WISCONSIN STATE LEGISLATURE

Joint Audit Committee

Committee Co-Chairs:
State Senator Robert Cowles
State Representative Samantha Kerkman

March 28, 2016

Mr. John Scocos, Secretary
Department of Veterans Affairs
201 West Washington Avenue
Madison, Wisconsin 53703

Dear Mr. Scocos:

We are in receipt of your letter, dated November 6, 2015, which you wrote in response to a request from Senator Julie Lassa for an audit of the Wisconsin Veterans Home at King.

Your letter states that the four skilled nursing facilities comprising the Wisconsin Veterans Home at King—Ainsworth, MacArthur, Olson, and Stordock—are licensed and regulated by the Wisconsin Department of Health Services (DHS) and "must meet the high regulatory standards."

Although your letter indicates there were no citations noted by a U.S. Department of Veterans Affairs annual survey in 2015, we reviewed the findings from the regulatory effort performed by DHS through regular surveys and through surveys conducted in response to complaints. In the period from January 1, 2013, through January 31, 2016, DHS conducted 58 surveys of the Wisconsin Veterans Home at King. These surveys identified a total of 86 deficiencies. After reviewing the findings, we have the following questions:

1. Most deficiencies (37) were found at Stordock. How does this facility differ from the other three skilled nursing facilities within the Wisconsin Veterans Home at King? For example, is the population at Stordock different from the other facilities? What specific actions have been taken, and when, to improve the quality of care provided to residents of Stordock?

2. Although the overall number of deficiencies decreased during this time period, the number of deficiencies associated with medication provision did not decrease in 2013 and 2015 (4 per year). What specific actions have been taken, and when, to ensure the accurate provision of medication to residents?

3. During this time period, 4 deficiencies related to inadequate handling of abuse allegations were identified. What specific actions have been taken, and when, to ensure that resident abuse does not occur? Have policies and procedures changed for identifying, reporting, and investigating resident abuse? If so, please provide these policies and identify the changes. If not, please explain why not.

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4. DHS identified an instance in which infection control procedures were not followed during a Norovirus outbreak at Stordock. In addition, a deficiency related to sanitization of dining areas was identified throughout Ainsworth. How many infectious disease outbreaks occurred within the Wisconsin Veterans Home at King during 2015? How were residents affected by any such outbreaks? What specific actions have been taken, and when, to ensure the risk of infectious disease is as small as possible?

5. The quality of toilet care assistance provided to residents was an identified deficiency throughout the time period. What specific actions have been taken, and when, to ensure that residents receive appropriate toilet assistance?

We would like to receive your response to these questions on or before Tuesday, April 12th. Thank you for your cooperation.

Sincerely,

Senator Robert Cowles, Co-chair
Joint Legislative Audit Committee

Representative Samantha Kerkman, Co-chair
Joint Legislative Audit Committee

Enclosure

cc: Joe Chrisman
State Auditor

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