Scott Walker
Governor

Kitty Rhoades
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF QUALITY ASSURANCE

SOUTHEASTERN REGIONAL OFFICE
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July 1, 2013

EMAIL

Michael Spitzer, Administrator
Milwaukee County Mhc Fdd, # 3141
9455 Watertown Plank Rd
Wauwatosa, WI 53226

Re: Survey Type: Health Survey
Survey Date: 05/22/2013
Survey Event ID: SH5C11

Dear Mr. Spitzer:

The Division of Quality Assurance surveys ICFs/IID to determine whether they meet the regulatory requirements to participate in the Medicaid program as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). A provider must meet the definition found in Section 1905(d) of the Social Security Act and be in compliance with all the requirements for long term care facilities established by the Secretary of the Centers for Medicare & Medicaid Services, found in 42 CFR part 483.400-480.

Based on your acceptable plan of correction, we have recommended to the Division of Long Term Care that your certification as an ICF/IID be continued.

Your facility will be expected to comply with these plans of correction on or before the correction date for each notice, unless your facility has been granted a written extended correction time for state violations per section 50.04(4)(c)4, Wis. Stats. If a violation required a long-range plan of correction, "benchmark" dates for partial correction, and each of these dates should be met.

If you have any questions, please contact me at the address in the letterhead, or telephone at (414) 227-4563.

Sincerely,

Jean Rucker /CAL

Jean Rucker
Southeastern Regional Field Operations Director
Division of Quality Assurance

Attachments

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52G046	A. BUILDING _____ B. WING _____	C 05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILWAUKEE COUNTY MHC FDD	9455 WATERTOWN PLANK RD WAUWATOSA, WI 53226

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W 000	INITIAL COMMENTS Surveyor: 03423 This is a result of a complaint/self-report survey conducted at MCMC/Hilltop FDD from 05/21-05/22/13. # of federal deficiencies: 4 Census: 61 Sample Size: 5 Supplemental sample: 2 Survey Coordinator: #03423	W 000		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Surveyor: 07165 Based on record reviews, review of facility self-report investigations and interviews, the facility did not follow its policy/procedures by completing a thorough investigation for 1 of 4 self report investigations reviewed. On 3/24/13, Client #1 bit Client #2's abdomen at the site of Client #2's colostomy stoma, causing a small open area. There was no statement from Certified Nursing Assistant (CNA)-C, who allegedly was the last person to see Client #1 prior to the incident, although the summary statement of the incident indicated CNA-C had seen Client #1 in the hallway sitting in her wheelchair about 10 minutes before the incident	W 149		

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

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W 149	Continued From page 1 occurred. A statement from Licensed Practical Nurse (LPN)- F indicated Client #1 was sitting next to Client #2 in the dining room just prior to the incident. The facility incident report indicates Client #1 attempted to bite Client #6 just prior to biting Client #2. Registered Nurse (RN)-B, who conducted the investigation was not aware that Client #1 had attempted to bite Client #6. The facility did not complete a thorough investigation in that the facility investigation did not include statements from all staff interviewed during the investigation, statements obtained did not include all pertinent information, and the facility did not discover during the investigation that an incident just prior to the reported incident had apparently occurred. A thorough investigation of client to client altercations is necessary to determine if all interventions to safeguard residents are employed. Findings include: A review of the facility policy & procedure regarding caregiver misconduct last revised 6/19/12, reveals the investigation will include interviewing and obtaining statements documented on the State form (DSL 2448-Witness Statement) from all staff/patients who may have been present at the time of the incident and all staff/patients who may have information regarding the incident. Statements will include: date and time, specific locations, where the witness was in proximity to the alleged incident, who was involved or in the area, and a description of the alleged incident. If a potential witness states they did not see or hear the incident they will need to state where they were in	W 149		

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W 149	Continued From page 2 relationship to when and where the incident allegedly occurred. On 5/21-5/22/13, Surveyor #07165 reviewed a facility self-report, and clinical records for Clients' #1 & #2. Client #1 was admitted to the facility on 10/7/11, with diagnoses including Impulse Control Disorder, Post Traumatic Stress Disorder, Moderate Mental Retardation, Cerebral Palsy and Personality Disorder. Client #1 utilizes a wheelchair for mobility, and requires stand by assist of one person for transfers. Client #2 was admitted to the facility on 3/14/05, with diagnosis including Anoxic Brain Disorder, Severe Mental Retardation, Seizure Disorder and Dysphagia with g-tube (gastrostomy tube). Client #2 self ambulates on the living unit. Clients' #1 & #2 reside on the same living unit in the facility. Surveyor #07165 reviewed the facility self-report investigation on 5/21-5/22/13. A "Description of events," submitted with the self report states on Sunday, March 24, 2013 at approximately 6:10 p.m., Client #1 was sitting in her wheelchair in the hallway about 20ft from Client #2, who was sitting in the dining room. Client #1 wheeled herself into the dining room to where Client #2 was sitting and quickly raised up his shirt and bit him where his colostomy bag was located. CNA-C had just seen Client #1 in the hallway, sitting quietly in her wheelchair. Client #2 yelled after Client #1 bit him, and staff immediately escorted Client #1 to the quiet room, where Client #1 was placed in	W 149		

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W 149	Continued From page 3	W 149		

four-point restraints. Client #1 remained physically and verbally aggressive as staff placed her in restraints.

According to initials on the 30 minute PM Rounds form for 3/24/13, CNA-C had completed the 6:00 p.m. rounds. A review of statements submitted with the self report revealed no statement from CNA-C was included. (CNA-C had reportedly seen Client #1 in the hallway during 30 minute rounds completed for 6:00 p.m.)

LPN-F submitted a written statement which indicated, "After CNA performed a 15 minute check on (Client #1), who was sitting next to (Client #2) in the dining room, she (Client #1) quietly grabbed his (Client #2) shirt, lifted it up and bit his (Client #2) colostomy bag and stoma... (Client #1) was placed in 4 points (restraints) for approximately 45 minutes."

A Written Statement obtained from CNA-G indicates, "Did not witness incident." There was no additional information obtained as to where the staff member was in relationship to the alleged client to client abuse as specified by the facility policy. According to documentation on the behavioral 15 minute check form, CNA-G was completing 15 minute checks for Client #1. This information was not included on the Written Statement form.

A Written Statement form from RN-H indicates, "see nurse progress note." A review of the nurse progress notes for 3/24/13, reveal no entry from RN-H regarding the incident with Clients' #1 & #2.

A review of the Assessment and Progress Record

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W 149	Continued From page 4 for Seclusion/Restraint completed by RN-H for the application of 4 point leather restraints applied on 3/24/13 at 6:10 p.m., revealed documentation that Client #1 attempted to bite Client #6, and was redirected away from the area. Client #1 went to her room but came right back and tried to bite (Client #2) and pull his g-tube. Placed in 4 point leather restraints. There had been no mention of a previous attempt by Client #1 to bite a peer in the facility self-report investigation. On 5/22/13 at 2:45 p.m., Surveyor #07165 spoke with RN-B, who had conducted the facility investigation. RN-B stated she had not obtained a written statement from CNA-C, who was responsible for the 30 minute checks for Client #1. RN-B stated she had spoken with CNA-C, who had stated he had seen Client #1 in the hallway by the nurses station. RN-B was not sure how Client #1 managed to get from the hallway to the dining room so quickly. Surveyor #07165 asked if RN-B was aware of the documentation on the Assessment and Progress Record for Seclusion/Restraint form indicating Client #1 had attempted to bite Client #6, prior to biting Client #2. RN-B stated she was not aware of an earlier attempt by Client #1 to bite a peer.	W 149		
W 154	483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated. This STANDARD is not met as evidenced by: Surveyor: 07165	W 154		

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W 154	Continued From page 5 Based on record reviews, review of facility self-report investigations and interviews, the facility did not thoroughly investigate, 1 of 4 self report investigations reviewed. On 3/24/13, Client #1 bit Client #2's abdomen at the site of Client #2's colostomy stoma, causing a small open area. There was no statement from Certified Nursing Assistant (CNA)-C, who allegedly was the last person to see Client #1 prior to the incident, although the summary statement of the incident indicated CNA-C had seen Client #1 in the hallway sitting in her wheelchair about 10 minutes before the incident occurred. A statement from Licensed Practical Nurse (LPN)- F indicated Client #1 was sitting next to Client #2 in the dining room just prior to the incident. The facility incident report indicates Client #1 attempted to bite Client #6 just prior to biting Client #2. Registered Nurse (RN)-B, who conducted the investigation was not aware that Client #1 had attempted to bite Client #6. Findings include: On 5/21-5/22/13, Surveyor #07165 reviewed a facility self-report, and clinical records for Clients' #1 & #2. Client #1 was admitted to the facility on 10/7/11, with diagnoses including Impulse Control Disorder, Post Traumatic Stress Disorder, Moderate Mental Retardation, Cerebral Palsy and Personality Disorder. Client #1 utilizes a wheelchair for mobility, and requires stand by assist of one person for transfers. Client #2 was admitted to the facility on 3/14/05,	W 154		

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W 154	Continued From page 6 with diagnosis including Anoxic Brain Disorder, Severe Mental Retardation, Seizure Disorder and Dysphagia with g-tube (gastrostomy tube). Client #2 self ambulates on the living unit. Clients' #1 & #2 reside on the same living unit in the facility. Surveyor #07165 reviewed the facility self-report investigation on 5/21-5/22/13. A "Description of events," submitted with the self report states on Sunday, March 24, 2013 at approximately 6:10 p.m., Client #1 was sitting in her wheelchair in the hallway about 20ft from Client #2, who was sitting in the dining room. Client #1 wheeled herself into the dining room to where Client #2 was sitting and quickly raised up his shirt and bit him where his colostomy bag was located. CNA-C had just seen Client #1 in the hallway, sitting quietly in her wheelchair. Client #2 yelled after Client #1 bit him, and staff immediately escorted Client #1 to the quiet room, where Client #1 was placed in four-point restraints. Client #1 remained physically and verbally aggressive as staff placed her in restraints. According to initials on the 30 minute PM Rounds form for 3/24/13, CNA-C had completed the 6:00 p.m. rounds. A review of statements submitted with the self report revealed no statement from CNA-C was included. (CNA-C had reportedly seen Client #1 in the hallway during 30 minute rounds completed for 6:00 p.m.) LPN-F submitted a written statement which indicated, "After CNA performed a 15 minute check on (Client #1), who was sitting next to (Client #2) in the dining room, she (Client #1)	W 154		

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W 154	Continued From page 7 quietly grabbed his (Client #2) shirt, lifted it up and bit his (Client #2) colostomy bag and stoma... (Client #1) was placed in 4 points (restraints) for approximately 45 minutes." A review of the Assessment and Progress Record for Seclusion/Restraint completed for the application of 4 point leather restraints applied on 3/24/13 at 6:10 p.m., revealed documentation that Client #1 attempted to bite Client #6, and was redirected away from the area. Client #1 went to her room but came right back and tried to bite (Client #2) and pull his g-tube. Placed in 4 point leather restraints. There had been no mention of a previous attempt by Client #1 to bite a peer in the facility self-report investigation. On 5/22/13 at 2:45 p.m., Surveyor #07165 spoke with RN-B, who had conducted the facility investigation. RN-B stated she had not obtained a written statement from CNA-C, who was responsible for the 30 minute checks for Client #1. RN-B stated she had spoken with CNA-C, who had stated he had seen Client #1 in the hallway by the nurses station. RN-B was not sure how Client #1 managed to get from the hallway to the dining room so quickly. Surveyor #07165 asked if RN-B was aware of the documentation on the Assessment and Progress Record for Seclusion/Restraint form indicating Client #1 had attempted to bite Client #6, prior to biting Client #2. RN-B stated she was not aware of an earlier attempt by Client #1 to bite a peer. The facility did not complete a thorough investigation in that the facility investigation did	W 154		

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W 154	Continued From page 8 not include statements from all staff interviewed during the investigation, and the facility did not discover during the investigation that an incident just prior to the reported incident had apparently occurred. A thorough investigation of client to client altercations is necessary to determine if all interventions to safeguard residents are employed.	W 154		
W 249	483.440(d)(1) PROGRAM IMPLEMENTATION As soon as the interdisciplinary team has formulated a client's individual program plan, each client must receive a continuous active treatment program consisting of needed interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan. This STANDARD is not met as evidenced by: Surveyor: 07165 Based on record review and interviews, the facility did not implement a specified program plan intervention for 1 (Client #1) of 5 clients sampled. During the afternoon of 5/15/13, Client #1 was placed on 1:1 behavioral observation related to an incident in which Client #1 bit Client #2. On 5/16/13 at 10:55 a.m., Client #1 bit Client #7 on the back of the hand causing a superficial break in the skin. Client #1 who had an order to receive 1:1 behavioral observation, was not receiving 1:1 behavioral observation when the incident on 05/16/13, occurred.	W 249		

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W 249	Continued From page 9 Findings include: Surveyor #07165 reviewed Client #1's record on 5/21-5/22/13. Client #1 was admitted to the facility on 10/7/11, with diagnoses including Impulse Control Disorder, Post Traumatic Stress Disorder, Moderate Mental Retardation, Cerebral Palsy and Personality Disorder. Client #1 utilizes a wheelchair for mobility, and requires stand by assist of one person for transfers. Client #1 has a Behavior Treatment Plan, last revised 11/2/12, which provides staff with instructions related to problem behaviors including, but not limited to: hitting, slapping, biting, scratching, pinching, grabbing and spitting. A review of Client #1's record revealed Client #1 has been exhibiting an increased frequency of biting behaviors since early March 2013. The level of supervision for Client #1 had been altered several times since early March in order to protect peers from being bitten by Client #1. In April and May 2013, Client #1 has had several medication changes with the purpose of decreasing her agitation and accompanying behaviors. According to a facility incident report, on 5/15/13 at 1:38 p.m., Client #1 bit Client #2 on the right wrist causing a superficial break in the skin. After this incident Client #1 was placed on 1:1 supervision for agitation.	W 249		

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W 249	Continued From page 10 A review of the physician's orders reveal an order written on 5/15/13 at 3:30 p.m., for "1:1 behavioral observation (staff within 5 feet), for aggression on AM and PM shift. Assigned staff should verbally redirect peers so they are not within 5 feet patient. Every 15 minute behavioral observation on night shift with door alarm activated. All for 24 hours." On 5/16/13 at 7:50 a.m., Client #1 was placed in restraints for attempts to bite staff and peers. Not redirectable. Client #1 was removed from restraint at 9:50 a.m., when calm. According to nursing documentation on 05/16/13 at 11:00 a.m., Client #1 was out of restraint for a short time, then bit a male peer, after unsuccessfully trying to bite another peer. According to a facility incident report, on 5/16/13 at 10:55 a.m., Client #1 bit Client #7 of the back of the left hand. Client #7 had 1 scratch like open area with a smaller open area in the bite mark. The area was cleansed. The incident report indicated the incident was witnessed by RN-I and Housekeeper-J. On 5/22/13 at 10:30 a.m., Surveyor #07165 spoke with RN-B regarding the biting incident involving Clients' #1 & #7 on 5/16/13. Surveyor #07165 asked who was the 1:1 staff assigned to Client #1 on 5/16/13, as the incident report does not mention a CNA being present. RN-B stated that RN-I was not aware that Client #1 was supposed to be receiving 1:1 behavioral observation until after the biting incident with Client #7, therefore no staff member had been assigned to provide the ordered 1:1 behavioral	W 249		

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W 249	Continued From page 11 observation. Surveyor #07165 asked how the RN would have known about the ordered 1:1 behavioral observation. RN-B explained that the day shift RN is to review the previous 24 hours of the 24 hour report log in order to determine which areas of concern continue on the new day. A review of the 24 hour report log revealed an entry on the afternoon shift of 5/15/13, indicated Client #1 was placed on 1:1 behavioral observation. Client #1 was placed in restraints after the incident with Client #7. When released she received 1:1 behavioral observation as indicated by her plan of care/physician's order.	W 249		
W 331	483.460(c) NURSING SERVICES The facility must provide clients with nursing services in accordance with their needs. This STANDARD is not met as evidenced by: Surveyor: 03423 Based on medical record review, review of facility documentation (3 investigations of client to client abuse), and staff interview, the facility did not provide 1 Client (#4) with needed nursing services, out of 3 clients needing nursing services following client to client allegations of abuse. On 03/04/13 at approximately 6:15 a.m.(night shift), Client #4 was bitten by Client #1 on the right ankle that left an open area, the upper right neck which left bruising and her left breast which also left bruising. Review of Nurses' Note documentation and the facility investigation of this client to client abuse revealed the night shift nurse did not complete a thorough assessment of	W 331		

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W 331	Continued From page 12 Client #4 following this incident, and the bites to Client #4 were discovered upon assessment by the day shift nurse at 9:30 a.m. on 03/04/13, causing a delay in treatment. Findings include: Surveyor #03423 reviewed Client #4's medical record on 05/21-05/22/13. Client #4 was admitted to the facility on 07/08/10, with diagnoses including Impulse Control Disorder, Psychotic Disorder, Mood Disorder and Mild MR. Review of Client #4's physician's orders for 03/04/13, revealed orders to obtain screens for Hepatitis C antibody, Hepatitis B surface antigen and HIV antibody. According to review of a facility report investigation, Client #4 was bitten by Client #1 on 03/04/13 at approximately 6:15 a.m. There was no Nurses' Note documentation completed by Registered Nurse (RN)-A, the night shift nurse on 03/04-03/05/13, until a late entry of the incident was documented on 03/08/13 at 3:15 a.m. Nurses' Note documentation on the day shift of 03/05/13 at 9:30 a.m., indicated, "Writer informed that res (resident) was attacked by roommate. Writer inspected res body for injury and observed reddened areas to (L) breast (bite mark), (R) neck (bite mark), and (R) ankle has open area (bite mark) noted..."	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52G046	A. BUILDING _____ B. WING _____	C 05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILWAUKEE COUNTY MHC FDD	9455 WATERTOWN PLANK RD WAUWATOSA, WI 53226

(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
W 331	Continued From page 13 Surveyor #03423 reviewed the facility self-report investigation of this client to client abuse on 05/21-05/22/13. Review of a statement obtained from RN-A on 03/05/13, during the course of the facility investigation revealed, "...This writer heard screaming and yelling in the bedroom occupied by Client #1 and Client #4. This RN observed on entering the room that Client #1 had Client #4 by the pajama top and was grabbing her arm...Upon entering the room this RN helped to separate Client #1; Client #1 was screaming, spitting, hitting and kicking at staff..." There was no evidence in the statement that RN-A assessed either Client #1 or Client #4 following this allegation of client to client abuse. A statement obtained from Certified Nursing Assistant (CNA)-D on 03/05/13 indicated, "Client #4 put the light on and I went down there to see what was wrong and Client #1 had (was) grabbing and swinging on Client #4 so I pulled Client #1 away and called for RN-A to come down to help..." Review of the summary statement of this investigation revealed, "There was a delay in knowing the extent of Client #4's injuries due to the night nurse on duty RN-A, not assessing Client #4 immediately after the altercation. He (RN-A) failed to fully assess Client #4..." At the daily meeting with facility administrative staff on 05/21/13 at 2:45 p.m., the Interim Director of Nursing confirmed that RN-A failed to complete a thorough assessment of Client #4 following this altercation.	W 331		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILWAUKEE COUNTY MHC FDD	9455 WATERTOWN PLANK RD WAUWATOSA, WI 53226

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W 331	Continued From page 14 Following the discovery of the injuries to Client #4 on 03/05/13 at 9:30 a.m., Client #4's physician was notified and treatments were ordered.	W 331		

PLAN OF CORRECTION

Name - Provider/Supplier:	
Milwaukee County Mental Health Division Rehabilitation Hilltop	
Street Address/City/Zip Code:	
9455 Watertown Plank Rd, Milwaukee, WI 53226	
License/Certification/ID Number (X1):	52A271
Survey Date (X3):	06/18/2013
Survey Event ID Number:	MHC011

ID Prefix Tag (X4)	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date (X5)
W149	Effective June 18, 2013 the facility has ensured that all staff conducting investigations for incidents of mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property have been retrained on the facilities policy/procedure for completing thorough investigations including but not limited to the attainment of witness statements from staff who would have knowledge of said incident. The purpose of the retraining is to ensure that thorough investigations are conducted for all residents as warranted including clients #1, #2 and #6. The retraining of the entity's Reporting and Investigation of Caregiver Misconduct and Injuries of Unknown Origin policy was facilitated by the Nursing Home Administrator. Date of completion: June 18, 2013 Responsible Persons: Michael P. Spitzer, NHA	06/18/2013
W154	Effective June 18, 2013, the facility has ensured that all incidents of mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of resident property are thoroughly investigated for residents of the entity including residents #1, #2 and #6. Effective June 18, 2013 all staff who conduct investigations for episodes of client mistreatment, neglect or abuse, including injuries of unknown source and misappropriation of client property have been trained on conducting thorough investigations including the need to promptly attain witness statements from all staff assigned to and any other staff on the unit where incidents took place. In addition, staff conducting investigations have been trained to ensure that witness statements of all staff who observed said incidents off the living unit are also collected to ensure a thorough investigation is ensued. For incidents noted as injury of unknown origin, witness statement will be collected from the staff assigned to the unit at the time of discovery in addition to the attainment of witness statements from staff who worked on said unit for at least the two consecutive shifts prior to the shift of discovery. The training had been provided by the Nursing Home	06/18/2013

PLAN OF CORRECTION

Name - Provider/Supplier:	
Milwaukee County Mental Health Division Rehabilitation Hilltop	
Street Address/City/Zip Code:	
9455 Watertown Plank Rd, Milwaukee, WI 53226	
License/Certification/ID Number (X1):	52A271
Survey Date (X3):	06/18/2013
Survey Event ID Number:	MHC011

	Administrator who completed the course on Conducting Internal Investigations of Caregiver Misconduct, sponsored by DHFS and the University of Wisconsin-Oshkosh. Effective June 18, 2013, postings of the Incident Investigation Protocol and Checklist developed by the entity have been placed at the nurses station of each unit to assist nursing staff with the prompt and thorough deployment of investigation for Caregiver Misconduct. Effective June 18, 2013, the NHA will direct/remind the Administrative Resource RN, Nursing Program Coordinator or RNIII when he is immediately notified of an incident of potential resident mistreatment to promptly distribute and collect witness statements to all staff assigned to the living unit as well as to staff who may have been present but not assigned to the living unit. Date of completion: June 18, 2013 Responsible Persons: Michael P. Spitzer, NHA Mary Lausier, NPC Gloria Diggs, RNIII Laurie Heinonen, RN	
W249	The facility will implement a specified program plan for Client #1 and all clients. The facility will ensure that the RN is aware of residents receiving 1:1 behavioral observation and ensures that staff are assigned to the supervision. RN I was retrained on the procedure for reviewing orders for resident supervision by the Nursing Manager. To ensure ongoing compliance, the RN's performance and documentation will be monitored by the Nursing Manager; i.e. specific to the implementation of new orders regarding behavioral observation checks. In the event additional deficient practices are identified, progressive discipline and necessary training will be initiated.	06/18/2013

PLAN OF CORRECTION

Name - Provider/Supplier:	
Milwaukee County Mental Health Division Rehabilitation Hilltop	
Street Address/City/Zip Code:	
9455 Watertown Plank Rd, Milwaukee, WI 53226	
License/Certification/ID Number (X1):	**52A271**
Survey Date (X3):	**06/18/2013**
Survey Event ID Number:	**MHC011**

	Date of completion: June 18, 2013 **Responsible Persons:** **Gloria Diggs, RN3** **Mary Lausier, Nursing Program Coordinator**	
W331	**The facility will provide needed nursing services and ensure that a thorough assessment is performed for a resident following an incident. Client #4 received a thorough nursing assessment as of 3/5/13 at 9:30 AM. The RN who failed to provide an immediate assessment was counseled by the Nursing Program Coordinator and the Interim Director of Nursing and received retraining regarding the need to perform an immediate assessment for a resident following an incident.** **To ensure compliance, the RN's performance and documentation will be monitored by the Nursing Manager. In the event additional deficient practices are identified, progressive discipline will be initiated and necessary retraining will be initiated.** **Date of completion: June 18, 2013** **Responsible Persons:** **Gloria Diggs, RN3** **Mary Lausier, Nursing Program Coordinator**	**06/18/2013**

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52G046	A. BUILDING _____ B. WING _____	C 05/22/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILWAUKEE COUNTY MHC FDD	9455 WATERTOWN PLANK RD WAUWATOSA, WI 53226

(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
W 000	INITIAL COMMENTS Surveyor: 03423 This is a result of a complaint/self-report survey conducted at MCMC/Hilltop FDD from 05/21-05/22/13. # of federal deficiencies: 4 Census: 61 Sample Size: 5 Supplemental sample: 2 Survey Coordinator: #03423	W 000		
W 149	483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This STANDARD is not met as evidenced by: Surveyor: 07165 Based on record reviews, review of facility self-report investigations and interviews, the facility did not follow its policy/procedures by completing a thorough investigation for 1 of 4 self report investigations reviewed. On 3/24/13, Client #1 bit Client #2's abdomen at the site of Client #2's colostomy stoma, causing a small open area. There was no statement from Certified Nursing Assistant (CNA)-C, who allegedly was the last person to see Client #1 prior to the incident, although the summary statement of the incident indicated CNA-C had seen Client #1 in the hallway sitting in her wheelchair about 10 minutes before the incident	W 149		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael P Spitzer | TITLE: NHA | (X5) DATE: 06/18/2013

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.

<table>
<tr><td rowspan="2">POLICY & PROCEDURE

MILWAUKEE COUNTY
BEHAVIORAL HEALTH DIVISION

Administration</td><td>DATE ISSUED:
12/09/03</td><td colspan="3">SUBJECT: Caregiver Misconduct. Reporting and Investigation of Caregiver Misconduct and Injuries of Unknown Origin</td></tr>
<tr><td>DATE REVIEWED* / REVISED:
08/01/08</td><td>SECTION:
List where filed in hard copy manual, i.e, under MS 3.1, "NS – Alpha "S", etc.</td><td>POLICY NUMBER:</td><td>PAGE(S)

1 of 9</td></tr>
</table>

PURPOSE: To provide patients/clients/residents, families (significant others), guardians, and MCBHD staff with a process for reporting and investigating matters of patient/client/resident abuse and injuries of unknown origins.

POLICY: Staff and all other persons with whom patients/clients/residents come in contact shall treat the patient/client/resident with courtesy, respect, with full recognition of their dignity and individuality, and shall provide them considerate care and treatment at all times.

MCBHD is committed to ensure compliance with Wisconsin Administrative Code HFS 134.46 and HSS 132.31, (Abuse and Restraints), HSS129, federal regulations 42 CFR 483.13, and Wisconsin Statue S48.981 Abuse or Neglected Children, Chapter 51 and Chapter 55. In addition HFS 13. Wis. Admin. Code.

This Policy is designed to protect the patient/client/resident throughout the process by which allegation of patient/client/resident abuse, neglect, mistreatment, and misappropriation of property is reported and investigated.

DEFINITION: 1. "Abuse means a significant disregard of the patient's/client's/resident's needs, dignity or interests, or of the behavior which a patient/client/resident has a right to expect of a staff consistent with the standards set out in s. HSS 129.11(1)(b). Abuse includes neglect and mistreatment." Acts "of abuse" towards children is also defined in S48.981 to include physical injury, sexual intercourse or sexual contact, or emotional damage".

Furthermore, abuse may be defined in the following way:

A. Physical Abuse - Acts consisting of:
   (1) Any physical motion or action, (e.g., hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs.

   (2) Unauthorized/inappropriate use of corporal punishment as well as the use of any restrictive, intrusive procedure to control behavior for the purpose of punishment.

B. Mental or Emotional Abuse - acts intended to result in humiliation, harassment as well as threats of punishments or deprivation or other emotional damage which harms a patient's/client's/resident's psychological or intellectual functioning.

C. Verbal Abuse - acts consisting of:

(1) Threatening words which cause the patient/client/resident, or family, or guardian, to feel fearful or intimidated;

(2) Words of coercion which tend to leave the patient/client/resident without the freedom to act, which is a violation of his/her rights;

(3) Words of extortion, which are used in attempts to illegally, deprive a patient/resident of money or property. The act of extortion is a crime;

(4) Words of vulgarity which include curse words, profanity, and obscenities;

(5) Words of a derogatory nature causing a patient/client/ resident to feel ridiculed; such words can include teasing, rude, or harsh language, words of scorn or contempt and deliberate lies.

D. Neglect - acts consisting of failure, refusal or inability on the part of the person exercising temporary or permanent control over patients /clients/residents to provide necessary care and treatment.

E. Other types of abuse include certain acts or gestures that are not always a crime, but are not therapeutic. They include the following:

(1) Improper/inappropriate restraints (physical and/or chemical)/seclusion's;

(2) Threatening acts or gestures (e.g. clenched fist);

(3) Failure to take therapeutic action when such action is indicated;

(4) Failure to take action when abuse arises from another patient/client/resident;

(5) Confinement to a locked room/area without proper authorization.

2. A brief description of other important terminology is:

A. "Abusive Incident means abuse or misappropriation of property but does not include an act or omission caused by factors beyond the staff's control;"

B. "Misappropriation of property means the taking or temporary or permanent use of something that belongs to a patient/client/resident,

without first obtaining the patient's/client's/resident's permission, whether it is the patient's/client's/resident's possession, property, money or other item of value';

C. "Reasonable cause means that the evidence leads one to believe the incident occurred;"

D. "Abuse standard may include staff's willful failure to provide goods or services necessary to avoid patient/client/resident physical or mental harm. It also may include staff's negligence in the manner in which goods or services are provided, even if staff did not intend to provide the goods or services in a negligent or improper manner."

INITIAL ASSESSMENT/NOTIFICATION

1. All staff witnessing or having knowledge of injury of unknown origin of possible alleged patient/resident/client misconduct should report it immediately to their supervisor. The initial report may be verbal which will be supported by a signed and dated incident report.

2. The supervisor shall immediately contact the appropriate MCBHD Administrative Staff to ascertain and determine how the investigation will be conducted. The minimum activities to be addressed are:

   A. The registered nurse, or designated staff, shall immediately assess the patient/client/resident. The assessment shall be documented by a registered nurse and/or physician.

   B. The Registered Nurse, or other appropriate staff, shall interview the patient/resident and witnesses as appropriate.

   C. If after the initial assessment of the allegation the supervisor finds reasonable cause, that further investigation is warranted, the appropriate staff will be directed (by an Administrative Staff) to notify the Milwaukee County Sheriff's Department or the Police Department, where the alleged abuse occurred.

   D. For children/adolescents, the Department of Human Services Protective Service Department must be notified immediately by the supervisor or professional clinical staff.

   E. The supervisor should assure that required documentation of the incident is completed in the record by the Registered Nurse or other appropriate staff.

F. The legal guardian must be notified if the patient is under 18 years of age or has a legal guardian under Chapters 51 & 55.

G. The Risk Management Incident/Accident Report shall be completed before the end of the employee's shift and submitted to their immediate supervisor.

H. The Program Administrator shall ensure that the incident is reported to the appropriate authority including:
   1.) *MCBHD Administrator or designee.*
   2.) *MCBHD Medical Director or designee.*

FORMAL INVESTIGATION PROCESS

1. The program Administrator or his/her designee shall be responsible for conducting the formal investigation. That investigation shall include.

   A. Interviewing and obtaining statements documented on State form **(DSL 2448-Witness Statement)** from all staff who may have been present at the time of the incident and all staff who may have information regarding the incident.

   B. Interviewing all patients/residents who may have observed and/or participated in the alleged incident.

   C. For children under 18 years of age, the investigation of abuse shall be coordinated with the Milwaukee County Protective Services Units or the Department of Health and Social Services. The Program Administrator and appropriate Department Director shall ensure such coordination.

2. To ensure that the patient's/resident's/client's safety is maintained during the investigation, the accused staff will be reassigned to an area or task that are not patient care related, until caregiver misconduct is substantiated or not substantiated. During the reassignment, the staff will be under the supervision of that area department.

3. When a patient grievance is filed alleging abuse an *Incident Report* must be filed by the staff member receiving the patient grievance.

4. When the abuse involves consideration of immediate disciplinary action, including possible discharge, the following steps should occur.

   A. Consultation shall be sought by the Program Administrator and the Human Resources Manager as to whether the charges are both serious enough and well founded to require immediate termination of the employee.

B. If the allegations appear to be well founded, the employee should be suspended.

(1) The employee shall be informed that there has been an allegation made against them and that he/she is being suspended without pay pending a hearing for discharge before the Personnel Review Board.

(2) The employee shall be informed that the formal charges along with the notice of hearing will be delivered by a Deputy Sheriff or by certified mail if the Deputy is unable to make service.

(3) The employee may be allowed to clean out any personal belongings and then must leave the premises.

(4) The supervisor should also obtain the employee's BHD keys and ID badge before he/she leaves.

C. The Program Administrator with the assistance of the Human Resources Manager will prepare the "Written Charges Against Civil Service Employees" (form 2923) and forward to the Human Resources Manager for review and processing. **(NOTE: THE WRITTEN CHARGES MUST BE RECEIVED BY THE PERSONNEL REVIEW BOARD WITHIN THREE WORKING DAYS FROM THE DATE THAT THE EMPLOYEE IS ACTUALLY SUSPENDED.)**

D. The Department Head shall report the incident to the appropriate licensing board (e.g., Nurse Aide Registry, Board of Nursing, Pharmacy Board, etc.).

E. If the final investigation reveals that all aspects of the allegation are unfounded, the written charges for dismissal will be withdrawn and the employee will receive appropriate back pay.

F. Any decision made by the Personnel Review Board is considered to be final.

5. If a staff is a witness to abuse and does not report or intervene in the alleged act, the witness could be deemed in the eyes of the law to have participated in the act of abuse, and disciplinary action will be initiated as outlined in the above procedure.

6. If it can be proven that an individual attempts reprisal on an individual who

has reported a case of abuse/neglect/mistreatment/misappropriation, that individual has also violated the rights of the patient/resident, the law as well as this policy and procedure and may be subject to disciplinary action and/or criminal prosecution. Reprisal towards residents may be defined in the following way:

a. Any physical motion or action, (e.g. hitting, slapping, punching, kicking, pinching, etc.) by which bodily harm or trauma occurs.

b. Unauthorized/inappropriate use of corporal punishment as well as use of any restrictive, intrusive procedure to control behavior for the purpose of punishment.

POLICY & PROCEDURE **MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION** **Rehabilitation Centers**	**DATE ISSUED** **08/11/06** **DATE REVISED** **01/23/08** **08/01/08**	**Addendum to the Caregiver Misconduct Policy:** Special Program Management and Reporting Guidelines for Allegations of Resident Mistreatment (including resident to resident mistreatment), Caregiver Misconduct, and Injuries of Unknown Origin in Hilltop (units 43E, 43F, & 44E), and Rehabilitation Center Central (units 44A, 44B, & 44C).

Policy: It is the policy of Milwaukee County Behavioral Health Division (MCBHD) to report allegations of resident mistreatment, caregiver misconduct, and injuries of unknown origin to the State of Wisconsin Bureau of Quality Assurance (BQA) per Federal Regulations pertaining to ICFMR's and Nursing Homes. For Hilltop (units 43E, 43F, & 44E) and Rehabilitation Central (units 44A, 44B, & 44C) special rules for managing and reporting patient mistreatment (including resident to resident mistreatment) apply. For Rehabilitation Center Central (Units 44A, 44B, & 44C) only, the initial investigation must be completed and if indicated a report filed with BQA within 24 hours of the occurrence of such an incident or knowledge of the occurrence of such an incident.

Procedure:

1. Immediately upon learning of an incident involving resident mistreatment staff members must take steps to protect residents from possible further incidents of mistreatment, misconduct, or injury. Examples of steps to protect residents include: increased staffing and behavior checks for patient to patient mistreatment, removal of patient alleged to have mistreated another, briefly securing patient valuables until acuity has died down, removal of staff for caregiver misconduct allegation, etc. Steps taken to protect the resident should be documented in the patient's record and on the Incident/Risk Management Report (form 4319 R5). See the MCBHD Incident/Risk Management Reporting Policy and Procedure for documenting and reporting an incident.

2. Mistreatment of residents and injuries of unknown origin must be reported to the Rehabilitation Centers administrator or his designated representative immediately after the resident has been protected.

3. **For Rehabilitation Central only (units 44A, 44B, & 44C),** the incident must be investigated by an assigned manager within 24 hours of the occurrence or knowledge of the occurrence of an incident. If the incident is reportable, Form DDE-2617 must be faxed** or e-mailed*** to BQA within 24 hours by the administrator or designated representative.

4. The definition of "Mistreatment" includes the following.

    a. Physical and sexual assaults on a resident by another resident/patient, staff member *, visitor, law enforcement, etc.
    b. Significant theft or significant destruction of a resident's property by another resident/patient, staff member*, visitor, law enforcement official, etc.
    c. Intentional abuse by a staff member* such as confinement or restraint contrary to the policy, causing pain or injury, substantial disregard for patient rights under Chapter 50 and 51, or causing mental or emotional damage to the resident.
    d. Sexual intercourse or sexual contact with a resident by a staff member*.
    e. The forcible administration of medications or giving ECT, research drugs etc. with the knowledge that no lawful authority or approval exists for the administration or procedure by a staff member*.
    f. Acts by a staff member* which are done with the intent to harass, intimidate, humiliate, threaten or frighten a resident.
    g. Neglect by a staff member* through intentional carelessness, negligence, or disregard of policy or recovery plan, which causes pain or injury, substantial disregard for patient rights under Chapter 50 and 51, or mental or emotional damage to the resident.
    h. Misappropriation of resident's funds or property by a staff member*.

5. For reporting purposes, mistreatment does not include staff member* inefficiency, or failure in performance of duties as a result of inability, incapacity, oversight, or good faith errors in judgment or discretion unless one of the following conditions can be met:

    a. It can be demonstrated that the staff member had received training relating to proper or required practice, protocol, conduct, or behavior when in circumstances substantially similar to the alleged incident and that the staff member's failure to follow the practice, protocol, conduct or behavior caused or contributed to resident mistreatment.

    b. It can be demonstrated that the staff person's conduct or behavior failed to meet the minimum expected competencies of a person employed in the staff member's position and that the conduct or behavior caused or contributed to resident mistreatment.

6. An injury of unknown origin is an injury, which the resident received from an unknown person or source, which requires nursing and/or medical care. An injury of unknown origin must be immediately reported to the Rehabilitation Centers administrator or designated representative and be investigated. For Rehabilitation Central Units (44A, 44B, 44C) an injury of unknown origin must be reported by the administrator or designated representative to BQA within 24 hours by sending Form DDE-2617 by FAX ** or e-mail***.

7. Immediate investigation and documentation of all incidents of resident mistreatment and injuries of unknown origin should include the following.

    a. Collection of physical and documentary evidence.
    b. Interviews of the alleged victim(s) and witness (is), if possible.
    c. Interviews of the accused individual(s), if possible.
    d. If indicated, involvement with other regulatory authorities, who may assist, e.g., Sheriff, Elder Abuse agency, Adult Protective Service agency, etc.
    e. A brief narrative must be written as part of the Management Review section of the MCBHD Incident Risk Management Report (form 4319 R5). The narrative should include: the steps taken to protect the resident(s), the effect(s) the incident had on the resident, the residents reaction to the incident, and any findings from the initial investigation (note also if the outcome was minor).
    f. The Rehabilitation Center administrator or his designated representative must be notified of the steps taken to protect the resident(s) immediately, and the findings of the investigation must be reported within 24 hours for Rehabilitation Central (44A, 44B, 44C) and within five days for Hilltop (43E, 43F, 44E).

8. Reportable Resident Mistreatment Incidents
   Incidents must be reported to Bureau of Quality Assurance (BQA) when, after the initial investigation the following three conditions are true:

    a. There is reasonable cause to believe that a suspected individual can be named and
    b. There is reasonable cause to believe that there is sufficient evidence to show the alleged incident occurred and
    c. There is reasonable cause to believe the incident meets or could meet the definition patient mistreatment including caregiver abuse, neglect or misappropriation.

9. MCBHD is not required to report an incident (exception injury of unknown origin) when after the initial investigation the following is found.

    a. A suspect cannot be named, or
    b. There is insufficient evidence to show the incident actually occurred, or
    c. The incident does not meet the definition of mistreatment, abuse, neglect, or misappropriation, and
    d. MCBHD cannot affirmatively rule out the incident as mistreatment, abuse, neglect, or misappropriation, but the effect

on the resident is minor (e.g. medical/nursing care is not needed, no mental/emotional damage, rights not significantly violated, minor property damage by another resident).

10. For Rehabilitation Central residents (units 44A, 44B, 44C), if an incident is reported to BQA within 24 hours using Form DDE-2617, then a follow-up Form DDE-2447 must be completed and submitted to BQA within 5 working days by the Rehabilitation Center administrator or his designated representative providing further details of the incident and investigation.

11. For Hilltop residents (units 43E, 43F, 44F), if the investigation warrants it, Form DDE-2447 must be completed and submitted to BQA within 5 working days by the Rehabilitation Center administrator or his designated representative providing details of the incident and investigation.

12. The Rehabilitation Centers Administrator is responsible for maintaining a database for all mistreatment incidents and investigations.

13. Consult the MCBHD Caregiver Misconduct Policy for more information on the investigation and reporting of caregiver misconduct throughout MCBHD.

* "staff member" includes full, part time, and temporary county employees regardless of where he/she works, employees of private contractors working for MCBHD, consultants, students and volunteers.

BQA Contacts
**Fax: 608-243-2020
***E-mail: caregiver_Intake@dnfs.state.wi.us

Prepared by:

Conducting Internal Investigations of Caregiver Misconduct

caregivers

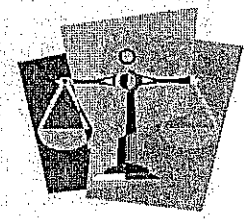
PREVENT *abuse/neglect* PROTECT *clients* PROMOTE *dignity*

FACILITATOR GUIDE

DHFS/DQA/OCQ

www.dhfs.state.wi.us/caregiver/training/trgIndex.HTM

What is Caregiver Misconduct?



Caregiver misconduct in Wisconsin includes the following:

- abuse of a resident
- neglect of a resident
- misappropriation of a resident's property

Caregiver Misconduct – Federal and State Definitions

Federal Language 42 C.F.R. §488.301 & WI Caregiver Law CH. HFS 13	Examples
ABUSE (Federal) The **willful infliction of injury**, unreasonable confinement, intimidation or punishment with resulting physical harm, pain or mental anguish.	
ABUSE (State) 1. An **act or repeated acts** by a caregiver or nonclient resident, that is **contrary to the entity's policies and procedures, not a part of the client's treatment plan and done intentionally to cause harm**, which causes or could cause pain, injury or death to a client, substantially disregards clients rights or a caregivers duties.	*Act done to cause harm:* • A caregiver repeatedly hits a resident on the back with a ladle and pushes the resident causing her to fall. • A caregiver kicks a resident in the groin.
2. An act or acts of **sexual intercourse or sexual contact** by a caregiver and involving a client.	*Sexual contact:* • A caregiver has sexual intercourse with a resident.
3. The **forcible administration of medication** or the performance of psychosurgery, electroconvulsive therapy or experimental research.	
4. A **course of conduct or repeated acts by a caregiver which serve no legitimate purpose** and which, when done with intent to harass, intimidate, humiliate, threaten or frighten a client, causes or could be reasonably expected to cause the client to be harassed, intimidated, humiliated, threatened or frightened.	*Course of conduct which serves no legitimate purpose:* • A caregiver frightens residents by holding a hammer and threatening to hit them with the hammer. • A caregiver takes a resident's doll away from her, shakes it in front of her and throws the doll on the floor and steps on it. • A caregiver nudges, pokes at or pushes a resident and verbally taunts him. The caregiver admits to engaging in this conduct for his own enjoyment in seeing the reactions of the residents.
Abuse does not include an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance as the result of inability, incapacity, inadvertency, or ordinary negligence in isolated instances, or good faith errors in judgment or discretion.	

NEGLECT (Federal) **Failure to provide goods and services** necessary to avoid physical harm, mental anguish or mental illness **NEGLECT (State)** An **intentional omission or intentional course of conduct** by a caregiver that is **contrary to the entity's policies and procedures, is not part of the client's treatment plan and, through substantial carelessness or negligence,** does any of the following: a. Causes or could reasonably be expected to cause pain or injury to a client or the death of a client. b. Substantially disregards a client's rights under either ch. 50 or 51, Stats., or a caregiver's duties and obligations to a client. Neglect is the **intentional carelessness, negligence, or disregard of policy, or care plan**, which causes, or could be reasonably expected to cause pain, injury, or death. Neglect does not include an act or acts of mere inefficiency, unsatisfactory conduct or failure in good performance as the result of inability, incapacity, inadvertency or ordinary negligence in isolated instances, or good faith errors in judgment or discretion.	*Intentional omission:* • A caregiver transfers a resident without using a gait belt or the Marissa lift. During the transfer, the client starts to slip and the caregiver lowers the resident to the floor. The caregiver then retrieves a gait belt and again transfers the resident without using the Marissa lift, first back to her bed, and then to her chair. • A caregiver fails to secure the resident's wheelchair in the van. The wheelchair rolls forward causing the resident to hit her head on the dashboard. • A caregiver fails to perform cares for an incontinent client and allows the client to lie incontinent for more than 1 1/2 hours until the next shift arrives and changes her, even though the client had asked the caregiver twice to care for her. *Intentional course of conduct:* • A caregiver leaves a client unsupervised and alone in an assisted living facility for approximately 50 minutes. • A caregiver leaves 4 clients with mental retardation alone in a van for approx an hour while in the grocery store. The caregiver left the keys in the ignition and the heater running. • A caregiver ties a resident to a chair in the dining room to prevent the resident from getting up out of the chair. • A caregiver pushes a resident onto the toilet to change the resident's pants and sits on the resident when she tries to stand up. • A caregiver leaves a resident outside for approx 2 hours without sun protection. The resident suffers first and second degree burns.

MISAPPROPRIATION OF PROPERTY (Federal) The **deliberate misplacement, exploitation or wrongful, temporary or permanent use of a resident's belongings or money** without the resident's consent.	
MISAPPROPRIATION OF PROPERTY (State) 1. The intentional taking, carrying away, using, transferring, concealing or retaining possession of a **client's movable property without the client's consent** and with the intent to deprive the client of possession of the property.	*Movable Property:* • A caregiver takes a comforter from one client and personal effects and clothing from another. • A caregiver takes prescription pain medication belonging to client.
2. **Obtaining property of a client by intentionally deceiving the client with a false representation** which is known to be false, made with the intent to defraud, and which does defraud the person to whom it is made.	*False representation:* • A caregiver borrows $5,000.00 from client but fails to repay the money or make any arrangements to do so.
3. By virtue of his or her office, business or employment, or as trustee or bailee, **having possession or custody of money or of a negotiable security, instrument, paper or other negotiable writing of a client**, intentionally using, transferring, concealing, or retaining possession of money, security, instrument, paper or writing without the client's consent	*Virtue of office:* • A caregiver in charge of client accounts cashes checks from the accounts of the clients and does not use the proceeds of the checks for the clients' benefit. • A caregiver cashes 2 checks on behalf of a client but keeps the cash. The caregiver alters the client's financial account records at the facility concerning the transaction.
4. **Intentionally using or attempting to use personal identifying information** to obtain credit, money, goods, services or anything else of value without the authorization or consent of the client	*Personal ID:* • A caregiver uses a client's identification to establish phone service and makes $800 of long-distance calls that are charged to the client.
5. Violating s. 943.38, Stats., involving the property of a client, or s. 943.41, Stats., involving **fraudulent use of a client's financial transaction card.**	*Transaction card:* • A caregiver uses a client's credit card to pay for her personal car insurance bill. The caregiver also used the client's financial transaction card for her own use.

INJURY OF UNKNOWN SOURCE (Federal) An injury should be classified as an "injury of unknown source" when both of the following conditions are met: • the source of the injury was not observed by any person **or** • the source of the injury could not be explained by the resident; **AND** • the injury is suspicious because of the extent of the injury **or** • the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) **or** • the number of injuries observed at one particular point in time **or** • the incidence of injuries over time. **INJURY OF UNKNOWN SOURCE (State)** Refer to Federal definition.	*Injury of Unknown Source:* • A CBRF resident appears at breakfast with a bruise on his shin. No notes appear in the resident's log regarding any incident, and no staff recall observing anything that could have led to the bruise. When asked, the client doesn't remember how he got the bruise. **AND** • A physical assessment conducted by the RN discovers other fresh bruises to the resident's abdomen and upper back. • The nurse checks the resident's records and finds a note about an unexplained bruise to the resident's abdomen 4 weeks earlier.

STEPS	PROCEDURES
Step One: Protect the Resident	• Supervisor immediately assesses resident's personal safety and potential of harm to other residents • If a caregiver is named, supervisor immediately removes the accused caregiver from the patient care area • Notify designated managers of the allegation
Step Two: Assess the Effect on the Resident	• Nursing supervisor immediately completes a body assessment and documents findings • Lead investigator/nursing supervisor must assess for psychosocial changes and document findings • Provide appropriate medical/psychosocial treatment and support to resident • Contact family members if resident wishes and is able to make his/her own decisions
Step Three: Investigate the Allegation	• Contact law enforcement if appropriate • Determine whether accused caregiver may continue working • Collect and protect evidence • Photograph injuries or other pertinent items • Obtain written, signed statements from all witnesses or persons with information • When possible, obtain a detailed account of the incident from the resident, including feelings, pain or discomfort • Obtain a written, signed statement from the accused caregiver • Determine if the resident or legal representative want to involve law enforcement • Document, document, document!
Step Four: Conclude the Investigation	• Review all components of the investigation • Determine whether the incident must be reported further

	• Submit required reports to other agencies, e.g. Division of Quality Assurance, DHFS; Adult Protective Services, etc. • Inform accused caregiver that a report to another agency has been submitted
Step Five: Follow-Up	• Contact the person who reported the incident. (Give no details of the investigation, only that administration is aware of the concern and is investigating) • Reassure the resident and family that the facility has zero tolerance for retaliation • Inform the resident and family if the caregiver will continue to be employed and make sure the resident is comfortable with the caregiver. If not, consider a re-assignment. • Stress to staff, residents, and family members your facility's commitment to a safe environment for all residents • Examine facility policies and procedures to determine how to prevent caregiver misconduct, improve reporting, support residents, etc. Plan educational workshops, in-services.

Scott Walker
Governor

Kitty Rhoades
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF QUALITY ASSURANCE

SOUTHEASTERN REGIONAL OFFICE
819 NORTH SIXTH STREET, Rm. 609B
MILWAUKEE WI 53203-1606

Telephone: 414-227-5000
FAX: 414-227-4139
dhs.wisconsin.gov

June 3, 2013

EMAIL

Michael Spitzer, Administrator
Milwaukee County Mhc Fdd, # 3141
9455 Watertown Plank Rd
Wauwatosa, WI 53226

Re: Survey Type: Recert Survey
Survey Date: 01/08/2013
Survey Event ID: 1JD311; 1JD321

Dear Mr. Spitzer:

The Division of Quality Assurance surveys ICFs/IID to determine whether they meet the regulatory requirements to participate in the Medicaid program as an Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID). A provider must meet the definition found in Section 1905(d) of the Social Security Act and be in compliance with all the requirements for long term care facilities established by the Secretary of the Centers for Medicare & Medicaid Services, found in 42 CFR part 483.400-480.

Based on your acceptable plan of correction, we have recommended to the Division of Long Term Care that your certification as an ICF/IID be continued.

Your facility will be expected to comply with these plans of correction on or before the correction date for each notice, unless your facility has been granted a written extended correction time for state violations per section 50.04(4)(c)4, Wis. Stats. If a violation required a long-range plan of correction, "benchmark" dates for partial correction, and each of these dates should be met.

If you have any questions, please contact me at the address in the letterhead, or telephone at (414) 227-4563.

Sincerely,

Jean Rucker /CAL

Jean Rucker
Southeastern Regional Field Operations Director
Division of Quality Assurance

Attachments

Scott Walker
Governor

Dennis G. Smith
Secretary

State of Wisconsin
Department of Health Services

DIVISION OF QUALITY ASSURANCE

SOUTHEASTERN REGIONAL OFFICE
819 NORTH SIXTH STREET, Rm. 609B
MILWAUKEE WI 53203-1606

Telephone: 414-227-5000
FAX: 414-227-4139
dhs.wisconsin.gov

January 23, 2013

E-MAIL

*****IMPORTANT NOTICE PLEASE READ CAREFULLY*****

Michael Spitzer, Administrator
Milwaukee County Mhc Fdd, # 3141
9455 Watertown Plank Rd
Wauwatosa, WI 53226

Survey Type: Fundamental
Survey Date: January 8, 2013
SOD Event ID: 1JD311; 1JD321

Re: Notification of Survey Results and Warning that Uncorrected Conditions of Participation and/or Repeat Standards will result in Termination of Provider Participation in the Wisconsin Medical Assistance Program under Title XIX of the Social Security Act

Dear Mr. Spitzer:

To participate in the Medicaid program as an Intermediate Care Facility for Individuals who are Intellectually Disabled (ICF/IID), a provider must meet the definition found in Section 1905(d) of the Social Security Act and be in compliance with all the requirements for long term care facilities established by the Secretary of the Centers for Medicare & Medicaid Services, found in 42 CFR part 483.400-480.

The Division of Quality Assurance surveys ICFs/IID to determine whether they meet the regulatory requirements. On 01/08/2013, a Fundamental/Life Safety Code survey was conducted at your facility by the Division of Quality Assurance. Enclosed are the Statements of Deficiencies (SOD) (Form CMS-2567).

Your facility faces potential termination due to the "Repeat Standard" deficiencies described in the enclosed SOD, as listed below:

W Tag #:	Federal Authority:	Nature of Deficiency	Repeat Standard or Condition of Participation
W125	483.420(a)(3)	Protection of Clients Rights	Repeat Standard
W159	483.430(a)	Qualified Mental Retardation Professional	Repeat Standard
W268	483.450(a)(1)(i)	Conduct Toward Client	Repeat Standard

Also enclosed is the State SOD. This SOD reflects violations of state administrative rules identified at this survey.

As a result of the state violations, your facility is at risk of suspension of admissions under s. 50.04(4)(d), Wis. Stats. Your facility has received state violations at the Class B level on the following dates:

Date Served	SOD Number	State Authority	Nature of Deficiency	Level
12/9/08	XH0I11	HFS 134.46(1)	Abuse care and treatment	B
9/3/9	666D12	HFS 134.6(1)(g)	Resident Safety	B
10/28/10	ZOUI11	HFS 134.60(3)(a)1.a	Act.Treat.-Dev Skills	B
10/28/10	ZOUI11	HFS 134.64(4)(b)1	Modified Diets	B
11/07/11	EY5Z11	HFS 134.60(3)(a)1.a	Act.Treat.-Dev Skills	B
05/08/12	W10X11	HFS 134.61(1)	Nursing Services	B
01/08/13	1JD311	HFS 134.6(1)(g)	Resident Safety	B

This history of state violations, including the violations cited at this most recent survey, may subject your facility to this enforcement sanction if you fail to correct the violations by 90 days from the date served. If the violations are found to be uncorrected by this date, the sanction will be imposed and will continue in effect until correction is verified by the Office.

PLAN OF CORRECTION

The Plan of Correction (POC) must be received in this office within ten calendar days of receipt of this letter (or the first working day if the due date is on a weekend or holiday or within 12 calendar days if the E-SOD was received on a Friday). Return the first page, signed and dated, of the Statements of Deficiencies (SOD), along with the completed POC form for those deficiencies which were noted on the SOD.

The plan of correction must specifically identify a date on or before 02/12/13, by which full correction will be achieved, a timetable for correction, and the name of the facility person responsible for correction.

To be acceptable, a provider's plan of correction must include the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice.

- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken.

- What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur.

- How the facility plans to monitor its performance to make sure solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan

must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system.

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the state. If the plan of correction is unacceptable for any reason, the state will notify the facility;

- Documentation to support a LSC waiver request (if appropriate) including: financial hardship statement; floor plan; cost estimate and additional safeguards implemented.

- The plan of correction on the original Statement of Deficiency and be signed and dated by the provider representative.

If you provide an acceptable plan of correction, a revisit will be conducted after the correction timetable noted in the plan of correction. If the Repeat Standard deficiencies are uncorrected at the time of revisit, your Title XIX ICF/IID Medical Assistance provider agreement will terminate 90 DAYS FROM EXIT. Termination appeal rights and an opportunity for an informal reconsideration process will be provided prior to the termination date.

This termination action can be rescinded only if compliance is verified for the above deficiencies prior to the termination date. If you have an unsuccessful revisit, you will have an opportunity to ask for verification of compliance making a "credible allegation," prior to the termination date. Such allegation must be made in writing. Compliance verification will be attempted if the Division of Quality Assurance accepts the "credible allegation". If correction is not verified at the credible-allegation survey, the termination will proceed. Further credible allegations will not be entertained.

The enclosed SOD also describes violations other than Repeat Standard deficiencies, such as Standard Level deficiencies and violations based solely on state law. The correction date and revisit schedule follow the same timetable as described for the Repeat Standard deficiencies. However, the failure to correct these deficiencies (other than Repeat Standard deficiencies) will not automatically result in termination but may result in some alternate sanctions.

INFORMAL DISPUTE RESOLUTION

You have the opportunity to dispute the survey findings through the informal dispute resolution (IDR) process.

To make your request, complete and send the attached Informal Dispute Resolution Request Form DQA F-62514, an original Wisconsin IDR Service Agreement, one copy of the SOD without the Plan of Correction and one copy of your supporting documentation for IDR review to MPRO at 22670 Haggerty Road, Suite 100, Farmington Hills, MI 48335-2611, Attention IDR Review Specialist. This request must be received by MPRO **on or before the tenth calendar day following receipt of the SOD** (or the first working day if the due date is on a weekend or holiday or within 12 calendar days if the E-SOD was received on a Friday). The day the facility receives the SOD by certified mail is Day 0.

In addition, please FAX the completed Informal Dispute Resolution Request Form DQA F-62514 to Gail Hansen, DQA IDR Intake, FAX # (608) 267-7119 on or before the tenth calendar day following receipt of the SOD (or the first working day if the due date is on a weekend or holiday). The day the facility receives the SOD by certified mail is Day 0.

See DQA Memo 08-008 for important information and further direction about IDR. The effective date of any enforcement action will not be delayed by an incomplete IDR process.

APPEAL RIGHTS

Enclosed find a form containing the state appeal provisions. This form explains your appeal rights as found in Ch. 50, Wis. Stats, relating to the state Statement of Deficiencies. Please initial, sign, and date the form and send it to this office.

If you choose to request a hearing on the violations identified in the state Statement of Deficiencies, your request for a hearing should identify the specific violations you are contesting and include a concise statement of the reasons for objecting to them. You may be represented at a hearing by counsel at your own expense. Please also provide this office with a copy of your request for a hearing on the state violations.

RESIDENT RELOCATION

You should be aware that you are responsible for resident relocation, should termination occur. A list of the pertinent statutory requirements that you must meet in closing your facility is shown in Attachment I.

If you have any questions, please contact me at the address in the letterhead or telephone at (414) 227-4563.

Sincerely,

Jean Rucker /CAL

Jean Rucker
Southeastern Regional Field Operations Director
Division of Quality Assurance

Enclosures

PLAN OF CORRECTION

Name - Provider/Supplier	
Milwaukee County Mental Health Division Rehabilitation ~~Central~~ – Hilltop	
Street Address/City/Zip Code	
9455 Watertown Plank Rd, Milwaukee, WI 53226	
License/Certification/ID Number (X1)	52A271
Survey Date (X3)	01/15/2013
Survey Event ID Number	D73M21

ID Prefix Tag (X4)	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date (X5)
W268	**The facility will ensure that the promotion of growth, development and independence are present within the learning environment of all clients including Residents #10, #12, #13, #14, #17 and #18. Staff assisting with all "family-style" meals will be directed not to utilize large paper aprons for any purpose other than what they were intended to be used for i.e., large paper aprons will not be used as placemats. Staff will be directed to use any and all protective, acceptable aprons (not towels), for affected residents in a dignified and respectful manner. Staff will be directed assist Client #15 and other affected residents with the safe and proper utilization of therapeutically approved utensils.** **Completion Date: 02/07/2013** **Persons Responsible:** **Jennifer Lang, QDDP** **Kristine Evans, QDDP** **Betty Walker, NPC** **Gloria Diggs, RN III**	
W125	**The facility will ensure the rights of all clients are upheld by providing and allowing free access to all areas of the living facility. This will be demonstrated by ensuring that all doors are unlocked to tub/shower rooms and kitchen/dining serving areas by the correction date of 02/07/2013. All facility staff has been informed of the resident's rights to have access to all areas of their living facility. To ensure ongoing compliance, there will be monitoring provided by the nursing staff on each shift.** **Completion date: 02/07/2013** **Responsible Persons:** **John Skibba, Maintenance Supervisor** **Gloria Diggs, BSN, RN III** **Betty Walker, MSN, RN, NPC**	

PLAN OF CORRECTION

Name - Provider/Supplier	
Milwaukee County Mental Health Division Rehabilitation Central	
Street Address/City/Zip Code	
9455 Watertown Plank Rd, Milwaukee, WI 53226	
License/Certification/ID Number (X1)	52A271
Survey Date (X3)	01/15/2013
Survey Event ID Number	D73M21

W159	The facility will ensure that the Qualified Developmental Disability Professional will integrate, coordinate and monitor the program for all developmentally disabled residents including but not limited to Client #3. The Qualified Developmental Disability Professionals have been directed by the NHA to ensure that all client IPP goals coincide with a complimentary data collection sheet; that all completed data sheets are retrieved at the end of the month and replaced with new data collection sheets for the new month; and that all quantifiable goals pertain to the prioritized list of needs as noted in the Comprehensive Functional Assessment. Completion Date: 02/07/2013 Responsible Persons: Jennifer Lang, QDDP Kristine Evans, QDDP Michael Spitzer, NHA	
W249	The facility will ensure that staff implements the active treatment program regarding approaches to manage maladaptive behavior for Client #1 as all other resident residing in the said FDD. All Hilltop patient-care staff will beinserviced on the need to: (a) implement the active treatment programs, including Behavioral Treatment Plans, for each client; (b) report observations of unsafe, potentially dangerous client behavior to the living unit nurse as soon as possible; and (c) utilize respectful language in addressing or discussing clients. In addition, BHD security staff will be in-serviced on topics (b) and (c). The Behavioral Treatment Plan for Client #1 will be in-serviced with RN-C. Completion Date: 02/07/2013 Responsible Persons: Gary Stark, PhD – Clinical Program Director Debora Zamacona-Hermsen, Psychologist Betty Walker, RN – Nursing Program Coordinator	

PLAN OF CORRECTION

Name - Provider/Supplier	
Milwaukee County Mental Health Division Rehabilitation Central	
Street Address/City/Zip Code	
9455 Watertown Plank Rd, Milwaukee, WI 53226	
License/Certification/ID Number (X1)	52A271
Survey Date (X3)	01/15/2013
Survey Event ID Number	D73M21

O430	**The facility will ensure that staff is briefed beforehand on the appropriate care regarding implementation of the Behavior Treatment Plan for Client #1 as well as for all residents residing in the said FDD.** **All Hilltop patient-care staff will be in-serviced on the need to (a) implement the active treatment programs, including Behavioral Treatment Plans, for each client; (b) report observations of unsafe, potentially dangerous client behavior to the living unit nurse as soon as possible; and (c) utilize respectful language in addressing or discussing clients. In addition, BHD security staff will be in-serviced on topics (b) and (c).** **Completion Date: 02/07/2013** **Persons Responsible:** **Gary Stark, PhD – Clinical Program Director** **Debora Zamacona-Hermsen – Psychologist** **Betty Walker, RN – Nursing Program Coordinator**	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	52G046	A. BUILDING _____ B. WING _____	C 01/08/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MILWAUKEE COUNTY MHC FDD	9455 WATERTOWN PLANK RD WAUWATOSA, WI 53226

(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
W 000	INITIAL COMMENTS Surveyor: 03359 This was a fundamental survey of MCMH/Hilltop/FDD conducted from 1/2 - 1/8/13. # of federal deficiencies: 4 Census: 62 Sample Size: 10 Supplemental Sample Size: 8 Survey Coordinator: #03359	W 000		
W 125	483.420(a)(3) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore, the facility must allow and encourage individual clients to exercise their rights as clients of the facility, and as citizens of the United States, including the right to file complaints, and the right to due process. This STANDARD is not met as evidenced by: Surveyor: 16584 Based on observations and staff interviews, the facility did not always ensure that they allowed and encouraged individual clients to exercise their rights as clients of the facility by providing them with free access to all areas of the living unit. Living Unit- 43- F was noted to have a locked tub/shower room as well as a locked door to the kitchen/serving area, preventing Clients access from the hallway. Findings include: On 1/3/13 at 12:30 p.m., Surveyor #16584 made	W 125		

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

Michael P. Sporer, MHA, CSW, NHA | Administrator | 02/07/2013

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.