

PLAN OF CORRECTION

The individual signing the first page of the CMS-2567, *Statement of Deficiencies (SOD)*, is indicating their approval of the plan of correction being submitted on this form.

Name - Provider/Supplier:	
Evansville Manor Nursing And Rehab, Llc	
Street Address/City/Zip Code:	
470 Garfield Ave, Evansville, WI 53536	
License/Certification/ID Number (X1):	525418
Survey Date (X3):	03/09/2020
Survey Event ID Number:	UQWT11

Preparation and submission of this plan of correction does not constitute an admission or agreement of the truth of the facts alleged or of the correctness of the conclusion set forth on the statement of deficiencies. This plan of correction is prepared and submitted at this time solely because of requirements under state and federal law.

ID Prefix Tag (X4)	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date (X5)
F585	Corrective Action taken for those residents alleged to have been affected by the deficient practice are: <ul style="list-style-type: none"> Grievance form for R3 was completed and filed Hearing aide was ordered, received, and distributed to R3 R3's POA was informed of grievance resolution 	4/10/2020
	Actions taken to identify other residents that may have been affected by the deficient practice are: <ul style="list-style-type: none"> All residents have potential to be affected by stated deficiency Grievance log reviewed for lacking resolutions Team interviewed for "word of mouth" grievances for documentation and resolution 	4/10/2020
	The measures the facility will take to ensure the problem will be corrected and will not reoccur: <ul style="list-style-type: none"> IDT educated on grievance policy and procedure Resident council educated on how to file a grievance Residents and families educated on right to file a grievance at care plan conferences All grievances reviewed for thorough follow-up 	4/10/2020
	Quality Assurance plan to monitor facility performance to make sure corrections are achieved: <ul style="list-style-type: none"> NHA or designee will audit grievances weekly x 4, bi-weekly x 2, and monthly x 1 Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee and Corporate Compliance 	Ongoing

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F677	<p>Corrective Action taken for those residents alleged to have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • R13's shower was received on 2/14 & 2/21 • R13' shower schedule was reviewed for monitoring • R13's shower schedule was entered on kardex 	4/10/2020
	<p>Actions taken to identify other residents that may have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • A house sweep was conducted to ensure all residents have had a recent shower, per facility policy 	4/10/2020
	<p>The measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <ul style="list-style-type: none"> • Nursing team educated on shower policy • Master shower schedule reviewed and adjusted as needed • Shower schedules entered on Careplan and kardex • Weekly skin assessments made to match shower schedule • Weekly skin tool to be completed by c.n.a and verified by nurse • Upcoming showers due, to be discussed by clinical team for follow-up 	4/10/2020
	<p>Quality Assurance plan to monitor facility performance to make sure corrections are achieved:</p> <ul style="list-style-type: none"> • DON or designee will perform shower audit weekly x 4, bi-weekly x 2, and monthly x 1 • Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee and Corporate Compliance 	ongoing

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F686	<p>Corrective Action taken for those residents alleged to have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • R7's wound reviewed by WCC nurse and wound MD, staged, and assessed for proper treatment. Orders and careplan reviewed and updated, interventions reviewed and in place • R8's orders and careplan reviewed, updated as needed • R12's careplan and kardex reviewed and updated • R13's treatment reviewed and adjusted. MD involved in plan of care. POA updated 	4/10/20
	<p>Actions taken to identify other residents that may have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • Residents with braden scores 12 or less were reviewed for appropriate interventions • In-house wounds assessed and staged appropriately 	4/10/20
	<p>The measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <ul style="list-style-type: none"> • DON, ADON, and licensed nurses educated on the following: <ul style="list-style-type: none"> ○ Importance of properly assessing, staging/categorization of wounds, and importance of monitoring wounds every 7 days ○ Appropriate management of treatments and monitoring effectiveness of treatments as recommended by the NPIAP. ○ Notification of DON, primary care physician, family, POA, and Guardians of all declines in wound status • Wound log created to monitor compliance in documentation of weekly skin assessments • Meeting with Hospice nurse, DON, ADON, and Regional Director of Clinical Services to ensure collaboration between Hospice and Center Nurses • Residents with air mattresses reviewed for appropriate settings based on weight and resident preference. Mattress settings added to pumps and Kardex • Residents with/at risk for breakdown, who utilize hoyer slings, were assessed for alternate model of slings, to minimize risk. Careplans updated as needed • Skin and wound care plans reviewed and updated • Observations of wound care to ensure proper practices 	4/10/20

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	Quality Assurance plan to monitor facility performance to make sure corrections are achieved: <ul style="list-style-type: none"> Regional Director of Clinical Services or designee will review wound log weekly x 4, bi-weekly x 2, and monthly x 1 Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee and Corporate Compliance 	ongoing
F689	Corrective Action taken for those residents alleged to have been affected by the deficient practice are: <ul style="list-style-type: none"> R8's careplan reviewed, with appropriate and current interventions in place 	4/10/20
	Actions taken to identify other residents that may have been affected by the deficient practice are: <ul style="list-style-type: none"> Risk Management incidents reviewed for implemented interventions 	4/10/20
	The measures the facility will take to ensure the problem will be corrected and will not reoccur: <ul style="list-style-type: none"> Education to licensed nurses of the following: <ul style="list-style-type: none"> Completion of Risk Management report and associated UDAs Making proper notification of falls to Nursing Manager on-call for discussion of fall interventions Falls to be reviewed during morning clinical meeting to ensure root cause of fall is identified, notifications were made, and appropriate interventions are entered onto care plan. Fall log initiated to trend effectiveness of interventions and interventions will be modified as needed All residents at high risk for falls had care plan review for appropriate interventions 	4/10/20
	Quality Assurance plan to monitor facility performance to make sure corrections are achieved: <ul style="list-style-type: none"> DON or designee will perform audit weekly x 4, bi-weekly x 2, and monthly x 1 Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee and Corporate Compliance 	ongoing

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F726	<p>Corrective Action taken for those residents alleged to have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • R1 no longer resides at facility • CMA removed from med-passing assignments 	3/10/20
	<p>Actions taken to identify other residents that may have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • No residents currently affected by said practice 	3/10/20
	<p>The measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <ul style="list-style-type: none"> • CMA removed from med-passing assignments • All facility licensed personnel credentials were reviewed and validated as appropriate • Facility policy reviewed and revised for proper utilization of Medication Technicians/Aides • Facility reviewed and revised Medication aide Job Description • Audit tool distributed to Human Resources to ensure proper licensure and contents of employee files 	3/10/20
	<p>Quality Assurance plan to monitor facility performance to make sure corrections are achieved:</p> <ul style="list-style-type: none"> • The HR Director, Administrator, or Designee will conduct audits of 2 employee files to ensure ongoing and sustained compliance weekly x 4, bi-weekly x 2, and monthly x 1 • Adverse findings will be immediately addressed. Findings will be reported to QAPI Committee and Corporate Compliance. 	ongoing

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F730	<p>Corrective Action taken for those residents alleged to have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • C.N.A C completed 12 hours of training as assigned • C.N.A I completed 12 hours of training as assigned • C.N.A M completed 12 hours of training as assigned 	4/10/20
	<p>Actions taken to identify other residents that may have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • Facility reviewed training schedule assigned for all certified staff, to ensure appropriate hours and content 	4/10/20
	<p>The measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <ul style="list-style-type: none"> • Certified Nursing Assistants were educated on their licensure requirement of 12 hours training annually • HR and clinical leadership educated on tracking, in congruence with annual eval • Tracking tool developed 	4/10/20
	<p>Quality Assurance plan to monitor facility performance to make sure corrections are achieved:</p> <ul style="list-style-type: none"> • HR or designee will audit files weekly x 4, bi-weekly x 2, and monthly x 1 • Adverse findings will be immediately addressed. Findings will be reported to QAPI Committee and Corporate Compliance 	ongoing

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F759	<p>Corrective Action taken for those residents alleged to have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • R14 and R15 receiving meds as ordered • R16 no longer resides in facility 	4/10/20
	<p>Actions taken to identify other residents that may have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • Medication pass audits initiated for all residents 	4/10/20
	<p>The measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <ul style="list-style-type: none"> • Pharmacy review of all resident medications and audit of medication carts • Two medication carts added so each unit has its own cart for organization and ease of use • Medications separated by med pass times upon cycle fill • Change from “on-demand” request for medications to cycle delivery • Nurse shift times adjusted to assist in medpass time starting promptly • Residents medication orders reviewed for concise regimen • Education to licensed nurses regarding the following: <ul style="list-style-type: none"> ○ Timeliness and safe administration of medications ○ Liberal medpass times versus specific time orders ○ Computer training to licensed nursing • Medication pass audits ongoing 	4/10/20
	<p>Quality Assurance plan to monitor facility performance to make sure corrections are achieved:</p> <ul style="list-style-type: none"> • Medication pass audits weekly x 4, bi-weekly x 2, and monthly x 1 • Adverse findings will be immediately addressed. Findings will be reported to QAPI Committee and Corporate Compliance 	ongoing
F760	Corrective Action taken for those residents alleged to have been affected by	

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	<p>the deficient practice are:</p> <ul style="list-style-type: none"> • R1 no longer resides at facility • Upon immediate discovery of occurrence: <ul style="list-style-type: none"> ○ R1 was assessed by nursing personnel to ensure no adverse reaction ○ Hospice IDT made aware, and made plan of care changes per protocol ○ NP made aware, orders noted and carried out ○ Reversal medication administered ○ Emergency personnel and local law enforcement called ○ Resident transferred to Mercy ER for evaluation ○ Assessed, VSS, returned to facility for continued monitoring and care ○ All orders reviewed and clarified 	3/10/20
	<p>Actions taken to identify other residents that may have been affected by the deficient practice are:</p> <ul style="list-style-type: none"> • Report was run to audit and clarify all liquid morphine orders in the facility • DON validated that transcription of orders is consistent with medication concentrations available • Carts were audited to ensure liquid medications available are appropriate to active orders only 	3/10/20
	<p>The measures the facility will take to ensure the problem will be corrected and will not reoccur:</p> <ul style="list-style-type: none"> • Pharmacy consultants completed med cart audits • Liquid narcotics were replaced with alternate forms • Administrator, Director of Nursing, and Human Resources educated on scope of CMA's • Involved staff member removed from medication pass duties and placed on unit as certified nurse aide (registry current) • Licensed professionals re-educated specifically pertaining to checks of medication orders to label 	3/10/20
	<p>Quality Assurance plan to monitor facility performance to make sure corrections are achieved:</p> <ul style="list-style-type: none"> • DON or designee will perform audit weekly x 4, bi-weekly x 2, and monthly x 1 • Adverse findings will be immediately addressed. Findings and trends will be reported to QAPI Committee and Corporate Compliance 	ongoing