**COUNTY OF MILWAUKEE**
**Behavioral Health Division Administration**
**INTER-OFFICE COMMUNICATION**

**DATE:** January 13, 2014

**TO:** Sup. Peggy Romo West, Chairwoman, Committee on Health and Human Needs

**FROM:** Héctor Colón, Director, Department of Health and Human Services
*Prepared by Jim Kubicek, Interim Administrator, Behavioral Health Division*

**SUBJECT:** **From the Director, Department of Health and Human Services, submitting an informational report on BHD's response to the State's survey of the Hilltop Program**

## Issue

At the October meeting of the Health and Human Needs Committee, BHD was asked to provide an informational report on the State's survey of the Behavioral Health Division's Hilltop program (Center for Independence and Development) and the required corrective action items.

## Background

The State Department of Health Services - Division of Quality Assurance (DQA) surveyed the Hilltop program from October 8 through October 14, 2013 as a result of a BHD caregiver misconduct that the facility proactively self-reported. DQA surveyed the facility to determine whether the facility met regulatory requirements to participate in the Medicaid program and to ensure compliance with all the requirements for long-term care facilities established by the Centers for Medicare and Medicaid.

The facility subsequently received violations that allege concerns regarding client protections. Specifically, BHD must ensure that fundamental protections are in place to safeguard residents against mistreatment, neglect or abuse. Further, mistreatment investigations must be thoroughly completed and related interventions are implemented timely to immediately safeguard all residents and to prevent reoccurrence. Finally, caregivers are to be informed of their responsibility in immediately reporting all incidences of resident mistreatment.

As a result, BHD responded swiftly to the issues identified by DQA and submitted an immediate removal plan which was accepted and verified as completed on October 14, 2014. The following improvement actions were identified and completed to address the concerns.

*BHD's Response to DQA:*

1. The facility removed caregivers from the resident care environments to provide for resident safety during the alleged misconduct investigations.

2. The facility determined caregiver misconduct findings were substantiated and the accused caregivers were not returned to the facility.

3. The facility self-reported the two incidents with findings of caregiver misconduct to the Wisconsin State Office of Caregiver Quality.

4. The facility initiated additional training sessions with all Hilltop employees via an online video presentation and discussion from the State Division of Quality Assurance entitled, *"Wisconsin's Caregiver Program: A Blueprint for Excellence;"* with a focus on caregiver misconduct definitions/examples and reporting requirements designed to impact direct caregivers. All employees were required to complete this training prior to their next scheduled working shift as well as attest to their required knowledge and role to immediately report incidents of suspected caregiver misconduct to their supervisor.

5. The Educational Services Department provided the DQA surveyor team the current existing employee orientation and annual training information regarding caregiver mistreatment education provided by the facility.

6. The facility developed and initiated additional "RN Supervisory Training" for the Hilltop Registered Nurses and LPNs. This training curriculum reviewed the RN responsibilities including, but not limited to: the delegation and supervision of caregivers as it relates to patient safety, scope of practice and ethics, resident protection and prevention and role in the reporting of mistreatment, including legal, facility and licensure compliance. All employees were required to complete this training prior to their next scheduled working shift as well as attest to their required knowledge.

7. The facility created a standardized investigation summary tool that identifies all interventions required in a mistreatment investigation. This will ensure that fundamental protections are in place to prevent resident mistreatment, neglect or abuse. The *"Post-Incident Investigation Protocol and Prevention Checklist for Hilltop"* will be utilized for all mistreatment allegations. It will include a 24-hour review with the investigating manager and an administrator to ensure all individual as well as system-wide interventions are addressed.

8. Nursing Leadership and Administration interviewed facility management staff who previously did not recognize a mistreatment allegation, which subsequently delayed the appropriate safeguarding processes. As a result, appropriate action was initiated.

9. All Administrative Resource staff received training materials related to triaging and responding appropriately to misconduct allegations in relationship to other responsibilities. Each manager submitted attestations acknowledging receipt and compliance expectations.

10. The BHD Interim Administrator participated in the educational sessions with the Hilltop PM and NOC shift employees on unit 43-F to further reinforce the above expectations including no tolerance for actions that may jeopardize the health and safety of our Hilltop residents, including no tolerance for retaliation against those employees who report as required.

11. Nursing Leadership identified and implemented an enhanced off shift management supervision schedule. On October 10, 2013, an Administrative Resource Manager will be redeployed to enhance supervisory oversight on the Long Term Care units to further observe and ensure appropriate resident care and treatment.

12. Nursing management/leadership flexed their current working schedules to be available for supervisory oversight of the Hilltop residents during times of high patient activity.

13. Hilltop management completed supervisory rounds a minimum of two times per shift. Managers asked caregivers on each unit if there were any reported mistreatment concerns to further reinforce the expectation of the identification and timely reporting of incidents and the need to immediately provide all necessary safeguards. Nursing Administration reviewed staff feedback on the audit tool to identify any supportive opportunities for improvement to mitigate resident risk during the program's closure process.

14. AR staff completed supervisory rounds a minimum of one time per shift. Supervisory rounds are conducted twice a shift when enhanced off-shift management supervision is available. Managers asked caregivers on each unit if there were any reported mistreatment concerns to further reinforce the expectation of the identification and timely reporting of incidents and the need to immediately provide all necessary safeguards.

Subsequently, a State and Federal statement of deficiency report(s) was also received on October 28, 2013 with alleged deficiencies that needed correction in addition to the immediate

actions already completed above. BHD provided a plan of correction which was accepted by DQA on November 11, 2013. BHD's written plan of correction, including a sample of the improvement items verified as corrected in the November 25 survey, is listed below for your reference (Part B.)

*BHD's Response to DQA Regarding Written Plan of Correction – Part B*

1. On November 1, 2013, all Behavioral Health Division Administrators on Call (AOCs), Nursing Program Coordinators (NPCs), Registered Nurses III (RNIIIs), Administrative Resources (ARs), managers, as well as the Hilltop Executive Leadership Team initiated a required training series. The above personnel will view a Wisconsin Division of Quality Assurance (DQA) video entitled, *"Conducting Internal Investigations of Caregiver Misconduct Training."* After viewing the video, participants are then directed to a training website where they are provided with information on the appropriate protocol for initiating an internal investigation on caregiver misconduct and a post-incident investigation checklist. The training was completed and verified.

2. Participants were asked to attest as to their understanding of their investigative roles regarding the identification of mistreatment, immediate reporting obligations and the implementation of the facility's Caregiver Misconduct Policy including the completion of a thorough investigation. The requirements for these areas, included, but were not limited, to the following: reporting allegations of caregiver misconduct right away, removing alleged caregivers during an investigation, safeguarding all residents, initiating thorough reviews, providing prompt guardian notification, proper implementation of policy, use of the post-incident checklist to ensure all elements are addressed, thoroughness of reviews, proper reporting notifications, implementation of corrective actions based on findings and the importance of the prevention of mistreatment.

3. BHD Administration is also exploring additional emergent external investigation resource services to assist in the fact-finding process that accompanies a thorough mistreatment allegation investigation. An external investigation service provider has been contacted and a current proposal is under development and review. This additional investigative resource will enhance the current BHD investigative team and completion of timely investigations and thorough reviews that will further assist the facility in the identification of proper improvement actions and corrections with a goal of abuse prevention. Communication with the external agency was initiated last October. A proposal(s) has been requested and received and is currently being reviewed to ensure options in accordance with all county and facility policies. This proposal and agreement detail are not yet completed.

4. On November 7, 2013, BHD leadership, including Human Resources and BHD's Educational Services, developed an on-going plan for a Hilltop Employee Caregiver Workshop that will incorporate additional training on effective and respectful resident communication. The focus of this employee workshop will include Cultural Competency and Cross Cultural Communication as well as: resident dignity and respect, diversity, rights and responsibilities, and interpersonal communication while creating positive relations/communication among all in the healthcare setting. A proposal has been received and further discussion and implementation options are currently being explored.

5. The BHD Interim Administrator scheduled additional consultation with the facility's direct caregivers (Certified Nursing Assistants) beginning November 1, 2013 to engage the staff in the development of additional improvement actions to promote the protection of the rights of all residents including an environment in which residents are not subjected to physical, verbal, sexual or psychological abuse or punishment. Leadership will further encourage reporting and convey action and accountability for appropriate conduct. Quarterly meetings will be scheduled.

6. On November 6, 2013, DQA training posters with information on misconduct detection with an emphasis on prevention were posted in the resident living environment. These posters reinforce the expectation that all residents be treated with dignity and respect and are safe from mistreatment. Facility staff was further reminded of the current Milwaukee County Employee Handbook that includes delineation of employment expectations including, but not limited to: open communication, zero tolerance for workplace retaliation or inappropriate workplace behavior, reporting with integrity, the County's commitment to safety, and appropriate employee performance and ethical conduct. Additional Employee Handbooks were provided to all BHD staff again the week of October 21, 2013.

7. On November 11, 2013, a letter was sent to all Hilltop guardians. The letter requests that if any concerns are identified about how their ward and/or loved one is or has been treated, they should contact Hilltop immediately. Business and non-business hour contacts were provided. Guardians were informed that upon contact, an investigation would be initiated immediately and appropriate actions taken as per policy.

8. Residents who have some capacity to understand the concept of "mistreatment by staff" and the ability to talk about this have also asked about potential mistreatment. Any allegations of Caregiver Misconduct will be investigated per policy.

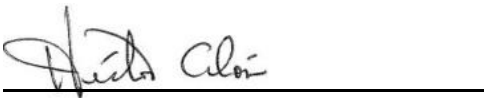
9. All Agency Registered Nurses continue to receive one (8) hour session of education before being able to work on a unit at BHD. This includes education related to the Caregiver Misconduct Policy. Education about caregiver misconduct will emphasize: 1) Recognition/identification of misconduct 2) Protection of residents 3) Immediate reporting and 4) All required documentation. An attestation by the RN will continue to be completed at the conclusion of this education.

**Summary Status:**

After conducting an unannounced survey on November 25, DQA also verified that BHD (Hilltop) had corrected the remaining deficiencies and recommended BHD's certification be continued. BHD received the final report identifying the above status from DQA on December 3, 2013.

**Recommendation**

This is an informational report. No action is necessary.



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Kelly Bablitch, County Board
Don Tyler, Director, DAS
Josh Fudge, Fiscal & Budget Administrator, DAS
Matt Fortman, Fiscal & Management Analyst, DAS
Steve Cady, Director of Research Services – Comptroller's Office
Janelle Jensen, Committee Clerk – County Clerk's Office
Jodi Mapp, Committee Clerk, County Clerk's Office