STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525717	A. BUILDING _____ B. WING _____	03/12/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
WI VETERANS HM MACARTHUR HALL	N2665 CTY RD QQ KING, WI 54946

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and record review, the facility did not consult with the physician for 1 Resident (R) (R39) of 22 sampled and 7 supplemental sampled residents when the resident experienced a change in condition with the potential for altered treatment. R39's medical record included documentation of skin changes and the need to alter treatment. The facility did not contact/notify the physician. Findings include: The facility's policy entitled Wound Prevention and Treatment Program (WPTP) with a review date of 2/5/2019 includes the following : Procedure: 1. When a skin change has been identified, the following will be started and/or updated: A. Initial wound evaluation is documented in EHR (electronic health record) by a RN (registered nurse) for significant changes. B. Appropriate treatment is initiated following the Skin Care Protocol WDVA 3331 or per provider order. C. Provider is notified of skin changes and initiation of treatment. On 3/12/2020, the Surveyor reviewed R39's medical record. R39 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. R39's MDS (Minimum Data Set) assessment dated [DATE], documented the R39 required extensive assistance of two staff for bed mobility and was dependent on staff for all transfers. R39's MDS also documented R39 was at risk for pressure injuries. R39's current plan of care with a revision date of 1/14/2020, indicated R39 had a skin integrity problem related to a history of pressure areas on R39's buttocks, fragile skin and maceration. On 3/10/2020 at 10:50 AM, the Surveyor interviewed R39. R39 indicated at times R39's buttocks gets sore. On 3/12/2020 at 8:49 AM, the Surveyor, with Licensed Practical Nurse (LPN)-L, observed R39 to have an open area on the right buttocks. The wound bed was observed to be pink and moist. The wound edges were defined and attached. The surrounding skin was pink and blanchable. The Surveyor observed LPN-L to apply [MEDICATION NAME] cream and [MEDICATION NAME] cream to the wound followed by a foam border dressing to cover the wound. On 3/12/2020, the Surveyor reviewed R39's Weekly Wound Observation. Documentation indicated a wound on R39's right buttocks described as dry skin - peeled off - superficial open area measuring 2.5 cm by 1.5 cm. Documentation included the following treatment plan: [REDACTED]. On 3/12/2020 at 12:11 PM, the Surveyor interviewed Registered Nurse (RN)-K. RN-K indicated RN-K was a wound care certified nurse. RN-K verified [MEDICATION NAME] cream, [MEDICATION NAME] cream and A, D and E ointment were ordered to treat the wound on R39's right buttocks. RN-K indicated the A, D and E ointment was added to the treatment plan on 3/10/2020 as a nursing order as A, D and E ointment does not require a physician's orders [REDACTED]. buttocks and the addition of the A, D and E ointment. RN-K stated R39's physician had not been updated on the open area or the addition of the A, D and E ointment likely because a physician's orders [REDACTED]. The Surveyor then asked RN-K given that this open area was new and required a change in the treatment plan should R39's physician been updated on the changes. RN-K stated R39's physician should have been updated on any changes in the treatment plan and any declines in the resident's skin.
F 0758 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and record review, the facility did not thoroughly monitor the use of [MEDICAL CONDITION] medications for 1 (Resident) (R32) of 5 residents reviewed for unnecessary medications. R32 was prescribed [MEDICATION NAME] (an antipsychotic medication) and was not monitored for possible adverse side effects of those medications related to TD (Tardive Dyskinesia). Findings include: R32 was admitted to the facility on [DATE], and had [DIAGNOSES REDACTED]. Review of R26's medical record revealed the following physician orders: ~ [MEDICATION NAME] 2 mg (milligrams) daily for depression. ~ Per Medication Administration Record [REDACTED]. On 3/12/2020, the Surveyor reviewed R32's care plan. R32's care plan with a review date of [DATE], included the intervention/task: BE AWARE: I am on antipsychotic medication(s), watch me for possible side effects/adverse reactions and notify the RN should any be present: EPS (Extrapyramidal Side effects), confusion, restlessness, TD (Tardive Dyskinesia), blurred vision, dry eyes, constipation, [MEDICAL CONDITION], anorexia, rashes, respiratory depression, [MEDICAL CONDITION]. On 3/10/2020 at 3:36 PM, the Surveyor interviewed RN (Registered Nurse)-I. RN-I indicated that following a review of R32's medical record, a TD screen was not completed on R32 since 2017. On 3/11/2020 at 11:45 AM, DON-B provided the Surveyor with R32's TD screen dated 3/11/2020. DON-B indicated the TD screen may not have been completed timely due to a computer error as the program is supposed to alert the staff when a TD screen needs to be completed. DON-B verified a TD screen should have been completed when the [MEDICATION NAME] was initially ordered. On 3/11/2020 at 1:00 PM, the Surveyor interviewed RN-H. RN-H indicated R32 did not have a TD screen completed since 2017. When R32 returned to the facility after a hospital stay the TD screen schedule was deleted and because R32 returned to the facility on the same dose of [MEDICATION NAME] and not a reduction in dose a TD screen was not completed. RN-H indicated a TD screen should have been completed.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff interviews, the facility did not ensure staff performed proper hand hygiene for 4 Residents (R) (R62, R78, R85 and R39) of 20 residents observed during provision of cares. In addition, the facility did not ensure sanitary distribution of drinking containers for 5 Residents (R34, R95, R82, R72 and R59) of 8 residents who attended an activity. The facility also did not ensure two washing machines used by residents were disinfected regularly which had the potential to affect all residents who used the washing machines for personal clothing (R17, R18, R65, R35, R2, R52, R36 and R10). In addition, the facility did not provide the proper waste receptacle for the disposal of used protective personal equipment (PPE) for 1 Resident (R39) of 1 resident reviewed on isolation precautions. Certified Nursing Assistant (CNA)-C and CNA-D did not perform proper hand hygiene when providing R62 incontinent cares. LPN (Licensed Practical Nurse)-E did not perform proper hand hygiene when providing R78's incontinent cares. CNA-G did not perform proper hand hygiene when providing R85 incontinent cares. CNA-O did not perform proper hand hygiene when emptying R39's catheter. ATA (Activity Therapy Assistant)-F did not distribute coffee cups in such a manner as to decrease the chance of contamination during an activity attended by R34, R95, R82, R72 and R59. Washing machines used by R17, R18, R65, R35, R2, R52, R36 and R10 were not disinfected. The facility did not provide a separate waste receptacle for used

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) PPE in R39's room. Findings Include: Facility provided policy titled Hand Hygiene with last revision date of 11/24/19 stated, Applies to: All employees, volunteers, and contracted services at the Wisconsin Veterans Home. Overview: Appropriate hand hygiene is essential in preventing transmission of infectious agents. Purpose: . To provide a clean and healthy environment for residents, staff, and visitors . 3. WVH (Wisconsin Veterans Home) endorses the My 5 Moments for Hand Hygiene approach promoted by the World Health Organization, which defines the key moments when health-care workers should perform hand hygiene. This approach recommends health-care workers to clean their hands: a. Before touching a patient b. Before clean/asceptic procedures c. After body fluid exposure/risk d. After touching a patient e. After touching patient surroundings 4. Other indications for hand hygiene include: a Before donning (putting on) and after removing gloves . 5. Wearing gloves IS NOT a substitute for hand hygiene . 1. On 3/10/20, Surveyor reviewed the medical record of R62. R62 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. or total loss of use of all four limbs and torso), Diabetes Mellitus (a disease in which blood sugar levels are too high) and Major [MEDICAL CONDITION] (a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life). On 3/10/20 at 12:54 PM, Surveyor observed CNA-C and CNA-D provide incontinent cares for R62. R62 was found to be incontinent of stool. CNA-C and CNA-D both donned two pairs of gloves, one set on top of the first set. During the course of cares, CNA-C cleansed R62's back perineal area. CNA-C removed the top set of gloves on CNA-C's hands and, without performing hand hygiene, applied clean incontinent product and linens. CNA-D removed R62's soiled linen and incontinent product, placed both on a designated spot, then removed CNA-D's top set of gloves. Without performing hand hygiene, CNA-D assisted R62 with clothing removal. CNA-C and CNA-D positioned R62 in bed and covered R62 with blankets. CNA-D removed the remaining glove from CNA-D's left hand and, without performing hand hygiene, touched R62's bed controls to adjust the height of R62's bed with CNA-D's bare left hand. CNA-D removed the remaining glove from CNA-D's right hand and, without performing hand hygiene, placed R62's perineal wash bottle on the counter and placed soiled gloves and wipes into garbage container. CNA-D then performed hand hygiene. CNA-C removed remaining gloves and performed hand hygiene. On 3/10/20 at 1:12 PM, Surveyor interviewed CNA-C who indicated CNA-C did not perform hand hygiene after perineal care because CNA-D had a second set on. CNA-C stated, That's easier and faster. Not sure if it's right or wrong but that's what I do. On 3/10/20 at 1:16 PM, Surveyor interviewed CNA-D who stated, when asked why CNA-D wore two sets of gloves, I do that all the time for (R62). (R62) [MEDICAL CONDITION] I always double glove in (R62's) room because I feel more comfortable. CNA-D verified CNA-D should have performed hand hygiene after glove removal before touching anything. 2. On 3/11/20, Surveyor reviewed the medical record of R78. R78 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. enough blood) affecting Right Dominant Side, [MEDICAL CONDITION] (damage or disease affecting nerves in roughly the same areas on both sides of the body, featuring weakness, numbness, and burning pain), Major [MEDICAL CONDITION] (a mental disorder characterized by a persistently depressed mood and long-term loss of pleasure or interest in life), Anxiety Disorder (exaggerated tension, worrying, and nervousness about daily life events), Diabetes Mellitus (a disease in which blood sugar levels are too high), [MEDICAL CONDITION] (gradual loss of kidney function), Chronic Pai[DIAGNOSES REDACTED] (pain that lasts for months and/or years after the body heals), [MEDICAL CONDITION] Fibrillation (an irregular and often rapid heart rate), and [MEDICAL CONDITION] (a chronic disorder that causes unprovoked, recurrent [MEDICAL CONDITION]). On 3/11/20 at 11:12 AM, Surveyor observed LPN-E and CNA-J provide incontinent care for R78. LPN-E donned gloves and checked R78 for incontinence by touching R78's incontinent product at the top and pulling outward to look. LPN-E removed the glove from LPN-E's left hand and, without performing hand hygiene, touched R78's bed controls to adjust the height of R78's bed with LPN-E's bare left hand. LPN-E removed the glove from LPN-E's right hand and performed hand hygiene. LPN-E and CNA-J completed R78's cares with no further concerns. On 3/11/20 at 11:30 AM, Surveyor interviewed LPN-E who verified LPN-E should have performed hand hygiene after glove removal and before touching R78's bed controls. 3. On 3/11/20, Surveyor reviewed the medical record of R85 which indicated R85 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. blood as well as it should), and [MEDICAL CONDITION] (a type of joint disease that results from breakdown of joint cartilage and underlying bone). On 3/12/20 at 8:36 AM, Surveyor observed CNA-G and LPN-E perform incontinent care for R85. During the course of cares, CNA-G cleansed R85's back perineal area and, without performing hand hygiene with expected glove change, applied clean incontinent product, assisted with repositioning R85, touched the wipe container to move it out of the way, fastened the straps of R85's clean incontinent product and adjusted R85's clothing. CNA-G then removed gloves and performed hand hygiene. CNA-G applied clean gloves and assisted in the application of heel protectors to R85's feet. CNA-G then removed gloves and, without performing hand hygiene, touched R85's bed controls to adjust the height of R85's bed. CNA-G then performed hand hygiene. On 3/12/20 at 8:55 AM, Surveyor interviewed CNA-G who verified CNA-G should have changed gloves and performed hand hygiene after peri care and before touching clean items. CNA-G further verified, when asked, that CNA-G should have performed hand hygiene after removing gloves and before touching bed controls. 4. On 3/12/2020, the Surveyor reviewed R39's medical record. R39 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. On 3/12/2020 at 8:49 AM, the Surveyor observed CNA-O empty R39's Foley catheter (a thin sterile tube inserted into the bladder to drain urine) drainage bag. CNA-O performed hand hygiene and donned gloves. CNA-O obtained a graduated cylinder (used to measure the volume of liquid) and alcohol wipes. After placing the graduated cylinder under the catheter drainage bag, CNA-O opened the drain valve, once empty CNA-O cleansed the drain valve with an alcohol swab and closed the valve. Without removing gloves or performing hand hygiene CNA-O opened the bathroom door using the door handle, emptied the graduated cylinder into the toilet, flushed the toilet, and again, opened the door leaving the bathroom. CNA-O then removed gloves and performed hand hygiene. On 3/12/2020 at 10:44 AM, the Surveyor interviewed CNA-O. CNA-O verified CNA-O should have removed gloves and performed hand hygiene after emptying the Foley drainage bag and before opening and closing the bathroom door. 5. On 3/12/20 at 8:28 AM, Surveyor observed ATA-F prepare coffee cups and pass out to residents attending an activity on 2nd floor. There were a total of eight residents attending the activity. During the process of placing filled coffee cups on the tables, ATA-F was observed to hold the coffee cups given to R34, R95, R82, R72 and R59 by holding the coffee cup with ATA-F's bare fingers curled around the rim of the coffee cup from above the cup where residents would be placing their lips to drink the coffee. On 3/12/20 at 9:30 AM, Surveyor interviewed ATA-F who indicated the facility provided annual training to all employee on infection prevention. After discussion of Surveyor observation, ATA-F verified ATA-F should not have held the coffee cups by the rims and stated, Sometimes I get in a hurry. On 3/12/20 at 11:12 AM, Surveyor interviewed DON (Director of Nursing)-B who stated, I would expect staff to follow policy. Surveyor discussed with DON-B the care observations made which affected R62, R78 and R85 DON-B verified hand hygiene should always be provided after glove removal and before touching clean items. DON-B verified staff should not have more than one set of gloves on at a time while providing cares. Surveyor discussed with DON-B the observation of coffee pass during trivia activity which affected R34, R95, R82, R72 and R59. DON-B verified the appropriate way to hold a cup to prevent contamination is to hold the cup below the rim. 6. On 3/11/2020 at 12:40 PM, the Surveyor observed two washing machines provided for the residents who wish to do their own personal laundry (R17, R18, R65, R35, R2, R52, R36 and R19). Upon opening the washing machine doors the Surveyor noted a strong odor. A black substance resembling mold/mildew was observed on the washing machine door seals coating the entire seal of both machines. The Surveyor also observed the same substance on the bottom and sides of the sink located next to the washing machines. On 3/11/2020 at 3:00 PM, the Surveyor interviewed Nursing Home Administrator (NHA)-A. NHA-A indicated the washing machines were donated to the facility by a member (resident). NHA-A indicated NHA-A did not recognize an odor and did not know what the black substance on the washing machine door seals or in the sink were. Surveyor asked NHA-A whose responsibility it was to clean the washing machines, was there a cleaning schedule and if the machines required routine maintenance cleaning. NHA-A was not aware of a cleaning schedule and referred Surveyor to housekeeping. On 3/12/2020 at 8:28 AM, the Surveyor observed a sign on the Hall 3 laundry room door that indicated the personal laundry washing machines were unavailable for use until further notice. On 3/12/2020 at 10:20 AM, the Surveyor interviewed Housekeeper (HK)-M. HK-M indicated the inside of the washing machines are cleaned weekly. HK-M indicated the black substance has been present on the washing door seals and in the sink for a long time. HK-M indicated a product called Alpha Cleaner is used on the washing machines and the sink as HK-M is unable to use bleach due to facility policy. HK-M indicated the members should leave the washing doors open after use but they do not remember to do so. 7. On [DATE]20 at 12:13 PM, the Surveyor observed a sign on R39's room door indicating facility staff should follow enhanced precaution procedures. Personal protective equipment (PPE) was located in the hall next to R39's room door. On [DATE]20, the Surveyor reviewed R39's medical record. R39's medical record included the following documentation: ~ On [DATE]20 at 6:53 AM, Nursing-Health Status Note Focused Assessment: FOLLOW-UP SINUSITIS (sinus infection): A&O X 3. Lung sounds CTA

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) (clear to auscultation) throughout. HRR (heart rate regular). Slight congested cough noted. No respiratory distress noted. Normal bowel sounds present x 4. Foley catheter patent and draining clear yellow urine. C/O (complaints of) sinus pressure, nasal congestion and coughing up grey sputum - writer did not observe a productive cough. C/O little pain to joints below both ears. Denies new muscle aches. Denies headache, head congestion, runny nose, sore throat, chills, increase weakness or tiredness or decrease appetite. Denies dizziness but than stated he does have [MEDICAL CONDITION] again and that it comes and goes. Remains on transmission based precautions - droplet. Remains on antibiotic for sinusitis with no adverse effects. VS (vital signs): 124/66 98.2 86 24 93% 2L/min NC (linked) On [DATE]20 at 12:20 PM, the Surveyor donned PPE and entered R39's room to interview R39. Following completion of the interview the Surveyor was unable to locate a receptacle to dispose of the PPE requiring the Surveyor to place the PPE in the resident's bedside garbage can. On 3/10/2020 at 10:50 AM, the Surveyor interviewed Licensed Practical Nurse (LPN)-L. LPN-L indicated there was not a separate garbage can for PPE in R39's room. On 3/10/2020 at 10:05 AM, the Surveyor interviewed Housekeeper (HK)-M. HK-M indicated when a member (resident) is placed on precautions a separate garbage can should be placed in the member's room. HK-M indicated a separate garbage can should have been brought up to R39's room. HK-M indicated HK-M was unaware if this had occurred as HK-M had not been if R39's room yet. On 3/12/2020 at 8:00 AM, the Surveyor interviewed Infection Preventionist (IP)-N. IP-N verified when a member is placed on isolation, a separate garbage can for the disposable of PPE is required.