and security team). **(Intermediate action)**

Root Cause 5: Fire drill feedback not provided to staff to drive improvement

Fire drill after AARs and other information are not routinely shared with staff, resulting in a lack of staff awareness about overall performance during drills. This increases the likelihood that staff are not aware of what needs to be improved during fire drills and decreases readiness during potential emergencies.

Recommendation: LHH will approve standard work outlining the steps LHH departments in the administrative and hospital buildings need to take in response to an emergency. AARs will be completed after every fire drill and will confirm whether the standard work steps were properly followed. Results of the AARs will be shared with all staff. This communication will identify what steps were not followed correctly during the alarm and will provide education for staff to mitigate any identified gaps. LHH will develop an accountability process for non-compliant staff. **(Stronger action)**

Monitoring Analysis and Findings

Policy and Process Flow

During the CMS monitoring survey, LHH did not properly implement its policy and procedure on the "Fire Response Plan" on 12/5/22, at 12:17 p.m. The facility fire alarm system was activated in a stairwell in the administration building, and no overhead announcement was made to the entire facility, including the 13 neighborhoods, to alert all residents, staff, and visitors to shelter in place. An IJ was declared on 12/6/22 at 12:43 p.m. Multiple facility attempts at

compliance with the IJ Removal Plan were observed during the time period of 12/8/22 through 12/13/22. This included multiple fire drills in which the facility failed to demonstrate compliance with the regulation. The Survey Team ultimately validated on-site that the IJ Removal Plan was implemented and effective through observation, interview, and record review.

Staffing & Competencies

Staff Performance

Seven staff and three residents did not follow the facility fire safety procedures during a Code Red (Fire Alarm Activation) when fire doors were opened. In addition, the facility did not make Code Red announcements as required by its Fire Response Plan. Some staff were observed not following the facility's Fire Response Plan policy and procedure, indicating they were not aware of facility policies and procedures for fire safety. Other staff observed did not follow the facility's fire response plan policy, indicating they understood facility fire policies and procedures but chose to not shelter in place.

8. Fire and Life Safety

Problem Statement

LHH fails to fully follow the Fire and Life Safety (FLS) code throughout the facility, which could lead to an unsafe environment for residents and staff. LHH staff fail to recognize and report out-of-compliance safety issues. This was evidenced in the monitoring survey with 21 K-tag findings, including, but not limited to, means of egress, fire alarm control functions, sprinkler systems, elevators, and electrical equipment.

Survey Citation(s) Reviewed

F584 (SS = D): Safe/Clean/Comfortable/Homelike Environment
F812 (SS = E): Food Procurement, Store/Prepare/Serve-Sanitary
F813 (SS = E): Personal Food Policy
F908 (SS = D): Essential Equipment, Safe Operating Condition
F921 (SS = L): Safe/Functional/Sanitary/Comfortable Environ
F925 (SS = D): Maintains Effective Pest Control Program
K163 (SS = D): Interior Nonbearing Wall Construction
K211 (SS = E): Means of Egress - General
K281 (SS = D): Illumination of Means of Egress
K321 (SS = D): Hazardous Areas - Enclosure
K324 (SS = D): Cooking Facilities
K344 (SS = F): Fire Alarm - Control Functions
K345 (SS = E): Fire Alarm System - Testing and Maintenance
K353 (SS = E): Sprinkler System - Maintenance and Testing
K363 (SS = E): Corridor - Doors
K374 (SS = E): Subdivision of– Building Spaces - Smoke Barrie
K511 (SS = E): Utilities - Gas and Electric
K521 (SS = E): HVAC
K531 (SS = D): Elevators
K711 (SS = E): Evacuation and Relocation Plan
K741 (SS = D): Smoking Regulations
K781 (SS = D): Portable Space Heaters
K909 (SS = D): Gas and Vacuum Piped Systems - Information an
K918 (SS = F): Electrical Systems - Essential Electric Syste
K919 (SS = D): Electrical Equipment - Other
K920 (SS = F): Electrical Equipment - Power Cords and Extens

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Lack of fire and life safety awareness

LHH staff members are not routinely trained on fire and life safety issues resulting in an inability for staff to identity and escalate potential life-safety problems. This increases the risk that important issues are not addressed and fixed in a timely manner, affecting the homelike environment and placing residents at risk for harm.

Recommendation: LHH will implement routine training to staff on fire and life safety compliance, so all LHH staff are able to recognize and report out of compliance safety issues. This will include fire and life safety education that incorporates examples of compliant and non-compliant scenarios based on the LHH environment. This education will be provided at time of hire and annually. LHH will create a calendar of monthly training topics for the year that cover aspects of the FLS regulations (e.g., means of egress, RACE, PASS, power strips, equipment in hallways, door stoppers, etc.) to provide to staff during rounding. LHH will implement training during rounds and document participation. LHH will include a training topic of the month in the weekly staff newsletter. **(Stronger action)**

Root Cause 2: Ineffective work order management process

LHH does not have an effective process to manage work orders, resulting in a lack of prioritization of orders, slower resolution, or issues remaining unresolved. This increases the risk that important issues are not fixed in a timely manner, affecting the homelike environment and placing residents at risk for harm.

Recommendation: LHH will implement a process to manage work orders daily. LHH will also create a process that includes creating an annual schedule for all regulatory preventative maintenance needs. This includes an audit of all outstanding work orders to determine priority. LHH will also provide training on work order submittal at future town halls and through the staff newsletter. The Director of Fire Life Safety will train the facility's unit clerks to manage the work order list on a daily basis and triage as necessary. LHH will retain a subject matter expert to support the Facilities team and coach leadership. All patterns and trends in work orders will be reported through QAPI. **(Stronger action)**

Root Cause 3: Lack of code compliance knowledge

The LHH Facilities Department lacks thorough regulatory and code compliance knowledge, resulting in a limited ability to proactively identify potential life safety issues. This increases the risk that important issues are not fixed in a timely manner, affecting the homelike environment and placing residents at risk for harm.

Recommendation: The LHH Facilities team will participate in the American Health Care Association Survey Preparation for the New Facilities Manager Training, which reviews the CMS nursing home life safety inspection process, provides an overview of the applicable codes and standards, addresses how to access and navigate the codes, identifies CMS survey tools and reports, and discusses some of the most commonly cited life safety deficiencies. All Facilities team members will participate in the one-hour online training. After training occurs, LHH will utilize the teach-back method to determine staff comprehension and document the education. **(Intermediate action)**

Root Cause 4: Ineffective preventative maintenance program

LHH does not have a formal preventative maintenance program, resulting in a lack of proactive, consistent maintenance on equipment throughout the facility. This increases the risk that equipment may break or be out of service, limiting timely services and care to residents.

Recommendation: The Facilities Department and the Biomedical Engineering Team will collaborate to create and implement a Preventative Maintenance Program to ensure equipment is in good working condition for the safety of residents and staff. LHH will train Facilities staff and vendors on compliance procedures to maintain equipment integrity through the Preventative

Maintenance Program. LHH will inventory all required items to preventive maintenance facility-wide and tag all equipment appropriately as per program protocol. A reoccurring work order schedule will be created to address all preventive maintenance. Leadership will consistently round to evaluate progress on tags submitted to the work order system. Progress will be monitored through QAPI. **(Intermediate action)**

Monitoring Analysis and Findings

Policy and Process Flow

CMS identified 21 K-tags during the monitoring survey. For example, it was observed on care units and other areas of the facility that equipment was blocking means of egress, staff had unapproved space heaters, daisy chained power strips were being used, inappropriate equipment was plugged into power strips, electrical panels were obstructed, outlet plates were broken, and combustible garbage was mixed with cigarette butts in the smoking area. It was found that the beam detector located in the therapy pool area was not tested, batteries failed the discharge tests in multiple areas, battery replacement was not documented, generator exercises were not documented, and light fixtures were not illuminated in stairwell.

9. Resident Quality of Care

Problem Statement

LHH does not adequately maintain programs with monitoring, training, and feedback mechanisms to ensure consistent resident quality of care. This was evidenced in the recent monitoring survey that identified that LHH lacked an effective wound management program that meets professional standards and quality of care and that meets the nutritional needs of residents and ensures proper positioning of residents during enteral feedings, which could result in actual harm. In addition, the survey identified inconsistent practices for residents in need of tube feeding and pain management practices.

Monitoring Survey Citation(s) Reviewed

F656 (SS = E): Develop/Implement Comprehensive Care Plan
F657 (SS = E): Care Plan Timing and Revision
F658 (SS = F): Services Provided Meet Professional Standards
F684 (SS = G): Quality of Care
F686 (SS = G): Treatment/Svcs to Prevent/Heal Pressure Ulcer
F692 (SS = G): Nutrition/Hydration Status Maintenance
F693 (SS = D): Tube Feeding Mgmt/Restore Eating Skills
F710 (SS = D): Resident's Care Supervised by a Physician
F726 (SS = F): Competent Nursing Staff
F838 (SS = F): Facility Assessment
F841 (SS = F): Responsibilities of Medical Director
F865 (SS = F): QAPI Prgm/Plan, Disclosure/Good Faith Attmpt
F697 (SS = D): Pain Management
F940 (SS = E): Training Requirements

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Lack of a functioning wound care program

LHH leadership did not ensure the wound care program continued to function appropriately after the retirement of a wound care nurse, resulting in a lack of individualized interventions being put into place. This worsened resident wounds and increased the risk of actual harm to the resident.

Recommendation: LHH will develop and implement an effective wound care program. This includes completing a full skin integrity assessment of all residents, updating the Braden risk score on each resident, deploying WOCN-certified nurses from the network to support program development, educating staff on wound care competencies and intervention, communicating skin integrity issues, and providing recommendations to the IDT for interventions to promote wound healing. The program will be enhanced to include appropriate, ongoing follow-up with patients with identified wound issues. LHH, through the QAPI Program's governing body, will also create a process to ensure the wound care program can continue during staff turnover. In addition, unit-level wound and nutrition meetings will occur on all nursing units to ensure wound

care program sustainability with meeting results reported to the QAA Committee for oversight, identification of gaps and recommendations for improvement. **(Stronger action)**

Root Cause 2: Lack of effective IDT wound care communication

The communication process between nurses and physicians is ineffective, resulting in potential delays in care and quality of care issues for residents with alterations in skin integrity. These increase the risk of harm to the resident and result in a lack of individualized care.

Recommendation: LHH will establish unit-based nutrition and wound care QAPI subcommittees to improve physician-nurse communication and treatment interventions. This sustainable infrastructure will ensure that the needs of residents are addressed related to wound care. The wound care specialist will hold the subcommittees accountable. **(Stronger action)**

Root Cause 3: Inconsistent tube feeding management

LHH nursing staff lacks an overall understanding of tube feeding orders and/or protocol, resulting in improper tube feeding management, including head-of-bed adjustments for residents. This increases the likelihood of inaccurate documentation and residents not receiving proper care.

Recommendation: LHH will continue with its current PIP, which includes a review of protocols and policies to align with best practices and regulatory compliance. It also includes education of all nursing staff to ensure proper documentation and validation of safe practices. LHH will conduct regular audits to ensure improvement in documentation practices and compliant practices using the tube feeding critical element pathway (CEP) tool. This PIP will be monitored through the QAPI Program. **(Stronger action)**

Root Cause 4: Inconsistent resident pain assessment documentation

Documentation of pain management is not consistently present in the EHR. This results in a lack of consistent evidence of resident pain assessments before and after *prn* pain medication administration and before routine pain medication. This increases the risk that resident pain is not properly managed through individualized care plans.

Recommendation: LHH will continue and complete a PIP, which includes nurse training on methods of pain assessment, LHH pain policy updates, pain assessment documentation requirements in the EHR, and care plan documentation. LHH will also complete chart audits to check compliance for required documented elements of pain assessment and reassessment. **(Stronger action)**

Monitoring Analysis and Findings

Policy and Process Flow

The monitoring survey indicated the facility assessment was not updated. The facility assessment is completed annually and then "placed on a shelf" and not utilized to ensure the resident population is evaluated to identify the resources needed to provide the necessary person-centered care and services. In addition, LHH failed to develop and implement comprehensive person-centered care plans and failed to ensure the care plans were updated and revised as changes happen to the resident needs. The facility assessment failed to ensure staff was competent to care for alterations in skin integrity.

Multiple deficiencies noted on the 2567 related to wound care showed that LHH failed to meet the needs of residents related to skin, hydration, care plan updates, and timely follow-up to identified needs. Interviews reinforced the concern of a lack of leadership related to the program as guidance was not provided by leadership or the QAA Committee.

Staffing & Competencies

Staff Performance

During interviews, staff reported challenges with the communication process between nurses and physicians. There is a lack of expertise at the leadership level related to wounds and wound care, causing a lack of direction and guidance to the program.

The survey also found the head-of-bed positions were lower than prescribed for residents who were receiving tube feedings.

During the monitoring survey, a nurse manager reviewed a resident's pain assessments and medication administration record. The resident's pain was not assessed with his 9 p.m. dose of acetaminophen. The pain should have been assessed by the nurse prior to administration of his acetaminophen. Review of the resident's 9 a.m. dose of acetaminophen revealed a pain score of zero, but the flowsheet was not completed.

Communication

Wound-related communication was ineffective and resulted in interventions not being implemented to promote wound healing. The monitoring survey indicated a communication gap between physicians and nurses in notification of a wound worsening.

10. Food and Nutrition Services

Problem Statement

The LHH Food and Nutrition Services (FNS) program lacks consistency in documenting residents' nutritional intake in the EHR, resulting in failure to properly assess intake adequacy and to follow through with treatment plans. In addition, LHH's menu management system is not routinely monitored to ensure residents receive the correct meals, as prescribed. Furthermore, LHH lacks a systemic approach to monitor weight variance and wound status and to assess intervention effectiveness. This places residents at risk for not having their nutritional needs met and other adverse outcomes.

Survey Citation(s) Reviewed

F658 (SS = F): Services Provided Meet Professional Standards
F692 (SS = G): Nutrition/Hydration Status Maintenance
F803 (SS = E): Menus Meet Resident Nds/Prep in Adv/Followed

Priority Root Causes and Recommendations

Please note: *LHH must receive appropriate funding to carry out recommendations. LHH will need permanent budgeted funding to ensure sustainability.*

Root Cause 1: Menu management system not routinely verified

LHH FNS does not have a system in place to routinely update and verify information in its menu management system, resulting in incorrect nutrient analysis of menus served and missing food items. This increases the risk that residents do not receive meals based on their prescribed dietary order to promote optimal health and safety.

Recommendation: LHH will identify an on-site menu management system superuser to manage the system and conduct routine quality assurance audits. A process will be created to include reviews of menu item accuracy for quality assurance. This support will also include reviewing all mechanical soft, thicken liquid diet menus and reviewing and analyzing diets related to diabetes management. LHH will also review the current menu management system contract to acquire the appropriate level of support that should be provided by the vendor to LHH (e.g., training). **(Stronger action)**

Root Cause 2: Lack of IDT collaboration around nutritional status

LHH lacks an interdisciplinary and systematic approach to routinely monitor residents who are at high risk for altered nutritional status, such as those with insidious weight loss or pressure ulcer(s). This results in untimely interventions to ensure residents maintain the best possible nutritional status. This increases the risk for further weight loss or not maintaining optimal nutritional status to promote wound healing.

Recommendation: LHH will reorganize its QAPI Program to have subcommittee involvement on all nursing units, including a wound and nutrition committee. LHH will also standardize the process for registered dietitians to review weight at least monthly based on a weight variance report provided by the clinical nutrition team and at least monthly for those with pressure injuries. **(Stronger action)**

Root Cause 3: Lack of EHR knowledge and inconsistent data-entry practices

LHH's EPIC EHR system is not fully configured for the SNF setting and staff lack EHR knowledge, creating challenges in completing accurate documentation. This results in incomplete nursing documentation (with missing data entry on oral diet, snack, and supplement intake), decreasing clinicians' ability to conduct accurate assessments due to the lack of essential resident information.

Recommendation: LHH will continue to prioritize updating its EPIC build to align with SNF-specific needs to simplify documentation of resident nutritional intake. LHH will assess EMR to identify opportunities for optimization, user knowledge deficits, and mitigation strategies within the software specific to nutrition. LHH will provide in-service training on the importance of oral nutritional intake documentation and how to correctly document in EPIC. LHH will create a process to audit and monitor proper nutritional documentation in the EHR. **(Stronger action)**

Root Cause 4: Use of outdated clinical nutrition standards of practice

LHH's current menu planning uses outdated standards of practice and lacks comprehensive systemic approaches to ensure residents maintain acceptable parameters of nutritional status. This increases the likelihood of residents not receiving the desired therapeutic diet to help manage their disease conditions or to achieve optimal nutritional status.

Recommendation: LHH's clinical nutrition team will review and update standards of care and practices based on current practice standards. LHH will then update, with a review from the medical director, the facility's clinical nutrition practice guidelines based on current standards. FNS leadership will review the updated guidelines with all members of the clinical nutrition team. **(Intermediate action)**

Monitoring Analysis and Findings

Policy and Process Flow

During the monitoring survey, six residents were on a mechanical soft diet with thicken liquids. It was identified that some sauces could not be provided for thicken liquids diet, and no proper substitute was provided.

Outdated menu planning included a no-concentrated-sweets diet for residents with a diagnosis of diabetes. LHH failed to implement a comprehensive systemic approach to ensure residents maintained acceptable parameters of nutritional status. During the monitoring survey, it was not evident that actual nutritional intake was compared to residents' estimated needs.

Currently, LHH has no standardized and routine weight variance review. The RD followed up on weight status primarily based on the MDS schedule instead of based on clinical condition, nutritional status, and whether current interventions are effective.

Staffing & Competencies

Competency and Qualifications

Incomplete nursing documentation in the EHR on oral diet, snack, and supplement intake affected how clinicians could conduct accurate assessments because of the lack of essential data.