May 8, 2013

To Whom It May Concern:

The Milwaukee County Behavioral Health Division submits the following removal plan and immediate corrections for your consideration and approval. The facility's nursing home implemented an immediate plan to ensure all residents are provided the right to reside in a safe living environment and not be subject to mistreatment, which includes but is not limited to physical aggression incited by others on the living unit (F223).

In addition, all episodes of client mistreatment are thoroughly investigated and the results of all investigations are reviewed to determine what additional interventions shall be deployed to ensure resident safety (F225).

The following measures will be implemented effective today; May 8, 2013 and will hence remove the immediate jeopardy status:

**Removal Plan**

Effective May 8, 2013, client #61 will not be re-admitted to the program due to high intensity/high frequency physical aggression toward peers.

Following any incident in which a resident willfully causes injury to another person or engages in behavior that could have caused significant injury, clinical leadership and law enforcement are contacted to determine immediate safeguard including legal removal from the facility. The transfer team will convene in consideration of affecting a transfer to a different facility.

During off shifts and on weekends and holidays when incidents occur in which residents willfully cause injury to another person or engages in willful behavior which potentially causes significant injury, upon notification, the administrator will contact a member of the clinical leadership team to make a determination as to the urgent need to transfer to another facilities warranted.

The census on 44A will be reduced based on clinical assessment of individuals as openings become available in the program in effort to reduce the frequency of patient interaction until an all single room status is achieved. This process will begin effective today, May 8, 2013 on Unit 44A. As of May 8, 2013, 15-minute rounds will be implemented on AM and PM shifts on 44A.

Staff assigned to Q15 minute rounds will continuously rove the unit throughout the AM. and PM. shift with particular attention to common areas where residents are present. The

Unit Nurses, NPC, DON and Administrative Resource personnel will oversee this initiative.

Effective May 8, 2013, 44A clinical staff were retrained regarding their resources and accountabilities for managing and escalating milieu. The RN will initiate procedures and summon resources appropriate to the type and nature of the assessed concern. Staff will utilize the Mandt training techniques of Crisis Cycle management, Maslow's Hierarchy of Needs and use of least restrictive interventions to ensure the safety of the milieu.

These actions would include but are not limited to:

- Following the resident's individual plan
- Following facility policies: Management of Agitation and Risk of Violence, Security Staff Utilization, Code 1 Procedure
- Summoning additional Clinical Staff
- Notifying Nursing Manager
- Summoning a staff member with rapport with the individual
- Requesting assistance from Rehabilitation and Social Services

Effective May 8, 2013, Rehab Service personnel we will begin to create a schedule that increases structured therapeutic programming on and off the unit to engage clients in purposeful activity thereby eliminating the opportunity for inappropriate behavior.

To ensure that all incidents of alleged mistreatment or misappropriation of resident property are reported and thoroughly investigated, the facilities post incident process investigation and analysis will be enhanced:

- The nurse manager will initiate a revised Post-incident Investigation Protocol and Prevention Checklist as of May 8, 2013.
- The facility will establish a team, which shall include the social worker, NPC, Clinical Program Director or designee whose purpose will be to ensure that incidents involving alleged mistreatment are thoroughly investigated, analyzed and reported. In addition, the team will ensure that the necessary and appropriate interventions are implemented based on summary findings.
- On the next business day following an allegation of resident mistreatment, the treatment plan will be reviewed and if implicated, will be revised.

The Administrator will ensure these corrective actions are achieved and sustained. Incidents of mistreatment and follow-up will be reviewed at the daily Safety Meeting led by the Administrator/designee. Incidents of mistreatment are summarized and reported on a quarterly basis. The Rehabilitation Centers Executive Committee and the Quality, Compliance and Patient Safety Council will be accountable to monitor facility trends, allocate resources and prioritize compliance activities.

Michael P. Spitzer, NHA

May 8, 2013
Date

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 52A271
(Formerly known as the Medicare Provider Number.)

February 28, 2013
By Overnight Mail and Facsimile

Michael Spitzer, Administrator
Milwaukee County Mental Health Division
Rehabilitation Central
9455 Watertown Plank Rd
Milwaukee, WI 53226

Dear Mr. Spitzer:

**SUBJECT: NOTICE OF IMMEDIATE IMPOSITION OF REMEDIES AND TERMINATION**
**Cycle Start Date: 1/8/13**

**SURVEY RESULTS**
On January 8, 2013 and January 15, 2013, Health and Life Safety Code surveys were completed at Milwaukee County MHD Rehab by the Wisconsin Department of Health Services to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicaid programs. The surveys found that your facility was not in substantial compliance, with the most serious deficiencies at scope and severity (S/S) level E, cited as follows:

- F279 -- S/S: E -- 483.20(d), 483.20(k)(1) -- Develop Comprehensive Care Plans
- F332 -- S/S: E -- 483.25(m)(1) -- Free of Medication Error Rates of 5% or More
- F371 -- S/S: E -- 483.35(i) -- Food Procure, Store/prepare/serve - Sanitary
- K18 -- S/S: E -- NFPA 101 -- Life Safety Code Standard
- K52 -- S/S: E -- NFPA 101 -- Life Safety Code Standard
- K62 -- S/S: E -- NFPA 101 -- Life Safety Code Standard
- K64 -- S/S: E -- NFPA 101 -- Life Safety Code Standard
- K147 -- S/S: E -- NFPA 101 -- Life Safety Code Standard.

The State advised you of the deficiencies noted above and provided you with a copy of the survey report (CMS-2567).

**FEDERAL MONITORING SURVEY AND UNREMOVED IMMEDIATE JEOPARDY**
In addition, a survey team representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on February 27, 2013. As the survey team informed you during the exit conference, the FMS has revealed that your facility continues to not be in substantial compliance. The survey found additional deficiencies, with the most serious deficiencies placing the health and safety of your residents in immediate jeopardy. These deficiencies were cited as follows:

- F223 -- S/S: K -- 483.13(b), 483.13(b)(1)(i) -- Free From Abuse/Involuntary Seclusion
- F225 -- S/S: K -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) – Investigate/Report Allegations/Individuals
- F226 -- S/S: K -- 483.13(c) – Develop/Implement Abuse/Neglect, Etc Policies

In addition, the following cited deficiencies constitute substandard quality of care (SQC) and a partial extended survey was also performed:

- F221 -- S/S: J -- 483.13(a) -- Right to be Free From Physical Restraints
- F223 -- S/S: K -- 483.13(b), 483.13(b)(1)(i) -- Free From Abuse/Involuntary Seclusion
- F225 -- S/S: K -- 483.13(c)(1)(ii)-(iii), (c)(2) - (4) – Investigate/Report Allegations/Individuals
- F226 -- S/S: K -- 483.13(c) – Develop/Implement Abuse/Neglect, Etc Policies

The immediate jeopardy to your residents' health and safety was considered to be ongoing at the conclusion of the Federal survey. **You must take immediate action to remove the immediacy of the deficiency and submit your allegation of removal to this office as soon as possible.** A summary of the immediate jeopardy deficiencies from the Federal survey is enclosed with this letter. A full Statement of Deficiencies on forms CMS-2567 will be sent to you at a later date.

**ALLEGATION OF REMOVAL**
**As the survey team indicated, you should submit a plan for removing the immediate jeopardy to this office at the address shown below.**

The allegation of removal must be signed and dated by an official facility representative. Send your allegation to the following address:

Elizabeth Honiotes, Branch Manager
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

**INFORMAL DISPUTE RESOLUTION**
The State agency offered you an opportunity for informal dispute resolution (IDR) following its survey visits. A request for IDR will not delay the effective date of any enforcement action. However, IDR results will be considered when applicable.

CMS has established an informal dispute resolution (IDR) process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing, to Elizabeth Honiotes, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your POC. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of

Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

**SUBSTANDARD QUALITY OF CARE (SQC)**
Your facility's deficiencies at described at F221, F223, F225 and F226 constitute SQC as defined at 42 CFR 488.301. Sections 1819(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require notification to the attending physician of each resident who was found to have received SQC and notification to the state licensing board responsible for licensing the facility's administrator.

In order for us to satisfy these notification requirements, and as required by 42 CFR 488.325(g), you must provide the following information to this office within ten (10) working days of your receipt of this letter: the name and address of the attending physician of each resident found to have received SQC as identified in the deficient practice(s) described at F221, F223, F225 and F226 on the enclosed summary of deficient practice. Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information in a timely manner will result in termination of your provider agreement or the imposition of alternative remedies.

**SUMMARY OF ENFORCEMENT REMEDIES**
As a result of the survey findings, the Centers for Medicare & Medicaid Services is imposing the following remedies:

- Federal Civil Money Penalty effective February 22, 2013
- Mandatory twenty-three (23) day termination effective March 22, 2013

The authority for the imposition of remedies is contained in subsection 1919(h) of the Social Security Act ("Act") and Federal regulations at 42 CFR Subpart F, Enforcement of Compliance for Long-Term Care Facilities with Deficiencies.

**CIVIL MONEY PENALTY**
In determining the amount of the Civil Money Penalty (CMP) that we are imposing for each day of noncompliance, we have considered your facility's history, including any repeated deficiencies; its financial condition; and the factors specified in the Federal requirement at 42 CFR §488.404. We are imposing the following CMP:

- Federal Civil Money Penalty of $5,500.00 per day beginning February 22, 2013 and continuing until substantial compliance is achieved or your provider agreement is terminated

The CMP continues to accrue at the amount of $5,500.00 per day until you have made the necessary corrections to achieve substantial compliance with the participation requirements, or your provider agreement is terminated. However, the amount of the CMP may be increased or decreased if we find that the noncompliance changes.

If you believe that you have documented evidence that should be considered in establishing the amount of the CMP, the following documents should be submitted to this office within fifteen (15) days from the receipt of this notice:

- Written, dated request specifying the reason financial hardship is alleged
- List of the supporting documents submitted
- Current balance sheet
- Current income statements
- Current cash flow statements
- Most recent full year audited financial statements prepared by an independent accounting firm,

including footnotes

- Most recent full year audited financial statements of the home office and/or related entities, prepared by an independent accounting firm, including footnotes
- Disclosure of expenses and amounts paid/accrued to the home office and/or related entities
- Schedule showing amounts due to/from related companies or individuals included in the balance sheets. The schedule should list the names of related organizations or persons and indicate where the amounts appear on the balance sheet (e.g., Accounts Receivable, Notes Receivable, etc.)
- If the nursing home requests an extended payment schedule of more than twelve (12) months duration, the provider must submit a letter from a financial institution denying the provider's loan request for the amount of the CMP

The CMP is due and payable and may be placed in an escrow account fifteen days after one of the following, whichever occurs first:

- The date on which an Independent IDR process is completed, if applicable or
- The date which is 90 calendar days after the date of the notice of imposition of the civil money penalty.

**CMP REDUCED IF HEARING WAIVED**

If you waive your right to a hearing, **in writing**, within 60 calendar days from receipt of this notice, the amount of the CMP imposed in this notice will be reduced by thirty-five percent (35%). To receive this reduction, the written waiver should be faxed to (443) 380-6627 and include your facility's name, certification number and survey cycle date referenced on the first page of this notice. **The failure to request a hearing within 60 calendar days from your receipt of our previous notice does not constitute a waiver of your right to a hearing for purposes of the 35% reduction.**

Any subsequent survey that results in a finding of continued noncompliance may affect the CMP. If, based on the new finding, the previously imposed CMP amount is continued or the CMP amount is changed, and you choose not to accept the new finding, it will be necessary for you to submit an additional request for a hearing on the subsequent survey finding. Alternatively, you may submit a written waiver of your right to a hearing on the subsequent survey finding.

A CMP case number will be assigned to your case only when the final CMP is due and payable. At that time you will receive a notice from this office with the CMP case number and payment instructions. Prior to the assignment of a CMP case number, you must ensure that your facility's name, CMS Certification Number (CCN), and the enforcement cycle start date appear on any correspondence pertaining to this CMP.

- Your CMS Certification Number (CCN) is 52A271.
- The start date for this cycle is 1/8/13.

**TERMINATION**

Since your facility participates in the Medicaid program, termination of your Medicaid provider agreement will be necessary in light of your noncompliance with the participation requirements. This action is mandated by Section 1919(h)(5) of the Act. The date of termination of your Medicaid provider agreement is March 22, 2013. Federal Financial Participation (FFP) will be continued for up to 30 days of covered services after March 22, 2013 for those qualified residents admitted prior to March 22, 2013. This continued payment is based on the condition that the Medicaid agency is making reasonable efforts to transfer the residents to other facilities.

We are required to provide the general public with notice of an impending termination and will publish a

notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Social Security Act.

**NURSE AIDE TRAINING PROHIBITION**

Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $5,000; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Because the facility was subject to an extended or partial extended survey, this provision is applicable to your facility. Therefore, Milwaukee County MHD Rehab is prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 27, 2013. You will receive further information regarding this from the State agency. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

**APPEAL RIGHTS**

This formal notice announced the finding of SQC which resulted in the loss of NATCEP approval and imposed:

- Federal Civil Money Penalty effective February 22, 2013
- Mandatory twenty-three (23) day termination effective March 22, 2013

If you disagree with the finding of noncompliance which resulted in this imposition and the finding of SQC which resulted in the loss of NATCEP approval, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. seq. **A written request for a hearing must be filed no later than 60 days from the date of receipt of this notice.** Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

**It is important that you send a copy of your request to our Chicago office to the attention of Steven Delich.** Failure to do so could result in our office proceeding with collection of the CMP.

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The DAB will issue instructions regarding the

proper submittal of documents for the hearing. The DAB will also set the location for the hearing. Counsel may represent you at a hearing at your own expense.

**INDEPENDENT INFORMAL DISPUTE RESOLUTION (INDEPENDENT IDR)**
In accordance with §488.431, when a civil money penalty subject to being collected and placed in an escrow account is imposed, you have one opportunity to question cited deficiencies through an Independent IDR process. You may also contest scope and severity assessments for deficiencies which resulted in a finding of actual harm or immediate jeopardy to resident health or safety (i.e., at a scope and severity level of G or above). To be given such an opportunity, you are required to send your written request to Steven Delich, Program Representative, at the Chicago address shown above or to Steven.Delich@cms.hhs.gov with an electronic copy of the request sent to CMSQualityAssurance@cms.hhs.gov.

In addition, send all documentation, such as facility policies and procedures, resident medical record information or other information on which the facility relies in disputing the survey findings directly to:

Stefan Graventstein, MD
6722 Gates Mills Blvd
Gates Mills, OH 44040

A copy of all documents should be sent to Steven Delich in the Chicago office.

This request must be sent during the same 10 calendar days you have for submitting a PoC for the cited deficiencies. An incomplete Independent IDR process will not delay the effective date of any enforcement action.

IDR and Independent IDR in no way are to be construed as a formal evidentiary hearing. They are informal administrative processes to discuss deficiencies. You will be advised verbally of our decision relative to the informal dispute, with written confirmation to follow.

A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;
- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

If you are requesting an IDR or Independent IDR, you must submit your request for within the same ten (10) calendar day timeframe for submitting your POC. In addition, your request must specify which process you are requesting for the disputed deficiency. You may select either an IDR or Independent IDR, but not both for a disputed deficiency. You must provide an acceptable POC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR or Independent IDR. Should the IDR or Independent IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes. If you have any questions concerning the instructions contained in this letter, please contact Steven Delich, Principal Program Representative, at (312) 886-5216.

**CONTACT INFORMATION**
For questions regarding the deficiencies cited please contact Christine Vause at (312) 353-9613 and fax

(443) 380-6750. For questions regarding this enforcement case, please contact Steven Delich, Program Representative, at (312) 886-5216.

Sincerely,

Heather A. Lang
Branch Manager
Long Term Care Certification
& Enforcement Branch

Enclosure: Summary Description

cc: Wisconsin Department of Health Services
Wisconsin Division of Health Care Access and Accountability
Wisconsin Board of Aging and Long Term Care
Michigan Peer Review Organization
National Government Services

Milwaukee County MHC Rehab Center
CCN: 52A271
Survey Date: 2/27/13

F221 (J)
**CFR 483.13 (a) Restraints**

**The resident has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.**

The facility failed to ensure individualized, least restrictive and safe approaches were identified and implemented to address residents' physically aggressive behaviors to prevent the inappropriate recurrent use of physical restraints after the initial emergent use of a physical restraint. These facility failures represent Immediate Jeopardy to the health and safety of three residents whose medical conditions placed them at risk for serious injury, harm or death (R41, R47 and R65) in a sample of 15.

For example, the facility applied four-point or ambulatory wrist-with-waist-belt restraints to R65 21 times from April 2012 to February 2013. R65 had pre-existing medical conditions that placed her at greater risk for negative restraint outcomes, such as respiratory arrest, cardiac arrhythmias (irregular heartbeats) or sudden death. R65's diagnoses included cardiomyopathy (heart muscle disease causing the heart to become weaker), hypertension, asthma and obesity. After the first restraint use on 4/18/12, the facility did not identify triggering factors, ways to prevent future restraint use for R65 or specific approaches to decrease or divert her from inappropriate behaviors. On 7/10/12, R65 was placed in four-point restraints and a spit hood, during which R65's blood pressure was elevated to 208/106 with a heart rate of 53. R65 was sent to a hospital for assessment of her elevated blood pressure during the restraint use. After 7/10/12, the facility physically restrained R65 19 more times, during which vital signs were sometimes not monitored and triggering factors and ways to prevent future restraint use were often not identified to determine individualized approaches to R65's behaviors.

This deficient practice resulted in an Immediate Jeopardy to three residents' safety, which began on 7/10/12 when R65 was restrained with four-point restraints for the second time. The Deputy Administrator, Behavioral Health Division; Administrator, Nursing Facility; Director of Nursing; and Nursing Program Coordinator were notified of the Immediate Jeopardy on 2/22/13 at 1:30pm. The Administrator was notified the Immediate Jeopardy had not been removed at the survey exit conference on 2/27/12 at 2pm.

F223 (K)

**§483.13(b) Abuse**
**The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.**

The facility failed to ensure that residents were free from abuse, including resident to resident abuse. For example, residents R68, R47, R48, and R56 and all other residents residing on hall 4-4-A were not protected from multiple incidents of resident to resident abuse by R61. The facility failed to develop and implement new strategies following the incidents to prevent further resident aggression and to protect residents from on-going abuse.

R61 was involved in the following resident to resident incidents:

On 9/5/12 R61 placed R68 in a headlock and punched him in the face. R68 suffered bruising around his left eye.

On 9/19/12 R61 and R47 were verbally abusing each other through name calling. R61 then began physically striking R47 in the head.

On 11/4/12 R61 began verbally threatening an unidentified resident. R61 then pushed this resident to the ground and attempted to kick her before staff intervened.

On 11/19/12 R61 jumped on R48's back and struck him on the right side of his face. R48 then responded by striking R61 in the face causing R61 to suffer a bloody nose and an abrasion to her lower lip.

On 12/6/12 R61 was noted to be hyperverbal and was threatening an unidentified peer that she was going to bust the resident's "[profanity] head"

On 2/8/13 R61 "entered the conference room [and] hit [R56] on [left] cheekbone."

On 2/15/13 R61 and R47 were noted to have been exchanging profanities. R61 then was observed by staff striking R47 "all over her body, including [her] head."

Review of resident R61's "Recovery Plan" titled "Alteration in Behavior-Safety" revealed that the facility failed to develop any new approaches to address R61's aggression between 11/4/11 and 1/10/13 and no new approaches were developed until 2/23/13.

This deficient practice represents an Immediate Jeopardy to all 21 residents residing on 4-4-A which began on 9/5/12 when R68 was placed in a headlock and was struck in the face by R61. The Deputy Administrator, Behavioral Health Division, Administrator, Nursing Facility, Director of Nursing and Nursing Program Coordinator were notified of the Immediate Jeopardy on 2/22/13 at 1:30pm.
The Administrator was notified that the Immediate Jeopardy had not been removed at the survey exit conference on 2/27/12 at 2pm.

F225(K)

**§483.13(c)(2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).**
**§483.13(c)(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.**
**§483.13(c)(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.**

The facility failed to ensure that all allegations of abuse, including resident to resident abuse, were immediately reported to the Administrator and state survey and certification agency and were thoroughly investigated. For example, the facility failed to ensure multiple incidents of resident to resident abuse involving residents R61, R68, R47, R48, and R56 and additional unidentified residents residing on hall 4-4-A were immediately reported to the Administrator and state survey and certification agency and were thoroughly investigated.

Record review revealed numerous incidents of resident to resident abuse:

On 9/19/12 R61 and R47 were verbally abusing each other through name calling. R61 then began physically striking R47 in the head. The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility provided an incident report consisting of a single page. Review of the incident report revealed that the Administrative review of the incident report was not conducted until 9/20/12 and that the state agency had not been notified of the incident. The investigation did not include interviews or statements by the four staff members identified as witnesses to the incident.

On 11/4/12 R61 began verbally threatening an unidentified resident. R61 then pushed this resident to the ground and attempted to kick her before staff intervened. The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility provided an incident report consisting of a single page. Review of the incident report dated 11/3/12 (sic) revealed that the Administrative review of the incident report was not conducted until 11/5/12 and that the state agency had not been notified of the incident. The investigation did not include interviews or statements by the two staff members identified as witnesses to the incident.

On 11/19/12 R61 jumped on R48's back and struck him on the right side of his face. R48 then responded by striking R61 in the face causing R61 to suffer a bloody nose and an abrasion to her lower lip. The facility was asked to produce evidence that this incident had been reported and

thoroughly investigated. The facility provided an incident report consisting of a single page. Review of the incident report revealed that the Administrative review of the incident report was not conducted until 11/20/12 and that the state survey and certification agency had not been notified of the incident. The investigation did not include interview or statements by the two staff members identified as witnesses to the incident.

On 12/6/12 R61 was noted to be hyperverbal and was threatening an unidentified peer that she was going to bust the resident's "[profanity] head" The facility was asked to produce evidence that this incident had been thoroughly investigated. The facility was unable to provide any documentation that indicated that the incident had been reported to the Administrator and state survey and certification agency and was thoroughly investigated.

On 12/17/12 R61 was noted to be agitated, cursing and swearing at staff and unidentified peers. The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility provided an incident report consisting of a single page. Review of the incident report revealed that the Administrator was not immediately notified of the incident, that an Administrative review of the incident report was not conducted until 12/18/12 and that the state agency had not been notified of the incident. The investigation did not include interviews or statements by the staff member identified as a witness to the incident.

On 12/19/12 R61 walked past an unidentified male peer who yelled obscenities at her and R61 struck him in the right shoulder. The facility was asked to produce evidence that this incident had been thoroughly investigated. The facility was unable to provide any documentation that indicated that the incident had been reported to the Administrator and state survey and certification agency or was investigated.

On 1/18/13 R61 was noted to be "very aggressive, swinging at other residents, threatening staff and other residents..." R61 ran up to an unidentified resident and was punching the air but towards this resident's personal space. The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility was unable to provide any documentation that indicated that the incident had been reported to the Administrator and state survey and certification agency and was thoroughly investigated.

On 2/8/13 R61 "entered the conference room [and] hit [R56] on [left] cheekbone." The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility was unable to provide any documentation that indicated that the incident had been reported to the Administrator and state survey and certification agency and was thoroughly investigated.

On 2/11/13 R61 struck R56 in the chest. The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility was unable to provide any documentation that indicated that the incident had been reported to the Administrator and state survey and certification agency and was thoroughly investigated.

On 2/15/13 R61 and R47 were noted to have been exchanging profanities. R61 then was observed by staff striking resident R47 "all over her body, including [her] head." The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility's investigation consisted of an incident report consisting of a single page. No witnesses to the event were identified and there was no indication that the state survey and certification agency was notified.

In an interview conducted on 2/21/13 at 9:45am, the Clinical Program Director and Director of Nursing conveyed their understanding that incidents of resident to resident abuse were reportable only if a resident suffered an injury.

This deficient practice represents Immediate Jeopardy to all 21 residents residing on 4-4-A which began on 9/19/12 when R61 and R47 verbally abused one another and R61physically struck R47 which was not appropriately reported or investigated. The Deputy Administrator, Behavioral Health Division, Administrator, Nursing Facility, Director of Nursing and Nursing Program Coordinator were notified of the Immediate Jeopardy on 2/22/13 at 1:30pm.

The Administrator was notified that the Immediate Jeopardy had not been removed at the survey exit conference on 2/27/12 at 2pm.

F226(K)

**§483.13(c) Staff Treatment of Residents (F224* and F226**)**
**The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.**

The facility failed to implement its abuse prohibition policy to ensure that residents were free from abuse, including resident to resident abuse, that all allegations were immediately reported to the Administrator and state agency and were thoroughly investigated. For example, the facility failed to implement its abuse prohibition policy by failing to prevent resident to resident abuse for R68, R47, R48, and R56 and additional unidentified residents residing on hall 4-4-A, failed to ensure that multiple allegations of resident to resident abuse involving residents R68, R47, R48, and R56 and additional unidentified residents residing on hall 4-4-A abuse were immediately reported to the Administrator and state survey and certification agency and were thoroughly investigated.

Review of the facility policy entitled "Caregiver Misconduct" with a revision date of 6/19/12 revealed that it was the policy of the facility that "Staff and all other persons with whom patients come in contact shall treat the patient with courtesy, respect, with full recognition of their dignity and individuality, and shall provide them with considerate care and treatment at all times…[the facility] reports all allegations of resident mistreatment…to the State of Wisconsin…the

definition of mistreatment includes the following…physical and sexual assaults on a resident by another resident…Immediate investigation and documentation of all incidents of resident mistreatment…should include the following…collection of physical and documentary evidence…interviews of the alleged victim(s) and witness (es)…"

On 9/5/12 R61 placed R68 in a headlock and punched him in the face. R68 suffered bruising around his left eye.

On 9/19/12 R61 and R47 were verbally abusing each other through name calling. R61 then began physically striking R47 in the head. The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility provided an incident report consisting of a single page. Review of the incident report revealed that the Administrative review of the incident report was not conducted until 9/20/12 and that the state survey and certification agency had not been notified of the incident. The investigation did not include statements by the four staff members identified as witnesses to the incident.

On 11/4/12 Resident R61 began verbally threatening an unidentified resident. Resident R61 then pushed this resident to the ground and attempted to kick her before staff intervened. The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility provided an incident report consisting of a single page. Review of the incident report dated 11/3/12 (sic) revealed that the Administrative review of the incident report was not conducted until 11/5/12 and that the state survey and certification agency had not been notified of the incident. The investigation did not include statements by the two staff members identified as witnesses to the incident.

On 11/19/12 R61 jumped on R48's back and struck him on the right side of his face. R48 then responded by striking R61 in the face causing R61 to suffer a bloody nose and an abrasion to her lower lip. The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility provided an incident report consisting of a single page. Review of the incident report revealed that the Administrative review of the incident report was not conducted until 11/20/12 and that the state survey and certification agency had not been notified of the incident. The investigation did not include statements by the two staff members identified as witnesses to the incident.

On 12/6/12 R61 was noted to be hyperverbal and was threatening an unidentified peer that she was going to bust the resident's "[profanity] head" The facility was asked to produce evidence that this incident had been thoroughly investigated. The facility was unable to provide any documentation that indicated that the incident had been reported to the Administrator and state survey and certification agency and was thoroughly investigated.

On 12/18/12 R61 was noted to be agitated, cursing and swearing at staff and unidentified peers. No investigation was provided regarding this incident, nor was evidence that the incident had been reported to the Administrator and state survey and certification agency.

On 12/19/12 R61 walked past an unidentified male peer who yelled obscenities at her and she struck him in the right shoulder. The facility was asked to produce evidence that this incident had been thoroughly investigated. The facility was unable to provide any documentation that indicated that the incident had been reported to the Administrator and state survey and certification agency and was thoroughly investigated.

On 1/18/13 R61 was noted to be "very aggressive, swinging at other residents, threatening staff and other residents..." R61 ran up to another resident and was punching the air towards the resident's personal space. The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility was unable to provide any documentation that indicated that the incident had been reported to the Administrator and state survey and certification agency and was thoroughly investigated.

On 2/8/13 R61 "entered the conference room [and] hit [R56] on [left] cheekbone." The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility was unable to provide any documentation that indicated that the incident had been reported to the Administrator and state survey and certification agency and was thoroughly investigated.

On 2/11/13 R61 struck resident R56 in the chest. The facility was asked to produce evidence that this incident had been reported and thoroughly investigated. The facility was unable to provide any documentation that indicated that the incident had been reported to the Administrator and state survey and certification agency and was thoroughly investigated.

On 2/15/13 R61 and R47 were noted to have been exchanging profanities. R61 then was observed by staff striking R47 "all over her body, including [her] head." The facility was asked to produce evidence that this incident had been reported and was thoroughly investigated. The facility's investigation consisted of an incident report consisting of a single page. No witnesses to the event were identified and there was no indication that the state agency was notified.

The facility's failure implement its abuse prohibition policy to protect residents from abuse and to report and investigate resident to resident abuse to prevent residents from further abuse posed an Immediate Jeopardy to residents that began on 9/5/12 when R61 placed R68 in a headlock and punched him in the face. The Deputy Administrator, Behavioral Health Division, Administrator, Nursing Facility, Director of Nursing and Nursing Program Coordinator were notified of the Immediate Jeopardy on 2/22/13 at 1:30pm.

The Administrator was notified that the Immediate Jeopardy had not been removed at the survey exit conference on 2/27/12 at 2pm.

**Michael Spitzer**

**From:** <Mike.Spitzer@milwcnty.com>
**To:** <mspitzer1@wi.rr.com>
**Sent:** Sunday, March 10, 2013 4:20 PM
**Subject:** Fw: IJ removal plan

----- Original Message -----
From: "Vause, Christine (CMS/CQISCO)" [Christine.Vause@cms.hhs.gov]
Sent: 03/08/2013 09:02 PM GMT
To: ""Mike.Spitzer@milwcnty.com"" <"Mike.Spitzer@milwcnty.com'>
Subject: RE: IJ removal plan
Hello Michael,

Per our telephone conversation, the removal plan (Fax'd to us at 2:2pm today) for the IJ's at F221, F223, F225 and F226 has been accepted.

Thank you,

Chris Vause

From: Vause, Christine (CMS/CQISCO)
Sent: Friday, March 08, 2013 1:43 PM
To: 'Michael Spitzer'; "Mike.Spitzer@milwcnty.com'
Subject: Removal
Plan**********

DEPARTMENT OF HEALTH & HUMAN SERVICES
BEHAVIORAL HEALTH DIVISION
Milwaukee County

March 8, 2013

Christine Vause, R.N., BSHA, MA
Nurse Consultant
U.S. Department of Health and Human Services
233 N. Michigan Avenue, Suite 600
Chicago, Illinois 60601

Dear Ms. Vause (Christine),

Please find attached the revised Removal Plan. I am hopeful that we have adequately addressed the components in your e-mail correspondence of 03/08/2013 alluding to what was missing from a comprehensive plan. Thank you for your time and attention to this matter and look forward to your response as early as today if feasible. The facility alleges that the Immediate Jeopardy for F221 will be removed Monday, March 11, 2013. The facility alleges that the Immediate Jeopardy for F223 will be removed Monday, March 11, 2013. In addition, the facility alleges the Immediate Jeopardy for F225 will be removed Monday, March 11, 2013. In closure the facility alleges the Immediate Jeopardy for F226 will be removed Monday, March 11, 2013.

Sincerely,

Michael P Spitzer NHA - 03/08/2013

Michael Spitzer, MHA, CSW, NHA
Administrator - Rehabilitation Center Central (SNF)
Milwaukee County Behavioral Health Division
Work #: 414-257-5782
Work Cell #: 414-630-2693

March 8, 2013

Christine Vause, R.N., BSHA, MA
Nurse Consultant
U.S. Department of Health and Human Services
233 N. Michigan Avenue, Suite 600
Chicago, IL 60601

Dear Ms. Vause:

The Milwaukee County Behavioral Health Division submits the following removal plan and immediate corrections for your consideration and approval. The facility's nursing home implemented an immediate plan to further assess residents with incident of restraint as to ensure utilization of least restrictive care and to prevent unnecessary restraint. The facility also immediately identified those residents who are assessed to render them at risk for potentially mistreating other residents and enhanced individualized interventions to ensure a living environment free from resident abuse or mistreatment.

**Restraint:**
The facility will have policies and procedures in place to ensure that residents are free of unnecessary restraint by utilizing the least restrictive methods prior to the consideration of any restraint application. The facility will ensure an individualized, comprehensive process to assess resident characteristics for indications of aggression, identify interventions and subsequently review causal factors of restrictive measures.

1. On February 24, 2013, the facility's Clinical Program Director completed a review of the care plans for 17 residents who were placed in physical restraints within the previous six months. New interventions were developed, based on each individual's needs and relevant clinical factors, as an alternative to restraint use. A copy of the revised care plans as it relates to physical restraint use for **R65 (MD), RR41 (CG) and R47 (PW) can be found in Appendix I.**

2. On February 26, 2013, a comprehensive interdisciplinary team reviewed the clinical history and needs of the above identified residents to identify underlying psychological and/or medical causes of behavior leading to restraint. The team then identified new individualized interventions to prevent or reduce future episodes of restraint and added them to the care plan. On February 27, 2013, the interventions were subsequently reviewed with the care teams and copied and placed in a reference binder for use by the direct care providers, including those members of the treatment team who may not consistently work on a particular care unit.

3. As of March 8, 2013 all scheduled Rehabilitation Center Central (RCC) staff *were trained* regarding the resident's right to be free from unnecessary restraint. The training included survey findings, review of alternatives to restraints, prevention and early intervention curriculum (Mandt). All staff reviewed the facility's policies including Seclusion and Restraint and Management of Agitation. All staff who "floats" or do not regularly work on Rehabilitation Central Center SNF units who have not been trained will receive training from the nurse

manager prior to being allowed to work on the unit. Only staff who have been trained are allowed to work on the unit.

4. As of February 25, 2013 each restraint intervention will require immediate administrative notification and a formalized staff debriefing and analysis as soon as possible but no later than the end of the shift during which the restraint occurred. Information from the Post-Restraint Treatment Team Review will be used to create or revise the behavioral care plan on the day the review is conducted. The review will be conducted by the treatment team by the next business day after the event. The Team Leader is responsible to ensure that the plan is revised and staff members are alerted to review the changes.

   Monday through Friday, Nursing Program Coordinators (NPC) and Psychology Staff will conduct debriefings. On weekends, the Administrative Resource will be notified of emergent restraint use on living units 44A, 44B, or 44C and will respond to evaluate the event.

5. As of February 25, 2013, all episodes of restraint use will prompt team review and/or treatment plan revision within one business day. The plan of care will be reviewed and/or revised by the R.N. during the shift the incident occurred and by the treatment team the next business day. A post restraint treatment team review tool was implemented on February 25, 2013.

   a. A systematic review of the restraint episode will answer the following questions:
      i. What are the medical symptoms that led to the consideration of the use of restraints?
      ii. Are these symptoms caused by unmet needs, lack of rehabilitative care, lack meaningful activities, need for environmental modification etc.
      iii. Can the causes of the medical symptoms be eliminated or reduced?
      iv. If causes can't be eliminated or reduced, has the facility attempted to use alternatives in order to avoid a decline in physical functioning associated with restraint use?
      v. If least restrictive, does the facility use for the least amount of time?
      vi. Does the resident or legal surrogate make an informed choice about the use of restraints to include provision of risks, benefits, and alternatives explained?

6. In the event that restraint is utilized, the documentation will reflect that the least restrictive measures to manage the resident's behaviors were attempted prior to the initiation of restraint:

   - This documentation will be located in the RN Assessment and Progress Note found on page one of the Restraint Implementation and Assessment Form narrative. It includes a description of violent or self-destructive behavior that jeopardized the immediate physical safety of the resident or others. It also documents less restrictive interventions attempted prior to the use of restraints. The RN will also document attempts at less restrictive interventions such as verbal de-escalation, 1:1 time with staff, medication, move to a less stimulating environment, pain/comfort measures, resident-specific diversional activities and additional treatment plan interventions.
   - On the Restraint Intervention Staff Debriefing form that will be completed immediately following any restraint intervention, the team will identify alternative interventions that were attempted prior to the event.

Documentation to reflect why less restrictive attempts were unsuccessful will be noted:

- On page one of the Restraint Implementation and Assessment Form under the "Alternatives/Less Restrictive Interventions Response" section.
- On page two of the Restraint Implementation and Assessment Form "Debriefing Process with Patient" section.
- On the Restraint Intervention Staff Debriefing Form
- On the Post-Restraint Treatment Team Review Form that will include a team review of the event (including the resident) and recommendations for adjustment to the plan to prevent future events.

7. As of February 25, 2013, two episodes of restraint use for a resident within 14 days will prompt clinical leadership and transfer team evaluations including the discussion of options. Such discussions will be brought to daily Noon Report meetings for review by the BHD Medical Director or designee and a comprehensive analysis regarding the necessity for transfer to an alternate level of care.

8. All Rehabilitation Center Central residents will be evaluated on February 26, 2013 for proper level of supervision (i.e. 15/30-minute checks, 1:1s).

9. Beginning February 26, 2013, weekly restraint reports will be generated. Any increase in utilization of physical restraint will be examined for causative factors. In addition, decreased restraint utilization will be analyzed to determine effectiveness of less restrictive techniques.

10. Facility practices regarding behavioral interventions have been reviewed and amended as indicated. Practices that have been amended include:

    a. Unit holds and restrictions protocol
    b. Elimination of reference to emergent restraint use in treatment plans

**Resident Mistreatment Prevention:**

The immediate correction, mandatory training, for all clinical staff ("Protecting our Nursing Home Residents") has been completed as of March 8, 2013. Ten group training sessions were conducted and individual sessions were conducted until all facility staff was trained. All staff was trained on the definitions of abuse, neglect and misappropriation of property and the immediate reporting requirement. The training also included the facility policy for reporting and investigation of resident mistreatment to include that all allegations of resident mistreatment are reported to DQA immediately or *"as soon as possible but not to exceed 24 hours"* after discovery of the incident. All staff who "floats" or do not regularly work on Rehabilitation Central Center SNF units who have not been trained will receive training from the nurse manager prior to being allowed to work on the unit. Only staff who have been trained are allowed to work on the unit.

On February 27, 2013, federal surveyors informed the facility that the Wisconsin DQA 2012 training reference "Resident-to-Resident Altercation" decision-making and action algorithm was inaccurate. The information was removed from the training packet. Facility staff that attended the training was updated and told to disregard the erroneous WI DQA tool. All facility nursing managers who provide after-hours and weekend coverage received training on policies requiring the immediate notification to the Rehabilitation Centers administrator and immediate reporting to DQA defined as *"as soon as possible but not to exceed 24 hours."*

A mandatory training "Implementing Individualized Plans for Residents with High Risk for Aggression and Mistreatment of Others" was initiated. As of March 8, 2013, thirty-five training sessions had been completed. All staff who "floats" or do not regularly work on Rehabilitation Central Center SNF units who have not been trained will receive training from the nurse manager prior to being allowed to work on the unit. Only staff who have been trained are allowed to work on the unit.

The facility will immediately report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin, and misappropriation of property to the facility administrator and to the Wisconsin Department of Quality Assurance (DQA). All staff has been trained to report all episodes of mistreatment as soon as they become aware. The facility will immediately report, defined as: as soon as possible but not to exceed 24 hours, all incidents of mistreatment after the discovery of an incident. The facility will ensure the incident follow-up includes review and/or revision of the treatment plan and ensures the appropriate interventions to safeguard residents in addition to preventing reoccurrence. A thorough investigation is launched immediately following the safeguarding of residents.

It is the objective of MCBHD Rehabilitation Central to conduct prompt, thorough (please refer to Appendix IV) and complete investigations to the Office of Caregiver Intake for all incidents of caregiver misconduct and all other episodes of resident mistreatment which shall include, but not be limited to, episodes of abuse, neglect, misappropriation of property, resident to resident altercations (submission of the entity's investigation will include the corresponding 2447 State report). In addition, comprehensive investigations for incidents of resident mistreatment also require prompt follow through. At the time the facility incident report is completed the NPC or designee (i.e., RN assigned to the unit) must begin collecting the following investigative material (Appendix II) to be assembled and submitted to the Office of Caregiver Intake by Clinical Program Director Dr. Larry Koszewski, PhD. (Please refer to **Appendix II** utilized by assigned investigator.)

**Additional Facility Interventions for Mistreatment Prevention:**

1. On February 26, 2013, facility data was utilized to identify residents at elevated risk for potentially mistreating other residents. The names of such residents residing on unit 44A identified by our facility who are at risk of being abusive to other residents appear on Appendix III. (Please refer to Appendix III.)

2. On February 26, 2013, a comprehensive interdisciplinary team reviewed the clinical history and needs of the above identified residents to identify underlying psychological and/or medical causes of behavior leading to mistreatment of other residents. The team included the clinical program director, social workers, psychologists and an occupational therapist. To address item #8 on your March 5, 2013 correspondence that it appears one person revised the care plans can be explained by the fact that the Clinical Program Director was the sole typist. It is for this reason his name appears more often on the Recovery Plans than the names of other interdisciplinary team members.

   The team then identified new individualized interventions based on medical records and past experience of daily discipline specific interactions with the said residents to prevent or reduce future episodes of mistreatment. These interventions were then added to the care plan. On February 27, 2013, the interventions were subsequently reviewed with the care teams and copied and placed in a reference binder for use by the direct care providers, including those members of the treatment team who may not consistently work on a particular care unit.

As of March 8, 2013, all scheduled RCC staff were trained regarding the residents right to be free from mistreatment. All staff were provided a review of facility's policies including caregiver misconduct, protection of resident to resident abuse including reporting requirements and notification, and the requirements or identification, prevention and protection from abuse. All staff who "floats" or do not regularly work on Rehabilitation Central Center SNF units who have not been trained will receive training from the nurse manager prior to being allowed to work on the unit. Only staff who have been trained are allowed to work on the unit.

3.

4. The facility will ensure that all episodes of resident-to-resident abuse are immediately reported to the Division of Quality Assurance. The plan of care will be reviewed and/or revised by the R.N. during the shift the incident occurred and by the treatment team the next business day.

5. The facility will ensure that all incidents of resident-to-resident abuse will be reviewed daily at the 9 a.m. safety meetings. The incident follow-up will include the review and/or revision of the treatment plan and appropriate incentives to safeguard residents and prevent re-occurrence to include monitoring for changes that would trigger abusive behavior, and a plan for re-assessment of the interventions on a regular basis.

6. As of March 8, 2013 all facility's social work staff had been trained on the elements of an effective prevention program including the protocol for the provision of daily resident Community Meetings. These meetings incorporate education that reviews the Behavioral Health Division's Non-Violence policy as well as the Community Statement summarizing the expectations and responsibilities of a safe and healing environment. Community Meetings were initiated on every resident care unit beginning February 25, 2013.

If you have any questions or require additional documentation, please contact Michael Spitzer, NHA at (414) 630-2693.

Sincerely,

Michael P. Spitzer, NHA

# Milwaukee County
# Behavioral Health Division
# Plan of Correction

## F 167

The facility will ensure that all survey results and the entity's POC from the most recent survey are clearly posted on Units 44A, 44B, and 44C for consumer and public review. In addition, a copy of all recent survey results and corresponding POC will be kept in a labeled, red binder at the nurse's station. A notification memorandum will be placed at unit entrance stations indicating that recent survey results are available for review without the need to ask for them. While making daily rounds, the administrator will ensure that the binder maintaining survey results and respective POC is at the nurse's station. The aforementioned monitoring responsibilities during weekend days will be the responsibility of the weekend Nurse Manager.

**Completion Date:** April 12, 2013

**Responsible person:** Michael Spitzer, Nursing Home Administrator

## F 221

The facility will ensure that individualized, least restrictive and safe approaches are consistently identified and implemented to address residents' physically aggressive behaviors. The interventions will prevent the inappropriate recurrent use of physical restraints after an initial emergent use of a physical restraint for all residents including residents R41, R47, R65, R17, R30, R61, R34, R35, R48, R52, R60 and R63. The facility submitted a removal plan to C.M.S. on March 8, 2013 for Tag F-221 that had been identified as a citation meriting immediate jeopardy status. The I.J. status has since been removed by C.M.S.

On February 24, 2013, the facility's Clinical Program Director completed a review of the care plans for 17 residents who were placed in physical restraints within the previous six months. New interventions were developed, based on each individual's needs and relevant clinical factors, as an alternative to restraint use.

On February 26, 2013, a comprehensive interdisciplinary team reviewed the clinical history and needs of the above identified residents to identify underlying psychological and/or medical causes of behavior leading to restraint. The team then identified new individualized interventions to prevent or reduce future episodes of restraint and added them to the care plan. On February 27, 2013, the interventions were subsequently reviewed with the care teams and copied and placed in a reference binder for use by the direct care providers, including those members of the treatment team who may not consistently work on a particular care unit.

As of March 8, 2013 all scheduled Rehabilitation Center Central (RCC) staff were trained regarding the resident's right to be free from unnecessary restraint. The training included survey findings, review of alternatives to restraints, prevention and early intervention curriculum (Mandt). All staff reviewed the facility's policies including Seclusion and Restraint and Management of Agitation. All staff that "float" or do not regularly work on Rehabilitation Central Center SNF units and who have not been trained will receive training from the registered nurse prior to working.

As of February 25, 2013 each restraint intervention has required immediate administrative notification and a formalized staff debriefing and analysis as soon as possible but no later than the end of the shift during which the restraint occurred. Information from the Post-Restraint Treatment Team Review will be used to create or revise the behavioral care plan on the day the review is conducted. The review will be conducted by the treatment team by the next business day after the event. The Team Leader is responsible to ensure that the plan is revised and staff members are alerted to review the changes.

Monday through Friday, Nursing Program Coordinators (NPC) and Psychology Staff will conduct debriefings. On weekends, the Administrative Resource will be notified of emergent restraint use on living units 44A, 44B, or 44C and will respond to evaluate the event.

As of February 25, 2013, all episodes of restraint use prompt team review and/or treatment plan revision within one business day. The plan of care will be reviewed and/or revised by the R.N. during the shift the incident occurred and by the treatment team the next business day. A post restraint treatment team review tool was implemented on February 25, 2013 and will continue to be utilized.

a. A systematic review of the restraint episode will answer the following questions:
    i. What are the medical symptoms that led to the consideration of the use of restraints?
    ii. Are these symptoms caused by unmet needs, lack of rehabilitative care, lack meaningful activities, need for environmental modification etc.
    iii. Can the causes of the medical symptoms be eliminated or reduced?
    iv. If causes can't be eliminated or reduced, has the facility attempted to use alternatives in order to avoid a decline in physical functioning associated with restraint use?
    v. If least restrictive, does the facility use for the least amount of time?
    vi. Does the resident or legal surrogate make an informed choice about the use of restraints to include provision of risks, benefits, and alternatives explained?

In the event that restraint is utilized, the documentation will reflect that the least restrictive measures to manage the resident's behaviors were attempted prior to the initiation of restraint:

- This documentation will be located in the RN Assessment and Progress Note found on page one of the Restraint Implementation and Assessment Form narrative. It includes a description of violent or self-destructive behavior that jeopardized the immediate physical safety of the resident or others. It also documents less restrictive interventions attempted prior to the use of restraints. The RN will also document attempts at less restrictive interventions such as verbal de-escalation, 1:1 time with staff, medication, move to a less stimulating environment, pain/comfort measures, resident-specific divisional activities and additional treatment plan interventions.
- On the Restraint Intervention Staff Debriefing form that will be completed immediately following any restraint intervention, the team will identify alternative interventions that were attempted prior to the event.

Documentation to reflect why less restrictive attempts were unsuccessful will be noted:

- On page one of the Restraint Implementation and Assessment Form under the "Alternatives/Less Restrictive Interventions Response" section.
- On page two of the Restraint Implementation and Assessment Form "Debriefing Process with Patient" section.
- On the Restraint Intervention Staff Debriefing Form
- On the Post-Restraint Treatment Team Review Form that will include a team review of the event (including the resident) and recommendations for adjustment to the plan to prevent future events.

As of February 25, 2013, two episodes of restraint use for a resident within 14 days will prompt clinical leadership and transfer team evaluations including the discussion of options. Such discussions will be brought to daily Noon Report meetings for review by the BHD Medical Director or designee and a comprehensive analysis regarding the necessity for transfer to an alternate level of care.

Beginning February 26, 2013, weekly restraint reports will be generated. Any increase in utilization of physical restraint will be examined for causative factors. In addition, decreased restraint utilization will be analyzed to determine effectiveness of less restrictive techniques.

**Completion Date:** April 12, 2013

**Responsible persons:** Larry Koszewski, Ph.D., Clinical Program Director
Patricia Meehan, Interim Director of Nursing

## F 222

The facility will ensure that for Resident 56 and all residents, less restrictive alternatives will be utilized for maladaptive behaviors prior to the use of prn medication. On 2/26/13 the plan for Resident 56 was reviewed and revised to include least restrictive approaches and diversional activities that will be utilized prior to the use of prn medication. All facility staff completed the training "Implementing Individualized Plans for Residents with High Risk for Aggression and Mistreatment of Others". All staff working with Resident 56 have been trained on his updated behavioral plan.

As of 4/10/13, the nurses who did not document less restrictive alternatives prior to use of prn chlorpromazine on 1/31, 2/2, 2/9, 2/11, 2/17 and 2/23 have received training on the requirement to attempt and document less restrictive approaches prior to the use of prn medication.

To ensure ongoing compliance, the Nursing Program Coordinator and RN3 will monitor prn medication use for Resident 56 on a weekly basis to verify that if prn medication is utilized. The documentation will include a description of less restrictive alternatives attempted. Nursing Program Coordinator/RN3 will individually follow up with the nurse for any instance when the required documentation is not present. The monitoring will continue weekly until the 100% threshold is met for three weeks. Results of the trended compliance monitoring will be reported at the Rehabilitation Centers Executive Committee.

**Completion Date:** April 12, 2013

**Responsible persons:** Audra Hale, RN3, Mary Lausier, Nursing Program Coordinator, Patricia Meehan, Interim Director of Nursing

## F 223

The facility will ensure that the following interventions are maintained to prevent resident-to-resident verbal and/or physical abuse of residents R68, R47, R48, R53 and R56 in addition to all other residents residing in the facility. The facility submitted a removal plan to CMS on March 8, 2013 for F223, which had been identified as a citation meriting immediate jeopardy status. The I.J. status has since been removed by C.M.S.

An immediate correction, mandatory training, for all clinical staff ("Protecting our Nursing Home Residents") was completed as of March 8, 2013. Ten group training sessions were conducted and individual sessions were conducted until all facility staff was trained. All staff was trained on the definitions of abuse, neglect and misappropriation of property and the immediate reporting requirement.

A mandatory training "Implementing Individual Plans for Residents with High Risk for Aggression and Mistreatment of Others" was initiated. As of March 8, 2013, thirty-five training sessions had been completed. All staff that "float" or do not regularly work on Rehabilitation Central Center SNF units who have not been trained will receive training from the nurse manager prior to being allowed to work on the unit. Only staff that has been trained is allowed to work on the unit.

Additional facility interventions for mistreatment prevention include utilizing facility data to identify residents at elevated risk for potentially mistreating other residents.

On February 26, 2013, a comprehensive interdisciplinary team reviewed the clinical history and needs of the above identified residents to identify underlying psychological and/or medical causes of behavior leading to mistreatment of other residents. To develop recovery plans, the team included the clinical program director, social workers, psychologists and an occupational therapist.

The team then identified new individualized interventions based on medical records and past experience of daily discipline specific interactions with the said residents to prevent or reduce future episodes of mistreatment. These interventions were then added to the care plan. On February 27, 2013, the interventions were subsequently reviewed with the care teams and copied and placed in a reference binder for use by the direct care providers, including those members of the treatment team who may not consistently work on a particular care unit.

As of March 8, 2013 all scheduled R.C.C. (SNF) staff was trained regarding the residents right to be free from mistreatment. All staff was provided a review of the facility's policies including caregiver misconduct, protection of resident-to-resident abuse including reporting requirements and notification, and the requirements or identification, prevention and protection from abuse. All staff who "float" or do not regularly work on Rehabilitation Central Center SNF units who have not been trained will receive training from the nurse manager prior to being allowed to work on the unit. Only staffs that have been trained are allowed to work on the unit.

The facility will ensure that all incidents of resident-to-resident abuse will be reviewed daily at the 9 a.m. safety meetings. The incident follow-up will include the review and/or revision of the treatment plan and appropriate interventions to safeguard residents and prevent re-occurrence to include monitoring for changes that would trigger abusive behavior, and a plan for re-assessment of the interventions on a regular basis.

As of March 8, 2013 all facility's social work staff had been trained on the elements of an effective prevention program including the protocol for the provision of daily resident Community Meetings. These meetings incorporate education that reviews the Behavioral Health Division's Non-Violence policy as well as the Community Statement summarizing the expectations and responsibilities of a safe and healing environment. Community Meetings were initiated on every resident care unit beginning February 25, 2013. Community meetings will be maintained on a daily basis and that any such action that residents are aware of should immediately be reported to nursing and/or social service staff.

**Completion Date:** April 12, 2013

**Responsible persons:** Jena Scherer, Social Services
Patricia Meehan, Interim Director of Nursing
Larry Koszewski, Ph.D., Clinical Program Director

**F 224**

The facility will ensure that resident R41 and all other residents residing in the facility will be free from misappropriation of property by other residents. As a standing agenda item for unit community meetings, residents will be reminded that there is an expectation that any level/magnitude of client property misappropriation cannot be tolerated. At the daily community meeting clients will also be encouraged to report all episodes of client property misappropriation to unit staff. In addition to monitoring the occurrence of misappropriation of property through inquiry at daily resident community meetings, monitoring for the prevalence of property misappropriation will occur at the daily 9:00 Safety meeting facilitated by the Administrator.

An immediate correction, mandatory training for all clinical staff ("Protecting our Nursing Home Residents") has been completed as of March 8, 2013. Ten group training sessions were conducted and definitions of abuse, neglect, misappropriation of property and the immediate reporting requirement were presented to attendees. As with all incidents of mistreatment abuse, neglect, injury of unknown origin, allegation of property misappropriation will immediately be reported to the Administrator by the covering Social Worker, RN, NPC or the evening and weekend Nurse Manager.

Residents and staff will be advised to report all episodes of resident misappropriation of property will be reported to DQA immediately.

**Completion Date:** April 12, 2013

**Responsible persons:** Jena Scherer, Social Services
Larry Koszewski, Ph.D., Clinical Program Director
Patricia Meehan, Interim Director of Nursing

## F 225

The facility will ensure that all alleged violations involving mistreatment, neglect, or abuse including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures.

These corrective measures apply to residents R41, R47, R53, R56, R48, R44, R61, R63 and R26 as well as violations involving mistreatment/abuse for all other residents residing on units 44A, 44B and 44C. The facility submitted a removal plan to CMS on March 8, 2013 for F225, which had been identified as a citation meriting immediate jeopardy status. The I.J. status has since been removed my C.M.S.

The immediate correction, mandatory training, for all clinical staff ("Protecting our Nursing Home Residents") has been completed as of March 8, 2013. Ten group training sessions were conducted and individual sessions were conducted until all facility staff was trained. All staff was trained on the definitions of abuse, neglect and misappropriation of property and the immediate reporting requirement. The training also included the facility policy for reporting and investigation of resident mistreatment to include that all allegations of resident mistreatment are reported to DQA and the Administrator immediately after discovery of the incident.

As of March 8th, all episodes of mistreatment have been immediately reported to DQA and the Administrator as per training guidelines. There have been no lapses with the immediacy of reporting following March 8th. To continue to ensure thorough monitoring of reporting mistreatment allegations, RNs assigned to unit's 44A, 44B and 44C will review the 24-hour report at the change of shift to ensure all episodes of mistreatment have been immediately reported to DQA and the Administrator. In addition the Nursing Program Coordinator or RN III will review the 24-hour nursing report to ensure that no episodes of mistreatment have gone unreported. If an episode of mistreatment has been identified as unreported the Administrator and DQA will be notified immediately. An investigation of any mistreatment allegation will be launched immediately.

As with all allegations of resident mistreatment, all staff accused of alleged abuse are immediately removed from the facility to safeguard all residents. The accused staff is indefinitely suspended pending the outcome of the investigation.

Following a review of the entity's thorough investigation, the Administrator determines if the employee is able to return to work on resident living units.

All staff who "float" or do not regularly work on Rehabilitation Central Center SNF units, i.e. "floats", who have not been trained will receive training from the nurse manager prior to being allowed to work on the unit. Only staff who have been trained are allowed to work on the unit.

All facility nursing managers who provide after-hours and weekend coverage have received training on policies requiring the immediate notification to the Rehabilitation Centers Administrator and immediate reporting to DQA defined as immediately.

The facility will immediately report all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown origin, and misappropriation of property to the facility administrator and to the Wisconsin Department of Quality Assurance (DQA). All staff has been trained to report all episodes of mistreatment as soon as they become aware. The facility will

immediately report all incidents of mistreatment after the discovery of an incident. The facility will ensure the incident follow-up includes review and/or revision of the treatment plan and ensures the appropriate interventions to safeguard residents in addition to preventing reoccurrence. A thorough investigation is launched immediately following the safeguarding of residents.

It will be the objective of MCBHD Rehabilitation Central to conduct prompt, thorough and complete investigations to the Office of Caregiver Intake for all incidents of caregiver misconduct and all other episodes of resident mistreatment which shall include, but not be limited to, episodes of abuse, neglect, misappropriation of property, resident-to-resident altercations (submission of the entity's investigation will include the corresponding 2447 State report). In addition, comprehensive investigations for incidents of resident mistreatment also require prompt follow through. At the time the facility incident report is completed, the NPC or designee (i.e., RN assigned to the unit) must begin collecting investigative material to be assembled and submitted to the Office of Caregiver Intake by Clinical Program Director Dr. Larry Koszewski, Ph.D.

**Completion Date:** April 12, 2013

**Responsible persons:** Michael Spitzer, Nursing Home Administrator
Dr. Larry Koszewski, Ph.D., Clinical Program Director
Mary Lausier, Nursing Program Coordinator

## F 226

The facility will implement its abuse prohibition policy to ensure that residents are protected from resident-to-resident abuse and that all allegations, including resident-to-resident abuse and misappropriation of property, are immediately reported to administrator and state survey and certification agency and were thoroughly investigated.

As with all allegations of resident mistreatment, all staff accused of alleged abuse are immediately removed from the facility to safeguard all residents. The accused staff is indefinitely suspended pending the outcome of the investigation.

Following a review of the entity's thorough investigation, the Administrator determines if the employee is able to return to work on resident living units and will monitor accordingly to prevent recurrence.

Policies are applicable for Residents R61, R47, R48, R56, R53, R26, R47, R21, R30 and R63 in addition to all other residents residing on Units 44A, 44B and 44C. The facility submitted a removal plan to CMS on March 8, 2013 for F226, which had been identified as a citation meriting Immediate Jeopardy status. The I. J. status has since been removed by C.M.S.

As of March 8, 2013, all scheduled RCC staff was trained regarding the residents right to be free from mistreatment. All staff was provided a review of facility's policies including caregiver misconduct, protection of resident-to-resident abuse including reporting requirements and notification, and the requirements or identification, prevention and protection from abuse. All staff who "float" or do not regularly work on Rehabilitation Central Center SNF units who have not been trained will receive training from the nurse manager prior to being allowed to work on the unit. Only staff who have been trained are allowed to work on the unit.

The facility will ensure that all episodes of resident-to-resident abuse are immediately reported to the Division of Quality Assurance. The plan of care will be reviewed and/or revised by the R.N. during the shift the incident occurred and by the treatment team the next business day.

The facility will ensure that all incidents of resident-to-resident abuse will be reviewed daily at the 9 a.m. safety meetings. The incident follow-up will include the review and/or revision of the treatment plan and appropriate incentives to safeguard residents and prevent re-occurrence to include monitoring for changes that would trigger abusive behavior, and a plan for re-assessment of the interventions on a regular basis.

As of March 8, 2013 all facility's social work staff had been trained on the elements of an effective prevention program including the protocol for the provision of daily resident Community Meetings. These meetings incorporate education that reviews the Behavioral Health Division's Non-Violence policy as well as the Community Statement summarizing the expectations and responsibilities of a safe and healing environment. Community Meetings were initiated on every resident care unit beginning February 25, 2013.

All facility nursing managers who provide after-hours and weekend coverage received training on policies requiring the immediate notification to the Rehabilitation Centers Administrator and immediate reporting to DQA.

**Completion Date:** April 12, 2013

**Responsible persons:** Patricia Meehan, Interim Director of Nursing
Michael Spitzer, Nursing Home Administrator
Mary Lausier, Nursing Program Coordinator
Larry Koszewski, Ph.D., Clinical Program Director

## F 248

The facility will ensure the provision of an ongoing, therapeutic program with activities designed to meet, in accordance with the comprehensive assessment, the interests and physical, mental and psychosocial well-being of each resident.

The facility will staff the program, Rehabilitation Center Central, with two additional Certified Occupational Therapy Assistant for each weekend day to provide therapeutic and meaningful programming 9:00 a.m. to 8:00 p.m. A calendar listing the weekend program schedule will be clearly posted on living units 44A, 44B and 44C.

The deployment of this initiative will be monitored by the Interim Rehabilitative Service Supervisor (I-RSS) and by the Administrator in the absence of the I-RSS. Each weekend day a call will be placed by the aforementioned staff to the assigned Certified Occupational Therapy Assistant (COTAs) for each weekend. The direct call to the assigned COTAs will ensure that the employee is present and that pre-planned meaningful therapeutic programming is occurring. In addition, the I-RSS (or Administrator in the absence of the I-RSS) will contact the assigned nursing manager to ensure that the assigned weekend COTA is available to all residents and providing meaningful and therapeutic programming. A summary of the day's program and activity will be drafted by the COTA. The weekend nurse manager will sign the summary as an observer of their attendance.

**Completion Date:** April 12, 2013

**Responsible persons:** Marcia Rosales, OTR, RSS
Michael Spitzer, Nursing Home Administrator

## F 252

The facility will ensure that it provides a safe, clean, comfortable, and homelike environment for residents that includes replacing the light in R36's room, near the foot of the bed. The light has been replaced. The hot water temperature for all three units including the showers for R59, r67, R66, R5, R11, R36, and R26, will be maintained above 100 degrees F. The 44C hot water temperatures will be monitored two times each week, with adjustments made to the existing temperature control to help keep temperatures above 100 degree F. The 44A hot water temperature controller has been replaced and the 44B hot water temperature will be monitored monthly for the first 3 months after controller replacement and quarterly thereafter. The same schedule will be implemented for 44C when that controller is replaced.

**Completion Date:** April 12, 2013

**Responsible persons:** John Skibba, Mechanical Utilities Engineer
Gregory Kurzynski, Operations and Maintenance Supervisor

## F 278

The Behavioral Health Division/Rehab Central facility and MDS Coordinator will ensure that the admission comprehensive, annual comprehensive, and quarterly Resident Assessment Instruments (RAI's) will be completed accurately (for residents #17, #41, and #56).
The MDS Coordinator has corrected the cited areas of the RAI for residents #17, #41, and #56. Specifically, sections E, H, J, and P were corrected for residents #17, #41, and #56. Section P now accurately reflects restraint use for resident #17, to coincide with the "Seclusion/Restraint Physician form". Section H now accurately reflects intermittent catheterizations for resident #17. Section J now reflects accurate fall information in section J (falls) for resident #17, to coincide with the Rehabilitation Centers Comprehensive Falls Assessment. Sections E (E0200 and E0300) have been corrected to accurately reflect the presence of physical, verbal or other behavioral symptoms for resident #41. Section P (P0100) has been corrected, to reflect the physical restraints "used less than daily" for resident #41. Section J (J1800) has been corrected to accurately reflect falls information, to coincide with the Rehabilitation Centers Comprehensive Falls Assessment, for resident #56. These deficient practices for the aforementioned residents have been corrected for each identified resident. There were no other residents warranting corrections to their respective MDS/RAI program.

The RAI's were then re-submitted/transmitted to CMS, as well as copies provided for the survey team. The MDS Coordinator notifies the specific discipline lead of any performance issues related to the incorrect areas of the RAI/MDS, to ensure accuracy of the completed data. The MDS Coordinator is responsible for checking all sections of the MDS/RAI, prior to "locking" the MDS and subsequently submitting the data to CMS. The MDS Coordinator performed the specific corrections of the MDS/RAI. MDS issues/updates/accuracy of completion are a standing agenda item for the Rehab Centers Executive Committee. The MDS Coordinator is responsible for the audit/checking of each MDS for completion and correctness. The individual MDS cited were corrected by the MDS Coordinator (as per the recommendations of the Federal surveyor), and then re-submitted to CMS.

**Completion Date:** April 12, 2013

**Responsible person:** Richard Ritacca, RN, MDS Coordinator

## F 279

The facility will ensure that a fall prevention care plan is developed for Resident 56 and all residents who experience a fall or are at risk to fall. On February 22, 2013, a fall risk care plan was developed and implemented for Resident 56. As of April 12, 2013, all facility residents will be screened for fall risks utilizing the Morse Fall Scale and fall prevention care plans will be implemented when indicated.

Nursing, Medical and Rehabilitation Services team members responsible for conducting fall screening/comprehensive fall assessments and developing and revising fall prevention plans will be in-serviced by April 10, 2013. The training will include use of the Morse Fall Screen and facility standards regarding post-fall management.

To ensure ongoing compliance, the Nursing Program Coordinator and Safety Risk/Management Nurse will monitor completion of the Morse Fall Screens and implementation of fall prevention care plans on a quarterly basis. Results of the trended compliance monitoring will be reported at the Rehabilitation Centers Executive Committee.

**Completion Date:** April 12, 2013

**Responsible persons:** Mary Lausier, Nursing Program Coordinator
Laurie Heinonen, Safety/Risk Management Nurse
Patricia Meehan, Interim Associate Administrator of Nursing

## F 280

The facility will ensure that care plans for all residents for whom physical restraints are used have care plans to address the symptoms that contributed to the use of restraints. Care plans for all residents for whom physical restraints have been used in the last six months have been reviewed and revised on or before February 28, 2013. These revisions incorporated interventions to reduce the behaviors that prompted the use of restraints, and to provide alternatives to the use of restraints as interventions. These include residents R17, R21, R30, R41, R47, R56, R60, R61, R65, R68, R28, R29, R34, R35, R36, R48, R52, and R63.

For each future incident involving the use of physical restraints, the treatment team will meet the next business day to review and revise the treatment plan to address the symptoms that prompted the use of restraints. Post incident treatment team review forms used by the treatment team to address the restraint incidents will be collated and summarized as a component of the quarterly program quality improvement review.

Care plans for all residents who have been determined to have an elevated risk for engaging in mistreatment of other residents have been reviewed and revised. These revisions incorporated interventions to address and reduce the symptoms that led to incidents of mistreatment.

For future incidents involving incidents of resident-to-resident mistreatment, an investigation will be initiated. When the investigation yields a finding indicating that a review and revision of the care plan is indicated, the treatment team will meet the next business day to review and

revise the treatment plan to address and reduce the symptoms that led to the incident of mistreatment. The data related to revision of the respective treatment plans will be collated and summarized as a component of the quarterly program quality improvement review.

The facility will ensure that for Residents 41, 20 and for all residents who experience a fall, the individual care plan will be updated related to safety and fall prevention per facility policy. The RN and/or appropriate team member will be responsible for establishing and updating the plan based on the assessment and team recommendations for the resident. Resident 41's plan was updated on 3/20/13. Resident 20's plan was updated on 3/19/13.

Nursing, Medical and Rehabilitation Services team members responsible for conducting fall screening/comprehensive fall assessments and developing and revising fall prevention plans will be in serviced by 4/10/13. The training will include use of the Morse Fall Screen and facility standards regarding post-fall management.

To ensure ongoing compliance, the Nursing Program Coordinator and Safety Risk/Management Nurse will monitor each resident fall incident to ensure that the care plan is updated incorporating recommendations from the Nursing Assessment, Incident Risk Management Report and Comprehensive Falls Assessment. The frequency of falls will be tabulated quarterly by the Quality Assurance.

**Completion Date:** April 12, 2013

**Responsible persons:** Mary Lausier, Nursing Program Coordinator
Laurie Heinonen, Safety/Risk Management Nurse
Patricia Meehan, Interim Associate Administrator of Nursing

## F 323

The facility will ensure that residents 47 and 60 and all residents who have been identified as having a history of self-harm have care plans to address these behaviors. The facility will ensure that staff are knowledgeable of the specific risks for self-harm for residents 47 and 60 and all residents who are identified as having a history of self-harm. The treatment team met to review and revise the plans of care for residents 47 and 60 and eight additional residents identified as having a recent history of self-harm.

The revised care plans were placed in binders developed as a staff reference and to inform caregivers of revised plans. On 3/13/13 the "Process for Communication of New Plans or Revisions to Existing Plans for Staff Members" was implemented. The process includes that the treatment team member who has assisted in the revision of the plan will notify the unit RN of the need for all team members to review the updated plan and sign the resident's review sheet in the binder. The unit RN will communicate that there is a new or revised plan by placing alert stickers in three places:

- The 24 hr. report board x 3 days (after the revision) for discussion in shift report
- The Nursing Assignment clipboard for each shift and
- The outside cover of the Behavior Plan binder

To ensure ongoing compliance, the RN 3/designee will monitor revised care plans in the binders on a daily basis (M-F) to ensure that revised plans are reviewed and signed off by staff. The RN3/designee will provide a weekly written summary of the binder audits to the Clinical Program Director and Nursing Program Coordinator. The monitoring of the binders and plans for each living unit will be added to the daily job duties of the RN3 manager.

**Completion Date**: April 12, 2013

**Responsible persons**: Lawrence Koszewski, Ph.D., Clinical Program Coordinator
Mary Lausier, NPC
Audra Hale, RN3

## F 325

The facility will ensure that for Resident 67 and all facility residents, weights are measured and discrepancies in weight are promptly reported to dietary staff. The Nursing staff member who did not report the weight loss for Resident 67 was retrained in the policy requirement to report unintentional weight loss of >10 lb in one month to the dietitian and MD/APNP. In addition, weight loss of 7.5% in three months and slow insidious weight loss should also be reported to the dietitian and MD/APNP. The dietitian who noted that the recorded weight was likely an error has been retrained regarding the need to reconcile the discrepancy.

The training for both individuals was completed as of 4/10/13. The Nursing Program Coordinator will monitor the documentation of resident weights and appropriate follow up when indicated per BHD policy. The monitoring will be completed on a monthly basis for three months. By 7/12/13, the results of the monitoring will be reviewed by the Nursing Program Coordinator and Administrator of Nursing to determine a plan for frequency of additional monitoring.

**Completion Date**: April 12, 2013

**Responsible persons**: Mary Lausier, Nursing Program Coordinator
Patricia Meehan, Interim Associate Administrator of Nursing

## F 329

The facility will ensure that for Resident 61 and all facility residents, medication will be administered in accord with physician orders and non-pharmacological alternatives will be developed and implemented prior to the use of lorazepam for anxiety. On March 1, 2013, the behavioral plan was revised to address Resident 61's alteration in safety/escalation of behavior using non-pharmacological alternatives. All staff working with Resident 61 has been trained on the updated behavioral plan. The NPC, RN3 and Clinical Program Director will monitor the implementation of Resident 61's plan.

To ensure ongoing compliance the Quarterly Medication Reviews will be conducted with treatment team input to monitor that residents who use psychoactive medications receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. The Consultant Pharmacist medication regimen review process will include appropriate indication/justification for use of medication. The Rehabilitation Centers Executive Committee and Pharmacy and Therapeutics Committee will provide ongoing oversight of the Medication Regimen Review process.

**Completion Date:** April 12, 2013

**Responsible persons:** Mary Lausier, Nursing Program Coordinator
Audra Hale, RN3
Dr. Larry Koszewski, Ph.D., Clinical Program Director

## F 356

The facility will ensure that the required nurse staffing information is posted on all three units of the facility in an area that is accessible to residents. The posting will detail the date, resident census and the total number and the actual hours worked by licensed and unlicensed nursing staff directly responsible for resident care per shift.

A memo was distributed to facility staff detailing the requirement for posting the information and parties responsible to maintain the information. As of April 1, 2013, a daily audit will be conducted on all three units to verify that the required staffing information is posted on the Social Worker's door, in an area that is accessible to all residents and visitors.

**Completion Date:** April 12, 2013

**Responsible persons:** Mary Lausier, Nursing Program Coordinator
Patricia Meehan, Interim Director of Nursing

## F 406

The facility will ensure that, for all residents who have an elevated risk for mistreatment of other residents, precursor behaviors are identified. Elevated risk will be considered to include residents who have been involved in a reported substantiated incident of mistreatment of another resident within the preceding six months. (R21, R30, R48, R60, R61, R66, R68) These precursors will be incorporated on rounds sheets to collect frequency data of the identified precursors until no longer clinically indicated. These rounds sheets will be reviewed at treatment planning conferences on at least a quarterly basis. Results of the observations will be utilized to develop interventions to reduce the occurrence of incidents of mistreatment.

The facility will ensure that, for all residents, regardless of their status regarding Specialized Psychiatric Rehabilitative Services, individual goals to overcome barriers to community living will be identified, and that progress toward these goals is assessed. Individual goals to address these barriers will be incorporated into the treatment plans for each resident. A rating scale will be developed and utilized at treatment planning conferences to assess progress toward these goals on at least a quarterly basis. The rating scale will be developed to capture staff assessment of progress, and also, for interview able residents, resident assessment of their own progress. The rating scales used by the treatment teams will be collated and summarized as a component of the program quarterly quality improvement review.

**Completion Date:** April 12, 2013

**Responsible persons:** Lawrence Koszewski, Ph.D., Clinical Program Director

## F 460

The facility will ensure that there is provision to assure full visual privacy for each resident. The facility will be investigating means and methods for installing an additional cubicle curtain track and cubicle curtains to provide privacy for residents including R17 and R20. Due to the nature of

the sloped ceiling where additional track needs to be supported, the manner in which the cubicle curtains will operate is not certain. An investigation and monitoring of solutions will be required. The track materials should be available to install a prototype by end of next week, March 29, 2013. Evaluation of this prototype may result in further modifications to provide structurally sound track, with cubicle curtains that are functional and safe to operate. The ultimate solution may entail remodeling the ceilings, from sloped to horizontal, in the resident's rooms to properly support the cubicle track and curtain. As residents are discharged some double occupancy rooms will be converted to single occupancy as a means of privacy.

As a temporary solution, the facility has ordered movable privacy screens, which will be available for staff to utilize with residents R17 and R20 along with any other resident in a double occupancy room, bed nearest the door, that needs privacy during care (Rms: 44A-1, 2, 6, 7, 35, 36, 37, 40; 44B-1, 2, 6, 7, 35, 36, 37, 40; 44C-1, 2, 6, 7, 31, 35, 36, 37, 39). The movable privacy screens will be in use by April 12, 2013.

As a temporary solution, the facility will be ordering movable privacy screens, which will be available for staff to utilize with the residents R17 and R20 along with any other resident in a double occupancy room, bed nearest the door, that needs privacy during care (Rms: 44-A 1, 2, 6, 7, 35, 36, 37, 40; 44B-1, 2, 6, 7, 35, 36, 37, 40; 44C-1, 2, 6, 7, 31, 35, 36, 37, 39). The movable privacy screens will be in use by April 12, 2013. To ensure ongoing compliance, the cubical curtains, track and mobile screens will be reviewed as part of environmental rounds a minimum of every 6 months.

**Completion Date:** April 12, 2013

**Responsible persons:** John Skibba, Mechanical Utilities Engineer
Lynn Gram, R.D., C.D., Assistant Hospital Administrator 2

## F 465

The facility will ensure to provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This includes providing the following:

Unit 44A:
Unit 44A dining room floor will be stripped and waxed by April 10, 2013.
The dining room missing cove base will be replaced by April 12, 2013.
R59's shower nozzle has been replaced, and the shower door is now able to close to prevent leaking.

Unit 44B:
Unit 44B room 30 vanity will have the missing formica face replaced by April 12, 2013.

Unit 44C:
For R21's room:
Missing bathroom wall tile will be replaced by April 12, 2013.
The leaking faucet handle has been repaired.
A towel rack will be installed by April 12, 2013.
Bedroom walls will be patched and painted by April 12, 2013.

The 44C dining room wall gouge will be patched and painted by April 12, 2013.

The hole in the wall at 44C room 13 (southwest entrance) will be patched and painted by April 12, 2013. A door closer will also be installed to help prevent the same future damage.

To ensure continued compliance, the physical environment will be monitored on an ongoing basis one time per month. Additionally, a monitoring tour will be conducted again in three months to supplement the standard twice a year registration.

**Completion Date:** April 12, 2013

**Responsible persons:** Gregory Kurzynski, Operations and Maintenance Supervisor
John Skibba, Mechanical Utilities Engineer

## F 497

The facility will ensure that for the 12 residents that have a diagnosis of dementia as well as for all the residents, the Certified Nursing Assistant staff assigned to the Rehabilitation Central Program will receive initial and annual dementia management in-service education.

- In conjunction with BHD Educational Services Department, the program will develop a plan to implement this training by April 12, 2013.
- As of April 1, 2013 all Certified Nursing Assistants hired for the program will receive dementia management training as part of their new employee orientation.

**Completion Date:** April 12, 2013

**Responsible persons:** Mary Kay Bultman, RN MSN, Director of Educational Services
Mary Lausier, Nursing Program Coordinator

## F 520

The facility will ensure that a quality assessment and assurance committee is mandated. The committee membership will consist of the Director of Nursing Services, a physician designated by the facility and at least three other members of the staff. Reminders of quarterly meeting dates will be sent to all members and attendance will be taken. The MD was trained by the Medical Director.

**Completion Date:** April 12, 2013

**Responsible persons:** Dawn Puls, M.D.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

| 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<br><br>Surveyor: 03359<br>This was a fundamental survey of MCMH/Hilltop/FDD conducted from 1/2 - 1/8/13.<br><br># of federal deficiencies: 4<br><br>Census: 62<br>Sample Size: 10<br>Supplemental Sample Size: 8<br>Survey Coordinator: #03359 | W 000 | | |
| W 125 | 483.420(a)(3) PROTECTION OF CLIENTS RIGHTS<br><br>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.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 16584<br><br>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.<br><br>Findings include:<br><br>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. Sperber, 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.

| 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 |

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|---|---|---|---|---|
| W 125 | Continued From page 1<br>general environmental observations of the 43- F living unit. At this time it was noted that Room #4, Client tub / shower room was locked. It was also noted that Room #28, entry door from the hallway to the kitchen/ serving area was locked. Because this door was locked, Clients would have to go down the hallway and then walk thru the dayroom area to have access to the kitchen.<br><br>On 1/7/13 at 11:05 a.m., Surveyor #16584 made general environmental observations of the 43- F living unit. At this time it was noted that Room #4, Client tub / shower room was locked. Surveyor #16584 unlocked the door to the tub/shower room and noted that this was the main tub/shower room for the living unit. The room also had a storage area where approximately 4 different clients had shoes stored as well as clean linens and bath towels.<br><br>At 11:10 a.m. on 1/7/13, Surveyor #16584 observed that Room #28, entry door from the hallway to the kitchen/ serving area was locked. Because this door was locked, Clients would have to go down the hallway and then walk thru the dayroom area to have access to the kitchen.<br><br>On 1/7/13 at 11:30 a.m., Surveyor # 16584 interviewed QDDP(Qualified Developmental Disability Professional) - M. At this time QDDP-M was asked why the Client tub/shower room entry door was locked as well as the door providing Clients access to the kitchen from the hallway. QDDP- M stated that she did not realize these doors were locked and that they should be open, giving Clients access to those areas. QDDP- M stated that she thought the Maintenance Department had changed the lock on the | W 125 | | |

| 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 |
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| W 125 | Continued From page 2<br>tub/shower room so that the door would not be able to be locked. QDDP- M stated she would follow- up with staff to see why these doors were being kept locked and that they would remain unlocked from now on.<br><br>On 1/7/13 at 1:20 p.m., Surveyor #16584 made observations of Room #4 the Client tub/shower room to be locked, denying Clients access to this room. | W 125 | | |
| W 159 | 483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL<br><br>Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 07165<br><br>Based on record reviews and interviews, the facility did not ensure the Qualified Developmental Disability Professional (QDDP) integrated, coordinated and monitored the program plan for Client #3, 1 of 10 clients reviewed.<br><br>Client #3 was reassigned to QDDP-L in late September 2012. As of 1/8/13, Client #3 has one goal that is not included in the data flow sheets, therefore the QDDP is not getting information to assist in monitoring progress of the goal. Client #3 has data collection for 2 goals combined, thereby making monitoring the progress of each goal impossible. Client #3 has data being collected on three goals which are no longer part of his active treatment priority objectives. Client | W 159 | Mike/ | |

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| W 159 | Continued From page 3<br>#3 does not have a QDDP quarterly progress note for the quarter ending in October 2012. The last quarterly QDDP progress note was written 8/14/12.<br><br>Findings include:<br><br>Surveyor #07165 reviewed Client #3's record on 1/7 & 1/8/13.<br><br>On 1/2/13, Surveyor #07165 reviewed the data flow sheets for Client #3 to determine the priority active treatment goals.<br>The following goals were listed on the December and January 2012-2013 data flow sheets.<br><br>* Given 3 verbal cues, is able to make 25 cents using a mixture of coins.<br>* Clothing organization (Monday, Wednesday, Friday)<br>* Given 2 verbal cues, will take a shower on time per day, brush his teeth.<br>* Makes a request for his $5.00 from Patient Trust (AM's one time per week Thursday)<br>* Completes laundry/washing task-getting all steps correct.<br><br>On 1/7 & 1/8/13, Surveyor #07165 reviewed the training objectives in Client #3's record.<br><br>There were 2 Activity of Daily Living skills (ADL) goals.<br>One for taking a shower daily and a second for brushing his teeth.<br>Since there is only one data entry point on the data flow sheets for both of these goals, there is no way of determining if a + is successful completion of one or both goals, or a - is | W 159 | | |

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| W 159 | Continued From page 4<br>unsuccessful completion of one or both goals.<br><br>The goals for making 25 cents with a mixture of coins, requesting $5.00 from Patient Trust, and the laundry/washing task were not found in the treatment section of the record.<br><br>The treatment plan section of Client #3's record included the following goal, which is not listed on the data flow sheet.<br>Given no more that 6 verbal cues will verbalize feelings of anger and frustration to staff.<br><br>A review of the QDDP quarterly progress reviews reveals the last QDDP progress note was written on 8/14/12.<br><br>On 1/8/13 at 2:50p.m., Surveyor #07165 spoke with QDDP-L, who has been responsible for Client #3's treatment plan since late September.<br><br>QDDP-L stated that she was assigned Client #3, and other clients in the 44E living unit at the end of September 2012. QDDP-L states many of the goals do not seem to make sense and need to be rewritten and changed. QDDP-L stated she was not surprised that Surveyor #07165 had found discrepancies between data flow sheets and current goals. QDDP-L stated that she thought she had written a quarterly progress note for Client #3 in November 2012, but could not locate the note. | W 159 | | |
| W 249 | 483.440(d)(1) PROGRAM IMPLEMENTATION<br><br>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 | W 249 | Mike/Gary | |

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| W 249 | Continued From page 5<br>interventions and services in sufficient number and frequency to support the achievement of the objectives identified in the individual program plan.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 07165<br><br>Based on review of facility investigations, record reviews and interviews, the facility did not ensure that staff implemented the active treatment program regarding approaches to manage maladaptive behaviors for Client #1, 1 of 10 sampled clients.<br><br>On 11/11/12, Client #1 was agitated related to disappointment after his mother delayed a home pass. Client #1 had been incontinent during the night, and upon awakening was informed he needed to wash his clothing. Security Guard-B stated he overheard an unidentified staff member state, "I hope he washes those pissy clothes". This further agitated Client #1. Client #1 went into his room, broke the faucet off the sink and was threatening staff. The faucet was taken from him by security staff. Throughout the morning Client #1 continued to demonstrate maladaptive behaviors. These included throwing a peer across the dining room, threatening staff with a cord from his radio and finally leaping over a counter at the nurses' station, landing on his torso. Multiple staff were required to subdue Client #1, and place him in restraints. During either the fall to the floor after leaping over the counter, or the scuffle to subdue him, Client #1 sustained a nondisplaced fracture to his left elbow. The facility's investigation of the | W 249 | | |

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| W 249 | Continued From page 6<br>incident concluded that Client #1's behavior treatment plan was not implemented. This was determined to have occurred due to both a lack of communication between staff regarding the behaviors Client #1 was exhibiting, and the unit Registered Nurse's (RN's) lack of familiarity with Client #1's treatment plan.<br><br>Findings include:<br><br>Surveyor #07165 reviewed Client #1's record, and a self-report investigation on 1/2-1/8/13.<br><br>Client #1 has a Behavior Treatment Plan (BTP) dated 6/9/11. This plan lists behavioral procedures to be utilized with Client #1. The BTP stresses the appropriate manner to interact with Client #1. Statements within the BTP include:<br>All staff working with (Client #1) should attempt to keep him in a more positive mood and minimize his agitation by providing him with a lot of non-contingent social attention throughout the day.<br>All staff members working with (Client #1) should attempt to interact with him in a manner that could increase his self-esteem.<br>When making requests of (Client #1), giving him directions, or providing with negative consequences for his maladaptive behavior; present requests to him in a calm, direct, respectful, matter-of-fact manner.<br><br>Client #1's BTP directs staff on the steps to follow when Client #1 starts to become frustrated/anxious/agitated. If Client #1 appears highly agitated and unable to calm down, the BTP instructs staff to ask him if he thinks a PRN (as necessary) medication would help him. | W 249 | | |

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| W 249 | Continued From page 7 | W 249 | | |

The BTP states if Client #1 makes any verbal threats to harm others, or engage in physical aggression or if he engages in any act of physical aggression toward others or property (including physical threats), staff are to immediately call for assistance and take the necessary steps to assure the safety of Client #1 and others in the area. Staff are cautioned to not intervene until enough staff are present unless someone's safety is immediately in jeopardy. The physician is to be called for an order to place Client #1 in 4-point restraints.

The following sequence of events is contained within a statement included in the investigation of the incident, submitted by Security Guard-B.

When Client #1 got up, he wanted to wash his clothes. A peer was calling Client #1 "pissy boy", and Client #1 attempted to go after Client #11. Security Guard-B blocked Client #1 from hitting Client #11. Security Guard-B felt staff did not help the situation by saying "I hope he washes those pissy clothes", which Client #1 could hear and further escalated his behaviors. Security Guard-B stated Client #1 started to cry.

Between 9:00 - 9:30a.m., Client #1 ripped the faucet from his sink and was going after staff, chasing them into the dining area. The tip of the faucet was sharp. The security guard took the faucet from Client #1. Approximately 30-45 minutes later, Client #1 asked Certified Nursing Assistant (CNA)-D for some laundry soap and CNA-D gave Client #1 a box that was empty. Client #1 thought CNA-D was "messing with him", and went to his room and got a radio cord and was going to go after CNA-D. The security guards

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| W 249 | Continued From page 8<br>prevented Client #1 from leaving his room. Client #1 did calm down at this point.<br><br>Between 11:15-11:30a.m., a peer (Client#16) was standing in front of Client #1 asking repetitive questions, which agitated Client #1. Client #1 pushed Client #16 down to the floor, then picked him up by his clothes and threw him onto the couch, head first. Client #1 calmed down following this incident.<br><br>At approximately 12:40p.m., Client #1 was going to go after Client #16 again. Instead, he went into the conference room. Client #1 overheard the RN and CNA's talking outside of the conference room, making a plan. Client #1 stated, "I'm not taking medication. I'm not going into restraints." Client #1 charged out of the conference room and over the counter at the center desk. Client #1 fell over a chair, landing on the floor. The remainder of Security Guard-B's statement described efforts to subdue Client #1 and take him to quiet room to be placed into restraints. Client #1 complained of left arm pain. A Code 4 was called. (Facility medical emergency code). Client #1 was cooperative with paramedics.<br><br>Surveyor #07165 reviewed a statement submitted by CNA-H.<br>CNA-H stated Client #1 had a pile of clothes smelling of urine about 8:30a.m. He was crying. The security guard was trying to comfort him. Client #1 kept repeating, "She's always picking on me," referring to CNA-J. Shortly after that, Client #1 came out of his room and started to chase CNA-H with a faucet, which was sharp at one end. About 10:35a.m., Client #1 pushed Client #16, then tried to kick him, but was stopped by | W 249 | | |

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| W 249 | Continued From page 9<br>the security guard. At the end of lunch, Client #1 focused on CNA-J and wanting to "beat her up".<br><br>Surveyor #07165 reviewed a statement submitted by Occupational Therapist (OT)-I.<br>OT-I indicated Client #1 was "terrorizing" the unit and the client was angry all day. OT-I indicated she told RN-C the Client #1 was out of control. OT-I wrote that she told RN-I that Client #1 should have been in the quiet room, especially when using the sink faucet as a weapon.<br><br>Surveyor #07165 reviewed a statement submitted by RN-C.<br>RN-C indicated Client #1 was upset over numerous things. She indicated that herself (RN-C), and security staff spent the majority of the day listening, helping to explain the situation of getting a pass, controlling anger, and giving praise when he seemed to calm down and following his behavior treatment plan as much as possible. Client #1 became more agitated in the afternoon. RN-C stated she quietly said she believed Client #1 should be placed in restraint, and the security officer who had been making headway in calming Client #1 requested 5 more minutes. The RN agreed and left the conference room. Within a few minutes, Client #1 charged out of the room and was fighting with the security guards. RN-C called a Code 1. An additional Code 1 was called to have the manpower to control Client #1. (Code 1 is the facility code for obtaining assistance with a behavioral disturbance). Client #1 continued to struggle against staff who were trying to subdue him. He complained of right arm pain. A Code 4 was called. Client #1 then began complaining of left arm pain. Client #1 was sent to the hospital for | W 249 | | |

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| W 249 | Continued From page 10<br>evaluation.<br><br>The summary statement included in the submitted self-report investigation, indicates Client #1 was frustrated, anxious, agitated and intrusive much of the morning, requiring much redirection and intervention from staff/security. Client #1 was able to calm for only short periods of time. This behavior is addressed in his BTP. Client #1 also exhibited physical aggression/gestures to others and property. He broke off the faucet in his room and attempted to go after staff. It was reported he removed a cord from a radio and held it as if to choke someone. During the interviews, staff reported physical aggression to a peer on the unit. This behavior is also addressed in the BTP. He exhibited these behaviors in the morning hours prior to the incident of jumping over the desk. There potentially appeared to have been communication issues among unit staff/security guards and the unit RN as she was not aware of all of Client #1's behaviors that morning. "The unit RN did not follow Client #1's treatment plan". She reported upon initial interview that she was not really familiar with his plan. RN-C is the regular part-time RN on the unit.<br><br>A review of Client #1's medical record reveals that while at the hospital he was diagnosed with a non-displaced left olecranon fracture (left elbow fracture). He returned to the facility on 11/11/12 with a left arm immobilizer.<br><br>Surveyor #07165 spoke with the Assistant Director of Nurses (ADON) on 1/7/13 at 10:15a.m. The ADON had completed the investigation of the behavioral incident resulting in | W 249 | | |

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| W 249 | Continued From page 11<br>a left elbow fracture to Client #1. The ADON stated the RN on the unit had not been aware of all the behavioral incidents of Client #1 occurring on 11/11/12, and has been instructed to improve communication with staff. In this case, security staff were more aware of what was happening with Client #1 than the unit staff.<br><br>Surveyor #07165 spoke with Security Guard-B on 1/7/12, at 3:30p.m. Security Guard-B stated he did not know which staff member had made the comment about Client #1 needing to wash his pissy clothes, but that Client #1 became more agitated after hearing the comment. The Security Guard stated that after Client #1 heard the pissy clothes comment, he went into his room and broke the faucet to use as a weapon to threaten staff. | W 249 | | |
| W 268 | 483.450(a)(1)(i) CONDUCT TOWARD CLIENT<br><br>These policies and procedures must promote the growth, development and independence of the client.<br><br>This STANDARD is not met as evidenced by:<br>Surveyor: 03359<br>Based on observation, interview, and record review, the facility did not promote the growth, development and independence in the clients' learning environment. This occurred for 1 of 10 sampled clients and 6 of 8 clients added to the sample.<br><br>Clients #10, #12, #13, #14, #17, and #18 were not provided opportunities to learn appropriate dining skills. Staff used large paper aprons, as place mats, to collect spilled food for clients. In | W 268 | Mike-Gaylyn | |

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| W 268 | Continued From page 12<br>addition to this, Client #10 wore a thin paper apron, as a clothing protector. Clients #13 and #14 wore a towel and two paper aprons as clothing protectors at one of the meals.<br><br>Client #15 was observed to use an oversized spoon, that was so large, she had difficulty scooping the food. Client #15 had not been provided with the more appropriate adaptive utensils, that had been identified in her program plan.<br><br>Findings include:<br><br>UNIT 43E<br>1.) On 1-3-13 at 8 am, Surveyor #03359 observed the breakfast meal on Unit 43E. COTA (certified occupational therapy assistant) - E placed a towel in Client #13's lap and then tied (2) thin paper aprons around her neck. At Client #13's place setting, another long thin paper apron was placed beneath her plate, cup, and utensils; in the fashion of an oversized place mat. Client #13 was observed to eat her breakfast meal in this fashion.<br><br>COTA - E tied a towel around Client #14's neck and then placed a thin paper apron over the towel and tied it around Client #14's neck. At Client #14's place setting, another long thin paper apron was placed beneath her plate, cup, and utensils; in the fashion of an oversized place mat. Client #14 was observed to eat her breakfast meal in this fashion.<br><br>At Client #12's place setting, a thin paper apron was placed beneath his plate, cup, and utensils; in the fashion of an oversized place mat. Client | W 268 | | |

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| W 268 | Continued From page 13<br>#12 was observed to eat his breakfast meal in this fashion.<br><br>CNA - F placed a thin apron around Client #10's neck. In addition to this, CNA - F placed a thin paper apron beneath Client #10's plate, cup, and utensils; in the fashion of an oversized place mat. Client #10 was observed to eat his breakfast meal in this fashion.<br><br>2.) On 1-7-13 at noon, Surveyor #03359 observed the lunch meal on Unit 43E. Client #14 was observed wearing a thin paper apron, as a clothing protector. At Client #14's place setting, another long thin paper apron was placed beneath her plate, cup, and utensils; in the fashion of an oversized place mat. Client #14 was observed to eat her lunch meal in this fashion.<br><br>At Client #12's place setting, a thin paper apron was placed beneath his plate, cup, and utensils; in the fashion of an oversized place mat. Client #12 was observed to eat his lunch meal in this fashion.<br><br>CNA - G placed a thin apron around Client #10's neck. In addition to this, CNA - G placed a thin paper apron beneath Client #10's plate, cup, and utensils; in the fashion of an oversized place mat. Client #10 was observed to eat his lunch meal in this fashion.<br><br>Client #17 had a thin paper apron tied around his neck and then draped onto the table beneath his plate, cup, and utensils; in the fashion of a place mat. Client #17 was observed to eat his lunch meal in this fashion. | W 268 | | |

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| W 268 | Continued From page 14<br><br>Client #18 had a thin paper apron tied around his neck and then draped onto the table beneath his plate, cup, and utensils; in the fashion of a place mat. Client #18 was observed to eat his lunch meal in this fashion.<br><br>The preceding information was shared with the Administrator and DON during an exit meeting on 1-7-13 at 3 PM. The facility provided no additional information to the survey team related to the dining observations.<br>Surveyor: 16584<br><br>3.) On 1/2/13, Surveyor #16584 conducted a review of the facility's "Incident/ Risk Management reports". The following was noted:<br><br>"Incident/ Risk Management Report", dated 10/2/12 at 5:45 p.m., states that Client #15 was noted to be sitting in the dining room eating her dinner and she began moving the teaspoon around in her mouth. Then Client #15 swallowed her teaspoon before anyone could stop her. Client #15 was under 1 to 1 supervision at the time and this staff person was afraid to put her hand into Client #15's mouth. Client #15 was sent to the emergency room for evaluation and treatment where they had to surgically remove the teaspoon from Client #15's bowels.<br><br>On 10/17/12, Client #15's Behavior Treatment Plan was updated to state the following;<br><br>Section G, "Client #15 shall eat meals and nourishments in the dining room with the 1 to 1 supervision. She should not be isolated in room | W 268 | | |

| 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 268 | Continued From page 15<br>#25 for meals. The following procedures should be implemented:<br>1.) Client #15 should sit a at a table without any peers.<br>2.) Client #15 should be provided with her special ( enlarged) eating utensils she requires to eat by the staff. The items being provided to Client #15 should be counted by the staff member providing 1 to 1 supervision. "<br><br>On 1/3/13 at 8: 35 a.m., Surveyor #16584 made observations of the breakfast meal on the 43- F unit. At this it was noted that Client #15 was seated at a table near the entry way of the dayroom, along with a staff member who was providing 1 to 1 supervision. Client #15 was observed to be eating with a very large serving spoon. Client #15 had been served scrambled eggs, 1 slice of bread and also a small plastic bowl of cereal. Surveyor #16584 observed Client #15 eat with the very large serving spoon by scooping the scrambled eggs onto the large spoon with her hand and then eating from the spoon. It appeared that Client #15 was having a difficult time raising the large serving spoon to her mouth, but was able to eat the eggs from the spoon. Surveyor #16584 noted that the large serving spoon was the only utensil provided to Client #15 for eating her breakfast meal. Client #15 was then observed to use the backside of the large serving spoon to spread jelly onto her bread. Client #15 was also observed to use the large serving spoon to try and eat the cereal from the small bowl. Client #15 did this with difficulty, spilling cereal onto the tray. Surveyor #16584 did not observe the direct care staff to assist Client #15 or offer additional utensil to make eating the breakfast meal easier for Client #15. | W 268 | | |

| 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 |

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| MILWAUKEE COUNTY MHC FDD | 9455 WATERTOWN PLANK RD WAUWATOSA, WI 53226 |

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|---|---|---|---|---|
| W 268 | Continued From page 16<br><br>On 1/3/13 at 12:15 p.m., Surveyor # 16584 made observations of Client #15 eating the lunch meal. It was noted that Client #15 was seated at a table near the entry way of the day room and was sitting with a staff person who was providing 1 to 1 supervision to her. Client #15 was served turkey with gravy, mashed potatoes, cranberry jello and a small bowl of lettuce salad. It was observed that the only utensil provided to Client #15 was a very large serving spoon. (The same spoon that Client #15 was observed to eat her breakfast meal with ). Client #15 proceeded to use her hand to scoop the turkey and gravy onto the spoon and then ate the turkey from the large spoon. Client #15 was able to eat all of the turkey and potatoes in this manner. Surveyor #16584 observed Client #15 attempt to use the very large serving spoon to eat the lettuce salad from the small bowl. Client #15 was unable to eat the salad with the spoon, and then stated to the staff member that she was finished. Surveyor #16584 did not observe the staff member assist Client #15 to make eating the lunch meal easier for Client #15, or offer the use of a different utensil.<br><br>On 1/7/13 at 11:30 a.m., Surveyor # 16584 interviewed QDDP (Qualified Developmental Disability Professional) - M in regards to Client #15's Behavior Treatment Plan and the above observations of Client #15 using a very large serving spoon to eat her meals with. QDDP- M stated that when Client #15 first returned from the hospital after she had swallowed the spoon on 10/2/12, she had gone out and purchased very large utensils for Client #15 to use, to prevent Client #15 from swallowing the utensils again. QDDP- M stated that the Behavior Treatment | W 268 | | |

| 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 |

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|---|---|---|---|---|
| W 268 | Continued From page 17<br>Plan was then updated for the use of the enlarged eating utensils, and that the Occupational Therapy Department special ordered adaptive utensils for Client #15 to use. QDDP- M stated that the adaptive utensils were ordered in October, 2012 and were made available for use in the beginning of November, 2012. QDDP- M stated that she does not know why staff were continuing to use the very large serving spoon, and they must have just grabbed whatever was available. QDDP- M stated that Client #15 is to be using both the adaptive fork and spoon at meals, and that these utensils were kept in a side room and would now be made available for use for Client #15. | W 268 | | |

# 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 |

| 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.**<br><br>**Completion Date: 02/07/2013**<br><br>**Persons Responsible:**<br>**Jennifer Lang, QDDP**<br>**Kristine Evans, QDDP**<br>**Betty Walker, NPC**<br>**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.**<br><br>**Completion date: 02/07/2013**<br><br>**Responsible Persons:**<br>**John Skibba, Maintenance Supervisor**<br>**Gloria Diggs, BSN, RN III**<br>**Betty Walker, MSN, RN, NPC** | |

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|---|---|
| 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 |

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| 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.<br><br>Completion Date: 02/07/2013<br><br>Responsible Persons:<br>Jennifer Lang, QDDP<br>Kristine Evans, QDDP<br>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.<br><br>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.<br><br>Completion Date: 02/07/2013<br><br>Responsible Persons:<br>Gary Stark, PhD – Clinical Program Director<br>Debora Zamacona-Hermsen, Psychologist<br>Betty Walker, RN – Nursing Program Coordinator | |
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| 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 |

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| 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.**<br><br>**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).**<br><br>**Completion Date: 02/07/2013**<br><br>**Persons Responsible:**<br>**Gary Stark, PhD – Clinical Program Director**<br>**Debora Zamacona-Hermsen – Psychologist**<br>**Betty Walker, RN – Nursing Program Coordinator** | |
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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.