

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016105	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2020
NAME OF PROVIDER OR SUPPLIER COUNTRY VILLA ASSISTED LIVING PULASKI		STREET ADDRESS, CITY, STATE, ZIP CODE 380 CREST DR PULASKI, WI 54162		
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N 000	Initial Comments On 05/02/2020, with information gathered through 05/05/2020, Surveyors conducted a complaint investigation at Country Villa Assisted Living Pulaski. Complaint was substantiated, and 1 deficiency was identified. Census: 35	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on interview and record review, the licensee did not ensure the Community Based Residential Facility (CBRF) and its operation complied with all laws governing the CBRF. The facility did not have enough caregivers to adequately respond to residents' needs and their declining health during a Coronavirus (COVID-19) outbreak at the facility beginning on 04/27/2020 through 05/04/2020. Twenty-five of 35 residents tested positive for COVID-19 virus during the outbreak. Findings include: The Department of Quality Assurance began receiving complaints about lack of adequate staffing and personal protective equipment related to a COVID-19 outbreak at the facility that began on 04/27/2020. 05/02/2020, approximately 2:30 pm, Surveyors	N 196		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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N 196	<p>Continued From page 1</p> <p>interviewed Administrator B:</p> <p>--On 05/02/2020, an interview was conducted with Administrator B regarding staffing and personal protective equipment concerns. Administrator B confirmed the facility's first positive case of COVID-19 was on 04/27/2020. All residents and staff were tested for COVID-19. The facility's census is 35. Out of the 35 residents, 25 tested positive and 11 staff tested positive. Additionally, Administrator B reported several of the facility staff quit due to the outbreak.</p> <p>Review of the Resident Roster provided by Administrator B on 05/02/2020 verified the census of 35. The roster identified the 25 residents that were positive.</p> <p>--Administrator B described efforts made with reaching out to Wisconsin Emergency Assistance Volunteer Registry (WEAVR) and confirmed there was a misunderstanding with the procedure for requesting volunteers. The facility thought the emergency operations from Madison, WI was sending assistance in the form of staff, but later found out they were providing them with a WEAVR list of staff to contact for assistance. Administrator B reported s/he called everyone on the list, but only received two return calls. Two nurses were scheduled. The WEAVR nurses informed Administrator B they would only feel comfortable conducting assessments, so this did not alleviate the facility's urgent need for caregivers.</p> <p>On 05/04/2020, Surveyor called Administrator B to verify availability of staffing for the facility. Administrator B informed the Surveyor s/he was at home sick with COVID-19 symptoms and had</p>	N 196			

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N 196	<p>Continued From page 2</p> <p>been home since Sunday.</p> <p>05/02/2020, approximately 4:30 pm, Surveyors interviewed Caregivers E and F:</p> <p>--On 05/02/2020, Surveyors interviewed Caregivers E and F. They informed Surveyors everyone listed on the schedule does not show up for work. On 05/02/2020, six caregivers were scheduled to work, but only three showed up. Both caregivers reported that all residents diagnosed with COVID-19 were very weak. Residents that were once independent now require a two person assist to transfer and most of them require assistance eating. Caregivers E and F reported if lunch is served at 12:00 pm, they may not get everyone served until 3:00 pm. Additionally, they are not always able to pass medications during the time frame specified on the Medication Administration Records (MARs), as cares and meals take two to three times longer to complete. Caregivers E and F also reported the nurses supplied through WEAVER and the Prevea (local clinic) working at the facility only assess, and do not help with cares or meals.</p> <p>05/04/2020, Surveyor interviewed Physician C and Physician Assistant D:</p> <p>--Physician C is a physician for Prevea (clinic) in Pulaski. Information reported during the interview included the following:</p> <p>--Physician C said they were notified by the county health department of an outbreak at Country Villa Pulaski. Physician C offered to provide temporary help until the facility was able to find a more permanent solution. They administered testing for all residents and staff, provided PPE (personal protective equipment),</p>	N 196			

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N 196	<p>Continued From page 3</p> <p>and nurses.</p> <p>--Physician Assistant D stated Director of Nursing (DON) G requested a Prevea contract be sent to Administrator B. Physician Assistant D reported this was done, but they never received a signed contract back from the facility. Physician C stated the Prevea nurses reported once they were at the facility there was no direction or communication provided by the management at the facility. The nurses conveyed to Physician C that they did not feel comfortable working at the facility with no leadership or direction.</p> <p>--On 05/02/2020 Physician C was informed by Owner A the facility no longer needed assistance. Owner A reported having adequate staffing through WEAVR and pool staffing agencies (PRN Staffing and STAT Staffing). Physician C also determined it was no longer safe for his/her employees to be at the facility. The Prevea nurses left, taking all equipment and supplies since they had not entered into any contract. They did leave the 6 powered air-purifying respirators (PAPR). Physician C also stated the WEAVR nurses said they would no longer be providing services for the facility. The WEAVR nurses also expressed they did not feel comfortable continuing their services at the facility.</p> <p>--Later that day, on 05/02/2020, Administrator B contacted Prevea to find out why the nurses were leaving and taking equipment and supplies. Physician C determined Owner A was not communicating with Administrator B about this change. When told Owner A said they were no longer needed, Administrator B seemed confused. Administrator B stated s/he did not know what to do as Prevea staff was included in</p>	N 196		

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N 196	<p>Continued From page 4</p> <p>the facility's schedule. Administrator B also reported they were not getting much help from WEAVR either.</p> <p>--As of 05/04/2020 Owner A continued to contact Prevea for supplies even though Owner A told Physician C their services were no longer needed. Physician C stated s/he informed Owner A many times that PPE must be obtained through the county health department. Physician C stated s/he does not think the facility has an adequate number of staff to provide care for 25 residents diagnosed with COVID-19.</p> <p>05/04/2020 Interview with Owner A:</p> <p>--On 05/04/2020, Owner A was interviewed. Owner A stated as of 05/03/2020, Registered Nurse (RN) H is currently managing the facility. RN H is an employee at Country Villa's Freedom location. Owner A is working remotely. Owner A stated the facility currently has 6 caregivers plus 2 medication passers. Owner A agreed to provide Surveyor with a copy of the schedule. Owner A stated s/he is very comfortable with the amount of caregivers at the facility. Owner A confirmed Prevea is no longer assisting the facility, and took most of the supplies and equipment with them with the exception of the PAPR devices.</p> <p>--Owner A reported s/he spoke to Prevea on 05/03/2020, about sending some volunteers. S/he was told they were looking into it. Owner A stated s/he had not entered into any formal contract, was not aware that was a possibility, but was open to doing so.</p> <p>Notes: Owner A's statement about the contract contradicts Physician C's statement that Owner A informed Prevea their services were no longer</p>	N 196			

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N 196	<p>Continued From page 5</p> <p>needed. Owner A did not inform Surveyor s/he told Prevea their services were no longer needed.</p> <p>--Owner A confirmed with Surveyor the facility needs more PPE in the form of gowns. Surveyor asked Owner A if WEA VR was still assisting. Owner A stated s/he was informed by the WEA VR volunteers they felt comfortable ceasing their services since RN H is now at the facility.</p> <p>Notes: Owner A's statement was inconsistent with what Physician C relayed regarding WEA VR nurses feeling too uncomfortable to remain at the facility.</p> <p>--Owner A reported 3 more staff were sent home the day before with symptoms of COVID-19, and test results were pending.</p> <p>05/04/2020 Interview with Caregivers E and F and M:</p> <p>--On 05/04/2020, Surveyors interviewed Caregiver E. Caregiver F was also present for the interview. Caregiver E reported there were 3 staff on the floor and 2 med passers on duty at 6:00 am. Caregiver E explained there should have been 6 caregivers, but 3 caregivers (agency staff) did not show up. By 2:00 pm, there were still only three caregivers. An activity staff arrived also arrived at the facility at 2:00 pm. The activity staff helps sanitize and provides one on one activities for residents. Another caregiver arrived at 2:30 pm and started their shift early. Caregiver E reported morning cares and breakfast were started at 6:00 am, but did not get finished until 11:00 am. Lunch was served at 12:00 pm, but was not completed until 2:20 pm.</p> <p>--Approximately 2:46 pm, Caregiver E informed</p>	N 196			

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N 196	<p>Continued From page 6</p> <p>Surveyor that Residents continued to get weaker as a result of the COVID-19 illness. Caregiver E reported they are supposed to work three twelve hour shifts, and then get a day off. Caregiver E expressed concern s/he will not get a day off due to lack of staff.</p> <p>--Caregiver E expressed concern that without more caregivers, cares and meal times are going to get less prompt than they already are. Caregiver E confirmed that having six caregivers scheduled would be sufficient; however, all six that are scheduled do not show up for work. Additionally, Caregiver E reported caregivers are sent home when feeling ill, but are asked to stay until they obtain coverage. Caregiver F confirmed the information Caregiver E reported to the surveyor, and did not have any additional information to add.</p> <p>--Approximately 8:35 pm, Caregivers E, F and M informed Surveyor they are concerned with the resident's level of care. They reported staffing levels prior to COVID-19 outbreak was 6 caregivers. They are working with less staff now, even with the significant number of residents with increased care needs. They reported numbers of residents needing assistance with transfers, including 10 residents needing 2 people, 4 residents needing a Hoyer lift, and 4 residents needing a sit to stand lift. Most of the residents were bed bound due to weakness from COVID-19 symptoms. The 6 am - 6 pm shift caregivers were responsible for getting all the residents up, cleaned, dressed, toileted, perform all cares, make rounds every 2 hours, plus serve all 3 meals, and if there is not a cook, those duties are added to their list.</p> <p>-- Caregivers E, F and M confirmed they are not</p>	N 196		

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N 196	<p>Continued From page 7</p> <p>always able to complete the 2 hour rounds. There are 12 residents that need caregivers to physically assist and feed them. They reiterated that lunch is taking between 2 - 3 hours and some residents are getting food that is cold by the time it is served. The caregivers feel residents are not getting the care they need or deserve. They identified there are 2 residents whose needs are more than they can provide for, but prior to COVID were doing well. They also reported 4 or 5 residents were on hospice with one resident actively dying.</p> <p>Review of Schedules:</p> <p>The written schedules were reviewed with Caregivers E and F during the interview on 05/04/2020. Caregivers E and F confirmed the number of caregivers identified on the written schedules were not the number of caregivers that actually showed up for duty on the following dates:</p> <p>The schedule for 05/02/2020 showed 6 caregivers/medication passers, 1 registered nurse and 1 cook. Caregivers E and F confirmed only 3 caregivers and 2 medication passers were present at the beginning of the shift.</p> <p>The schedule for 05/04/2020 showed 5 caregivers/medication passers, 1 cook, 1 RN, 1 licensed professional nurse (LPN), 1 cook and a housekeeper. Caregivers E and F confirmed 3 caregivers and 2 medication passers were present at the beginning of the shift.</p> <p>05/04/2020 Interview with RN H:</p> <p>--On 05/04/2020, RN H was interviewed. RN H reported s/he is a nurse from Country Villa's</p>	N 196		

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N 196	<p>Continued From page 8</p> <p>Freedom location. S/he is now only working at Country Villa Pulaski. RN H stated s/he thinks they are doing very well with their staffing. They are using their own staff and adding agency staff to fill in shifts.</p> <p>--Currently, RN H stated they are scheduling 6 caregivers, 2 medication passers, a cook and a housekeeper. RN H reported that s/he can only make the schedule in two to three day increments as staff availability is always changing. RN H stated s/he feels the facility has adequate staff to provide for the residents. Surveyor asked RN H about PPE supplies. RN H informed Surveyor they were in need gowns and are running low on N95 masks. RN H was unclear how to obtain more N95 masks on short notice. Surveyor recommended getting in touch with the county health department.</p> <p>On 05/04/2020, at 5:34 pm, Surveyor received an e-mail from RN J with a copy of the most recent staff schedule for 05/05/2020 and 05/06/2020. The schedule reflected 8 caregivers, 2 medication passers, 2 Licensed Professional Nurses, 1 Registered Nurse, a cook and one housekeeper. It remains unknown if the pattern of staff not showing up for shifts will persist.</p> <p>Interviews with WEAVR Volunteers:</p> <p>--On 05/04/2020, Surveyor contacted Physician I. Physician I is a WEAVR volunteer, who is a retired physician. Physician I reported s/he was never contacted by Country Villa.</p> <p>Note: Physician I's statement contradicted information provided by Administrator B. During the interview on 05/02/2020, Administrator B told Surveyors everyone on the list was contacted.</p>	N 196		

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N 196	<p>Continued From page 9</p> <p>--On 05/04/2020, RN J was interviewed. RN J is a registered nurse volunteer from WEAVR. RN J began volunteering at the facility on 04/30/2020. RN J thought there were only 4 confirmed cases, but was surprised to find out there were a lot more. RN J described Administrator B as working in "crisis mode." RN J said there were about 5 or 6 Prevea employees at the facility. RN J was told they would only be there until a crisis management team from Madison arrived, but no such crisis team arrived. RN J said no one was available to cook for residents. RN J asked a friend who is also an RN to volunteer to cook.</p> <p>RN J reported the following concerns:</p> <ul style="list-style-type: none"> -caregivers were not trained on proper infection control procedures -there was a caregiver passing medications who had never done so before -There was a resident with unstable blood sugar that received insulin when it should have been held -There was no glucagon in facility, they used glucagon from another resident who was out in the hospital to try to get blood sugar up -Residents need oral hydration, feeding, bathing and dressing -Staffing levels do not meet resident needs -No COVID or Emergency plan in place -High school students working with no training or direction/no systems in place -Stool on carpet, and handrail, door knobs, etc. not being cleaned or wiped down -There were staff changing gloves between residents but not gowns going from a positive room to a negative room -No dedicated staff for positive/negative residents - all staff seeing all residents -Resident needs are changing constantly 	N 196			

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N 196	<p>Continued From page 10</p> <p>-RN J called DON G to inquire how things were going today, Monday, 05/04/2020, and if help was still needed. DON G still has not returned the call.</p> <p>-Staff need direction on changing needs.</p> <p>-Events exceed normal daily activities and facility does not have precautions in place.</p> <p>-RN J expressed concerns there should be standing orders for nebulizers and inhalers that could help the residents.</p> <p>RN J stated his/her opinion the best place for facility residents was to remain in the home, provided an appropriate number of trained staff were available to cook, clean, and meet resident needs. RN J reported that as of 05/03/2020, resident needs were being met, but not timely.</p> <p>--On 05/04/2020, RN L was interviewed. RN L is a nurse with WEAVR that volunteered to work at the facility. RN L was advised s/he would only be needed at the facility until a crisis management team arrived to provide support. RN L later found out there was no crisis management team. The volunteer nurses were not given any physician orders, and no charts to write in. Nurses only received residents' face sheets. RN L reported Prevea "crippled" the staffing when they pulled their staff and left with all of the supplies, as Administrator B was factoring them into the schedule. RN L stated Pre-COVID staffing would potentially be appropriate, but needs to be increased.</p> <p>RN L reported the following concerns:</p> <p>-Med Tech was passing meds on cart s/he never did before</p> <p>-Too few staff to monitor rapidly changing conditions</p>	N 196		

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N 196	<p>Continued From page 11</p> <ul style="list-style-type: none"> -Owner called and wanted RN L to identify any residents that could be sent to hospital -RN L wouldn't do that as resident needs could be met in the facility if they had more staff -Physician K set standards for the volunteers and what vitals and assessments they should complete -Conditions vary by the hour -Staff over fatigued -Residents missing meals and don't drink all day because they are fatigued and staff don't notice or have not been in room to observe -Insulin given by med person to a resident with low blood sugar; could not stabilize and needed to be sent out. -There was no plan for crisis mode -RN H appears to have act together, but unsure where s/he will find staff -Independent residents needs have changed and require more assistance -Staff not trained to assess for change of conditions, or to do vitals -Volunteer nurses took verbal orders for oxygen and medication changes and wrote in notes, but unsure how the changes happened or how were given to medication passers -When WEAVR nurses arrived there was no stethoscope, no knowledge of how orders get changed/updated -WEAVR nurses told there was a COVID book with guidance - never saw book -Staff are wearing PAPR's, sharing between shifts, not sure if sanitized or filters changed or batteries charged -Facility stopped nebulizer treatments, but nothing put in place for residents that needed. -Residents had fevers of 105 degrees F <p>On 05/05/2020, Surveyor received a phone call from Veterinarian N. Veterinarian N is a volunteer</p>	N 196			

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N 196	<p>Continued From page 12</p> <p>on the WEAVR list provided to the facility. Veterinarian N reported s/he received an email that identified Country Villa Pulaski as a facility in need. Veterinarian N stated s/he called the facility and spoke to Administrator B. Administrator B was so ill s/he had to put the phone down. Administrator B asked if Veterinarian N could cook, but Veterinarian N informed Administrator B s/he is not a cook. Veterinarian N initially committed to working a shift, but decided not to after viewing the news media. Additionally, Veterinarian N had friends who are registered nurses that advised against volunteering there. Veterinarian N confirmed the facility did not reach out to him/her. Veterinarian N was the one that made contact with Country Villa.</p> <p>Note: Information reported by Veterinarian N contradicted Administrator B's statement that all volunteers on the WEAVR list were contacted.</p> <p>Summary/Conclusion:</p> <p>The licensee did not ensure adequate staffing to meet the needs of facility residents during a COVID-19 outbreak beginning on 04/27/2020 through 05/04/2020, during which 25 of 35 residents tested positive for the virus. The licensee did not adequately staff the facility to care for residents in their weakened frail state caused by COVID-19.</p> <p>Beginning on 04/30/2020, the facility misunderstood how to obtain and utilize WEAVR resources. At some point during the beginning of the outbreak, the facility thought a crisis management team was on the way. The facility did not understand they were only going to be provided with a list of WEAVR volunteers, and it would be up to the facility to find staff. During this</p>	N 196		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 0016105	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 05/05/2020
NAME OF PROVIDER OR SUPPLIER COUNTRY VILLA ASSISTED LIVING PULASKI		STREET ADDRESS, CITY, STATE, ZIP CODE 380 CREST DR PULASKI, WI 54162		
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N 196	Continued From page 13 time, the facility did not seek additional staff. Once WEAVER volunteers arrived, there was a misunderstanding of what their role would be in the facility. The WEAVER nurses were only there to provide assessment, which did not alleviate the staffing issues. The facility continued to schedule 6 to 8 caregivers, but all scheduled staff did not show up for duty. Administrator B's efforts to schedule additional staff was made more challenging when Owner A told Physician C Prevea services were no longer needed, without informing Administrator B. Additionally, expectations for WEAVER volunteers and Prevea nurses were not clearly communicated.	N 196		