STATE OF WISCONSIN / DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance / Bureau of Nursing Home Resident Care

TOP TEN FEDERAL HEALTH CITATIONS – NATION, STATE, REGIONAL OFFICE – 1/1/2015 – 7/23/2015

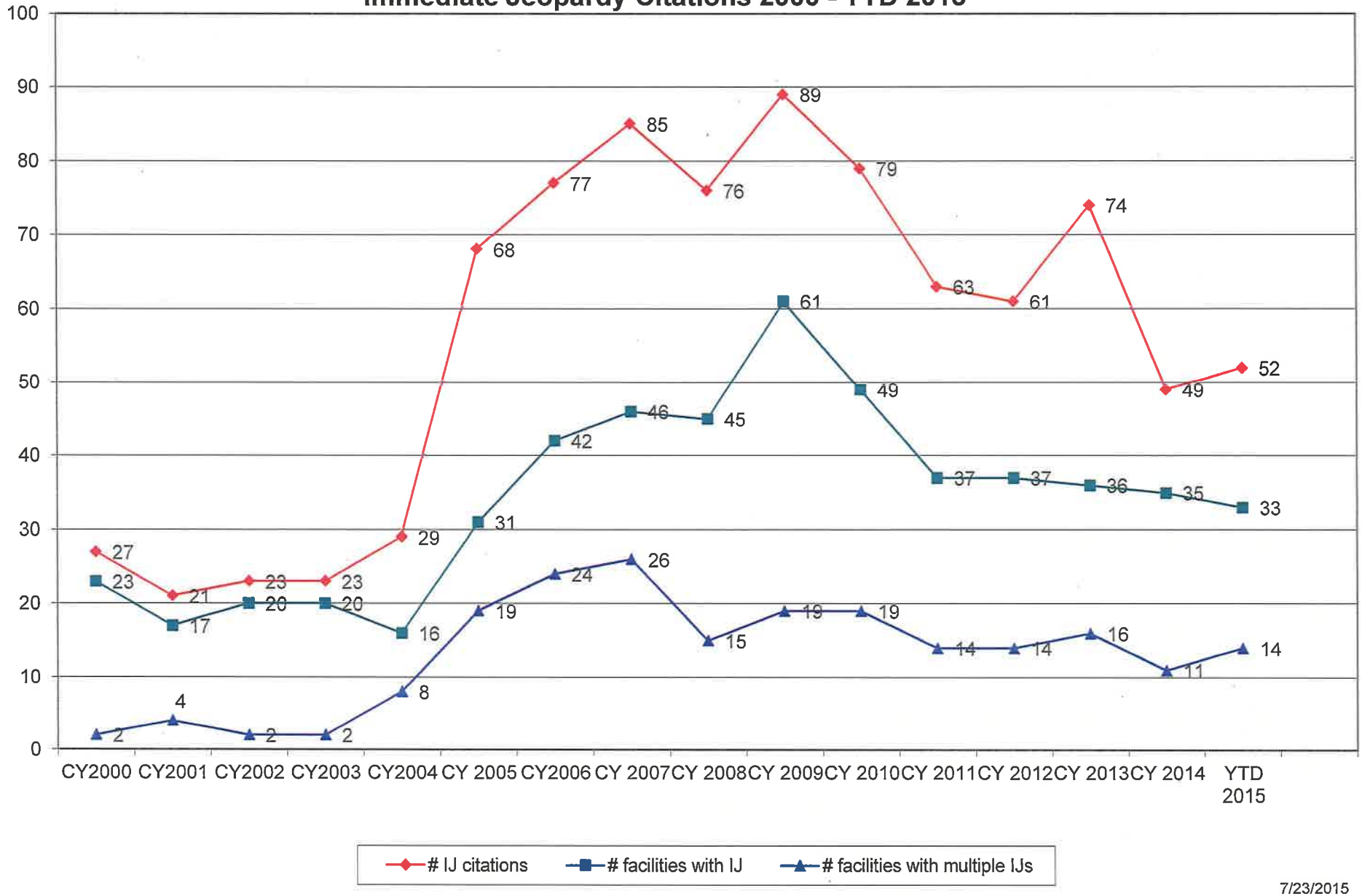
Nation	State	Southern (Madison)	Southeastern (Milwaukee)	Northeastern (Green Bay)	Northern (Rhinelander)	Western (Eau Claire)
F323 - supervision to prevent accidents (2867)	F441 - infection control (122)	F441 - infection control (22)	F323 - supervision to prevent accidents (43)	F314 - prevention of pressure ulcers (37)	F441 - infection control (22)	*F280 - periodically review and revise the plan of care (30)*
F441 - infection control (2801)	F323 - supervision to prevent accidents (118)	F225 - investigate allegations of abuse (21)	F309 - care promotes highest level of well-being (32)	F441 - infection control (29)	F371 - store, prepare, and serve food under sanitary conditions (15)	F441 - infection control (26)
F371 - store, prepare, and serve food under sanitary conditions (2466)	F225 - investigate allegations of abuse (99)	F323 - supervision to prevent accidents (21)	F225 - investigate allegations of abuse (29)	F225 - investigate allegations of abuse (26)	F329 - drug regimen is free of unnecessary drugs (14)	F323 - supervision to prevent accidents (22)
F309 - care promotes highest level of well-being (2386)	F314 - prevention of pressure ulcers (98)	F282 - care in accordance with care plan (17)	F314 - prevention of pressure ulcers (26)	F371 - store, prepare, and serve food under sanitary conditions (24)	F315 - services to restore normal bladder function and prevent infection (13)	F371 - store, prepare, and serve food under sanitary conditions (21)
F279 - develop comprehensive care plan (1572)	F371 - store, prepare, and serve food under sanitary conditions (85)	F329 - drug regimen is free of unnecessary drugs (17)	F441 - infection control (23)	F315 - services to restore normal bladder function and prevent infection (23)	F279 - develop comprehensive plan of care (11)	F309 - care promotes highest level of well-being (20)
F329 - drug regimen is free of unnecessary drugs (1555)	F309 - care promotes highest level of well-being (85)	F309 - CARE PROMOTES HIGHEST LEVEL OF WELL-BEING (17)	F329 - drug regimen is free of unnecessary drugs (19)	F323 - supervision to prevent accidents (21)	F323 - supervision to prevent accidents (11)	F282 - care in accordance with care plan (18)
F431 - labeling of drugs and biological (1538)	F329 - drug regimen is free of unnecessary drugs (77)	F425 - medication system assures accurate receipt and administration (16)	F279 - develop comprehensive care plan (19)	F425 - medication system assures accurate receipt and administration (19)	F282 - care in accordance with care plan (10)	F279 - develop comprehensive care plan (17)
F514 - documentation (1365)	F425 - MEDICATION SYSTEM ASSURES ACCURATE RECEIPT AND ADMINISTRATION (73)	*F157 - promptly consult with MD after significant condition change (16)*	F425 - medication system assures accurate receipt and administration (18)	*F157 - PROMPTLY CONSULT WITH MD AFTER SIGNIFICANT CONDITION CHANGE (17)*	F309 - care promotes highest level of well-being (10)	F225 - INVESTIGATE ALLEGATIONS OF ABUSE (15)
F282 - care in accordance with care plan (1200)	F315 - services to restore normal bladder function and prevent infection (69)	F314 - prevention of pressure ulcers (14)	*F514 - documentation (16)*	*F226 – DEVELOP AND IMPLEMENT POLICIES AND PROCEDURES PROHIBITING ABUSE (16)*	F425 - MEDICATION SYSTEM ASSURES ACCURATE RECEIPT AND ADMINISTRATION (9)	F314 - prevention of pressure ulcers (13)
F225 - INVESTIGATE ALLEGATIONS OF ABUSE (1181)	F282 - care in accordance with care plan (57) F279 – DEVELOP COMPREHENSIVE CARE PLAN (57)	F371 - store, prepare, and serve food under sanitary conditions (14)	*F157 - PROMPTLY CONSULT WITH MD AFTER SIGNIFICANT CONDITION CHANGE (12)*	F329 - drug regimen is free of unnecessary drugs (14) *F156 – Provision of information regarding rights, rules, services, and charges (14)*	F225 - INVESTIGATE ALLEGATIONS OF ABUSE (8) F314 - prevention of pressure ulcers (8)	F329 - drug regimen is free of unnecessary drugs (13)

ITALICS – not in State's Top Ten BLUE/SMALL CAPS - new to Top Ten compared to entity's 2014 data

Source: WI DQA
Distributed by LeadingAge Wisconsin, July 2015

STATE OF WISCONSIN/Department of Health Services
Division of Quality Assurance/Bureau of Nursing Home Resident Care

Immediate Jeopardy Citations 2000 - YTD 2015

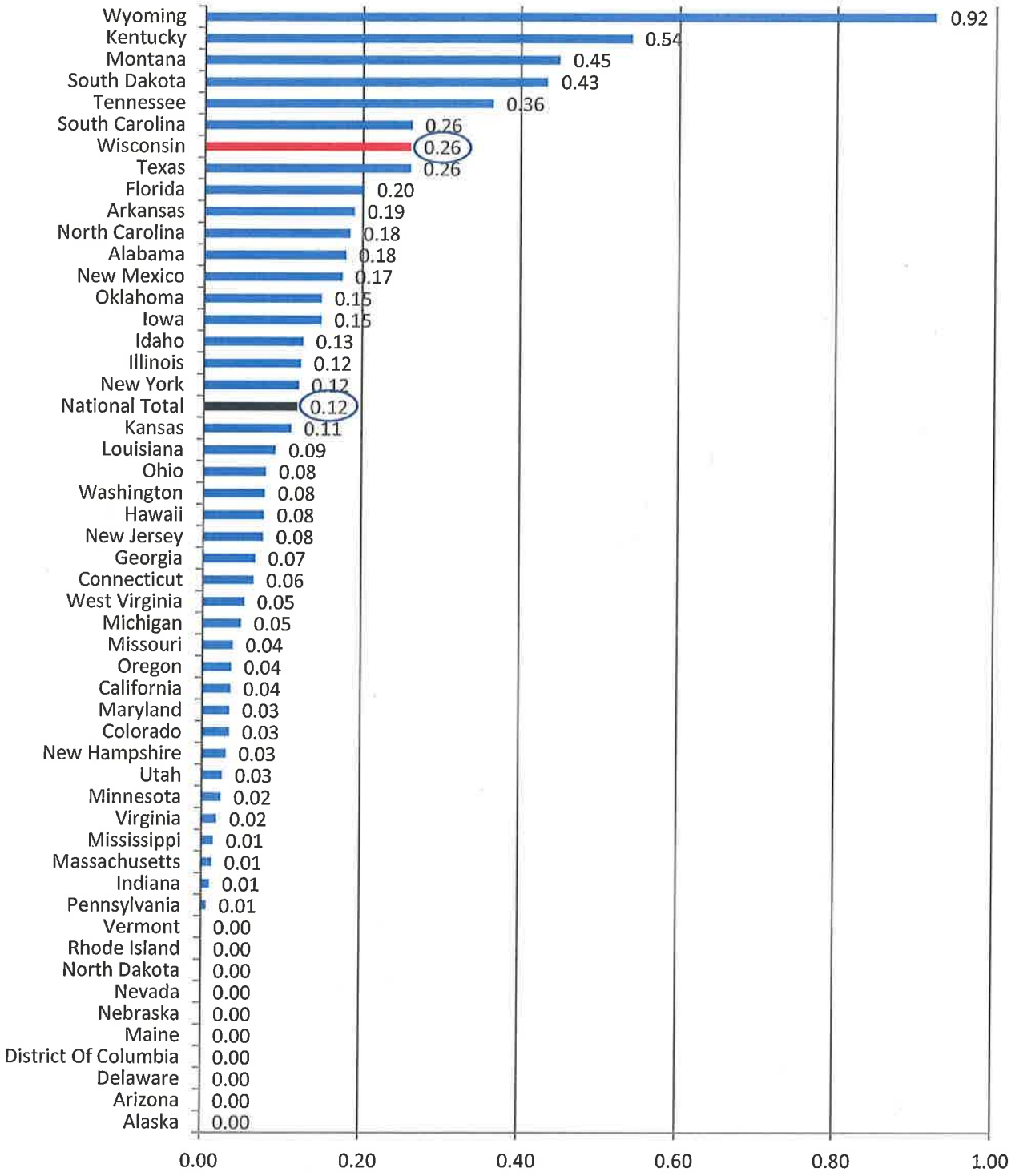


7/23/2015

Source: WI DQA
Distributed by LeadingAge Wisconsin, July 2015

STATE OF WISCONSIN / DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance / Bureau of Nursing Home Resident Care

Average # Immediate Jeopardy Citations per Recertification Survey First Half 2015 (1/1 - 6/30/15)



Source: WI DQA
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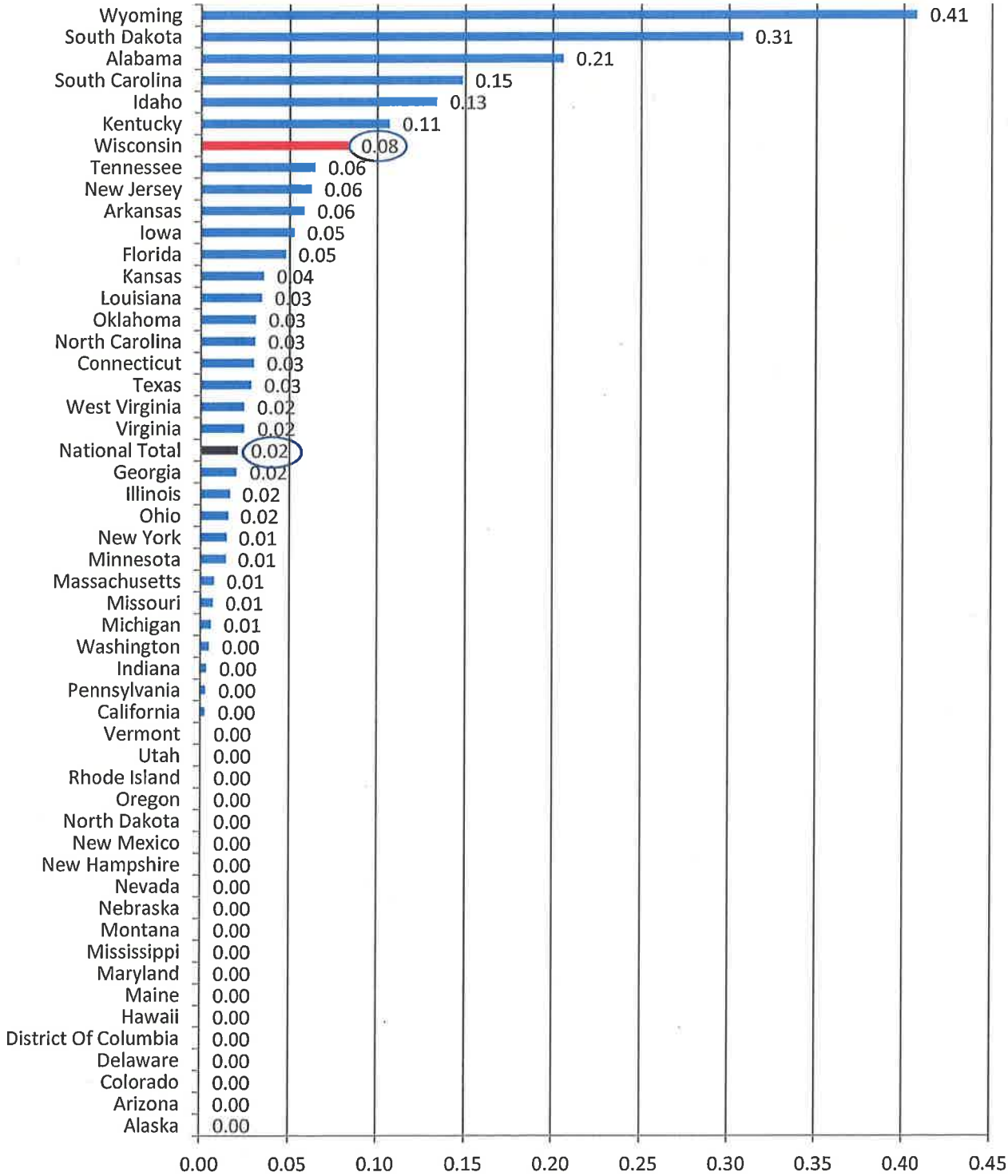
STATE OF WISCONSIN / DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance / Bureau of Nursing Home Resident Care

Average # Immediate Jeopardy Citations per Complaint Survey First Half 2015 (1/1 - 6/30/15)



Source: WI DQA
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STATE OF WISCONSIN / DEPARTMENT OF HEALTH SERVICES
Division of Quality Assurance / Bureau of Nursing Home Resident Care

WISCONSIN
IMMEDIATE JEOPARDY CITATIONS
1/1/15 – 7/24/15

Tag	*Description of Regulation*	*Number of Citations*
F309	Care and services to attain/maintain highest practicable level of well-being	14
F157	Facility immediately consults with a physician when a resident has a significant change in condition	9
F323	Facility is free of hazardous environment; provides supervision and assistive devices to prevent accidents	5
F314	Services and treatment to prevent and/or to heal pressure ulcers	5
F441	Infection control program designed to investigate, control and prevent the spread of infection	4
F327	Facility must provide each resident with sufficient fluid intake to maintain proper hydration and health	4
F329	Each resident's drug regimen is free of unnecessary drugs	3
F281	Professional standards of practice	2
	6 tied with one citation each (F225, F226, F325, F328, F371, F463)	1

SUMMARY OF IJ CITATIONS ISSUED IN 2015
Statement of Deficiency has been served and a Plan of Correction received

F157. (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is--
(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
(B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
(C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment)…

- Resident's intake was significantly less than required, especially over the last three days before discharge when it was 91-100% less than required. This occurred despite CNA efforts to get the resident to drink. Staff did not notify the MD of the resident's significantly changed condition.

- The facility did not notify MD when a resident who had been placed on an increased dose of Coumadin had an emesis of approximately 30 ml of blood. Resident was hospitalized the next day after a dark red emesis. Protime was greater than 120 (reference range is 10.1-12.9) and INR (International Normalized Ratio) > 10.0 (reference range is .9-1.1). Resident diagnosed with hemorrhage of gastrointestinal tract.

- Resident's intake significantly decreased after developing noro virus. Despite a temporary care plan to push fluids and assess for dehydration, staff did not follow through. Staff also continued giving Lasix. Staff did not consult with the physician regarding the resident's changing condition. Resident admitted to hospital and required three days of IV fluids.

- Resident who previously had no episodes of hypoglycemia became unresponsive with a blood sugar of 57. Given sugar and responded but nurse did not notify MD or chart on the incident. No monitoring of the resident the next day despite limited food intake and no MD contact regarding the resident's changed condition. Resident again became unresponsive (blood sugar 29 or 49) and then became pulseless and non-breathing.

- Resident admitted with recent leg fracture and developed symptoms indicative of a pulmonary embolus. Nursing did not comprehensively assess and did not notify the physician of the change in condition, leading to the resident's death. MD indicated resident's chances for survival would have been much higher had he been consulted when the condition change first occurred.

- When an LPN noted that a resident had slurred speech, she contacted the on-call RN who said she would talk to the Director of Nurses (DON) in the morning. There was no RN assessment at the time and no consult with a physician. Although the resident's symptoms continued over the next ten day, the primary care physician did not know of the resident's changed condition until he made routine rounds ten days later. MD indicated any physician would have given immediate orders if they had been contacted at the onset.

- Facility was aware that the resident's underlying infection was resistant to Cipro; however, the facility did not inform the physician and continued to give Cipro. As the resident's condition declined, nursing staff consulted with the physician only once and then failed to give complete information regarding the resident's condition. Additionally, as daily fluid intakes showed the resident was taking in less than 50% of the fluids she required, staff did not consult with the physician, did not revise the care plan with options for increasing fluid intake, and did not consult with the family regarding intravenous feedings.

- The facility failed to promptly consult with a physician when a venous or arterial ulcer doubled in size and failed to consult with the physician when the ulcer had an odor and the facility feared that the resident might develop gangrene. The resident developed a gangrenous, unstageable pressure ulcer and needed an above-the-knee amputation of the leg. The physician stated the leg may have been saved had the facility sought earlier medical intervention.

F225. 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 to other officials in accordance with State law through established procedures (including to the State survey and certification agency)…The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
F226. The facility must develop and 8implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

- CNA threatened to shower a resident who had a life-long fear of water due to a near-drowning incident as a child and was verbally abusive to the resident. NHA took CNA's word for what happened (as she did in other instances) and did not investigate thoroughly and, thus, allowed the

CNA to continue working. Facility did not have a system in place for investigating allegations since the two who previously had the position were fired.

F281. The services provided or arranged by the facility must-- (i) Meet professional standards of quality.

- Resident with diabetes became unresponsive due to hypoglycemia. Nurse gave sugar but did not notify MD or chart on the incident. No monitoring of the resident the next day despite limited food intake. Resident again became unresponsive (blood sugar 29 or 49) and then became pulseless and non-breathing. CNAs incorrectly gave CPR (on bed because couldn't find crash cart) and facility delayed at least 25 minutes before calling 911.

- When a resident's tracheostomy tube became partially dislodged, three nurses, who did not have proper training for tracheostomy care, failed to reinsert the trach tube according to professional standards of practice (failed to lie the resident down and fully extend her head and neck, failed to keep emergency equipment such as an obturator and tube of a smaller size in the resident's room, failed to use an obturator to insert the tube, failed to keep the opening moist, and failed to recognize this as an emergency and seek emergent transport from the facility). The facility did not transport the resident to the emergency room until 93 minutes later. ER staff noted a false passage from attempts to jam the tube into the resident's throat. The resident died.

F309. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

- Facility failed to provide CPR to a full-code resident who was on hospice care.

- Facility did not provide appropriate monitoring, assessment, and care of a diabetic resident who injured her foot. Foot eventually became necrotic and infected with MRSA and dry gangrene.

- Facility failed to provide appropriate pain management for two residents who experienced recurrent, episodic excruciating pain with cares and/or treatments.

- Resident admitted with recent leg fracture and developed symptoms indicative of a pulmonary embolus. Nursing did not comprehensively assess and did not notify the physician of the change in condition, leading to the resident's death.

- When resident became unresponsive, staff did not implement CPR because resident was too big and they didn't know how to move him from his wheelchair.

- Facility staff failed to recognize and assess a resident who had a significant change in condition, including changes in behaviors, changes in the resident's ability to assist with feeding himself and drinking and overall changes in intake and failing to recognize that the resident's fluid intake was low. The resident ultimately became unresponsive and had to be transported to the hospital, where the physician personally spent 120 minutes performing lifesaving critical interventions.

- Facility staff did not perform cardiopulmonary resuscitation on a resident who was full-code. RN thought the resident "looked dead" even though CNAs stated the resident was warm to touch.

- Resident became unresponsive (blood sugar 29 or 49) and then became pulseless and non-breathing. CNAs incorrectly gave CPR (on bed because couldn't find crash cart) and facility delayed at least 25 minutes before calling 911.

- Resident had a history of quickly becoming septic. When resident developed an elevated temperature, nursing did not appropriately monitor or assess and did not notify MD as had been requested. Resident was admitted to hospital in septic shock.

- On-call RN did not come in to assess a resident when told by an LPN that the resident had slurred speech and symptoms of a possible stroke. There was no RN assessment of the resident over the next ten days, when the resident was seen by the physician during routine rounds.

- The facility failed to provide nursing assessment and care that could have led to earlier diagnosis of the resident's bowel obstruction as no one was monitoring the bowel elimination sheets. The resident was admitted to the hospital and was noted to have a significant amount of stool in the colon. The resident was diagnosed with a bowel obstruction, but the intestines were so ischemic and necrotic that the surgeon could not operate. The family elected to place the resident on hospice care and he returned to the facility. Over the next 24 hours, until the resident's death, the facility did not adequately address the significant pain the resident was experiencing.

- When a resident developed skin ulcers, the facility failed to identify if the ulcers were venous or arterial, failed to refer the resident with venous or arterial ulcers to a vascular specialist as directed in the facility's policy, failed to change the care plan with changes in treatment as the ulcer on the left foot worsened, and failed to promptly get an order for a wound clinic consult when the facility feared that the foot might become gangrenous. The resident developed a gangrenous, unstageable pressure ulcer and needed an above-the-knee amputation of the leg.

F314. Based on the comprehensive Assessment of a resident, the facility must ensure that--
(1) 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
(2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

- Facility failed to provide appropriate monitoring and care to prevent development and worsening of facility-acquired pressure ulcers for three residents.

- Six residents developed multiple stage 2 and stage 3 pressure ulcers without adequate monitoring or appropriate intervention when the pressure ulcers worsened.

- Facility did not ensure an RN assessment when the LPN identified that a pressure ulcer had re-developed. Subsequently, the facility did not evaluate the anti-thrust cushion in this resident's wheelchair and did not implement any changes to the care that the CNAs were to provide. CNA care cards, in relation to pressure ulcer prevention, simply directed them to elevate heels when he allowed and to lie down after lunch. There was no contact with the physician and no change in orders. Resident developed a stage 4 pressure ulcer with sepsis.

- Staff did not recognize that the resident's illnesses had made her even more immobile than what she had been, which, in turn, increased her risk for pressure ulcer development. Staff did not respond by implementing more aggressive measures to prevent a pressure ulcer from developing until after the area had already broken down. Even then, staff did not seek new treatments when weekly rounds showed the pressure ulcer had deteriorated. The resident, subsequently, developed an infected, unstageable pressure ulcer.

- Nursing did not accurately identify the resident's risk for pressure ulcer development on admission, did not revise the care plan when a resident's pressure ulcers opened, did not do weekly assessment and monitoring of the pressure ulcers, did not determine whether two-hour repositioning was frequent enough, did not ensure that the resident's bed was free of barriers that would reduce the pressure-relieving qualities of the bed, and did not provide appropriate treatments for the stage of the pressure ulcers. The resident developed two stage 3 pressure ulcers

which, after debridement, were both stage 4 pressure ulcers. She has needed to have a colostomy to keep stool off the areas.

F323. The facility must ensure that –
(1) The resident environment remains as free from accident hazards as is possible; and
(2) Each resident receives adequate supervision and assistance devices to prevent accidents.

- Newly admitted resident eloped with visitors who had swiped the exit door. CNA didn't know if she was supposed to be checking on him and facility had no measures in place to ensure residents could not leave when visitors left.

- (1). Following extensive remodeling, facility did not alarm the exit doors from the unit, which allowed one resident to get outside undetected. Facility became aware when a construction worker found the resident tipped over in wheelchair. (2). Because of remodeling, the audio portion of the nurse call system was not functioning. A resident sustained a subdural hematoma when she fell from bed trying to get to the bathroom without assistance because no one responded to the call light.

- A resident eloped twice from the facility during the winter months. The first time, staff did not check outside or do a head count when a door alarm sounded late at night. The resident was found by the police. The second time, the resident eloped because the facility had just installed a new alarm system and had not yet put the new bracelets on the residents who had been identified as elopement risks. An off-duty staff person happened to spot the resident.

- Surveyor observed a resident underneath a hair dryer in the beauty shop who had a nasal cannula in her nose and who was receiving liquid oxygen from an attached tank. The surveyor confirmed that the hair dryer was one that was producing heat and not one that just dried the hair by circulating air. Two other female residents who receive liquid oxygen and both stated they have had their hair dried underneath the dryer while their oxygen was running.

- The facility did not assess whether residents needed a grab bar and did not thoroughly assess the risks the grab bar might pose. In this case, the resident, who did not use the grab bar, had a history of falling from bed, and was known to sleep in a fetal position with her head near the grab bar, was found with her neck pressed against a bar of the grab bar and her body weight pulling her neck into the grab bar. She was not breathing and had a pulse of 20. A facility nurse stated the resident would have died if they had not found the resident when they did.

F325. The facility must ensure that a resident…Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that his is no possible; and receives a therapeutic diet when there is a nutritional problem.

- A resident, who required a soft food diet, received a hot dog when the occupational therapist took him to the wrong dining, room, and the cook and dietary aide failed to note his dietary restrictions on the back of the dietary card/meal ticket. The resident choked and required the Heimlich maneuver at least three times to expel food. Despite this, the resident became pulseless and non-breathing. He revived but has suffered anoxic encephalopathy.

F327. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

- Resident's intake significantly decreased after developing noro virus. Despite a temporary care plan to push fluids and assess for dehydration, staff did not follow through with these approaches to ensure adequate fluid intake. Staff also continued giving Lasix. Resident admitted to hospital and required three days of IV fluids.

- Despite documenting that staff should encourage the resident to drink, this was not carried over to the CNA care cards. Although this resident drank fluids at meal time, staff did not have water in his room because he required thickened fluids. Because he could not independently drink, he needed staff to provide him with fluids between meals. Staff documented that the resident was eating and drinking poorly after 3/15/15, but no one identified that a problem existed, assessed the resident, or implemented interventions to help the resident maintain adequate fluid intake. Resident was diagnosed with dehydration at the emergency room and required 6.9 liters of fluid to rehydrate.

- The facility failed to ensure that a resident, who was being treated with an ineffective antibiotic for an infection, maintained appropriate fluid intake (fluid intake in the week before the resident was hospitalized was 55% less than what the resident needed. The resident died due to severe dehydration with hypernatremia, e-coli UTI, dementia with obtundation, and possible aspiration.

- The facility failed to assess a resident's risk for dehydration on admission ("assessment" was done by an LPN), failed to monitor the resident's fluid intake, and failed to assess the resident's hydrational status, particularly as the resident was losing weight. Facility staff did not transcribe the dietitian's recommendation for a supplement and did not get an order for it. The resident was hospitalized after suffering a seizure, which was attributed to hypernatremia. The resident required 4.8 liters of fluid to rehydrate.

F328. The facility must ensure that residents receive proper treatment and care for the following special services…Tracheostomy care.

- When a resident's tracheostomy tube became partially dislodged, three nurses, who did not have proper training for tracheostomy care, failed to reinsert the trach tube according to professional standards of practice (failed to lie the resident down and fully extend her head and neck, failed to keep emergency equipment such as an obturator and tube of a smaller size in the resident's room, failed to use an obturator to insert the tube, failed to keep the opening moist, and failed to recognize this as an emergency and seek emergent transport from the facility). The facility did not transport the resident to the emergency room until 93 minutes later. ER staff noted a false passage from attempts to jam the tube into the resident's throat. The resident died.

F329. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used... (iii) Without adequate monitoring…

- When a nurse practitioner inappropriately gave orders to increase the Coumadin dose of a resident who had been stable, the facility did not monitor the resident and did not notify MD when the resident had an emesis of approximately 30 ml of blood. Resident was hospitalized the next day after a dark red emesis. Protime was greater than 120 (reference range is 10.1-12.9) and INR (International Normalized Ratio) > 10.0 (reference range is .9-1.1). Resident diagnosed with hemorrhage of gastrointestinal tract.

- Facility missed a lab for PT/INR monitoring of a resident who was on Coumadin and did not closely monitor. One month later, the resident developed a subdural hematoma from excessive Coumadin.

- The facility continued to give Cipro when culture tests had proven resistant, which allowed the underlying infection to essentially go untreated. As the resident's condition worsened, she quit taking fluids and she became dehydrated. Notes from the emergency room indicated the resident would likely die from the septic infection that she had. The resident died due to severe dehydration with hypernatremia, e-coli UTI, dementia with obtundation, and possible aspiration.

F371. The facility must store, prepare, distribute and serve food under sanitary conditions.

- The facility served poached eggs to a resident using non-pasteurized eggs. The cook on the unit was unaware that there was a difference between pasteurized and non-pasteurized eggs and did not recognize that the wrong type of eggs had been brought to the unit. The cook admitted to not having a thermometer and not taking the temperature of the eggs.

F441. 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 (3) Maintains a record of incidents and corrective actions related to infections.

- Facility failed to identify an outbreak of flu or acute respiratory illness and failing to put appropriate measures in place to prevent the spread of an infection.

- Staff did not isolate residents or implement appropriate precautions for residents who became ill will flu-like symptoms or acute respiratory distress.

- After the Infection Preventionist quit because her hours had been reduced, the facility gave these duties to the DON, who did not have training in infection control. When residents became ill with gastrointestinal symptoms, the DON did not recognize that an outbreak had occurred, did not isolate the residents who were ill, and delayed 4-5 days before implementing measures to prevent the spread of the illness. The outbreak eventually spread to all units and affected almost 20% of residents.

- The facility did not recognize when an outbreak (influenza-like illness) had occurred, did not isolate residents who became ill, did not use appropriate precautions when caring for ill residents, did not stop staff from floating, and did not require sick staff to remain home until they had been symptom free for 48 hours. Eventually, 36% of residents became ill and one was hospitalized with gastroenteritis.

F463. The nurses' station must be equipped to receive resident calls through a communication system from--(1) Resident rooms; and (2) Toilet and bathing facilities.

- Because of remodeling, the audio portion of the nurse call system was not functioning. A resident sustained a subdural hematoma when she fell from bed trying to get to the bathroom without assistance because no one responded to the call light.