

PLAN OF CORRECTION

Name - Provider/Supplier:	
Wi Veterans Home Stordock 700	
Street Address/City/Zip Code:	
N2665 Cty Rd Qq, King, WI 54946	
License/Certification/ID Number (X1):	52A223
Survey Date (X3):	04/02/2014
Survey Event ID Number:	PQUH11

ID Prefix Tag (X4)	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date (X5)
	<p>This Plan of Correction constitutes the Wisconsin Veteran's Homes written response to the written allegation of noncompliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law.</p>	
F 241	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></p> <ul style="list-style-type: none"> • Member's catheter drainage bag was covered on 03-31-2014. • Member's signage was removed from visibility on 03-31-2014. <p><i>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</i></p> <ul style="list-style-type: none"> • Members with indwelling catheters have the potential to be affected. • All members living in SH have the potential to be affected by PHI signage being placed in visible areas in their room. • All nursing staff will be re-educated that drainage bags shall be covered at all times when a member is out of their room and/or if the bag is visible from the door into the member's room. • All nursing staff will be re-educated regarding protected health information (PHI), emphasizing that signage shall not be placed in a member's room visible to non-direct care staff, volunteers or visitors. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <ul style="list-style-type: none"> • All nursing staff will be re-educated on policy # 121-00-25, Foley Catheter Care & Use of Legband Catheter Holder (strap), emphasizing that drainage bags shall be covered at all times. • All nursing staff will be re-educated on protected health information (PHI), emphasizing that signage shall not be placed in a member's room visible to non-direct care staff, volunteers or visitors. • All nursing staff will be re-educated on member rights. <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated</i></p>	05/02/2014

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	<p><i>for its effectiveness. The plan of correction is integrated into the quality assurance system:</i></p> <ul style="list-style-type: none"> • Nursing supervisor/designee will conduct monthly random audits, for a three-month period and then quarterly thereafter with results reported to Nursing Quality Improvement Committee, on all members with a Foley catheter and using a drainage bag to ensure bag is covered appropriately. • Nursing supervisor/designee will conduct monthly random room audits for a three-month period and then quarterly thereafter, with results reported to Nursing Quality Improvement Committee to ensure no PHI is visible for non-direct care staff, volunteers and visitors. 	
F 312	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></p> <ul style="list-style-type: none"> • The identified staff was re-educated regarding proper perineal care and use of the "Stop and Watch" tool to inform RN staff on changes with members. • Identified member # 2 was assessed to make sure no noted skin issues in the perineal area. <p><i>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</i></p> <ul style="list-style-type: none"> • All members who require assistance from staff for incontinence care have the potential to be affected. • All direct care staff will be re-educated on proper perineal care. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <ul style="list-style-type: none"> • All direct care staff will be re-educated on proper perineal care in accordance to policy and procedure "Assisting in Long-Term Care," sixth edition by Gerlach and Hegner. • All nursing staff will be educated on proper use of the "Stop and Watch" tool. <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:</i></p> <ul style="list-style-type: none"> • Nursing supervisor/designee will conduct random observation of perineal care on a monthly basis for a three-month period and then quarterly thereafter, with results reported to Nursing Quality Improvement Committee. 	05/02/2014

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F 314	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></p> <ul style="list-style-type: none"> • Identified CNA staff were re-educated on the need to report to RN when interventions are not effective using the "Stop and Watch" tool. • Identified licensed staff were re-educated on how to properly develop a plan of care for individuals on wound care and on how to properly assess and document on wounds including: cause, characteristics, and measurements of wound. • Identified member #1 was assessed by RN-Wound Care Consultant, behind ears with O2 tubing, noting blanchable reddened areas with order in place for protection including placing padding on the tubing. Plan of care updated for pressure areas on heels, treatment daily to heel ulcer, continues on weekly wound rounds. • Identified member # 2 was assessed by RN and care plan updated; heel boots and treatment changed, heel ulcer healed on 4-18-14. <p><i>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</i></p> <ul style="list-style-type: none"> • All members who have been identified as high risk for pressure sore development have the potential to be affected. • All nursing staff will be re-educated on use of the "Stop and Watch" tool. • All nursing staff will be re-educated on assessing a wound and documentation. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <ul style="list-style-type: none"> • Changes have been put into place in ECS system for licensed staff to check padding on O2 tubing daily. • Changes have been made to CNA duties to include the use of foam ear protectors when placing new O2 tubing. • All nursing staff will be re-educated on wound assessment and documentation through review of Policy #11-00-22A and # 111-00-22C. • Identified CNA staff were re-educated on the need to report to RN when interventions are not effective using the "Stop and Watch" tool. • Identified licensed staff were re-educated on how to properly develop a plan of care for individuals on wound care and on how to properly assess and document on wounds including; cause, characteristics, and measurements of wound.
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	<p><i>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:</i></p> <ul style="list-style-type: none"> • Nursing supervisors/designee will conduct monthly random checks for a three-month period and then quarterly thereafter, with results reported to Nursing Quality Improvement Committee on members wearing O2 tubing to ensure tubing is padded appropriately. • Nursing supervisors/designee will conduct monthly random chart audits for a three-month period and then quarterly thereafter, with results reported to Nursing Quality Improvement Committee on wound charting to ensure documentation is done completely. • Nursing supervisors/designee will conduct monthly random checks for a three-month period and then quarterly thereafter, with results reported to Nursing Quality Improvement Committee to ensure staff's understanding and use of the "Stop and Watch" tool. 	
F 425	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></p> <ul style="list-style-type: none"> • Members # 31 and # 32 who were identified had an oral assessment done to ensure no sign of thrush (infection) noted. • Staff identified was re-educated on need to offer water and instruct member to rinse and spit after medication given. <p><i>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</i></p> <ul style="list-style-type: none"> • All members receiving an oral steroid inhaler have the potential to be affected. Those receiving an oral steroid inhaler have been assessed to ensure no signs of thrush. • All licensed staff will be re-educated on the need to offer water and instruct the member to rinse and spit after use of steroid inhalers. • Change added to the medication record that licensed staff will sign out separately stating water was offered and instruction given to member to rinse and spit after use of steroid inhaler. <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <ul style="list-style-type: none"> • All licensed staff will be re-educated on the need to offer members water and 	05/02/2014

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	<p>instruct members to rinse and spit after use of steroid inhaler.</p> <ul style="list-style-type: none"> • Change added to the medication record that licensed staff will sign out separately stating water was offered and instruction given to member to rinse and spit after use of steroid inhaler. <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:</i></p> <ul style="list-style-type: none"> • Nursing supervisor/designee will do monthly random audits during medication pass for a three-month period and then quarterly thereafter, with results reported to Nursing Quality Improvement Committee, to ensure licensed staff is providing water and instructing members receiving steroid inhalers to rinse and spit 	
F 441	<p><i>What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:</i></p> <ul style="list-style-type: none"> • Identified staff was provided job instruction/counseling on hand hygiene. • No adverse issues noted for members # 7 and # 14 due to improper hand hygiene; rooms had been cleaned on daily basis. No illness noted to either member due to this cite. • Identified staff have been re-educated on monitoring for an infectious outbreak on a nursing unit. <p><i>How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:</i></p> <ul style="list-style-type: none"> • All members have the potential to be affected by improper hand hygiene practices. • All staff will demonstrate appropriate hand hygiene techniques. • All members have the potential to be affected by failure to adhere to policy/procedure during a Norovirus outbreak. • Policy on Infectious Gastrointestinal Illness (Including Norovirus) will be updated. • Checklist will be made for Nursing Supervisors to use as a tool for notifying all departments. • Staff Call-in slip will be updated with additional instructions per policy IC 01-06 Infectious Gastrointestinal Illness. • Scheduling PAs will maintain a line list of nursing staff in each building who call 	05/02/2014

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	<p>in with infectious symptoms, to be monitored by nursing supervisors 24/7 so unit can be placed on restrictions as needed per policy.</p> <p><i>What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur:</i></p> <ul style="list-style-type: none"> • All nursing staff will be re-educated on Hand Washing/Hand Hygiene policy IC 01-04. • All staff will be educated on updated call-in slip. • All staff will be educated on updated policy, IC 01-06 Infectious Gastrointestinal Illness (Including Norovirus). • All nursing supervisors will be educated on Notification Checklist for an outbreak. • Scheduling PAs will maintain a line list of nursing staff in each building who call in with infectious symptoms, to be monitored by nursing supervisors 24/7 so unit can be placed on restrictions as needed per policy. <p><i>How the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system:</i></p> <ul style="list-style-type: none"> • Nursing supervisors/designee will do random hand washing/hand hygiene audits monthly for a three-month period and then quarterly thereafter, with results reported to Nursing Quality Improvement Committee • Nursing supervisors/designee will do random monitoring of GI logs monthly for a three-month period and then quarterly thereafter, with results reported to Nursing Quality Improvement Committee. • Nursing supervisor/designee will do random monitoring of Scheduling PA line list of staff to ensure compliance of staff returning to work appropriately related to staff symptoms monthly for a three-month period and then quarterly thereafter, with results reported to Nursing Quality Improvement Committee. 	

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