

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2013
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700	STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>Surveyor: 29791</p> <p>This was a recertification and complaint survey conducted at Wisconsin Veterans Home - Stordock beginning 2/4/13 through 2/7/13.</p> <p># of federal citations issued: 10</p> <p>The most serious citation is F498 cited at a scope/severity level of E (potential for harm/pattern).</p> <p>Census: 196 Sample Size: 30 Supplemental Sample: 5 Survey Coordinator: #29791</p>	F 000		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and</p>	F 225		

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.

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 1</p> <p>to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 18815</p> <p>Based on staff interviews and record review, the facility did not ensure all allegations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property were reported to the state survey and certification agency and thoroughly investigated. The facility did not have evidence that further potential abuse was prevented while the investigation was in progress for 1 (resident #19) of 8 abuse allegations reviewed.</p> <p>An allegation of harassment and verbal abuse was reported to the facility on 1/10/13 involving LPN (Licensed Practical Nurse)-P. The allegation was not reported to the state agency, was not</p>	F 225			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 2</p> <p>thoroughly investigated, and LPN-P was allowed to continue working without direct supervision in direct patient care prior to the completion of the investigation into the allegation of abuse.</p> <p>Findings include:</p> <p>A facility complaint was investigated regarding alleged harassment and verbal abuse by LPN-P towards member #19. The complaint indicated LPN-P was in member #19's room attempting to administer medications to the member. Member #19 was refusing to take the medications. LPN-P started out talking to the member in a normal tone of voice with the tone of voice escalating to hollering at the member. The complaint indicated LPN-P advised member #19 to take the d**n meds and if the member would not take the meds, LPN-P would not give a d**n. Per the complaint, LPN-P then stated to member #19 "you need to take your d**n drugs, do you want to die?" The complaint indicated there were other witnesses to the incident including staff and member #33, who lives across the hall from member #19.</p> <p>On 2/6/13 surveyor #18815 was provided with the timeline of the incident completed by the facility regarding the allegation of harassment and verbal abuse involving member #19 and LPN-P. The timeline indicated the allegation was reported to the facility at approximately 4:00 p.m. on 1/10/13 by RN (Registered Nurse)-A, who had received the allegation of harassment and verbal abuse complaint from a visitor to the facility. LPN-P also advised the facility of an allegation of verbal abuse. LPN-P was informed an investigation was being completed and the LPN was asked if the</p>	F 225			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 3</p> <p>member was swore at. LPN-P denied swearing at member #19. Other staff named as witnesses were interviewed at this time with inconsistencies noted between staff who were named as witnesses and the visitor complaint. One staff indicated member #19 was upset after LPN-P left the room and stated "we went nose to nose and (the LPN) stormed out," other staff indicated member #19 was not upset, and one staff indicated LPN-P was walking out of member #19's room and stated "f*** it."</p> <p>Member #19's MDS (Minimum Data Set) dated 11/27/12 indicated the resident was assessed to be severely cognitively impaired. Member #19 was interviewed on 1/10/13 by the facility. The member is hard of hearing. Member #19 indicated medications were refused, denied being yelled at by the LPN, and was happy. Surveyor #18815 did not interview member #19 regarding the allegation of abuse due to the member's cognitive status.</p> <p>Member #33 was not interviewed at this time even though the member was named as a witness to the allegation of harassment and verbal abuse. LPN-P continued to provide direct care to members without direct supervision for the remainder of the afternoon shift. The investigation continued on 1/11/13.</p> <p>On 1/11/13, the facility interviewed LPN-P at the beginning of the afternoon shift regarding the allegation of verbal abuse. LPN-P indicated the member was not happy and refused to take medications. The LPN indicated conversation was in a loud and clear manner because the member is hard of hearing. LPN-P denied</p>	F 225			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	<p>Continued From page 4</p> <p>swearing at the member while in the member's room or when leaving the member's room. The investigation was completed on 1/11/13 after the interview with LPN-P.</p> <p>On 2/6/13 at 4:24 p.m. surveyor #18815 interviewed LPN-P regarding the allegation of harassment and verbal abuse. LPN-P indicated the shift started at 2:30 p.m. on 1/10/13 and at approximately 3:45 p.m. the allegation of abuse occurred. LPN-P verified the facility asked on 1/10/13 after the incident if member #19 was swore at during medication administration. LPN-P also verified working the remainder of the afternoon shift until 11:00 p.m. on 1/10/13 and stated "I worked the shift after the incident without supervision."</p> <p>On 2/7/13 at 11:25 a.m. surveyor #18815 interviewed ADON (Assistant Director of Nursing)-J regarding the allegation of verbal abuse. ADON-J verified the allegation was not documented in the medical record of member #19, was not reported to the state agency, and stated the allegation was not reported because the facility determined "there were inconsistencies in the stories of the reporter and (other staff), and (member #19) was not fearful." ADON-J also verified members were not protected during the allegation of abuse investigation, which was not completed with LPN-P until 1/11/13 because LPN-P "wasn't supervised when working" the rest of the afternoon shift on 1/10/13.</p> <p>On 2/7/13 at 1:05 p.m. surveyor #18815 interviewed ADON-J regarding interviewing member #33, who was identified as a witness to</p>	F 225			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 225	Continued From page 5 the allegation of verbal abuse and interviewing other members to determine if they have been abused or mistreated. ADON-J verified member #33 and other members were not interviewed. ADON-J then stated "I don't know why (member #33) or other members were not" interviewed.	F 225			
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Surveyor: 18815 Based on staff interview and policy review, the facility did not operationalize its written policies and procedures to prohibit abuse, neglect, mistreatment, and misappropriation of resident property for 1 (resident #19) of 30 total sampled residents. An allegation of harassment and verbal abuse was reported to the facility on 1/10/13 involving LPN (Licensed Practical Nurse)-P. The allegation was not reported to the state agency, was not thoroughly investigated, and the facility did not protect other residents by allowing staff to continue to work with direct resident contact after receiving an allegation of potential abuse. The facility's deficient practices had the potential to affect all residents in the facility.	F 226			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 6</p> <p>Findings include:</p> <p>On 2/7/13 surveyor #18815 reviewed the facility policy and procedure on abuse dated February 2012, which was entitled Member Abuse, Neglect, Mistreatment and the policy entitled Member Abuse, Neglect, Mistreatment, Misappropriation of Property and Injuries of Unknown Source dated February 2012. The policy entitled Member Abuse, Neglect, Mistreatment documented the following:</p> <p>The purpose of the policy of the Wisconsin Veterans Home at King indicated the policy is to ensure compliance with all applicable federal and state statutes, rules and regulations and to protect the member's right to be free from abuse, neglect, and mistreatment.</p> <p>The nursing supervisor is to be notified immediately to determine what further steps need to be taken to protect the member. The nursing supervisor continues the investigation process by interviewing the member and witnesses. The nursing supervisor may apply further restrictions to keep the member safe. The incident report is initiated in nurse charting.</p> <p>The policy entitled Member Abuse, Neglect, Mistreatment, Misappropriation of Property and Injuries of Unknown Source documented the following:</p> <p>The purpose of the policy of the Wisconsin Veterans Home at King indicated the policy is to ensure compliance with all applicable federal and state statutes, rules and regulations and to protect the member's right to be free from abuse,</p>	F 226			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 7</p> <p>neglect, mistreatment, and misappropriation of property and injuries of unknown source.</p> <p>The policy indicated Verbal Abuse is the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to members or their families, or within hearing distance regardless of their age, ability to comprehend, or disability. As soon as the incident is reported, staff shall immediately determine what measures shall be implemented to protect the member (s). The facility immediately notifies the Division of Quality Assurance (DQA), which means as soon as possible, but not to exceed 24 hours after discovery of the incident, with final report within 5 working days of the incident.</p> <p>A facility complaint was investigated regarding alleged harassment and verbal abuse by LPN-P towards member #19. The complaint indicated LPN-P was in member #19's room attempting to administer medications to the member. Member #19 was refusing to take the medications. LPN-P started out talking to the member in a normal tone of voice with the tone of voice escalating to hollering at the member. The complaint indicated LPN-P advised member #19 to take the d**n meds and if the member would not take the meds, LPN-P would not give a d**n. Per the complaint, LPN-P then stated to member #19 "you need to take your d**n drugs, do you want to die?" The complaint indicated there were other witnesses to the incident including staff and member #33, who lives across the hall from member #19.</p> <p>On 2/6/13 surveyor #18815 was provided with the</p>	F 226			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 8</p> <p>timeline of the incident completed by the facility regarding the allegation of harassment and verbal abuse involving member #19 and LPN-P. The timeline indicated the allegation was reported to the facility at approximately 4:00 p.m. on 1/10/13 by RN (Registered Nurse)-A, who had received the allegation of harassment and verbal abuse complaint from a visitor to the facility. LPN-P also advised the facility of an allegation of verbal abuse. LPN-P was informed an investigation was being completed and the LPN was asked if the member was swore at. LPN-P denied swearing at member #19. Other staff named as witnesses were interviewed at this time with inconsistencies noted between staff who were named as witnesses and the visitor complaint. One staff indicated member #19 was upset after LPN-P left the room and stated "we went nose to nose and (the LPN) stormed out," other staff indicated member #19 was not upset, and one staff indicated LPN-P was walking out of member #19's room and stated "f*** it."</p> <p>Member #19's MDS (Minimum Data Set) dated 11/27/12 indicated the resident was assessed to be severely cognitively impaired. Member #19 was interviewed on 1/10/13 by the facility. The member is hard of hearing. Member #19 indicated medications were refused, denied being yelled at by the LPN, and was happy. Surveyor #18815 did not interview member #19 regarding the allegation of abuse due to the member's cognitive status.</p> <p>Member #33 was not interviewed at this time even though the member was named as a witness to the allegation of harassment and verbal abuse. The facility did not feel the current</p>	F 226			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	<p>Continued From page 9</p> <p>information warranted being sent in as a self-report to the state agency. LPN-P continued to provide direct care to members without direct supervision for the remainder of the afternoon shift. The investigation continued on 1/11/13.</p> <p>On 1/11/13, the facility interviewed LPN-P at the beginning of the afternoon shift regarding the allegation of verbal abuse. LPN-P indicated the member was not happy and refused to take medications. The LPN indicated conversation was in a loud and clear manner because the member is hard of hearing. LPN-P denied swearing at the member while in the member's room or when leaving the member's room. The investigation was completed on 1/11/13 after the interview with LPN-P.</p> <p>On 2/6/13 at 4:24 p.m. surveyor #18815 interviewed LPN-P regarding the allegation of harassment and verbal abuse. LPN-P indicated the shift started at 2:30 p.m. on 1/10/13 and at approximately 3:45 p.m. the allegation of abuse occurred. LPN-P verified the facility asked on 1/10/13 after the incident if member #19 was swore at during medication administration. LPN-P also verified working the remainder of the afternoon shift until 11:00 p.m. on 1/10/13 and stated "I worked the shift after the incident without supervision."</p> <p>On 2/7/13 at 11:25 a.m. surveyor #18815 interviewed ADON (Assistant Director of Nursing)-J regarding the allegation of abuse. ADON-J verified the allegation was not documented in the medical record of member #19, was not reported to the state agency, and stated the allegation was not reported because</p>	F 226			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 226	Continued From page 10 the facility determined "there were inconsistencies in the stories of the reporter and (other staff), and (member #19) was not fearful." ADON-J also verified members were not protected during the allegation of abuse investigation, which was not completed with LPN-P until 1/11/13 because LPN-P "wasn't supervised when working" the rest of the afternoon shift on 1/10/13. On 2/7/13 at 1:05 p.m. surveyor #18815 interviewed ADON-J regarding interviewing member #33, who was identified as a witness to the allegation of verbal abuse and interviewing other members to determine if they have been abused or mistreated. ADON-J verified member #33 and other members were not interviewed. ADON-J then stated "I don't know why (member #33) or other members were not" interviewed.	F 226			
F 278 SS=E	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and	F 278			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	<p>Continued From page 11</p> <p>false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 10573</p> <p>Based on staff interview and record review, the facility did not ensure that 4 (member #6, #11, #13 and #14) out of 30 sampled members MDS (Minimum Data Set) assessments accurately reflected their status.</p> <p>Member #14's annual MDS assessment completed on 1/15/13 and the quarterly MDS assessment completed on 10/16/12 did not accurately reflect antipsychotic and antidepressant medications taken by the member.</p> <p>Member #6's quarterly MDS assessment completed on 12/11/12 incorrectly identified the member as using a catheter.</p> <p>Member #11's significant change MDS assessment dated 10/30/12 incorrectly identified the member as having one venous/arterial ulcer present.</p>	F 278			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	<p>Continued From page 12</p> <p>Member #13's quarterly MDS assessment dated 9/25/12 and the annual MDS assessment dated 12/18/12 incorrectly identified the member as having UTIs (urinary tract infections) within the last 30 days.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Member #14's face sheet dated 6/1/10 indicated that he was admitted to the facility on 4/9/07 with diagnoses including diabetes, renal insufficiency, depression, severe diabetic neuropathy, a below the knee amputation and a history of heart failure. <p>Member #14's Physician Order dated 1/2/13 documented an order for aripiprazole 4 mg (milligrams) daily with an original start date of 8/27/09. Aripiprazole is an antipsychotic. The Physician Order also documented an order for duloxetine 60 mg daily with an original start date of 5/3/07. Duloxetine is an antidepressant.</p> <p>Member #14's quarterly MDS of 10/16/12 and the annual MDS of 1/15/13 incorrectly indicated the member did not receive any antidepressants or antipsychotic medications.</p> <p>On 2/6/13 at 7:25 a.m. RN (Registered Nurse)-C identified herself to surveyor #10573 as the MDS Coordinator for the second floor. RN-C verified to surveyor #10573 that member #14's annual and quarterly MDS' were inaccurate for the area of medication usage. RN-C stated she would correct the MDS'.</p> <ol style="list-style-type: none"> Member #6's face sheet dated 10/1/12 	F 278		

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	<p>Continued From page 13</p> <p>indicated that he was admitted to the facility on 6/13/12 with diagnoses including dementia depression, a pacemaker and benign prostatic hyperplasia.</p> <p>Residents #6's quarterly MDS of 12/11/12 incorrectly indicated the member was using a catheter.</p> <p>On 2/6/13 at 7:25 a.m. RN (Registered Nurse)-C identified herself to surveyor #10573 as the MDS Coordinator for the second floor. RN-C verified to surveyor #10573 that member #6 did not use a catheter and that his quarterly MDS inaccurately indicated a catheter was in use. RN-C stated she would correct the MDS. Surveyor: 18815</p> <p>3. Member #11's face sheet contained within the medical record and dated 12/20/12, indicated the member was re-admitted to the facility on 10/20/12 with diagnoses to include diabetes mellitus and chronic kidney disease.</p> <p>Member #11's significant change MDS, dated 10/30/12, incorrectly indicated the member had one venous/arterial ulcer present.</p> <p>4. Member #13's face sheet contained within the medical record and dated 12/29/10, indicated the member was admitted to the facility on 12/29/10 with diagnoses to include urge incontinence and a history of Escherichia Coli sepsis.</p> <p>Member #13's quarterly MDS, dated 9/25/12, incorrectly indicated the member had a UTI within the last 30 days. Member #13's annual MDS, dated 12/18/12, also incorrectly indicated the</p>	F 278			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	Continued From page 14 member had a UTI within the last 30 days. On 2/6/13 at approximately 12:45 p.m. surveyor #18815 interviewed ADON (Assistant Director of Nursing)-J regarding member #11's venous/arterial ulcer indicated on the MDS and member #13's UTIs indicated on the two MDS assessments. ADON-J verified member #11 did not have a venous/arterial ulcer present at the time of the assessment and the MDS would be corrected. ADON-J also verified member #13 did not have UTIs as indicated on the two MDS assessments and the MDS assessments would be corrected.	F 278			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Surveyor: 30571 Based on observation, record review and staff and resident interviews, the facility did not ensure that 2 (resident #8 and #9) of 8 residents reviewed for pressure ulcers received appropriate care to promote healing and/or to prevent ulcers from developing.	F 314			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 15</p> <p>Resident #8 was assessed to be at risk for the development of pressure ulcers and had a plan of care intervention to reposition every 2 hours with heels elevated off mattress all shifts when in bed. That intervention was not consistently implemented.</p> <p>Resident #9 was assessed to be at risk for the development of pressure ulcers and had a recently healed right heel ulcer. The resident had a plan of care intervention for a heel lift boot to the right foot when in bed. That intervention was not consistently implemented.</p> <p>Findings include:</p> <p>The Quick Reference Guide entitled "Pressure Ulcer Prevention" published by the National Pressure Ulcer Advisory Panel (NPUAP) in 2009 indicated to prevent pressure ulcers in individuals considered to be at risk for the development of pressure ulcers, ensure the heels are free of the surface of the bed. Heel protection devices should elevate the heels completely (offload them) in such a way as to distribute the weight of the leg along the calf without putting pressure on the Achilles tendon. Ensure the heels are free of the surface of the bed. Using a pillow under the calves so the heels are elevated (i.e., "floating") will accomplish the reduction of pressure on heels.</p> <p>1. Resident #8's admission facesheet, dated 8/1/12, indicated the resident was admitted to the facility with diagnoses to include Parkinson's disease and dementia. The resident's most recent MDS (Minimum Data Set), dated 11/27/12,</p>	F 314			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 16</p> <p>indicated the resident required extensive assistance for transfers and personal cares and was at risk for the development of pressure ulcers. Record review also indicated the resident was at high risk for pressure ulcers per the Braden Scale.</p> <p>Resident #8 had a nursing order, dated 1/16/13, to be repositioned every 2 hours with heels elevated off mattress all shifts when in bed. A progress note with the order indicated that staff observed redness to both heels with blanchable areas and the resident complained of pain upon palpation to the left heel.</p> <p>Review of the resident's skin assessments indicated the resident had reddened heels on 1/18/13, 1/22/13 and 1/25/13. The resident was also noted to have a reddened coccyx on 12/7/12, 12/11/12, 12/14/12, 12/18/12, 12/21/12 and 12/25/12.</p> <p>On 2/6/13 at 8:40 a.m., surveyor #30571 observed resident #8 in bed with both heels in direct contact with the mattress.</p> <p>On 2/7/13 at 8:15 a.m. and 9:13 a.m., surveyor #30571 again observed resident #8 in bed with both heels in direct contact with the mattress.</p> <p>On 2/7/13 at 9:18 a.m., surveyor #30571 interviewed CNA (Certified Nursing Assistant)-F regarding resident #8's heels. CNA-F stated, "I think they're usually elevated because he's stiff. I think he usually asks for them. When he's in his recliner, I think they're usually up too."</p> <p>On 2/7/13 at 9:32 a.m., surveyor #30571 entered</p>	F 314			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 17</p> <p>the resident's room with RN (Registered Nurse)-H who verified the resident's heels were in direct contact with the mattress and stated, "I will make sure we get them elevated right away." Surveyor #30571 and RN-H checked the resident's heels at that time and noted them to be reddened and blanchable. RN-H used a pillow to float the resident's heels and stated a treatment to toughen the heels would be started. RN-H also notified the CNA working the unit that the resident's heels were elevated.</p> <p>2. Resident #9's admission facesheet, dated 10/23/12, indicated the resident was admitted to the facility with diagnoses to include diabetes and dementia. The resident's most recent MDS, dated 12/28/12, indicated the resident required assistance for transfers and toileting and was at risk for the development of pressure ulcers. The resident was also assessed to be at high risk for pressure ulcers per the Braden Scale.</p> <p>Resident #9 had a plan of care intervention to apply heel lift boot to right foot when in bed. On the resident's Personalized Member Care sheet, dated 2/7/13, an additional comment instructs the AM and PM staff to make sure to apply heel lift boot if member lays down after meals or is in bed.</p> <p>A skin assessment, dated 1/25/13, noted the ulcer on the resident's right heel as a 1 cm (centimeter) x 1 cm blanchable, improving ulcer with necrotic tissue and no undermining or tunneling. Charting on 1/31/13 indicated the area was nearly finished with the current treatment and documentation on 2/2/13 listed the area as healed.</p>	F 314			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 18 On 2/4/13 at 1:30 p.m., surveyor #30571 observed resident #9 in bed wearing socks and slippers with feet resting on the mattress. The resident was not wearing a heel boot on the right foot. FM (Family Member)-Q indicated the sore on the resident's heel was closed. FM-Q further stated, "The wound nurse looks at it and (resident #9) wears the spongy boot on his heel at night. He doesn't wear it now because it's pretty much healed...just a little tender because the scab came off." On 2/5/13 at 11:12 a.m., surveyor #30571 interviewed FM-Q who indicated the resident developed a right heel pressure ulcer in the facility and was non-ambulatory for a period of time prior to admission. Also at that time, surveyor #30571 observed resident #9 in bed wearing socks and slippers with feet resting on the mattress. The resident was not wearing a right heel boot. On 2/6/13 at 2:55 p.m., surveyor #30571 again observed resident #9 in bed wearing socks and slippers with feet resting on the mattress. The resident was not wearing a right heel boot. Surveyor #30571 interviewed resident #9 at that time who stated, "I wear the boot at night. I guess it's on both. I take them off in the morning." On 2/6/13 at 3:00 p.m., surveyor #30571 interviewed CNA-I who stated, "He's supposed to have them on. He wears both (the heel boot and heel protector) at night. He should have the boot on when in bed." CNA-I entered the resident's room at that time, removed the resident's right	F 314			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 19 shoe and place a heel boot on the resident's right foot.	F 314			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Surveyor: 29173 Based on observation, staff and member interview and record review, the facility did not ensure that a member who entered the facility without a indwelling catheter was not catheterized unless the member's clinical condition demonstrated that catheterization was necessary for 1 (member #3) of 10 members reviewed for catheters in a total sample of 30 members. Member #3 had an indwelling catheter without medical justification and it was the member's preference to not have a Foley catheter. Additionally, there was no evidence found that the member was educated about the risks and benefits of the indwelling catheter. Findings include:	F 315			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 20 The CDC (Centers for Disease Control) "Guideline for the Prevention of Catheter Associated Urinary Tract Infections", printed 2009, revealed the following standards of practice: "Appropriate Urinary Catheter Use: Insert urinary catheter only for appropriate indications, and leave in place only as long as needed. Minimize urinary catheter use and duration in all patients, particularly those at higher risk for CAUTI (Catheter Associated Urinary Tract Infections) such as women, the elderly and patients with impaired immunity. Avoid used of urinary catheters in...nursing home residents for management of incontinence..." "Examples of appropriate indications for indwelling urinary catheter use:...acute urinary retention or bladder outlet obstruction...need for accurate measurements of output in critically ill patients, peri-operative use for surgical procedures, assist in healing of open sacral wounds, patients requiring prolonged immobilization, end of life care." The facility's policy titled, "Foley Catheter: Monitoring and Frequency of Change," dated December 2011 indicated, "...Upon initial insertion of a urethral Foley Catheter and for newly admitted members with a Foley catheter, the charge nurse shall initiate immediate planning and removal of the catheter...The RN shall collaborate with the physician regarding a trial of catheter removal, if appropriate..."	F 315			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 21</p> <p>On 2/4/13 surveyor #29173 reviewed the medical record of member #3. The face sheet dated 6/15/11, indicated member #3 was admitted to the facility on 5/31/11 with diagnoses to include Foley catheter inserted on 7/20/12 due to chronic incontinence, atrial fibrillation, CHF (congestive heart failure), chronic fatigue, depression and osteoporosis.</p> <p>The most recent annual MDS (Minimum Data Set), dated 12/3/12, indicated member #3 was cognitively intact and independent with transfers and ambulation. The MDS also noted member #3 required extensive assistance from staff for personal hygiene and bathing. Additionally, the MDS revealed member #3 had an indwelling Foley catheter.</p> <p>Member #3's Urinary Incontinence/Catheter CAA (Care Area Assessment), dated 12/3/12 indicated, "Recent increase in diuretics, and has since been incontinent of urine...Has urinary catheter due to chronic incontinence. Diuretics causing urge incontinence, has history of CHF/pulmonary edema. Member is exhausted by going to the bathroom. Member is short of breath, and is weakened by bathroom trips, wants to remain dry and wanted catheter."</p> <p>Physician's notes for member #3 indicated:</p> <p>- On 7/19/12, "...urinary incontinence with inadequate control with depends. Have offered a Foley catheter as a comfort measure to allow her less exhaustion and more freedom. This will be trialed if she agrees to consider this as a trial."</p>	F 315			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 22</p> <p>- On 8/6/12, "...she has a Foley catheter in so there are less trips to and from the bathroom in relation to her continuing on her lasix...On exam, alert, 91 year old in no distress...Foley catheter has been a good relief as far as less up and down activities to the bathroom and will continue with that long term...Urinary incontinence, controlled with Foley catheter.</p> <p>- On 10/08/12, "...Her CHF continues to be well compensated at this point with the use of diuretics...exam shows member alert and oriented...urinary incontinence with indwelling Foley."</p> <p>-On 11/15/12, "...does have edema that is about 2+. It's more on the left side where she has the urine Foley bag attached. The elastic bands cause this and today she is quite swollen she says. We will ask for this bag to be changed from one side of the leg to the other side midday to decrease problems there."</p> <p>- On 12/18/12, "...has CHF but actually is fairly well compensated at this time. She has been feeling better, oxygen level has been good and she has not needed to wear oxygen during the day except as needed...She has a Foley catheter because it was too much effort getting up and down to the bathroom during this past year and she has had no difficulties with this except a band around her leg causing some increased edema on the left leg. It's 2+ edema whereas on the right she is just 1+ where she doesn't have the bag today."</p> <p>-On 1/7/13, "has been doing really well and actually hadn't been as hypoxic. We have</p>	F 315			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	<p>Continued From page 23</p> <p>weaned her off her oxygen most of the time except at night..."</p> <p>The current physician orders for 2/2013, revealed the following specific to the urinary catheter for member #3: "Change Foley catheter as needed, freedom from incontinence and discomfort, original date 7/20/12."</p> <p>The care plan for member #3 addressing urinary elimination, dated 11/28/12 indicated, potential for impaired skin integrity, UTI's (Urinary tract Infections), related to: medication use, Foley catheter manifested by: history of incontinence. The care plan listed the following approaches:</p> <ul style="list-style-type: none"> *urinary incontinence pads/briefs *toilet on individual schedule *Foley catheter change monthly and as needed <p>The personalized member care card dated 2/6/13, and utilized by direct care staff indicated, "Toileting Ability: Independent Toileting all shifts."</p> <p>On 2/5/13 at 10:10 a.m. surveyor #29173 interviewed member #3 in her room. Surveyor #29173 asked member #3 how she felt about the indwelling Foley catheter. Member #3 replied, "I use to go to the bathroom the normal way, without a catheter, until they started given me more water pills...The pills would make me go more and they wanted me to save my energy...It's not as ideal as I wish it was. I'd rather not have the catheter and go to the bathroom like I normally did...I don't believe there're giving me as many water pills as they use to." When asked about her understanding of the risk and benefits related to the placement of an indwelling catheter,</p>	F 315			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 315	Continued From page 24 member #3 stated, "I don't recall them telling me anything." On 2/5/13 at 10:50 a.m. surveyor #29173 interviewed RN (Registered Nurse)-L regarding the catheter for member #3. RN-L verified member #3's physician ordered the catheter due to her chronic incontinence and because the member was wet all the time. RN-L stated, "she (member #3) likes to do everything on her own...she has breathing issues and was on a lot of lasix." When asked for a current bladder assessment, trials to discontinue the catheter, any type of urology consult or nursing assessment which demonstrated the medical necessity for the continued use of a urinary catheter, RN-L presented none. RN-L agreed there was no documentation identifying medical justification for the use of the indwelling Foley catheter. RN-L was then asked about a risk benefit statement for member #3 related to the placement of the catheter. RN-L indicated no risk or benefits statement was given. RN-L stated, "I know she (member #3) really doesn't like the catheter. I can talk to the doctor about it." No further assessments or documentation was provided by the facility regarding member #3's indwelling Foley catheter.	F 315			
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.	F 323			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 25 This REQUIREMENT is not met as evidenced by: Surveyor: 29173 Based on observation, staff interview and record review, the facility did not ensure each member received adequate supervision and assistance devices to prevent accidents for 2 (members #17 and #20) of 20 members reviewed for falls in a total sample of 30 members. Member #20 was at risk for falls. The plan of care indicated the member was to have a personal alarm on at all times. On 2/6/13 and 2/7/13 member #20 was observed in a recliner chair in her room without a personal alarm. Member #17 was observed to be transferred to the toilet without the assistance of a gait belt for safety and was at risk for falls. Findings include: 1. The face sheet, dated 1/11/13 and contained within the medical record, indicated member #20 was admitted to the facility on 1/11/13 with diagnoses of dementia, depression, hypertension, and rheumatoid arthritis. The initial MDS (Minimum Data Set), dated 1/29/13, indicated member #20 had severe cognitive impairment, and required staff assistance for transfers and ambulation. The CAA (Care Area Assessment), dated 1/29/13, indicated member #20 triggered for falls	F 323			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 26</p> <p>stating, "History of falling: two falls since her transfer from another building, while walking and rolled out of bed, no serious injuries noted. Has impaired balance during transitions gait problems even with mobility aid or personal assistance. Risk factors: has had falls prior to admission. Has a history of dementia and poor judgement/safety awareness. She has a tabs alarm on at all times...has cognitive impairment...has poor eyesight, medications and urinary incontinence all increase resident #20's fall risk."</p> <p>The current physicians order's for 2/2013 indicated, "Fall/Injury Prevention: Personal alarm (TABS) on at all times."</p> <p>The 1/13/13 plan of care indicated member #20 was at risk for falling due to poor balance and unable to move body and get around. Approaches for safety listed on the plan of care indicated, "a personal tabs alarm to be worn at all times.</p> <p>The personalized member care card utilized by direct care staff for member #20 indicated, "personal alarm (TABS) at all times."</p> <p>Fall incident reports indicated member #20 had a witnessed fall in her room on 1/19/13, resulting in swelling on the back of her head. The personal alarm (TABS) was put into place following the 1/19/13 fall. The record also indicated member #20 had an unwitnessed fall out of bed on 1/29/13, without injury.</p> <p>On 2/6/13 at 3:20 p.m. surveyor #29173 observed member #20 up in her recliner chair in her room. No type of personal alarm was observed on the</p>	F 323			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 27</p> <p>member. Surveyor #29173 did note a personal alarm (TABS) mounted to member #20's bed frame.</p> <p>On 2/6/13 at 3:25 p.m. surveyor #29173 and RN(Registered Nurse)-A observed member #20 in her room sitting in her recliner. RN-A confirmed member #20 did not have a personal alarm on. RN-A stated, "she should have a tab alarm on at all times. She just came over here from another building...Staff should have the tab alarm on her even when she is up in her recliner chair." Surveyor #29173 then observed RN-A remove the personal alarm (TABS) from the head of the bed frame. RN-A mounted the device to the back of the recliner chair and clipped the string onto member #20's shirt.</p> <p>On 2/7/13 at 9:20 a.m. surveyor #29173 observed member #20 up in her recliner chair in her room. No type of personal alarm was observed on the member. Surveyor #29173 did note a personal alarm (TABS) mounted to the member #20's bed frame.</p> <p>On 2/7/13 at 9:25 a.m. surveyor #29173 and CNA(Certified Nursing Assistant)-B entered member #20's room. CNA-B verified member #20 was up in her recliner chair without any type of personal alarm device. CNA-B confirmed that member #20 should have a personal alarm on at all times and stated, "I'm glad you caught that." CNA-B then removed the tabs alarm off the head of the bed frame, attached it to the recliner chair and placed the clip on member #20's shirt.</p> <p>Surveyor: 29791</p>	F 323			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 28 Facility policy titled Gait Belt/Transfer Belt, revised October 2012, states "a gait/transfer belt shall be used by facility staff whenever there is a need to physically assist a member to stand, transfer, and or ambulate." 2. According to the face sheet, dated 7/23/12, member #17 was admitted on 7/26/11 with diagnoses to include legal blindness related to macular degeneration and glaucoma. The most recent comprehensive MDS (minimum data set) assessment, dated 7/17/12, indicated member #17 experienced 2 or more falls with no injury and 2 or more falls resulting in minor injury within the prior 3 months. The most recent quarterly MDS assessment, dated 1/15/13, indicates member #17 requires extensive assistance of one staff member for transfers between surfaces and the toilet. The electronic medical record indicated member #17 experienced a recent witnessed fall on 1/25/13 within the member's bathroom. Member #17 stepped back to sit on the toilet and fell to the member's buttocks. Member #17 has a risk for falls care plan with interventions dated 5/20/12 that indicate member #17 is to have a pressure sensitive alarm on at all times, floor mat in place when in bed/recliner, and a tabs alarm while in the wheelchair due to a history of multiple falls and self transfer attempts. On 2/5/13 at 11:23 a.m., surveyor #29791 observed CNA-B transfer member #17 to the bathroom. Member #17 was seated in the recliner in the member's bedroom. CNA-B removed the sensor mat, clip alarm and turned off the seat sensor alarm from the member's	F 323			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 29</p> <p>recliner. CNA-B removed blankets from member #17's lap and placed member #17's walker in front of member #17. CNA-B assisted member #17 to stand from the recliner, and without a gait belt, assisted member #17 to transfer from the recliner chair to the bathroom with aid of only the walker. CNA-B placed a hand on member #17's back during the transfer and verbally prompted member #17 to hold the grab bars in the bathroom and to reach back to the toilet seat when sitting. After member #17 used the toilet, CNA-B assisted member to stand and replace clothing. With assistance of only the walker, CNA-B assisted member #17 to a seated position in the member's wheelchair just outside the bathroom. CNA-B then affixed the clip alarm to the member's shirt and activated the pressure sensitive alarm in the member's wheelchair. CNA-B then wheeled member #17 to the lounge area. Surveyor #29791 observed a gait belt hanging in member #17's open closet.</p> <p>On 2/7/13 at 1:50 p.m., surveyor #29791 interviewed CNA-B regarding member #17 and use of a gait belt. CNA-B stated she usually uses a gait belt when walking with the member in the hall and therapy does as well. CNA-B stated that she does not usually use the gait belt when ambulating member #17 within the member's room and to the bathroom. CNA-B stated she was unaware of member #17's recent fall.</p> <p>On 2/7/13 at 2:00 p.m., surveyor #29791 interviewed ADON (Assistant Director of Nursing)-J regarding gait belt use. ADON-J stated that gait belts are expected to be used for any member who requires assistance with ambulation.</p>	F 323			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332 SS=D	<p>483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE</p> <p>The facility must ensure that it is free of medication error rates of five percent or greater.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 29173</p> <p>Based on observations, staff and member interviews and record review, the facility did not ensure it was free of a medication error rate of five percent or greater in 3 (member #10, #31, and #32) of 12 members observed during medication administration. The calculated rate of medication error rate was 9.5%.</p> <p>Member #31 was given a short-acting insulin injection (Novolog), seventy minutes before a meal on 2/4/13, and seventy-eight minutes before a meal on 2/5/13.</p> <p>Member #32 was given a short-acting insulin injection (Novolog), thirty minutes before a meal on 2/5/13.</p> <p>Member #10 was given a short-acting insulin injection (Novolog), sixty-eight minutes before a meal on 2/5/13.</p> <p>The manufacturer's recommendation and facility's recommendation directed the medication (Novolog) to be administered within fifteen minutes before or after a meal.</p> <p>Findings include:</p>	F 332			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	<p>Continued From page 31</p> <p>Novo Nordisk, the manufacturer of Novolog insulin, directed the following: "Novolog should generally be given immediately within 5-10 minutes prior to a start of a meal. ...Novolog has a more rapid onset of action and a shorter duration of activity than regular human insulin. An injection of Novolog should immediately be followed by a meal within 5-10 minutes."</p> <p>On 2/6/13 at 2:05 p.m. ADON (Assistant Director of Nursing)-J provided surveyor #29173 with a communication slip form, undated, from the facility's pharmacy. ADON-J stated, the form was given to all nursing staff and is hanging up in all the medication rooms. The form indicated, "Insulin Recommendations: Rapid Acting, Aspart (Novolog), dosing time: 0-15 minutes before a meal or 0-15 minutes immediately after a meal."</p> <p>1. On 2/4/13 at 11:18 a.m. surveyor #29173 observed medication pass with LPN (Licensed Practical Nurse)-M, who sanitized her hands, applied gloves and entered the room of resident #31. A blood glucose measurement was obtained, and the results were 317. According to the medical record, member #31 was ordered to receive Novolog insulin 8 units and a sliding scale Novolog insulin. The order directed, "For blood sugars ranging from 301 to 400, give 8 units of insulin...at meals and at bedtime." LPN-M withdrew and administered 16 units of Novolog insulin at 11:20 a.m. No other medications or supplements were given at that time.</p> <p>A continuous observation of member #31 by surveyor #29173 began at 11:21 a.m. At no time did a staff member enter the resident's room. At</p>	F 332			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	<p>Continued From page 32</p> <p>11:55 a.m. surveyor #29173 interviewed resident #31, who stated that his lunch meal was served at 12:30 p.m..."I always eat during the second meal time...No I don't keep any snacks in my room." At 12:30 p.m. resident #31 was set up and given a meal tray outside his room. At 12:32 p.m. Member #31 began to drink a glass of juice and consume some bread with lunch meat.</p> <p>On 2/4/13 at 11:50 a.m. surveyor #29173 asked CNA (Certified Nursing Assistant)-N what time member #31's lunch meal would be served. CNA-N stated, "We have two lunch seating's on this floor, one at 11:30 a.m. and a second seating at 12:30 p.m. He (Member #31) eats at 12:30 p.m. with the second seating."</p> <p>On 2/4/13 at 12:20 p.m. surveyor #29173 interviewed CNA-O regarding member #31's meal times. CNA-O stated, "he always eats in the second seating for lunch...around 12:30 p.m."</p> <p>On 2/4/13 at 12:21 p.m. surveyor #29173 interviewed CNA-G regarding member #31's meal times. CNA-G stated, "he eats in the second seating for lunch at 12:30 p.m....he always has."</p> <p>On 2/5/13 at 11:10 a.m. surveyor #29173 observed LPN-M, enter the room of member #31. A blood glucose measurement was obtained, the results were 286. According to the medical record, member #31 was ordered to receive Novolog insulin 8 units and a sliding scale of Novolog insulin. The order directed, "For blood sugars ranging from 251 to 300, give 6 units of insulin...at meals and at bedtime." LPN-M withdrew and administered 14 units of Novolog insulin at 11:12 a.m. No other medications or</p>	F 332			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 332	<p>Continued From page 33</p> <p>supplements were given at that time. Member #31 was immediately interviewed by surveyor #29173. Member #31 told surveyor he would not be eating the lunch meal until 12:30 p.m.</p> <p>2. On 2/5/13 at 11:14 a.m. surveyor #29173 observed LPN-M, obtained a blood glucose measurement on member #32, the results were 252. According to the medical record, member #32 was ordered to receive a sliding scale of Novolog insulin. The order directed, "For blood sugars ranging from 251 to 300, give 18 units of insulin...before meals and as needed." LPN-M withdrew and administered 18 units of Novolog insulin at 11:16 a.m. No other medications or supplements were given at that time. Member #32 did not receive his lunch meal until 11:46 a.m. Member #32 began eating a ham loaf at 11:48 a.m.</p> <p>3. On 2/5/13 at 11:20 a.m. surveyor #29173 observed LPN-M, obtained a blood glucose measurement on member #10, the results were 184. According to the medical record, member #10 was ordered to receive a sliding scale of Novolog insulin. The order directed, "For blood sugars ranging from 101 to 200, give 7 units of insulin." LPN-M withdrew and administered 7 units of Novolog insulin at 11:22 a.m. No other medications or supplements were given at that time. Member #10 and his wife were immediately interviewed by surveyor #29173. Member #10 and his wife told surveyor #29173 he would not be eating the lunch meal until 12:30 p.m. When surveyor #29173 asked member #10 if he would be eating anything prior to the lunch meal, member #10 stated, "I don't munch on anything before lunch."</p>	F 332			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 34 On 2/5/13 at 11:45 a.m. surveyor #29173 spoke with LPN-M regarding insulin administration. LPN-M verified that rapid-acting insulin, such as Novolog, should be administered zero to fifteen minutes prior to a meal or right after a meal; and the insulin recommendation form was contained in the medication room. LPN-M told surveyor #29173 she does all the insulin's for the third floor. LPN-M went on to say, "I start around 11:15 a.m...I've always done it this way...If there was a blood glucose measurement below one hundred, I would use my judgement and not give the insulin."	F 332		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.	F 425		

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 425	<p>Continued From page 35</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30571</p> <p>Based on observation, staff interview and policy review, the facility did not provide pharmaceutical services regarding the dispensing (proper labeling) of medications for 1 of 3 medication rooms. The second floor medication room refrigerator contained medications whose indications noted they were to be used or discarded within a certain time frame upon opening.</p> <p>Findings include:</p> <p>The facility's policy, Preparing Medications for Intramuscular, Subcutaneous and Intradermal Administration, revised April 2011, indicates multi-use vials are to be labeled with date opened and initials.</p> <p>Prescribing information for the use of Levemir contains instructions to throw away an opened vial that has been kept in the refrigerator after 42 days of use, even if there is insulin left in the vial.</p> <p>Patient information for the use of Novolin contains instructions to throw away an opened vial after 6 weeks (42 days) of use, even if there is insulin left in the vial.</p> <p>On 2/7/13 at 2:10 p.m., surveyor #30571 observed the second floor medication room. Upon review of the prescribed medications stored in the med room refrigerator, surveyor #30571 noted 3 vials of opened, undated insulin.</p>	F 425			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 36 1. Resident #34 was prescribed 20 units in the morning and 38 units in the evening of Levemir insulin. The opened bottle contained an affixed label that stated, "Discard after 42 days." The bottle was not labeled with a date or initials. 2. Resident #35 was prescribed 145 units in the morning and 110 units in the evening of Levemir insulin. The opened bottle contained an affixed label that stated, "Discard after 42 days." The bottle was not labeled with a date or initials. 3. Resident #15 was prescribed Novolin insulin per sliding scale instructions. The opened bottle was not labeled with a date or initials. On 2/7/13 at 2:15 p.m., surveyor #30571 interviewed LPN (Licensed Practical Nurse)-K who verified the vials were opened and undated. LPN-K stated, "These insulins should be dated. I'll dispose of them afterwards."	F 425		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441		

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 37</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Surveyor: 30571</p> <p>Based on observation, staff interview and policy review, the facility did not establish and maintain an infection control program designed to help prevent the development and transmission of disease and infection as evidenced by nursing staff not appropriately removing gloves and/or cleansing hands during 3 of 11 observations where hand hygiene was indicated.</p> <p>CNA (Certified Nursing Assistant)-D did not</p>	F 441			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 38</p> <p>remove soiled gloves before touching personal and shared items after providing peri-care for resident #7.</p> <p>CNA-E did not perform hand hygiene between glove changes or after removing soiled gloves before touching personal and shared items during the provision of peri-care for resident #8.</p> <p>CNA-F did not remove soiled gloves before touching personal and shared items after providing peri-care for resident #23.</p> <p>Findings include:</p> <p>The purpose of the facility's HANDWASHING/HAND HYGIENE policy, revised August 2012, is:</p> <ol style="list-style-type: none"> 1. To remove visible dirt, harmful organisms and body fluid from the hands. 2. To prevent the spread of disease. <p>The policy states, "Hand washing/hand hygiene shall be performed before & after direct member contact, after removing gloves, using the restroom, handling/serving/eating food, handling and/or contact with contaminated or potentially contaminated equipment or articles, after blowing your nose, putting your hand to face with sneezing or coughing and after smoking. Wearing gloves shall not be a substitute for hand hygiene."</p> <ol style="list-style-type: none"> 1. Resident #7's admission facesheet, dated 5/22/12, indicated the resident was admitted to the facility with diagnoses to include dementia and diabetes. The resident's most recent MDS 	F 441			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 39</p> <p>(Minimum Data Set), dated 12/11/12, indicated the resident required extensive assistance with transfers and toileting and was frequently incontinent of bowel and bladder.</p> <p>On 2/5/13 at 9:55 a.m., surveyor #30571 observed CNA-D provide incontinence cares for resident #7. CNA-D began by donning clean gloves and wheeling the resident to the bathroom. CNA-D assisted the resident to a standing position, pulled down the resident's pants and removed the resident's brief. CNA-D indicated the brief contained a small amount of urine. CNA-D wrapped the wet brief in the chux pad resting on the resident's wheelchair seat and removed gloves. Without performing hand hygiene, CNA-D donned clean gloves, placed a clean chux pad on the wheelchair and a clean brief on the resident before retrieving peri-wipes. CNA-D provided backside peri-care and, without removing gloves or sanitizing hands, adjusted the resident's brief, pulled up the resident's pants, tucked in the resident's shirt and touched the resident's wheelchair. CNA-D then assisted the resident to a sitting position, removed gloves and, without performing hand hygiene, touched the bathroom door handle while wheeling the resident out of the bathroom and into the bedroom. CNA-D then sanitized hands.</p> <p>On 2/5/13 at 10:06 a.m., surveyor #30571 interviewed CNA-D who verified the facility trains employees to remove gloves after peri-care and immediately sanitize hands. CNA-D stated, "I know I didn't do it. I didn't want to leave him standing too long." CNA-D also verified hand hygiene was not performed when the resident was in a sitting position before personal and</p>	F 441			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 40</p> <p>shared items of the resident were touched.</p> <p>2. Resident #8's admission facesheet, dated 8/1/12, indicated the resident was admitted to the facility with diagnoses to include dementia, Parkinson's disease and urinary retention. The resident's most recent MDS, dated 11/27/12, indicated the resident required extensive assistance with transfers and toileting, had a foley catheter and was frequently incontinent of stool.</p> <p>On 2/5/13 at 8:15 a.m., surveyor #30571 observed CNAs E and G perform incontinence cares for resident #8. Both CNAs donned clean gloves and prepared to transfer the resident from wheelchair to bed. CNA-E removed a blanket from the resident's lap and surveyor #30571 observed the resident to be naked from the waist down. Resident #8 was sitting in the wheelchair with an open bottom sling in place and a chux pad underneath. Surveyor #30571 observed the resident to be incontinent of a moderate amount of loose, watery stool which had soiled the sling. CNA-G retrieved wipes and provided backside peri-care while CNA-E used a wipe to clean the soiled sling. Resident #8 was subsequently transferred to bed where incontinence cares continued. CNA-E removed the sling from both the lift and underneath the resident as well as the resident's catheter leg strap. CNA-E provided frontal peri-care as well as catheter care and removed gloves. Without performing hand hygiene, CNA-E donned new gloves, proceeded to provide backside peri-care and again removed gloves. Without performing hand hygiene, CNA-E touched the resident's shirt and donned clean gloves before attaching the resident's leg strap and adjusting the catheter tubing. CNA-E</p>	F 441			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 41 then washed hands.</p> <p>On 2/5/13 at 8:35 a.m., surveyor #30571 interviewed CNA-E who verified the facility trains employees to sanitize hands between glove changes and/or after the removal of gloves during incontinence cares. CNA-E stated, "That's what I was doing, or trying to do. It's hard when you have a lot going on. At least, I changed my gloves."</p> <p>3. Resident #23's admission facesheet, dated 6/21/12, indicated the resident was admitted to the facility with diagnoses to include seizure disorder and severe dementia. The resident's most recent MDS, dated 12/21/12, indicated the resident required extensive assistance with transfers and toileting and was frequently incontinent of bowel and bladder.</p> <p>On 2/7/13 at 9:55 a.m., surveyor #30571 observed CNAs F and G provide incontinence cares for resident #23. CNA-G donned clean gloves, placed a sling around the resident's back and lifted the resident to a standing position. Both CNAs assisted with pulling down the resident's pants and removing the resident's brief which contained a small amount of urine. The resident was lowered onto an in-room commode after which CNA-G removed gloves and washed hands and CNA-F donned clean gloves. When the resident was finished using the commode, CNA-F lifted the resident to a standing position and provided both front and backside peri-care. Without removing soiled gloves, CNA-F placed a clean brief on the resident, pulled up the resident's pants and touched the lift, lift control and sling buckle. CNA-F then removed gloves</p>	F 441			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 42 and, without performing hand hygiene, unhooked and removed the lift sling, unfastened the leg strap on the lift, pulled out the resident's wheelchair, placed the foot pedals on the wheelchair and touched various items of the resident's clothing before assisting the resident with donning glasses. CNA-F then washed hands.	F 441			
F 498 SS=E	On 2/7/13 at 10:10 a.m, surveyor #30571 interviewed CNA-F who indicated she normally removes gloves after peri-care and sanitizes hands. CNA-F stated, "I didn't do either. I forgot." 483.75(f) NURSE AIDE DEMONSTRATE COMPETENCY/CARE NEEDS The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Surveyor: 30571 Based on observation, record review and staff interview, the facility did not ensure 4 of 11 nurse aides observed providing care were able to demonstrate competency in skills and techniques necessary to care for 4 (#7, #8, #23 and #17) of 6 residents observed requiring staff assistance for cares. CNA-D did not remove soiled gloves before touching personal and shared items after providing peri-care for resident #7.	F 498			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 498	Continued From page 43 CNA-E did not perform hand hygiene between glove changes nor after removing soiled gloves before touching personal and shared items during the provision of peri-care for resident #8. CNA-F did not remove soiled gloves before touching personal and shared items after providing peri-care for resident #23. CNA-B transferred member #17 to the toilet without the assistance of a gait belt for safety. Findings include: The purpose of the facility's HANDWASHING/HAND HYGIENE policy, revised August 2012, is: 1. To remove visible dirt, harmful organisms and body fluid from the hands. 2. To prevent the spread of disease. The policy states, "Hand washing/hand hygiene shall be performed before & after direct member contact, after removing gloves, using the restroom, handling/serving/eating food, handling and/or contact with contaminated or potentially contaminated equipment or articles, after blowing your nose, putting your hand to face with sneezing or coughing and after smoking. Wearing gloves shall not be a substitute for hand hygiene." 1. On 2/5/13 at 9:55 a.m., surveyor #30571 observed CNA-D provide incontinence cares for resident #7. In the bathroom, CNA-D assisted	F 498			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 498	<p>Continued From page 44</p> <p>the resident to a standing position, pulled down the resident's pants and removed the resident's brief which contained a small amount of urine. CNA-D wrapped the wet brief in the chux pad resting on the resident's wheelchair seat and removed gloves. Without performing hand hygiene, CNA-D donned clean gloves, placed a clean chux pad on the wheelchair and a clean brief on the resident before retrieving peri-wipes. CNA-D provided backside peri-care and, without removing gloves or sanitizing hands, adjusted the resident's brief, pulled up the resident's pants, tucked in the resident's shirt and touched the resident's wheelchair. CNA-D then assisted the resident to a sitting position, removed gloves and, without performing hand hygiene, touched the bathroom door handle while wheeling the resident out of the bathroom and into the bedroom.</p> <p>On 2/5/13 at 10:06 a.m., surveyor #30571 interviewed CNA-D who verified the facility trains employees to remove gloves after peri-care and immediately sanitize hands. CNA-D stated, "I know I didn't do it. I didn't want to leave him standing too long." CNA-D also verified hand hygiene was not performed when the resident was in a sitting position before personal and shared items of the resident were touched.</p> <p>2. On 2/5/13 at 8:15 a.m., surveyor #30571 observed CNAs E and G perform incontinence cares for resident #8. Following breakfast in the dining room, surveyor #30571 observed resident #8 naked from the waist down in a wheelchair with an open bottom sling in place and a chux pad underneath. Surveyor #30571 observed the resident to be incontinent of a moderate amount of loose, watery stool. CNA-G provided backside</p>	F 498			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 498	<p>Continued From page 45</p> <p>peri-care and the resident was transferred to bed. CNA-E removed the sling from both the lift and underneath the resident as well as the resident's catheter leg strap. CNA-E provided frontal peri-care as well as catheter care and removed gloves. Without performing hand hygiene, CNA-E donned new gloves, provided backside peri-care and again removed gloves. Without performing hand hygiene, CNA-E touched the resident's shirt and donned clean gloves before attaching the resident's leg strap and adjusting the catheter tubing.</p> <p>On 2/5/13 at 8:35 a.m., surveyor #30571 interviewed CNA-E who verified the facility trains employees to sanitize hands between glove changes and/or after the removal of gloves during incontinence cares. CNA-E stated, "That's what I was doing, or trying to do. It's hard when you have a lot going on. At least, I changed my gloves."</p> <p>3. On 2/7/13 at 9:55 a.m., surveyor #30571 observed CNAs F and G provide incontinence cares for resident #23. CNA-G donned clean gloves, placed a sling around the resident's back and lifted the resident to a standing position. Both CNAs assisted with pulling down the resident's pants and removing the resident's brief which contained a small amount of urine. The resident was lowered onto an in-room commode. When the resident was finished using the commode, CNA-F donned clean gloves, lifted the resident to a standing position and provided both front and backside peri-care. Without removing soiled gloves, CNA-F placed a clean brief on the resident, pulled up the resident's pants and touched the lift, lift control and sling buckle.</p>	F 498			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 498	<p>Continued From page 46</p> <p>CNA-F then removed gloves and, without performing hand hygiene, unhooked and removed the lift sling, unfastened the leg strap on the lift, pulled out the resident's wheelchair, placed the foot pedals on the wheelchair and touched various items of the resident's clothing before assisting the resident with donning glasses.</p> <p>On 2/7/13 at 10:10 a.m, surveyor #30571 interviewed CNA-F who indicated she normally removes gloves after peri-care and sanitizes hands. CNA-F stated, "I didn't do either. I forgot." Surveyor: 29791</p> <p>4. According to the face sheet, dated 7/23/12, member #17 was admitted on 7/26/11 with diagnoses to include legal blindness related to macular degeneration and glaucoma. The most recent comprehensive MDS (minimum data set) assessment, dated 7/17/12, indicated member #17 experienced 2 or more falls with no injury and 2 or more falls resulting in minor injury within the prior 3 months. The most recent quarterly MDS assessment, dated 1/15/13, indicates member #17 requires extensive assistance of one staff member for transfers between surfaces and the toilet. The electronic medical record indicated member #17 experienced a recent witnessed fall on 1/25/13 within the member's bathroom. Member #17 stepped back to sit on the toilet and fell to the member's buttocks.</p> <p>On 2/5/13 at 11:23 a.m., surveyor #29791 observed CNA-B transfer member #17 to the bathroom. Member #17 was seated in the recliner in the member's bedroom. CNA-B</p>	F 498			

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

PRINTED: 02/21/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 52A223	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/07/2013
NAME OF PROVIDER OR SUPPLIER WI VETERANS HM STORDOCK 700			STREET ADDRESS, CITY, STATE, ZIP CODE N2665 CTY RD QQ KING, WI 54946		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 498	<p>Continued From page 47</p> <p>removed the sensor mat, clip alarm and turned off the seat sensor alarm from the member's recliner. CNA-B assisted member #17 to stand from the recliner, and without a gait belt, assisted member #17 to transfer from the recliner chair to the bathroom with aid of only the walker. After member #17 used the toilet, CNA-B assisted member to stand and replace clothing. With assistance of only the walker, CNA-B assisted member #17 to a seated position in the member's wheelchair just outside the bathroom.</p> <p>On 2/7/13 at 2:00 p.m., surveyor #29791 interviewed ADON (Assistant Director of Nursing)-J regarding gait belt use. ADON-J stated that gait belts are expected to be used for any member who requires assistance with ambulation.</p> <p>Please see citation text at F323 for additional information regarding member #17 and CNA-B.</p>	F 498			