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To: Nursing Homes

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From: Paul Peshek, Chief
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cc: Otis Woods, Administrator
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Immediate Jeopardy Citations

In the first four months of 2009 we have seen a sharp increase in the number of immediate jeopardy citations in Wisconsin nursing homes. As of today's date, long term care surveyors in the Bureau of Nursing Home Resident Care have issued 52 citations at the level of immediate jeopardy. This is more than half of the number issued in 2008. The purpose of this memo is to highlight the types of situations that been cited at the level of immediate jeopardy over the last 15 months. You are encouraged to review your facility's policies, procedures, and practices to ensure compliance with all state and federal regulations.

Immediate jeopardy occurs whenever noncompliance with a federal regulation:

- Has caused, or is likely to cause, serious injury, serious harm, serious impairment, or death to a resident; and
- Immediate corrective action is, or was, needed to prevent serious harm from occurring.

(For further information on immediate jeopardy determination, see the guidelines in Appendix Q of the State Operations Manual at the following link:

http://www.cms.hhs.gov/manuals/downloads/som107ap_q_immedjeopardy.pdf

The majority of immediate jeopardy citations in Wisconsin in the past 15 months have fallen into the following categories:

- *Failure to appropriately supervise residents to reduce the risk for accidents (F323).* The interpretive guidelines at F323 direct surveyors to consider immediate jeopardy for "Fall(s) that resulted in or had the potential to result in serious injury, impairment, harm or death (e.g. fracture or other injury that may require surgical intervention and/or results in significant decline in mental and/or physical functioning), **and** the facility had no established measure(s) or practice(s), or ineffective measure(s) or practice(s), that would have prevented the fall or limited the resident's injury." Immediate jeopardy has been cited when residents have experienced repeated falls and staff did not assess each fall, did not attempt a root cause analysis of the fall (e.g., is the resident getting up because s/he needs to use the bathroom?), and did not implement new approaches to try to limit the number of falls. In many cases, staff continued with the same approaches, even though these had already proven to be ineffective, or implemented "new" approaches that were already supposed to be a part of the care plan

based on previous fall reviews. In these situations, surveyors did not cite immediate jeopardy because the residents fell but because staff failed to react so as to limit or prevent the number of future falls.

Some of these citations involved continued reliance on alarms, even those that had proven to be ineffective in preventing falls. A federal hearing decision from a Wisconsin citation, addressed alarms when it stated: "...the use of alarms by a facility, while arguably beneficial, does not substitute for appropriate supervision of accident-prone residents. Alarms may enhance supervision but are never substitutes for it...the alarm is useless as an assistance device if the staff member is too far from the resident when the alarms sounds to come to the resident's assistance and prevent the resident from falling..."

- *Failure to have an infection control program designed to investigate, control, and prevent the development and transmission of infectious disease(s) (F441).* Immediate jeopardy citations at F441 occurred because facilities did not have a surveillance program that was actively and contemporaneously identifying infections and residents with symptoms that might be infectious, tracking this information, and responding with measures to prevent further spread when it should have become apparent that an outbreak had occurred. In some of these facilities, the infection control program was geared toward a retrospective analysis of what had happened in a facility and providing this information to the Quality Assurance Committee on a quarterly basis; the program was not designed to quickly identify and respond so as to proactively prevent the further spread of an infection. In some facilities, the only infections that were being tracked were those being treated with an antibiotic, while ignoring symptoms that were spreading rapidly and which were not being treated with antibiotic therapy. In some facilities, residents who were sick with symptoms were brought together with residents who were not sick for communal dining, activities, or therapy. In some facilities, sick staffs were allowed to work resulting in transmission of their illness to residents. And in many of these citations, staff who called in sick were not asked to identify their symptoms and were not given direction as to when they could safely return to work.
- *Failure to promptly consult with the physician following a significant change in condition (F157).* These immediate jeopardy citations involved incidents where residents had significant changes in their physical conditions. These included changes in neurological signs following a head injury, signs of gastrointestinal bleeding in residents on anticoagulant therapy, worsening of a pressure ulcer in terms of size or odor, and chest pain. In all these cases, there was either no contact, an untimely contact with the physician, or a fax sent to the physician's office at a time when the office was closed. The federal regulation requires the facility to "consult with" the physician, not to "notify" the physician. These citations may have been avoided had the facilities developed clear guidelines on what constituted a significant change in condition (for example, as defined by the Association of Medical Directors), had clear policies that the expectation was to promptly "consult with" the physician when faced with a significant change, and consistently implemented these policies. This would include making sure that nurses knew what to do when they were unable to reach the attending physician.
- *Failure to provide each resident with sufficient fluid intake to maintain proper hydration and health (F327).* Immediate jeopardy was identified at F327 when residents were eventually admitted to the hospital, diagnosed as being severely dehydrated, and requiring the need for intravenous fluids. In many of these cases, nursing staff had assessed the resident as being at risk, or at high risk, for dehydration and had implemented measures to monitor fluid intake. Staff, however were not monitoring fluid intake to determine if residents were meeting their assessed fluid needs. As a result, no one was aware that daily intake was far less than assessed need. In some situations, there was no

reassessment of the resident's fluid needs when the resident developed symptoms that increased the need for fluids (e.g., temperature, chronic diarrhea) or began taking medications that increase the need for fluids. In some cases there was no consultation with the physician about the continued need of a diuretic (a fluid-depleting medication) when the resident was struggling with chronic diarrhea.

- *Failure to take measures to prevent the possibility of food-borne illness (F371)*. All these citations involved the serving of unpasteurized undercooked eggs to residents. The revised interpretive guidelines at F371 give the following example as reflective of immediate jeopardy: "The facility purchased unpasteurized shell eggs for all cooking purposes. The cook prepared and served sunny-side-up eggs with barely cooked yolks (i.e., not cooked to at least 145 degrees F. for at least 15 seconds)...Using unpasteurized shell eggs to prepare undercooked eggs for eating increased the risk of residents being infected with Salmonella, which could lead to a life-threatening illness." These citations could have been avoided had staff used pasteurized eggs to serve eggs with runny yolks or if staff had cooked unpasteurized eggs at 145 degrees for at least 15 seconds.
- *Failure to prevent the development of stage 4 pressure ulcers (F314)*. Immediate jeopardy citations at F314 occurred because the facility did not develop proactive individualized approaches for preventing pressure ulcers in residents identified as being at risk or high risk for developing pressure ulcers. Staff did not monitor skin on a routine basis; in some cases, the first documentation of a skin problem was when a stage 4 pressure ulcer had developed. In other cases, staff identified stage 1 or stage 2 pressure ulcers but did not respond by developing approaches to prevent further deterioration, and did not monitor the condition of the pressure ulcers daily.

According to the severity guidelines at F314, immediate jeopardy should be considered when a resident develops an avoidable, stage 4 pressure ulcer; shows deterioration or no improvement in a stage 4 pressure ulcer that was present on admission; develops an avoidable, stage 3 or stage 4 pressure ulcer with associated soft tissue or systemic infection; or develops an avoidable stage 3 or 4 pressure ulcers as a result of extensive failures in pressure ulcer care.

- *Inappropriate nursing assessment and follow up after a resident experienced a significant condition change (F309)*. The majority of the immediate jeopardy citations at F309 occurred for the following reasons:
 1. **Cardiopulmonary resuscitation**. Staff could not quickly determine that a resident wanted resuscitative efforts in the event of cardiac arrest and did not begin, or did not promptly begin, cardiopulmonary resuscitation. Facilities need to have a system whereby they can quickly identify who is full code or no code. Staff needs to be trained on how to quickly respond when cardiopulmonary resuscitation is indicated.
 2. **Head injuries**. Staff did not monitor, or did not closely monitor, neurological signs of residents who had fallen and hit their heads. When neurological signs began to deteriorate, staff did not ensure RN assessment of the resident or promptly consult with the physician as needed.
 3. **Cardiac symptoms**. In these citations, residents displayed symptoms of cardiac problems, such as persistent complaints of chest pain, drop in oxygen saturation levels, anxiousness and/or diaphoresis. The nurse did not assess the resident's pain or vital signs and did not consult with the physician regarding the change in the resident's symptoms.
 4. **Coumadin**. In these citations, residents who were on Coumadin or other blood-thinning medications displayed symptoms of bruising or bleeding and/or got back lab reports with panic prothrombin or INR levels. Nurses did not ensure RN assessment of the resident and

did not promptly consult with the physician regarding the changed symptomatology or the abnormal lab reports.

5. Choking. Residents experienced an episode of choking. Staff did not perform the Heimlich maneuver or did not assess the resident after the choking was relieved and did not monitor the resident's condition even though the resident continued to show problems with breathing.

In all these cases, there was not a prompt RN assessment, and either no contact, or an untimely contact, with the physician. These situations may have been avoided had staff promptly notified the charge nurse of the condition change, or if licensed nurses had promptly assessed the resident when notified of the condition change, recognized the seriousness of the condition change, and taken appropriate follow-up action based on an accurate assessment.

- *Resident-to-resident abuse (F224)*. These citations involved residents who were aggressive, unpredictable, fast, and impulsive; and who had a pattern of physically or sexually assaulting other residents. We did not cite immediate jeopardy because the facility had admitted these individuals, or because they occasionally acted out, but because the residents were volatile and unpredictable and the facility had not appropriately managed their behaviors. Instead of proactively working to prevent abuse from occurring in the first place, facility staff relied on redirecting the aggressive resident or separating the resident after an aggressive act had been committed. These citations may have been avoided had staff assessed the time, place, and triggers of each incident, proactively developed and implemented approaches to modify the environment (which may have necessitated a psychiatric consult); and/or more closely supervised the potentially aggressive resident to help reduce the number of opportunities for resident-to-resident altercations.
- *Failure to immediately and thoroughly investigate allegations of serious abuse (F225 or F226)*. Immediate jeopardy citations at F225 involved supervisory failure to immediately and thoroughly investigate allegations of abuse or repeated allegations of abuse. In these instances, family or staff reported allegations of abuse and sexual misconduct to the appropriate manager/supervisor, who then failed to investigate the allegations of abuse. Failure to investigate the allegations and the failure to keep residents safe while the investigation was being conducted, created opportunities for further abuse to occur. These citations may have been avoided had management immediately and thoroughly investigated the allegations of abuse and put measures in place, e.g., employee suspension or closer supervision whenever an outside person came to visit, to ensure the safety of residents while the investigation was being conducted.
- *Failure to follow professional standards of practice (F281)*. We issued citations at F281 because of a failure to develop, or to follow, professional standards of practice which led to a serious outcome, or a potential serious outcome, at a quality of care or quality of life regulation. Immediate jeopardy citations at F281 most often involved:
 1. LPNs practicing outside the scope of their practice. N6, Nurse Practice Act, at N 6.04(1) defines standards of practice for licensed practical nurses.

"In the performance of acts in basic patient situations, the L.P.N. shall, under the general supervision of an R.N. or the direction of a physician, podiatrist, dentist or optometrist...:

 - (b) Provide basic nursing care; [which is defined at N 6.02 as care that can be performed following a defined nursing procedure with minimal modification, in which the responses of the patient to the nursing care are predictable].
 - (c) Record nursing care given and report to the appropriate person changes in the condition of a patient."

LPNs do not have the training to assess condition changes and must report resident condition changes to the appropriate person.

2. Registered nurses (RNs) failing to assess residents or to report significant changes in residents' conditions to the physician, as required at N6, Nurse Practice Act.

These citations may have been avoided had LPNs promptly notified the charge registered nurse of resident condition changes, or if registered nurses had promptly assessed the resident when notified of the condition change, recognized the seriousness of the condition change, and taken appropriate follow-up action based on an accurate assessment.

The above areas of concerns address the majority, but not all, of the immediate jeopardy citations that the Bureau of Nursing Home Resident Care has issued in the last 15 months. I am making this information available so that you and your Quality Assessment and Assurance Committee can review your facility's policies, procedures, and standards of practice in these critical areas, and identify areas that may need strengthening, so that you can avoid citations in these areas. Please review this information with your QAA Committee to ensure that facility practices in these areas adequately protect residents. Additional assistance in developing standards of practice can be found online at:

- WI Clinical Resource Center <https://wrcr.chsra.wisc.edu/>
- CMS Sharing Innovations in Quality (SIQ) <http://siq.air.org/>
- National Guideline Clearing House <http://www.guideline.gov/>

A facility cited with immediate jeopardy must remove the jeopardy within 23 days from the last date of survey or face termination from the Medicare and/or Medicaid program(s). Nursing homes cited with immediate jeopardy are eligible for civil money penalties in the higher range of \$3,050 to \$10,000 for each day that immediate jeopardy exists. Additionally, nursing homes with immediate jeopardy often face denial of payment for new admissions until the facility is determined to be in substantial compliance.

If you have questions, please contact your Regional Field Operations Director at the location and phone number below.

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