

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/12/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>52A223</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b>  <b>01/27/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>WI VETERANS HM STORDOCK 700</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>N2665 CTY RD QQ</b> <b>KING, WI 54946</b>
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F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 14307</p> <p>This was a self-report investigation survey conducted at Wisconsin Veterans Home - Stordock on 1/27/14.</p> <p># of federal citations issued: 3</p> <p>F224, F282, and F323 were all cited at a scope/severity level of D (potential for more than minimal harm/isolated).</p> <p>Census: 196 Sample size: 11 Surveyor #14307</p>	F 000		
F 224 SS=D	<p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 14307</p> <p>Based on record review and staff and resident interviews the facility did not prevent the potential for mistreatment, abuse, or neglect towards residents for 1 out of 11 sampled residents.</p>	F 224		

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

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 224	<p>Continued From page 1</p> <p>Resident #1 required 1 to 1 supervision at all times when out of his room. On 1/23/14 this supervision was not continuously provided under the watch of CNA-A (Certified Nursing Assistant) allowing resident #1 to wander into resident #2's room and attempt to touch him inappropriately.</p> <p>Findings include:</p> <p>A review of the facility's policies and procedures entitled "Member Abuse, Neglect, Mistreatment, Misappropriation of Property, And Injuries of Unknown Source" last revised October 2013 indicated:</p> <p>Neglect - is the failure of a caregiver or fiduciary to provide the goods or services necessary to maintain the health or safety of an elder or self-neglect.</p> <p>The facility shall report all incidents meeting regulatory criteria according to DQA Memo 11-032 to the Division of Quality Assurance as soon as possible, not to exceed 24 hours or discovery of the incident) with the final report within 5 working days of the incident.</p> <p>5. If the incident is related to abuse or neglect: 5.3 - The Nursing Supervisor reports the incident to Administration Immediately via telephone or face to face contact. Together a decision is made whether or note the incident meets the criteria to be reported to DQA Office of Caregiver Quality.</p> <p>An incident report dated 1/23/14 at approximately 5:30 p.m. Resident #1 was noted to have severe dementia and a history of attempts to touch others inappropriately. CNA-A was providing 1 to</p>	F 224			

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F 224	<p>Continued From page 2</p> <p>1 supervision for resident #1 in the day room where he was eating supper, when she turned away for a few moments. Resident #1 ambulated around the corner from the day room into resident #2's room a few doors down, rubbed his chest and attempted to touch his penis through his clothes according to initial comments by staff.</p> <p>During an interview with surveyor #14307 on 1/27/14 at 9:40 a.m. CNA-A confirmed that she was aware resident #1 was to be within 3 to 5 feet supervision at all times when out of his room and had received specific education about the importance of this. CNA-A indicated she was next to resident #1 but turned away from him for less than a minute talking with other staff, when he left the area. CNA-A verified resident #1 had entered resident #2's room and made sexual comments per resident #2. CNA-A indicated she was distracted when she turned away from resident #1 but did not intentionally look away from him. CNA-A indicated resident #1 seems to have little insight into his behaviors due to his severe dementia.</p> <p>In an interview with surveyor #14307 on 1/27/14 at 9:00 a.m. NHA-D (Nursing Home Administrator) confirmed the facility is looking at this possible incident of neglect for CNA-A not following resident #1's care plan of direct supervision and being aware of the importance of follow through. NHA - D indicated that during the investigation resident #2 verified resident #1 had not touched him inappropriately but was attempting to.</p> <p>In an interview with surveyor #14307 on 1/27/14 at 10:40 a.m. resident #2 stated a couple days ago resident #1 came into his room grabbing at</p>	F 224		

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F 224	Continued From page 3 his shirt and then his pants towards his groin area. He indicated he didn't say anything or touch me but I pushed him off and a girl came in right behind him. Resident #2 stated he was not afraid of resident #1 and felt he didn't have his right mind.  During an interview with surveyor #14307 on 1/27/14 at 10:55 a.m. SW-E (Social Worker) verified resident #1 was very confused and does not comprehend his actions. SW-E verified resident #2 confirmed he was not assaulted by resident #1.  During an interview with surveyor #14307 on 1/27/14 12:30 a.m. ADON-C (Assistant Director of Nursing) verified CNA-A was aware of the need for continual direct supervision within 3 to 5 feet of resident #1 and had not followed his care plan. ADON-C verified that CNA-A had received specific training in October on the need for this type of supervision.  During an interview with surveyor #14307 on 1/27/14 at 12:40 p.m. DON-B (Director of Nursing) confirmed resident #1 needs to be watched carefully and kept at arms length from other residents due to grabbing their arms and hands, not letting go, and his history of attempts to touch others inappropriately. She verified CNA-A did not follow the care plan for resident #1 as indicated on 1/23/14.	F 224			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of	F 282			

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F 282	<p>Continued From page 4 care.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 14307</p> <p>Based on record review and staff and resident interviews the facility did not ensure services provided were in accordance with the plan of care for 1 out of 11 sampled residents.</p> <p>Resident #1's care plan indicated he needed 1 to 1 supervision within reach of 3 to 5 feet at all times when out of his room. On 1/23/14 resident #1 was not provided direct supervision and wandered into another residents room attempting to touch him inappropriately.</p> <p>Findings include:</p> <p>Review of resident #1's medical record by surveyor #14307 on 1/27/14 showed he was admitted to the facility on 10/16/13 with diagnoses of severe dementia and Parkinson's disease scoring 3 out of 30 on his cognitive test. Resident #1 was able to ambulate independently with his walker, quickly at times and other times moving slowly.</p> <p>Prior to admission resident #1 had no history of sexual aggression but was noted to make crude sexual remarks to nurse aides during cares. Nurses notes indicated on 10/18/13 at 6:30 a.m. resident #1 went over to his roommate, resident #3 and attempted to hug and kiss him. Resident #1's care plan indicated he required 1 to 1 supervision.</p>	F 282			

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F 282	<p>Continued From page 5</p> <p>On 10/18/13 at 5:40 p.m., resident #1 was being supervised by CNA-A (Certified Nursing assistant) in the day room during meal time. CNA-A left the dining room to go to the restroom while 2 other nurse aides were present. CNA-A did not tell these staff she was leaving briefly to use the restroom. Resident #1 quickly got up and walked down the hallway to his room where resident #3 was sleeping in his wheelchair and gave him a bear hug. He had been followed close behind by other nurses aides who redirected resident #1 from the room.</p> <p>Resident #1's care plan was adjusted on 10/21/13 to 1 to 1 supervision means within 3 to 5 feet. Be sure my 1 to 1 staff is with me when I move about the unit. I am very quick. All staff including CNA-A received re-education on this revision in his need for closer 1 to 1 supervision for resident #1.</p> <p>Review of a facility self-report by surveyor #14307 on 1/27/14 indicated on 1/23/14 at approximately 5:30 p.m. CNA-A was providing 1 to 1 supervision for resident #1 in the day room where he was eating supper, when she turned away. Resident #1 ambulated around the corner from the day room into resident #2's room a few doors down, rubbed his chest and attempted to touch his penis through his clothes according to initial comments by staff.</p> <p>During an interview with surveyor #14307 on 1/27/14 at 9:40 a.m. CNA-A confirmed that she was aware resident #1 was to be within 3 to 5 feet supervision at all times when out of his room and had received specific education about the importance of this. CNA-A indicated she was next to resident #1 but turned away from him for</p>	F 282			

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F 282	Continued From page 6 less that a minute talking with other staff when he left the area. CNA-A verified resident #1 had entered resident #2's room and made sexual comments to him per resident #2. CNA-A indicated she was distracted when she turned away from resident #1 and did not intentionally look away from him.  During an interview with surveyor #14307 on 1/27/14 12:30 a.m. ADON-C(Assistant Director of Nursing) verified CNA-A was aware of the need for continual direct supervision within 3 to 5 feet of resident #1 and had not followed his care plan as indicated. ADON-C verified that CNA-A had received specific training in October on the need for this type of supervision.	F 282			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Surveyor: 14307  Based on record review and staff and resident	F 323			

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F 323	<p>Continued From page 7</p> <p>interviews the facility did not ensure that 1 out of 11 residents sampled for abuse or neglect received adequate supervision to prevent resident to resident contact.</p> <p>Resident #1 required 1 to 1 supervision at all times when out of his room. On 1/23/14 this supervision was not continuously provided allowing resident #1 to wander into resident #2's room and attempt to touch him inappropriately.</p> <p>Findings include:</p> <p>Review of resident #1's medical record by surveyor #14307 on 1/27/14 showed he was admitted to the facility on 10/16/13 with diagnoses of severe dementia and Parkinson's disease scoring 3 out of 30 on his cognitive test. Resident #1 was able to ambulate independently with his walker, quickly at times and other times moving slowly.</p> <p>Review of resident #2's medical record by surveyor #14307 on 1/27/14 showed he was admitted on 2/17/10 with diagnoses of a cerebral vascular accident (stroke), arthritis, and depression. Resident #2 was noted to have speech that was difficult to understand due to his stroke but was his own decision maker.</p> <p>Prior to admission resident #1 had no history of sexual aggression but was noted to make crude sexual remarks to nurse aides during cares. Nurses notes indicated on 10/18/13 at 6:30 a.m. resident #1 went over to his roommate, resident #3 and attempted to hug and kiss him. Resident #1 was placed on 1 to 1 supervision.</p> <p>On 10/18/13 at 5:40 p.m., resident #1 was being</p>	F 323			

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F 323	<p>Continued From page 8</p> <p>supervised by CNA-A (Certified Nursing Assistant) in the day room during meal time. CNA - A left the dining room to go to the restroom while 2 other CNAs were present. CNA-A did not tell these staff she was leaving. Resident #1 quickly got up and walked down the hallway to his room where resident #3 was sleeping in his wheelchair and gave him a bear hug. He had been followed close behind by other CNAs who redirected resident #1 from the room.</p> <p>Resident #1's care plan was adjusted on 10/21/13 to 1 to 1 supervision means within 3 to 5 feet. Be sure my 1 to 1 staff is with me when I move about the unit. I am very quick.</p> <p>All staff including CNA-A received education on this revision and the need for closer 1 to 1 supervision for resident #1.</p> <p>Review of a facility self-report by surveyor #14307 on 1/27/14 indicated on 1/23/14 at approximately 5:30 p.m. CNA-A was providing 1 to 1 supervision for resident #1 in the day room where he was eating supper, when she turned away for a few moments. Resident #1 ambulated around the corner from the day room into resident #2's room a few doors down, rubbed his chest and attempted to touch his penis through his clothes according to initial reports by staff.</p> <p>During an interview with surveyor #14307 on 1/27/14 at 9:40 a.m. CNA-A confirmed that she was aware resident #1 was to be within 3 to 5 feet supervision at all times when out of his room and had received specific education about the importance of this. CNA-A indicated she was next to resident #1 but turned away from him for less that a minute talking with other staff when he</p>	F 323			

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F 323	<p>Continued From page 9</p> <p>left the area. CNA-A verified resident #1 had entered resident #2's room and made sexual comments to him per resident #2. CNA-A indicated she was distracted when she turned away from resident #1 and did not intentionally look away from him. CNA-A indicated resident #1 seems to have little insight into his behaviors due to his severe dementia.</p> <p>In an interview with surveyor #14307 on 1/27/14 at 9:00 a.m. NHA-D (Nursing Home Administrator) confirmed CNA-A had not follow resident #1's care plan of direct supervision and being aware of the importance of follow through. NHA-D indicated that during the investigation resident #2 verified resident #1 had not touched him inappropriately but was attempting to.</p> <p>In an interview with surveyor #14307 on 1/27/14 at 10:40 a.m. resident #2 stated a couple days ago resident #1 came into his room grabbing at his shirt and then his pants towards his groin area. He indicated he didn't say anything or touch me but I pushed him off and a girl came in right behind him. Resident #2 stated he was not afraid of resident #1 and felt he didn't have his right mind.</p> <p>On 1/27/14 resident #1 was observed lying on his bed in his room with supervision outside his door. He had a single room. Resident #1 was noted to have supervision within arms length at all times when out of his room in the Day Room.</p> <p>During an interview with surveyor #14307 on 1/27/14 at 10:55 a.m. SW-E (Social Worker) verified resident #1 was very confused and does not comprehend his actions. She indicated due to his severe dementia he seems to have lost all</p>	F 323			

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F 323	<p>Continued From page 10</p> <p>inhibitions in his manner of speech and actions resulting in inappropriate behavior. SW-E verified resident #2 confirmed he was not assaulted by resident #1.</p> <p>During an interview with surveyor #14307 on 1/27/14 12:30 a.m. ADON-C (Assistant Director of Nursing) verified CNA-A was aware of the need for continual direct supervision within 3 to 5 feet of resident #1 and had not followed his care plan. ADON-C verified that CNA-A had received specific training in October on the need for this type of supervision.</p> <p>During an interview with surveyor #14307 on 1/27/14 at 12:40 p.m. DON-B (Director of Nursing) confirmed resident #1 needs to be watched carefully and kept at arms length from other residents due to grabbing their arms and hands, not letting go, and his history of attempts to touch others inappropriately. She verified CNA-A did not follow the care plan for resident #1 as indicated on 1/23/14.</p>	F 323			