Harmony Healthcare International (HHI)

Independent Investigation

St. Louis Missouri Veterans Home

10600 Louis and Clark Boulevard, St. Louis, MO 63136

12.4.17

Preliminary Report

Confidential

To: **Missouri Department of Public Safety**
Nathan Weinert, Deputy Counsel

From: **Harmony Healthcare International (HHI)**
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Date: December 4, 2017

Re: **St. Louis Missouri Veterans Home (MO)**
Preliminary Report
Independent Investigation, November 16th, 2017 – December 15th, 2017

Please see report of the preliminary findings for the recent investigation at **St. Louis Missouri Veterans Home (MO).** Our findings indicate **Substandard Quality of Care** with **Triggers for Immediate Jeopardy** that require further investigation.

> **Immediate Jeopardy** is a defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

The community would benefit from a **refinement** of the **Model of Care** and **Culture** via leadership change, reallocation of resources, utilization of quality metrics and increased transparency at all levels of organizational functionality. The correction process involves educating, supporting, training and fostering a person-centered care approach with ongoing systems enhancement. An immediate change of the Administration is recommended.

The Harmony Healthcare International (HHI) Team is grateful for the opportunity to work with DPS, MVC and the SLVH staff, families and community. It is apparent that all parties involved are invested in the provision of the highest quality care rendered to the Veterans at SLVH.
A comprehensive report will be completed by December 15th, 2017.

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Overview of the Investigation

Harmony Healthcare International (HHI)
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Overview of the Investigation

The investigation of the St. Louis Missouri Veterans Home entailed three components:

- **Regulatory Compliance**
  A review of facility compliance with the State Operations Manual (Rev 11.22.17).

- **Quantitative Analysis**
  A review and comparison with benchmarks of nurse sensitive indicators, employee engagement variables, and veteran outcomes.

- **Qualitative Analysis**
  A culmination of comments received from 140 individuals including Veterans, family members, community members and staff.

The scope of the Harmony Healthcare International (HHI) investigation includes:

- **Investigate Allegations** of wrongdoing that have been raised involving the St. Louis Missouri Veteran's Home.

- Conduct a **General Survey** into the care provided and conditions existing at the St. Louis Missouri Veteran's Home.

- Conduct a full and complete review and reinvestigation of the **158 Points** investigated by the United States Department of Veterans Affairs as part of its annual survey in September.

- Conduct an **Additional Investigation**, as necessary, into any areas of concern discovered during the ongoing survey, including investigation of any additional complaints received by St. Louis Missouri Veterans' Home or Department of Public Safety.

Process of the Investigation

Process of the Investigation

The process for the investigation included a combination of **on-site and off-site reviews** of **data, reports, feedback, survey and regulatory requirements.**

On-Site visits were completed on **November 16, 17, 22, 23, 24, 26, 27, 29, and 30**. During this time, the Harmony Healthcare International (HHI) team performed:

- Interviews with Staff
- Interviews with Family Members
- Interviews with Veterans
- Interviews with the Leadership Team
- Direct Observation of Care
- Policy and Procedure Review
- Chart Reviews
- Data Collection
- Data Review

Interviews with Staff, Family Members and Veterans

Interviews were completed on-site, off-site and by phone. Information was received from staff members and family members of the Veterans through secure fax, email and phone messages. In total, 144 interviews were completed. At this point in time, calls, emails and facsimile reports continue to be received through the Harmony Healthcare International (HHI) offices. While a few of the staff, resident and family interviews (6 of 144 or 4%) were positive in nature, the majority (96%) include reports of concerns in the following categories:

1. Concerns with Resident Care specific to:

   - Facility acquired Pressure Injury
   - Indwelling Catheters used for convenience
   - Resident assist with Activities of Daily Living, hygiene and grooming for nails and hair
   - Urinary tract infections
   - Communication with families regarding changes in medications or treatments
   - Timeliness of medication delivery
   - Response time to calls for assistance
   - Oral Hygiene i.e., Dental Care
   - Dehydration
   - Nutrition and Weight Loss
   - Safety
   - Falls and falls with injuries

2. Lack of Cleanliness within the environment with offensive odors noted in resident care areas.

3. Issues with Communication with Staff, with a loss of confidence in resident hand-off processes.

Interviews with Staff, Family Members and Veterans (continued)

4. High turnover rate of staff, with many identifying the loss of long term staff members.

5. Coverage of staff vacancies through mandatory overtime.

6. Workplace violence, with two staff reports of being threatened by co-workers.

7. Perception of a hostile work environment.

8. Process for disciplinary action with staff members placed on administrative leave without understanding of the rationale for the action taken.

Interviews with the Leadership Team

The interview with the leadership team, including **the Administrator, Director of Nurses,** and **members of the Missouri Veterans Commission** reported initial awareness of family concerns on May 8, 2017, with actions taken to investigate the concerns. [redacted]

[redacted] The leaders reported that the issue involved three key concerns:

[redacted]

The leaders report that **two Quality Nurses** were sent to the facility to assess the residents included in the report. They **did not find evidence to substantiate concern**. The leaders report that, while the St. Louis Veterans Home is not perfect, it is the best performing clinical environment of the Missouri Veterans Home System.

During the interview, the leaders noted the **Deficiency Free Survey** of September 18-22, 2017 of the facility. They noted that the survey included a **7 or 8-member survey team** with over 40 years of survey experience. The leaders state that the building is the best it has ever been clinically.

Leaders mentioned during the interview that **issues of communication** and customer service have been addressed through the **addition of an evening shift assistant administrator** and a **guest relations staff member.**

Their current strategy is to **hold on admissions until staffing is stabilized**. They have worked to increase recruitment rates. An increase has been requested in the shift differential to facilitate recruitment. The leaders noted that the issue of staffing is complicated by **60 staff members** on intermittent family **medical leave of absence**, which leaves only **105 eligible** CNAs for filling **mandatory 8 hour overtime shifts.** Shortly after arriving at the facility, the Administrator **attempted to stop using mandatory overtime (referred to as "mandation"),** through a select a schedule option. This was trialed for six months, after which

Interviews with the Leadership Team (continued)

the staff voted to return to mandatory overtime. Leaders noted that in an effort to increase hiring, they offer a CNA training program.

Leaders noted that they have added a Veterans Hotline for 24-hour calls, and they have purchased new furniture for the A Wing, with plans to replace furniture throughout the organization. They have repaired the four whirlpools that were non-functioning, so that 12 whirlpools are available. The Administrator is implementing his vision of having the whirlpools be a spa type of environment with towel warmers.

With respect to family and Veteran concerns, the Administrator has implemented a VIP list (Veterans with Individualized Preferences) to focus corrective attention on the families and Veterans who have reported concerns.

The Administrator states that he has increased staff meetings, including "Coffee with Mr. Carter" to encourage staff to discuss their concerns and thoughts. He implemented Grand Rounds within two weeks of the May 8, 2017 meeting. During Grand Rounds, which are held daily, leaders round on each unit and ask about resident-specific information and inquire about the availability of supplies and equipment.

The Director of Veterans Homes Program noted that the administrative team, including the Administrator and Director of Nurses, is the best leadership team the organization has had. She noted that the Administrator is a fine leader and that she has confidence in his skills. She noted that the facility has been in a constant state of survey or investigation since May, and that staff are tired of the constant survey and investigation process. She expressed that the facility should be celebrating, but instead they are in survey mode, and that the Central Office for the Veterans Homes program has been on site for over two months.

Direct Observation of Care

Throughout the nine days on site, the investigative team observed care during the day, evening and night shifts. Care in the main dining room and satellite dining rooms was observed. Resident care provided during routine daily care, medication administration, recreational and restorative therapy was observed. Residents spoke openly about the care they received, with concerns noted regarding the frequency of bathing and showers, the response to calls for assistance, and assistance with physical care such as turning, repositioning, wound and dental care.

- **Dignity:** Issues with Veteran dignity were noted with residents in all areas and wings of the organization noted to wear clothing soiled with food stains and spills.

- **Cleanliness:** Issues were noted with cleanliness of the environment, with odors noted in Veteran wings of the facility, in particular, in the pod areas surrounding shared bathroom facilities. Issues were noted with cleanliness of equipment and wheelchairs with food and debris noted on the foot pedals of manual and power chairs.

- **Staffing Sufficiency:** Issues with staffing adequacy were identified during interviews with Veterans, family members and staff members. During 9 days of observation, issues were noted with delays in response to Veteran call lights and requests for assistance.

- **Medication Administration:** Issues were noted with the timely administration of medications, with one CMT (Certified Medication Technician) administering medications, checking blood sugars, administering nebulizer treatments to as many as 50 residents. At an average of 5 minutes per resident to review the order, obtain the medication, locate and identify the resident, administer the medication and document the administration, this requires at least 4 hours of time. Given that many of the medications require a blood pressure or heart rate check prior to administration, an assignment of 50 residents exceeds the policy of a two-hour window for timely medication administration (as stated in policy one hour prior or one hour following the designated time).

- **Resident Safety:** Issues noted with the safety of the dining room with multiple observations of no nurse in the dining room while residents were eating. Since nurses are the only members of the healthcare team who have BLS (Basic Life Support) competence, choking concerns are present when residents are dining without a nurse present in the main dining room.

Direct Observation of Care (continued)

- **Dining Experience:** Creation of an appealing dining experience is helpful in promoting good intake in a relaxed environment. The main dining room is a busy location, with Veterans lining up to get their dining trays prior to 7a.m. each day. The dining room provides a blended tray distribution with some residents choosing their meal selections and others having trays delivered to their tables. The concern with this system is that some residents sit waiting for their meals and assistance while others at the same table are starting their meals to avoid allowing food to get cold.

- **Personal Hygiene and Dental Care:** Many residents were noted to have an issue with personal hygiene, requiring attention for bathing and grooming. Issues were noted with failure to receive oral care, with residents who require attention for dental care and tooth brushing.

Policy and Procedure Review

The review of the policies and procedures included focus on policies impacting areas of concern identified by staff, Veterans and family members. In particular, policy review focused on administration, nursing care, emergency management, infection control, resident centered care, staff communication, resident communication, treatment and management of pain management, fall prevention, hydration and nutrition, psychotropic medication use, medication administration, urinary function, and wounds.

Inconsistencies between practice and policies were noted in the following areas:

- **Cardio-pulmonary resuscitation:** Policy last revised 1.3.13. Policy does not specify which members of the staff are CPR certified.
- **Catheter Care (Indwelling Catheter):** Policy issued 2.1.09, never revised. Policy does not specify frequency of catheter care.
- **Catheterization:** Policy issued 2.1.09, never revised: Policy not consistent with current evidence based practice, and does not include information on frequency of changing indwelling catheter.
- **Cleaning of Wheelchair, Geri chair, Bedside Commode, Personal Care Items:** Policy issued 2.1.09, never revised.
  Compliance with policy not demonstrated during rounds on units.
- **Diet Order:** Policy issued 2.1.09, revised 3.31.14: States process for diet order.
  Compliance with policy not demonstrated during rounds on units.
- **Maintaining Bowel and Bladder:** Policy issued 2.18.11, revised 6.28.16: Policy notes that toileting programs are not necessary on Veterans who are unable to participate due to cognitive impairment, which is not consistent with evidence based strategies for promoting continence.
- **Medication Administration:** Policy issued 2.11.09, revised 6.28.16: Policy states that medications must be administered within one hour before or one hour after the designated time. Compliance with policy not demonstrated during rounds on units, discussion with staff and observation of practices. Practices inconsistent with this policy noted with medications delayed in administration, and with BID medications administered during a single dose.
- **Psychotropic Drug Protocol:** Policy issued 2.1.09, never revised: Policy is not consistent with current evidence based and recommended practice for obtaining informed consent from persons served prior to initiating treatment with psychotropic medications.

Policy and Procedure Review (continued)

- **Abuse/Neglect Prohibition and Reporting:** Policy issued 12.1.02, revised 6.7.12: States that staff members shall immediately report suspected abuse or neglect events to the Shift Supervisor on duty or their designee. The policy states that the reporting of an abuse or neglect event shall be considered an allegation and shall be treated as such. The person reporting an allegation shall be assured confidentiality to the fullest extent possible. Compliance with policy **not demonstrated.** Practices inconsistent with the policy were noted with two situations in which staff members reporting abuse or neglect were placed on administrative leave (as of this report, the administrative leaves for these staff members exceeded 14 days). The two staff members involved perceived the placement on administrative leave as punitive in nature.

  Additionally, the policy identifies neglect as a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. It includes withholding or inadequately providing food and hydration. [redacted]. Multiple reports of hospital transfers for **dehydration** support the concerns raised by Veteran family members. Observations during the 9 days on site reflected that, although hydration stations are in resident care areas, the level of fluid within the hydration stations does not fluctuate during the 24-hour period, and access to drinkware are not adjacent to the hydration stations.

  The policy states that the investigation of alleged Abuse/Neglect shall result in an investigation and the alleged perpetrator shall be placed on administrative leave pending the outcome of the investigation. The investigation must be completed within 5 working days. Practice was not consistent with this policy, as in two situations during the 9 days of site visit, two staff members were placed on administrative leave for reporting abuse/neglect. **Neither situation was resolved within 5 days.** Personnel files in both cases were reviewed and did not provide documentation for the disciplinary action or administrative leave.

- **Change of Shift Report:** Policy issued 2.1.08, never revised. Compliance with policy not followed consistently as identified by reports of information not communicated between shifts.
- **Resident and Family Satisfaction Survey:** Policy issued 12.10.03, revised 3.5.12: The policy states a resident and family satisfaction survey is completed annually in March and provides a comparison of satisfaction levels from the current year to the prior year. Compliance with this policy was not demonstrated.

Policy and Procedure Review (continued)

- **Per Occurrence Investigations**: Policy issued 12.01.02, revised 6.28.16: The policy indicates that all Per Occurrences are promptly reported, thoroughly investigated and appropriate action is taken. Compliance with this policy was not demonstrated as exemplified in the Veteran Grievance Log and during the 144 interviews completed in which family members produced written documentation of email and letter correspondence with the Director in which they reported concerns with care provided. They reported failure to respond in a timely manner and failure to complete a thorough investigation and take appropriate action.
- **Resident Council:** Policy issued 7.1.93, revised 3.5.12: The policy states that all residents are encouraged to participate in Resident Council. Representation/advocacy for residents who are cognitively impaired will occur by the local Ombudsman, another member of the resident council (officer) or a family member or interested friend/advocate. Compliance with this policy was not demonstrated. [redacted]
- **Sick Leave:** Policy issued 1.1.98, revised 8.15.16: The policy states that the supervisor may require a physician's statement in support of the request for leave indicating the employee's fitness for duty upon return to work. Compliance with the policy was not demonstrated. The Administrator reports that physician notes for return following an illness are not required. Staff members report that physician notes for return following an illness are not accepted. Therefore, fitness for duty cannot be assured.
- **Permitted Uses and Disclosures of Protected Health Information**: Policy issued 5.20.05, revised 2.5.17: Policy states that protected health information may be shared for treatment, payment or operational purposes on a need to know basis, utilizing the minimum necessary rule with MVC workforce members, with MVC business associates and/or other covered entities for activities related to treatment, payment or health care operations. Compliance with this policy was not demonstrated. The restriction on protected health information was overapplied on the information required for consistent care of Veterans, including information on person-centered care and preferences. This unnecessary restriction impedes Veteran care and their ability to receive appropriate treatment for example with positioning, food choice and hydration.

Policy and Procedure Review (continued)

- **Resident Complaints/Grievances:** The policy states that all residents have an avenue to voice complaints/grievances with respect to treatment received or not received. Compliance with this policy was not demonstrated. Review of the grievance log included the following, which demonstrate an inconsistent approach to identifying and responding to complaints and grievances:

2017	Number of Grievance	Issues Noted
[redacted]		

Policy and Procedure Review (continued)

2017	Number of Grievance Reports	Issues Noted
[redacted]		

Chart Reviews

Medical records were reviewed for Veterans on each wing of the organization. Records were selected in a stratified random sampling method in addition to including selection of residents for whom concerns were reported during the 144 interviews completed over the course of the 9 days of site visit. Following are observations from the medical record review:

Chart Reviews (continued)

Personnel File Reviews

Personnel files were reviewed for several staff members. Records were selected in a stratified random sampling method in addition to including selection of staff on administrative leave. Files were evaluated for length of tenure, completion of background check, licensure (if appropriate), orientation, annual required education, performance appraisals, and disciplinary actions. Following are observations:

Initials of staff member/position	Length of tenure	Comments
[redacted]	[redacted]	Staff member on administrative leave. No documentation in file related to issue surrounding administrative leave. [redacted] Issue with timely documentation [redacted] Annual performance appraisal with satisfactory rating
		Staff member on administrative leave. No documentation in file related to issue surrounding administrative leave. [redacted] Annual performance appraisal, noted to do "great job" [redacted]: Annual performance appraisals not in personnel file [redacted]: Employee of the month recognition [redacted]: Annual performance appraisal, noted to do "great job" [redacted] Annual performance appraisal, noted to do "great job"
		Resigned, effective [redacted] Performance appraisals noted as outstanding for [redacted] Performance appraisal noted as successful for [redacted] Employee of the month recognition [redacted] Corrective action [redacted] for a negative verbal interaction with co-worker
		No performance appraisal in file Corrective action [redacted] for tardiness.

Personnel File Reviews (continued)

Initials of staff member/position	Length of tenure	Comments
[redacted]	[redacted]	Performance appraisals noted as successful for [redacted]; [redacted]; outstanding for [redacted]; successful for [redacted] Corrective action [redacted]: unacceptable conduct Corrective action [redacted]: MDS compliance Recently on administrative leave with no documentation in file regarding recent administrative leave.
		Background check complete Orientation checklist and educational information (facility training) not present in file
		Performance appraisal outstanding for [redacted] successful for [redacted] Corrective action: [redacted] for Veteran sent to emergency department without a report called Education current and documentation in file for all years [redacted] to [redacted]
		Background check complete Orientation documentation in file No facility educational information in file
		Performance appraisal for [redacted] only Corrective action: [redacted] for refusal of mandation Corrective action: [redacted] for tardiness
		Performance appraisals for all years of employment Corrective action: [redacted] for missing a mandatory meeting Corrective action: [redacted] for unacceptable conduct (refusing mandation) Corrective action: [redacted] for taking bereavement leave for fiance's mother (later rescinded)
		Performance appraisals for [redacted] Corrective action: [redacted] for refusal of mandation Corrective action: [redacted] for refusal of mandation Corrective action: [redacted] for sleeping on job
		Background check completed Orientation completed
		Background check completed Orientation completed

Data Collection

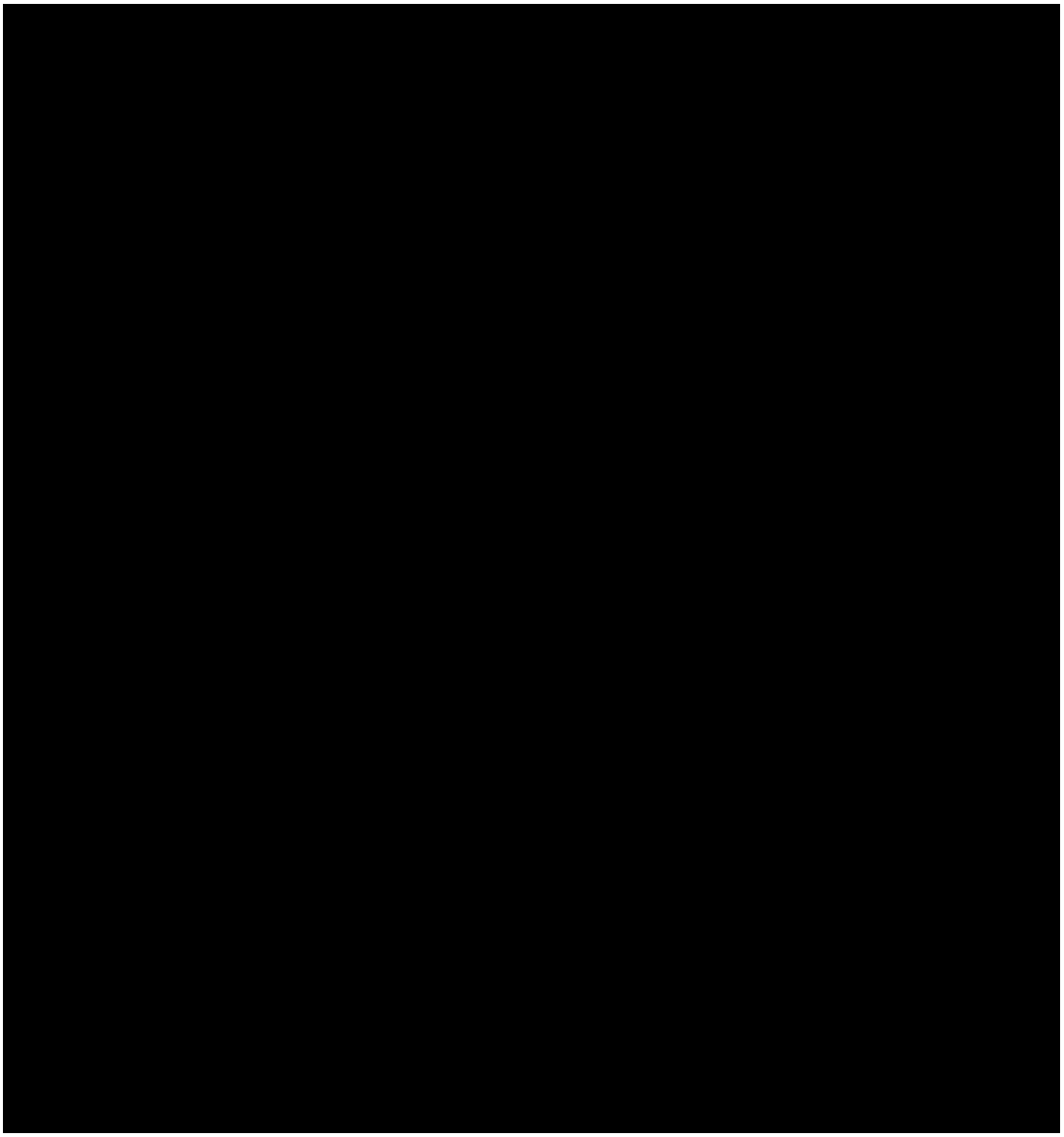
Data from the Key Factor Meeting Minutes were reviewed for 2017. These data reflect the following information:

- Employee Engagement

2017						
Resignations	Oct	Sep	Aug	Jul	Jun	Mar
CNA	18	13	3	14	4	2
Licensed Nurses	5	4	2	4	1	1
Terminations						
CNA	14	16	6	16	12	5
Licensed Nurses	1	0	1	0	0	0
Total Caregiver Departures						
CNA	32	29	9	30	16	7
Licensed Nurses	6	4	3	4	1	1
Vacancies						
RN	10	11	9	7	10	12
LPN	9	8	5	4	4	3
NA II/I	44	22	8	12	25	10
ADNS	1	0	0	0	0	0
RN Supervisor/Manager	1	3	0	0	1	2
RN Supervisor/Shift	1	1	1	1	1	1
Total Nursing Vacancies	66	45	23	24	41	28

Data Collection (continued)

- Resident Care Data

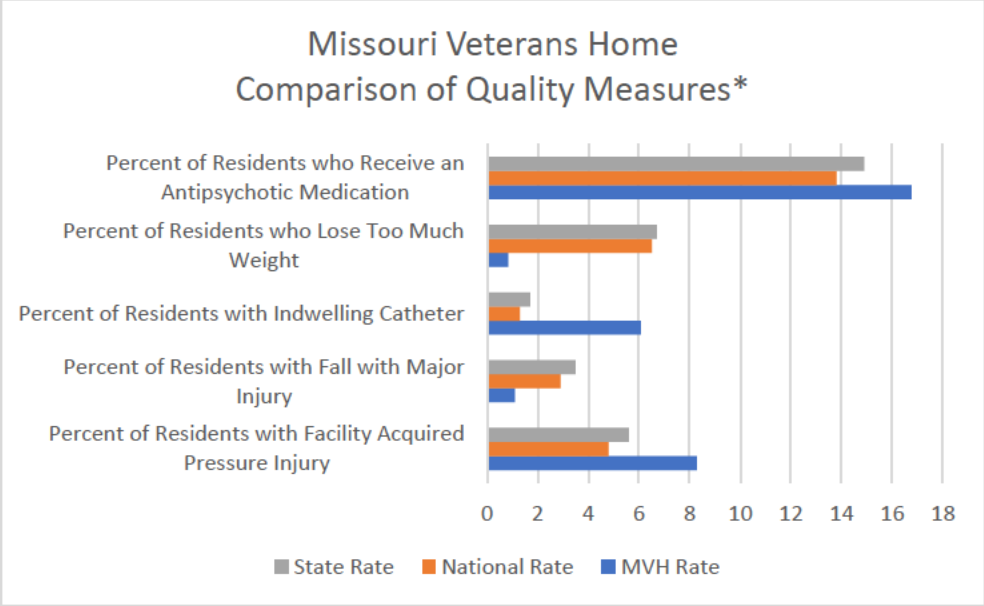


Data Review

Initial analysis of rates of facility:

- acquired **pressure injury**
- residents with **indwelling catheters**
- residents who receive an **antipsychotic medication**

Exceed national rates as noted below in comparison with data accessed from the National Nursing Home Quality Improvement Campaign (Accessed 12.2.17).



*National Nursing Home Quality Improvement Campaign.
https://www.nhqualitycampaign.org/Statistics.aspx?opt=LSQM Accessed 12.2.17

Data Review: Staff Interviews: Key Themes

Qualitative findings from interviews completed and emails received from Veterans, family members, staff and others regarding care received at the Missouri Veterans' Home:

- Staff Interviews, Key themes:
  - **Hostile, stressful work environment** with micromanagement by senior leaders. Not an easy place to stay. The Central Office is not helpful and are protective of the senior leadership team.
    - **CNA** feels **threatened** about her job.
    - CNA shared with the wife of a Veteran, if the Administrator doesn't stop firing or placing CNAs on leave, the resident family members will need to

    - CNA reports being scolded in public.
    - Staff are scared and just trying to keep their jobs
    - The [redacted] watches her kids while at work from a camera she has in her home. [redacted].
    - Managers and supervisors are all friends of the Administrator.
    - [redacted] is outgoing and well-loved by the Veterans. She was put on administrative leave because she complained about the care Veterans were receiving.
    - [redacted] ordered a new car shortly after starting, but the [redacted] questioned priorities since the facility needed another vehicle for transportation of the Veterans. This staff member felt that the attack on the [redacted] followed her criticism of the purchase of a car with facility funds for the [redacted].

Data Review: Staff Interviews: Key Themes (continued)

- [redacted] asks for escort from the police to his car at night for both he and the [redacted].
- The [redacted] was a long-term staff member at the home and she identified some concerns with Administration. She was written up and discredited by [redacted].
- Staff member feels she is being **bullied by Administration.** She is near retirement age, and feels that she is being targeted.
- **Roles of new Assistant Administrator and Guest Relations** not clearly understood. Perceived to be unfair positions.
- **Loyalty and longevity** mean nothing and get staff members nowhere. She was passed over for positions that were taken by the Administrator's friends.

- **Communication** is a key issue with selective information presented to staff. Staff who complain worry about retaliation.
- **Morale** is bad. This staff member is just fed up with the situation. This individual stays working here because he cares about the residents.
- **Insufficient staffing** resulting in **mandatory overtime**. Example is presented of a CNA having a mandation shift of an **additional 8 hours** three times in one week.
  - Mandated to stay a double on Thanksgiving Day. This nurse did three double shifts in the past 9 days.
  - All 5 nurses were mandated to do doubles yesterday (Thanksgiving Day).
  - Mandation is necessary and happened prior to the arrival of this CNA. (1 comment)
  - Changes have been made in the policy. There used to be a 7-minute grace period, but that was removed. If you are even 1-2 minutes late, you are afraid you will be fired.
  - **FMLA** necessary because she has a back injury and cannot work more than 8 hours in a shift or 40 hours in a week.
  - The FMLA hours are used in place of mandation, which is using up her FMLA time. She doesn't know what she will do when her FMLA time is exhausted.
  - **CNAs** doing multiple mandatory overtime shifts in a week. If a CNA refuses twice to do a double shift, she/he is fired.

Data Review: Staff Interviews: Key Themes (continued)

- All day shift CNAs were mandated to stay (12.2.17).
- There are H and I staff, but this is not effective. It hasn't decreased mandation.
- **The policy for mandation is not followed.** It is supposed to be for extreme weather issues. When this caregiver started, mandation was in place, but only happened once or twice a year. Now it is a daily occurrence. The staffing office is supposed to call H and I staff, or look for volunteers, but they just use mandation, because it is easier.
- **Mandatory overtime** results in staff members just sitting. The CNA reporting the issue stated that "they want a body, that is what they will get."
- CNA states that the facility is like a prison.
- Beginning with Thanksgiving weekend, there is to be a **Manager on Duty** which includes all social workers (who are not managers), but excludes the Administrator and Assistant Administrators. The goal of this new program is unclear, but there is a form that the Manager on Duty needs to have staff in all wings sign (3 comments).
- This program was mentioned in March, but is just now being implemented. Neither the Administrator nor the Assistant Administrators are part of the rotation, but all social workers are on the list (although they are not considered managers)
- Problems have been going on a long time, longer than the current Administration, but this is the worst things have ever been. The [redacted] **is patronizing and dismisses concerns**.
- [redacted] doesn't know how to talk to people. He has clique. He is trying to fire the older staff and bring in new staff.
- [redacted] **bought a car with organization money** and his license plate says, [redacted]

- **Turnover** is significant There have been many retirements.
  - Lots of turnover. The preceptor differential was stopped because we are always "precepting" new staff.
- **The dining room** is an issue and all social workers are expected to be in the dining room at noon. [redacted] do not spend the hour at noon in the dining room, but go in around 12:55 and get their lunches and take them back to [redacted].

Data Review: Staff Interviews: Key Themes (continued)

- Following a recent Hero's Farewell, [redacted] loudly and publicly criticized a change that was made which made the event longer.
- The VIP list is a concern. Some families are difficult to please, but all Veterans should be VIPs.
- Following policy is not consistent as with timing of therapeutic recreation activities. The policy specifies that activities are not to be scheduled at specific times within the dementia wing, to allow time for residents to participate. The staff member states that the schedule of activities was forced by Administration. This staff member feels the schedule is to track them, and not for the benefit of the residents. He feels the scheduling system, designed by administration, is not resident-centered.
- Concerns with recreational therapy with the departure of the department director. Current administration is all about the Administrator and the Assistant Administrator.
- Resident care is inadequate. Residents receive skin tears because they are pulled up by their briefs. Residents die alone because no one is able to sit with them. CNAs run the units and nurses don't listen to them. Residents who are bedridden are not getting attention. Many residents have pressure ulcers because they are not getting turned and repositioned.
- Issues with aides fighting within the facility.

Data Review: Family Interviews: Key Themes

- Many are complaining; however, the **service is great.**
  - **Mr. Carter** is great. He has attempted to make changes and is trying to get it right. (1 comment)
  - **Food is good** (2 comments)
  - **Price is right** for the service provided.
- **Resistance from Administrator to listening to concerns.** Veteran's daughter states that she requested her father's medical records twice. She heard from [redacted] within one hour of the request that it would be 4 days until she received the records. The Veteran's handbook stated the records should be available within 4 hours and a hard copy within 48 hours. She was told that, because the VA Surveyors were coming that week, they would be busy and they would not be able to get her the records. The resident's daughter was told [redacted] requires approval for release of the medical records. It was over 4 weeks until she received the medical records.
- Resident's daughter stated that her expectations are that her father have his teeth brushed once a day, that his hands are cleansed before meals, that he is kept comfortable and clean, that he not be neglected and that he not be hurt. She was told by the LPN that her expectations were too high and that she was going about correcting the situation in the wrong way. She was told that although the staff loved her father, the LPN didn't want him to receive retaliation for her actions.

[redacted]

Data Review: Family Interviews: Key Themes (continued)

- Veteran **safety issues**. [redacted]
  - [redacted]
  - [redacted]
- **Insufficient staffing** and staff don't stay because there are no raises. Some staff have been very overworked secondary to mandation. Insufficient staff for overnight coverage (2 comments).
  - **Staff look tired.** When this wife mentioned how the staff appear overworked, [redacted] said it was okay, because they want the extra money.
  - Wife reports that during weekends, especially, there is **insufficient staffing.**
  - Daughter reports that many times during her visits there are no caregivers present in the hallways. She looks, but cannot find anyone to answer her questions.
  - Wife reports concerns with **staffing levels.** States that she hears the staff talk and she is concerned with staff being mandated to work an additional 8-hour shift. She states she has heard staff talk about not receiving a raise in over 5 years.

Data Review: Family Interviews: Key Themes (continued)

- **Mandatory overtime** results in issues with staffing. Staff appeared tired.
- **Steady turnover of staff** with new staff constantly on and no one knows the residents.
- Wife feels that she has met more than 200 new faces in caregivers. Her husband has been in the facility for a year and she finds that she doesn't know anyone. She knows that people are getting fired.

- **Staff are insensitive.** Daughter reports that CNAs are young and either don't care or choose not to care.
  - Family reports that staff **talk around Veteran**, rather than with him or to him, as if he wasn't in the room.

Data Review: Family Interviews: Key Themes (continued)

- **Expectations** of the wife of one of the Veteran's was submitted in writing during the investigation. Specifically, the wife stated, "When I put my husband in this VA home, I expected that he would get the best quality care humanly possible. He has served his country well in the younger days by being an officer during war time in the United States Army. I had hoped that his last days would be his best days, and by signing him here at this home, he would be treated with the respect and dignity he so richly deserves for the dedication and honor bestowed upon him as a soldier in the United States Army. She states that she believes this VA Home can be the best one in the world, but it takes actions (where each one of us has a role) not just talk. "Treat others as you desire to be treated" and when you give your best, know that the best will come back to you. One thing is certain about this life – "As a man lives, so he/she dies." But it is up to each individual which way you want to go – because the **here determines the after.**

Data Review: Family Interviews: Key Themes (continued)

- **Issues with response to call lights** noted by resident's son. He stated that the response time for his father was significant. He was told that the expectation for a response to a call was 4 minutes, but that is not what occurred.
- [redacted]
- **Call lights turned off at desk** rather than being answered. Resident's daughter reported that her father would put on the call light and not receive a response. Her father would ask to use the bathroom and would be told that the staff was **too busy.**

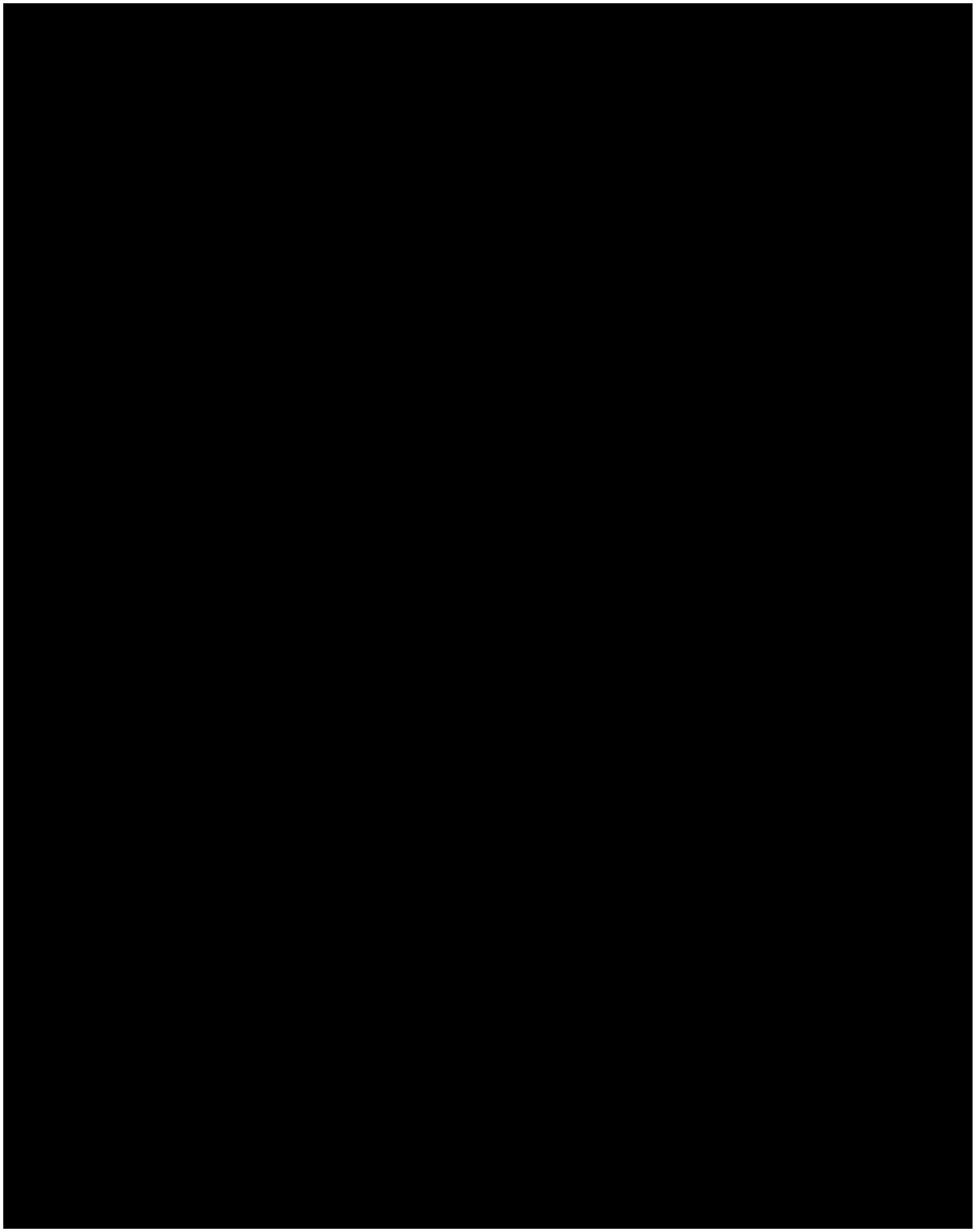
- **Turnover** of staff has increased, maybe because staff have better opportunities elsewhere.
  - Wife noted that she used to know the people who worked there, but now
- [redacted]

Data Review: Family Interviews: Key Themes (continued)

- **Facility cleanliness** is an issue with odors noted in the wings.
  - The Veteran's room is **not clean** and it has an odor (4 comments).
  - [redacted]
  - The **place is clean and care has been good (1 comment)**
  - [redacted]
  - [redacted]
  - Sister-in-law reports that the shared bathroom smells.
  - **Odors unbearable.**
- **Personal care of Veterans.** The Veteran is not clean and has a lack of hygiene.

[redacted]

Data Review: Family Interviews: Key Themes (continued)



Data Review: Family Interviews: Key Themes (continued)

- [redacted]

- **Communication with staff** is an issue.
  - Daughter reports that she has repeatedly requested that she be called 1st rather than calling her mother. This has not occurred.
  - [redacted]
  - [redacted]
  - Daughter reports that there **has not been a care meeting** for her father **in 6 months**. She contacted the social worker, but was told that she is on administrative leave.
  - Daughter just wishes the staff would notify her of issues with her father. During his first year, the staff would call, but this year his care has not been good.
  - [redacted]
  - [redacted]
  - There is **no phone in the resident rooms**. Wife reports that she has repeatedly asked for her husband's phone to be plugged in for charging. He does not remember to do so. She is unable to contact him, and is not able to access anyone at the desk.
  - Sometimes there is no one available at the desk and when she calls, there is **no one to answer the phone**. There are no phones in Veteran rooms, so she is not able to find out how her father is.

Data Review: Family Interviews: Key Themes (continued)

- Sister-in-law reports that she has asked to make sure that her brother's phone is charged, since it is his only means of contacting him.
- **Difficult to speak with a nurse** related to staffing levels.
- Issues with getting residents to **outside appointments** due to lack of communication and due to transportation difficulties. Example is given of a Veteran who had an appointment at a local hospital. The Veteran's son called and was told that the CNA had called out and there was no one who could get the resident ready to go in time. The appointment had to be rescheduled.
- [redacted]
- [redacted]
- **Dignity issues** were noted [redacted]
- [redacted]

- **Timely administration of medications** is an issue.
  - Resident's son shared a copy of his medication record as submitted as a portion of his transfer packet. The record reflects BID medications given at the same time. For example, noted on the emergency transfer form from the Missouri Veterans' Home – St. Louis is indicated, Doxycycline Monohydrate 100 mg ordered/scheduled twice a day, given a double dose at 10:40pm; Famotidine 20 mg ordered/scheduled BID, given a double dose at 10:40pm; Hydralazine 25 mg ordered/scheduled at 8am, given at 3:51; Levetiracetam 500 mg ordered/scheduled twice a day given two doses at 10:40pm; Metoprolol tartrate 25 mg ordered/scheduled twice a day, given two doses at 3:51pm.

Preliminary Summary

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Preliminary Summary

The results of the general survey depict **Substandard Quality of Care** with multiple deficiencies noted and **Triggers for Immediate Jeopardy** that require further investigation. Although these triggers require further review, the corrective action for all elements identified in this report should be addressed immediately and there is a strong recommendation for leadership change. Over the weekend, while preparing this report, we continued to receive calls from staff and family with concern of employee walk out.

While the concerns raised are significant, the support for correction of the current situation is strong. Residents, staff members and family members all expressed a desire for the organization to be successful. The interviews completed indicate that the concerns are widespread and prevalent from all areas of the organization. Although 4% of the interviews were positive, overall, the interviews indicate **a loss of confidence** in the ability of those currently in leadership at a local and divisional level to correct what are perceived to be serious systemic issues. The issues identified are correctable but will require **sustained attention** and a **change in the model of care** and **culture**.

Preliminary Findings

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Preliminary Findings

I. Investigate allegations of wrongdoing that have been raised involving the St. Louis Missouri Veteran's Home.

The preliminary findings show that the assertions towards the St. Louis Missouri Veteran's Home have merit and impact the current service delivery and atmosphere within the organization. Current leaders of the facility and the Commission of the Veterans Homes are not in agreement with the allegations which may impede correction of the identified and validated issues.

The community would benefit from a refinement of the Model of Care and Culture via leadership change, reallocation of resources, utilization of quality metrics and increased transparency at all levels of organizational functionality.

The correction process involves educating, supporting, training and fostering a person-centered care approach with ongoing systems enhancement.

An immediate change of the Administration is recommended.

Preliminary Findings (continued)

II. **Conduct a General Survey** into the care provided and conditions existing at the St. Louis Missouri Veteran's Home. The results if the general survey depict **Substandard Quality of Care** with **deficiencies** in:

- **Resident Rights**
  Safe/Clean/Comfortable/homelike Environment
- **Freedom from Abuse, Neglect and Exploitation**
  Free from Abuse and Neglect
- **Quality of Care**
  Treatment/Services to
  Free of Accident / Hazards / Supervision/ Devices
  Nutrition / Hydration Status
- **Behavioral Health Services**
  Psychosocial Concerns
- **Pharmacy Services**
  Unnecessary Psychotropic Medication Use
  Medication Error
- **Administration**
  Employ / Engage Staff with Adverse Actions
- **Quality of Life**
  Activities of Daily Living (Bathing, Dressing, Oral Hygiene, Functional Mobility
  Physical Restraints
  Parental / IV Fluids
  Bowel/Bladder Incontinence, Catheter and UTI
- **Infection Control**
  Cleanliness of the environment
  Surveillance for infection prevention
  Compliance with standard precautions

and **Triggers for Immediate Jeopardy** that require further investigation.

Preliminary Findings (continued)

II. Conduct a General Survey

Immediate Jeopardy Triggers (continued)

Issue	Triggers
A. Failure to protect from Abuse.	1. Staff yelling, swearing, gesturing or calling an individual derogatory name; As documented in comments from resident families in which resident was scolded [redacted]
B. Failure to Prevent Neglect.	1. Failure to carry out doctor's orders; As noted in failure to give medications timely and administering BID medications as a double dose one time a day. Improper feeding/positioning of individual with known aspiration risk; residents with feeding/positioning issues in dining room without the presence of a nurse. 2. Repeated occurrences such as falls which place the individual at risk for harm without intervention. In this situation, he is at risk for continued pressure injury due to the repeated occurrence of failing to turn and reposition him, since he is not able to do so himself.

Preliminary Findings (continued)

II. Conduct a General Survey

Immediate Jeopardy Triggers (continued)

Issue	Triggers
C. Failure to protect from psychological harm.	1. Presence of behaviors by staff such as threatening or demeaning, resulting in displays of fear, unwillingness to communicate, and recent or sudden changes in behavior by individuals; Example of Staff and residents report concerns with being able to speak for fear of retaliation.
D. Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed.	1. Lack of monitoring and identification of potential serious drug interaction, side effects, and adverse reactions; [redacted]
E. Failure to provide adequate nutrition and hydration to support and maintain health.	1. Failure to provide adequate nutrition and hydration resulting in malnutrition; e.g., severe weight loss, abnormal laboratory values; Example of residents no having easy access to hydration.

Preliminary Findings (continued)

III. The results of the review and reinvestigation of the 158 points show that the following areas did not meet compliance with the regulatory requirements.

Reference Number	Standard Description
15 K	Required Training of Nurses' Aides
17 5	Required Retraining
17 6	Continued Competencies of Nurse Aides
18 l.	Proficiency of Nurse Aides
21 o.	Clinical Records
25 5	Clinical Records
36 51.70	Resident Rights
38 9. l A., B., C., D.	Notification of Changes
45 e. 1.	Privacy and Confidentiality
46 f. 2.	Grievances
47 g.	Survey Results
61 b.	Notice of bed-hold policy
62 c.	Equal Access to Quality of Care
64. 51.90	Resident Behavior and Facility Practices
65 b.	Abuse
65 4.	Neglect
67. 51.100	Quality of Life a. Dignity
69. 4.	Staff of Visitors may attend meeting at groups invitation
92	Comprehensive Care Plans
96 51.120	Quality of Care
98 b.	Activities of Daily Living
102 d.	Pressure Sores
103 e.	Urinary and Fecal Incontinence
108 l.	Accidents
109 j.	Nutrition
110 k.	Hydration
114 n.	Medication Errors
115 51.130	Nursing Services
136 51.170	Dental Services
140	Drug Regimen Review
144	Infection Control
154	Dining and Resident Activities

Preliminary Findings (continued)

IV. **Additional investigation,** as necessary, into any areas of concern discovered during the ongoing survey, including investigation of any additional complaints received by St. Louis Missouri Veterans' Home or Department of Public Safety.

Areas that require additional investigation to explore the extent to which the structure and process factors contribute to the systemic problems causing **Substandard Quality of Care** and **Triggers for Immediate Jeopardy** that require further investigation include:

- Retaliation
- Nepotism
- Re-Hospitalizations
- Mortality: The practices to identify, assess and intervene to prevent the rapid decline with death within 30 days of admission sans hospice.
- Medical Record Accuracy
- Falls
- Falls with Major Injury
- Staff Competencies
- Staff Procedures
- Enforcement Procedures
- Care Planning
- Nutrition
- HIPAA and PHI
- Dignity
- Disaster Emergency Preparedness

Immediate Jeopardy is a defined as "a situation in which the **provider's noncompliance** with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

Recommendations

Recommendations

An immediate and significant change in culture within the organization is required for correction of the systemic and pervasive concerns noted. Multiple issues with regulatory compliance exist within the organization. Following are recommendations for consideration:

- **Management:** A substitute facility manager or administrator with authority to hire, terminate or reassign staff, obligate facility funds, alter facility procedures, and manage the facility to correct deficiencies identified in the facility's operation.

- **Employee Engagement:** To initiate change within the organization, it is imperative that employees be part of a team which features transparency and in which they feel that that they have a voice. The role of leaders within this environment must be one of establishing a safe place to provide care. Given the large number of staff members who have left or have been asked to leave the facility, the reputation for recruitment is a significant concern. Eligible individuals within the community are aware of the reputation of the organization, which will be a difficult hurdle to overcome. It is urgent that the priority change from recruitment to retention. The organization must transform from one with a reputation for recruiting unskilled workers to one which is an employer of choice for highly desirable and recruitment-worthy staff members. This requires establishing an environment of transparency with servant style leadership.

- **Model of Nursing Care:** Related to the turnover of unlicensed nursing staff, care is being largely rendered by staff members who are unfamiliar with the Veterans and their person-centered care needs. A refinement in the model of care should be considered. The Veteran Administration has a strong reputation throughout the country for support of nursing practice. It is recommended that a model change be considered to include moving the skill mix of the nursing team to a higher percentage of registered nurses, with medication delivery by registered nurses rather than medication technicians. Although this presents a higher hourly expense, the current expense of perpetual turnover, training and inadequate resident care is far costlier. Staffing levels should be evaluated and the use of mandatory overtime should be tracked and eliminated.

- **Reestablishing the Voice of the Veteran in all aspects of care**: It is recommended that Veteran's be part of organizational decision-making on a regular basis, with Veteran representatives included in leadership meetings, and Veteran-safety meetings.

Recommendations (continued)

- **Care Rounds:** Modifying the current Grand Rounds, which focus on resident specific information to rounds that focus on quality improvement and Veteran safety.

- **Directed In-Service Training:** The facility has deficiencies where there are knowledge gaps in standards of practice, staff competencies and the requirements of participation. Education is essential to correct the noncompliance.

- **Directed Plan of Correction:** Focused action(s) from the divisional and facility level to address the noncompliance, the root cause(s) along with the incorporation of the key components of systemic approach to prevent further deficiencies.

- **Key Components of Systemic Approach:** The 7 elements necessary for the prevention of Abuse and Neglect.

    - Prevent
    - Screen
    - Identify
    - Train
    - Protect
    - Investigate
    - Report and Respond

Appendix
Health Inspection Descriptors

Appendix: Health Inspection Descriptors

- Scope and Severity Matrix
- Definitions
- Principles of Immediate Jeopardy
- Immediate Jeopardy Example Triggers
- Components of Immediate Jeopardy

Appendix: Scope and Severity Matrix

Health Inspection Scope, Severity and Levels				
Leveling	Severity	Scope		
		Isolated	Pattern	Widespread
Level 4 (Immediate Jeopardy)	Immediate jeopardy to resident health or safety	J	K	L
Level 3	Actual harm that is not immediate jeopardy	G	H	I
Level 2	No actual harm with potential for more than minimal harm that is not immediate jeopardy	D	E	F
Level 1	No actual harm with potential for minimal harm	A	B	C

Ratings A, B, C: Depicts the facility **met the requirements**.

Ratings D and E: Depicts the facility **met the requirements provisionally** and requires corrective actions taken or corrective action plan within 20-business days of receipt of survey report.

Ratings F, G, H, I: Depicts the facility did **not meet the requirements** provisionally and requires corrective actions taken or corrective action plan within 20-business days of receipt of survey report.

Ratings J, K, L: Depicts the facility did **not meet the requirements (Immediate Jeopardy)** and requires immediate corrective actions to abate the situation.

Appendix: Definitions

Substandard Quality of Care is any deficiency in 42 C.F.R.

- 42 C.F.R. §483.13, Resident Behavior and Facility Practices
- 42 C.F.R. §483.15 Quality of Life, or
- 42 C.F.R. §483.25, Quality of Care,

that constitutes:

  - immediate jeopardy to resident health or safety;
  - or a pattern of or widespread actual harm that is not immediate jeopardy;
  - or a widespread potential for more than minimal harm that is not immediate jeopardy, with no actual harm.

Immediate Jeopardy

- Immediate Jeopardy is interpreted as a crisis situation in which the health and safety of individual(s) are at risk (see SOM §3010).

- The primary goals of these Immediate Jeopardy guidelines are to identify and to prevent serious injury, harm, impairment, or death.

- **Immediate Jeopardy:** "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." (See 42 CFR Part 489.3.)

- **Abuse:** "The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." (See 42 CFR Part 488.301.)

- **Neglect:** "Failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." (See 42 CFR Part 488.301.)

Appendix: Principles of Immediate Jeopardy

- Only **One Individual** needs to be at risk. Identification of Immediate Jeopardy for one individual will prevent risk to other individuals in similar situations.
- **Serious harm, injury, impairment, or death** does **NOT** have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.
- Individuals must not be subjected to abuse by **anyone** including, but not limited to, entity staff, consultants or volunteers, family members or visitors.
- Serious harm can result from **both abuse and neglect.**
- **Psychological** harm is as serious as physical harm.
- **Abuse or neglect**, consider Immediate.

The serious harm, injury, impairment or death may **have occurred in the past**, may be **occurring at present**, or may be **likely to occur in the very near** future as a result of the jeopardy situation.

Immediate Jeopardy procedures must not be used to enforce compliance quickly on more routine deficiencies.

Immediate Jeopardy Triggers

The listed triggers do not automatically equal Immediate Jeopardy. The team must investigate and use professional judgment to determine if the situation has caused or is likely to cause serious harm, injury, impairment or death.

Harm does **not** have to occur before considering Immediate Jeopardy.

Appendix: Immediate Jeopardy Example Triggers

Triggers describe situations that cause the surveyor to **consider if further investigation** is needed to determine the presence of immediate jeopardy. The listed triggers do not automatically equal Immediate Jeopardy. The team must investigate and use professional judgement to determine if the situation has caused or is likely to cause serious harm, injury impairment or death.

Issue	Triggers
A. Failure to protect from abuse	1. Serious injuries such as head trauma or fractures; 2. Non-consensual sexual interactions; e.g., sexual harassment, sexual coercion or sexual assault; 3. Unexplained serious injuries that have not been investigated; 4. Staff striking or roughly handling an individual; 5. Staff yelling, swearing, gesturing or calling an individual derogatory name; 6. Bruises around the breast or genital area; or Suspicious injuries; e.g., black eyes, rope marks, cigarette burns, unexplained bruising.
B. Failure to Prevent Neglect	1. Lack of timely assessment of individuals after injury; 2. Lack of supervision for individual with known special needs; 3. Failure to carry out doctor's orders; 4. Repeated occurrences such as falls which place the individual at risk of harm without intervention; 5. Access to chemical and physical hazards by individuals who are at risk; 6. Access to hot water of sufficient temperature to cause tissue injury; 7. Non-functioning call system without compensatory measures; 8. Unsupervised smoking by an individual with a known safety risk; 9. Lack of supervision of cognitively impaired individuals with known elopement risk; 10. Failure to adequately monitor individuals with known severe self-injurious behavior; 11. Failure to adequately monitor and intervene for serious medical/surgical conditions; 12. Use of chemical/physical restraints without adequate monitoring; 13. Lack of security to prevent abduction of infants; 14. Improper feeding/positioning of individual with known aspiration risk; 15. Inadequate supervision to prevent physical altercations.

Appendix: Immediate Jeopardy Example Triggers (continued)

Issue	Triggers
C. Failure to protect from psychological harm	1. Application of chemical/physical restraints without clinical indications; 2. Presence of behaviors by staff such as threatening or demeaning, resulting in displays of fear, unwillingness to communicate, and recent or sudden changes in behavior by individuals; or 3. Lack of intervention to prevent individuals from creating an environment of fear.
D. Failure to protect from undue adverse medication consequences and/or failure to provide medications as prescribed.	1. Administration of medication to an individual with a known history of allergic reaction to that medication; 2. Lack of monitoring and identification of potential serious drug interaction, side effects, and adverse reactions; 3. Administration of contraindicated medications; 4. Pattern of repeated medication errors without intervention; 5. Lack of diabetic monitoring resulting or likely to result in serious hypoglycemic or hyperglycemic reaction; or 6. Lack of timely and appropriate monitoring required for drug titration.
E Failure to provide adequate nutrition and hydration to support and maintain health.	1. Food supply inadequate to meet the nutritional needs of the individual; 2. Failure to provide adequate nutrition and hydration resulting in malnutrition; e.g., severe weight loss, abnormal laboratory values; 3. Withholding nutrition and hydration without advance directive; or 4. Lack of potable water supply.

Appendix: Immediate Jeopardy Example Triggers (continued)

Issue	Triggers
F. Failure to protect from widespread nosocomial infections; e.g., failure to practice standard precautions, failure to maintain sterile techniques during invasive procedures and/or failure to identify and treat	1. Pervasive improper handling of body fluids or substances from an individual with an infectious disease; 2. High number of infections or contagious diseases without appropriate reporting, intervention and care; 3. Pattern of ineffective infection control precautions; or 4. High number of nosocomial infections caused by cross contamination from staff and/or equipment/supplies.
G. Failure to correctly identify individuals.	1. Blood products given to wrong individual; 2. Surgical procedure/treatment performed on wrong individual or wrong body part; 3. Administration of medication or treatments to wrong individual; or 4. Discharge of an infant to the wrong individual.
H. Failure to safely administer blood products and safely monitor organ transplantation.	1. Wrong blood type transfused; 2. Improper storage of blood products; 3. High number of serious blood reactions; 4. Incorrect cross match and utilization of blood products or transplantation organs; or 5. Lack of monitoring for reactions during transfusions.

Appendix: Immediate Jeopardy Example Triggers (continued)

Issue	Triggers
I. Failure to provide safety from fire, smoke and environment hazards and/or failure to educate staff in handling emergency situations.	1. Nonfunctioning or lack of emergency equipment and/or power source; 2. Smoking in high risk areas; 3. Incidents such as electrical shock, fires; 4. Ungrounded/unsafe electrical equipment; 5. Widespread lack of knowledge of emergency procedures by staff; 6. Widespread infestation by insects/rodents; 7. Lack of functioning ventilation, heating or cooling system placing individuals at risk; 8. Use of non-approved space heaters, such as kerosene, electrical, in resident or patient areas; 9. Improper handling/disposal of hazardous materials, chemicals and waste; 10. Locking exit doors in a manner that does not comply with NFPA101; 11. Obstructed hallways and exits preventing egress; 12. Lack of maintenance of fire or life safety systems; or 13. 13. Unsafe dietary practices resulting in high potential for food borne illnesses.
J. Failure to provide initial medical screening, stabilization of emergency medical conditions and safe transfer for individuals and women in active labor seeking emergency treatment (Emergency Medical Treatment and Active Labor Act).	1. Individuals turned away from ER without medical screening exam; 2. Women with contractions not medically screened for status of labor; 3. Absence of ER and OB medical screening records; 4. Failure to stabilize emergency medical condition; or 5. Failure to appropriately transfer an individual with an un-stabilized emergency medical condition.

Appendix: Components of Immediate Jeopardy

1. Harm

    a. **Actual:** Was there an outcome of harm? Does the harm meet the definition of Immediate Jeopardy, e.g., has the provider's noncompliance caused serious injury, harm, impairment, or death to an individual?

    b. **Potential:** Is there a likelihood of potential harm? Does the potential harm meet the definition of Immediate Jeopardy; e.g., is the provider's noncompliance likely to cause serious injury, harm, impairment, or death to an individual?

2. **Immediacy:** Is the harm or potential harm likely to occur in the very near future to this individual or others in the entity, if immediate action is not taken? (Refer to the SOM §3010(B)(6) for timelines during normal termination.)

3. Culpability

    a. Did the entity know about the situation? If so when did the entity first become aware?

    b. Should the entity have known about the situation?

    c. Did the entity thoroughly investigate the circumstances?

    d. Did the entity implement corrective measures?

    e. Has the entity re-evaluated the measures to ensure the situation was corrected?

Stated lack of knowledge by the entity about a situation does **not excuse** an entity from knowing and preventing Immediate Jeopardy.