Findings

Findings support or illustrate an entity•s noncompliance with a requirement. Cite only findings attributable to the entity. Each statement of deficient practice is followed by the specific findings (**who, what, where, when, how**) that illustrate the entity•s noncompliance for each case/issue referenced in the deficient practice statement. The facts are presented in a concise and logical sequence. The findings include the outcomes, descriptions of actions/situations, identifiers, and sources. Any evidence that supports a finding and affects the deficiency determination must be incorporated into the deficiency citation.

When details for a number of individual examples have been described to illustrate a particular deficient practice, a final entry may describe additional similar findings and identifiers to demonstrate the magnitude of the problem.

Facts

A fact is an actual occurrence, something known to exist or have happened. The findings are facts that allow the entity to compare what it did or failed to do, against what is required. The findings support the deficient practice statement. For example, if residents #1, 3, 5, and 7, are discussed in the deficient practice statement, the findings are the facts to support the noncompliance for residents #1,#3, #5, and #7. Without the presence of facts, the evidence can be construed to mean that an assumption was made, rather than a known conclusion about the entity•s practice.

Failure to include pertinent facts may prevent the entity from discovering what contributed to the deficient practice. For example, there may be many reasons for the failure of a patient to receive a needed treatment, such as: the patient was not scheduled for a treatment; the staff had not been trained regarding how to provide the treatment; trained staff were not available to provide the treatment; trained staff were available but forgot to provide the treatment; proper authorization for treatment was not provided; or, the patient refused the treatment.

Identification of the pertinent facts gives the entity the means to examine the failure to comply, in light of the specific circumstances or contexts, which the failure occurred.

When writing a deficiency citation, try to provide answers to basic questions--Who?, What?, When?, Where?, and How?. Based on the nature of the deficiency, it may be impossible or inappropriate to answer each question. However, this approach facilitates inclusion of the pertinent facts. Deficiency citations identify:

**how** the deficiency was determined, and how the evidence relates to the requirement;
**what** entity practice was noncompliant;
**who** were the residents or staff involved;
**where** the deficient practice occurred, e.g., specific locations in the entity or documents; and

Organization of findings:

The findings should be organized in a chronological and logical order. Grouping related findings and facts under applicable statements of the deficient practice statement assists the entity in focusing on the development of plans to correct its deficient practices rather that on correction of the findings. The organization of the findings should clearly convey to the reader the sequential order of events that resulted in a citation. For example, situations or cases are presented in a logical sequence to show individual deterioration over time or date.

When setting forth a series of facts and events, start by setting out the relevant background facts (e.g., •Resident #1 was at risk for weight loss as set forth in the MDS dated XX/XX/XX.) Then, if possible, set out the events in chronological order.

The following example, Exhibit 3-10 illustrates a citation from the home health requirements. The citation is written based on two separate requirements contained in the language of the requirement. It includes two statements of deficient practice and organizes the relevant findings/facts under those statements.

| | Changes in Plan of Care<br><br>1. Patient # 7 began receiving services on 11/20/XX. The plan of care dated 11/23/XX, indicated that services were to include skilled nursing services for wound care and home health aide assistance for activities of daily living. On 11/28/XX, the nurse's note states: "care plan revised as the home health aide can do wound care. Sufficient healing has occurred so that skilled services are not indicated. Wound needs to be cleansed during bathing."<br><br>Observation on the 12/8/XX home visit indicated that the wound was healed. Interview with Patient #7 indicated that the patient wondered about the whereabouts of the nurse who used to come to clean the wound. She had not seen her in a long time. Interview with the nurse indicated that as the person was progressing well, there was no need to inform her about the change in the plan of care.<br><br>2. Patient # 10 was admitted for service on 11/13/XX. The plan of care, dated 11/13/XX, identified an occupational therapy (OT) consultation to determine if environmental modifications to the home were indicated.<br><br>An OT note of 11/17/XX states: "Consultation not indicated." No additional information was recorded. Interview with Patient #10 on 12/8/XX indicates that he was satisfied with the services received, but, "I hope that the person who is supposed to help with the arrangement of the house gets here soon. It is difficult for me to get around here."<br><br>Interview with the Director of Services on 12/8/XX confirmed that the person was not informed of the changes to the plan of care." |
|---|---|

Exhibit 4-1: **Effective** Documentation for Principle #4

| TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| G145 | 483.14(g) Standard<br>Coordination of patient services<br>A written summary report for each patient is sent to the attending physician at least every 62 days.<br><br>This standard is not met as evidenced by;<br><br>Based on record review and staff interview, it was determined the home health agency failed to ensure a written summary report which included a compilation of pertinent factors of patient•s clinical progress had been sent to the physicians• office for 2 of 2 sampled patients (# 4, and 5) who required a 62 day summary.<br><br>Findings include:<br><br>1. Patient #4 was admitted for home health services on XX/XX/XX. The plans of care for the certification periods XX/XX/XX to XX/XX/XX and XX/XX/XX to XX/XX/XX included goals which stated •Patient will experience stable cardiopulmonary status as evidenced by clear lung sounds, no chest pain, SaO2 (saturation of arterial blood) greater than or equal to 92%.• Summary reports addressing the patients progress or lack of progress were not available as part of the Patient•s clinical record.<br><br>2. Patient #5 was admitted for home health services on XX/XX/XX with the diagnosis of pressure ulcer and congestive heart failure. The plan of care for the certification period XX/XX/XX to XX/XX/XX included goals which stated •Patient will have pressure ulcer healed with no sign or symptoms in 10 weeks•. The summary report addressing the status of the patient•s wound was not available as part of the clinical record.<br><br>Staff interview on XX/XX/XX confirmed the HHA had not sent written summary reports to the physicians, until after the surveyor inquiry when summary reports were then completed and faxed to the physician during the survey. |

Exhibit 4-2: **Effective** Documentation for Correction of IJ during Survey- Principle #4

| TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| F223<br>S/S= J | 42 CFR 483.13(b) Requirement<br>Abuse.. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.<br><br>The requirement is not met as evidenced by:<br><br>Based on staff interviews and record review, the facility failed to prevent 1 of 21 sample residents (#5) from being assaulted by staff and failed to report the assault to the appropriate authorities in a timely manner and failed to take actions to prevent further such incidents to residents resulting in immediate jeopardy.<br><br>Findings include:<br><br>Interviews with 3 CNAs A, B, C, on duty on 7/10/XX, indicated that they observed a certified nursing assistant (CNA)(E-1) •throw• a resident (R#5) to the ground during a picnic at the facility on 5/26/XX. The CNA, who observed R#5 becoming agitated, went to the resident to bring him back into the facility. When the resident became •uncooperative and irritated• and refused to go into the building, the CNA gave the resident a •bear hug.• The resident fell to the ground at which time the CNA dragged the resident by the back of his shirt into the facility, a distance of approximately 30 - 40 feet. Nurses notes on 6/1/XX state that the resident had abrasions on the lower lumbar and upper left thoracic regions, but was not able to say how he got them. During an interview with the facility administrator on 7/11/XX, the administrator said, •I was not aware of the incident until 6/1/XX when a staff member asked for medication to put on {resident #5's} cuts. I notified the health department on 6/1/XX.• The administrator acknowledged he did not remove the CNA from providing resident care until questioned by the surveyor on 7/11/XX.<br><br>The administrator was notified of the immediate jeopardy at 2:00 p.m. on 7/11/XX. At 3:00 p.m., the administrator notified the survey team that the involved CNA had been removed from duty and that the CNA would be fired. |

Exhibit 5-2 illustrates how material in Interpretive Guidelines can be used to support the citation. The critical factor is whether or not the evidence relates directly to the language and requirement within the regulation.

**Exhibit 5-2: Effective Documentation for Principle #5**

| TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| W214 | 42 CFR 483.440 ( c ) (3) (iii)<br>The comprehensive functional assessment must identify the client•s specific developmental and behavioral management needs.<br>.<br>This Standard is NOT MET as evidenced by:<br><br>Based on observations, staff interview, and record review, the facility failed to include in the comprehensive functional assessment, the client•s cognitive ability for 2 of the 4 clients in the home ( #2, #3).<br><br>The findings include:<br><br>Review of Client #3•s medical records, dated between XX/XX/XX and XX/XX/XX, revealed 11 evaluations conducted by the professional staff. None of the evaluations specified any deficits that may have contributed to his diagnosis or his reported developmental level of functioning. Observations on XX/XX/XX and XX/XX/XX confirmed that ....In an interview on XX/XX/XX, LPN1 said, •I am unclear about the client•s identified strengths.• |

Exhibit 6-1: **Effective** Documentation for Principle #6

| TAG | SUMMARY STATEMENT OF DEFICIENCIES |
|---|---|
| W345 | 42 CFR 483460(d)<br>The facility must utilize registered nurses as appropriate and required by State law to perform the health services specified in this section.<br><br>This STANDARD was NOT MET as evidenced by:<br><br>Based on record review, the facility for the period between 7/1/xx and 9/30/XX, utilized Licensed Practical Nurses (LPNs) to review the health status of residents for 4 of 10 sampled records (2, 6, 12, 19) . Section 76543 of the Code of Professional Health Practices (State Requirement) requires that this function be performed only by Registered Nurse (RNs). |

2) the authority having jurisdiction has made a determination of noncompliance with State or local law, has taken and sustained an adverse action (See Exhibit 6-2.).

An adverse action is any procedure taken by a State Agency that goes beyond the approval of a plan of correction, such as, fines, ban on admissions, loss of license, etc. The authority having jurisdiction is the person or persons who have the authority to make a final determination of noncompliance and are responsible for signing the correspondence notifying the facility of the adverse action. A final determination means the determination has not been appealed or is no longer being appealed by the entity.

| TAG | SUMMARY STATEMENT OF DEFICIENCIES |
| --- | --- |
| G170 | 42 CFR 484.30 Skilled Nursing Services<br>The HHA furnishes skilled nursing services in accordance with the plan of care.<br><br>This requirement is NOT MET as evidenced by:<br><br>Staff interview and review of seven clinical records requiring RN skilled services revealed that the RN did not comprehensively assess the patients or furnish the frequency of visits required by the Plan of Care for 4 of the 7 patients (H3 H5, H6, H7). See G174 for additional information regarding patients H3, H5, and H7.<br><br>1.Review of H3's clinical record indicated physician orders for twice daily RN visits from 10/01 to 10/08/XX to administer IV antibiotics, assess the stats of and perform a dressing change to the Stage 3 ulcer of the left heel. The aide sheet for 10/04 reflected that the aide had changed the heel dressing that AM. The record shows two LPN visits and an evening dressing change by the LPN on 10/04 but does not contain information of an RN visit, assessment or dressing change on 10/04/XX. Interview at 10:30 A.M. on 11/10/XX with supervising nurse confirmed that on 10/04/XX an aide had performed the AM dressing change on H3's Stage 3 pressure ulcer of the heel. The supervising nurse reported that although the RN was ill and had not made the planned AM or PM visits that day, the agency•s LPN had performed the visits and supervised the aide.<br><br>2. Review of H5's clinical record indicated that the Plan of Care for H5 required RN visits from 4 to 5 times the week of 10/07/XX and 3 times a week for 3 weeks beginning 10/4/XX to assess the patient•s response to changes in the medication to control her angina and blood pressure. The RN visited only 3 times (10/07, 10/08 and 10/10) during the week of 10/07 and limited her assessment to checking breath sounds and blood pressure. The RN did not evaluate for signs and symptoms or complications of either hypo or hypertension or for compliance with dietary restrictions or known side effects which accompany the use of calcium channel blockers.<br><br>3. Review of H6's clinical record indicated the RN did not visit H6 twice daily as required by the Plan of Care to monitor the institution of sliding scale insulin for the newly diagnosed brittle diabetic. The Plan of Care required twice daily visits from --- to ---. The actual visit frequency was ---. |

## Principle #8: COP Deficiencies

The evidence for the citation of noncompliance with a Condition Of Participation explains how the extent or severity of deficient practices justifies a conclusion of noncompliance at the COP level. The COP citation includes a statement(s) of deficient entity practice(s) and findings to support the determination of non-compliance with a condition level requirement. The findings may be incorporated either by cross references to those requirements which must be corrected to find the COP in compliance or by narrative description of the individual findings. The COP citation includes ONLY those requirements that must be corrected to achieve compliance with the COP.

The determination that an entity is not in compliance with an applicable COP is one of the most serious decisions the RO or SA can make. The decision as to whether there is compliance with a particular COP depends upon the manner and degree to which the entity satisfies the various requirements and standards within each COP. If a COP is determined to be deficient, the HCFA-2567 should identify the specific practices that must be corrected before the entity can be found to be in compliance. If these practices refer to requirements specified at Standards or other subsidiary requirements, the deficient practices and individual findings would be cited at the relevant requirements. The findings under these subsidiary requirements may be referenced under the COP citation.

For certain provider and supplier types, a COP may stand alone at a single survey data tag without accompanying standards or other requirements. The text of the particular COP may have multiple components. Based on the evaluation of the evidence, an entity can be cited at a COP level even if it violates only one component of multi-component regulations.

For example, in the Ambulatory Surgery Center program, 42 CFR 416.43 Condition for Coverage Evaluation of Quality (tag Q 9) has multiple requirements:
(1) conduct an ongoing, comprehensive self-assessment of the quality of care provided, (2) include active participation of the medical staff, (3) include review of the medical necessity of the procedures performed and appropriateness of care, (4) use the findings, when appropriate, in the revision of the center policies and (5) use the findings, when appropriate, in the consideration of clinical privileges.

There may be entity practices relevant to standards that are deficient, yet not essential for a determination of compliance with the COP. Most likely it is because the nature of these practices, individually or collectively, does not justify a conclusion of noncompliance and warrant an adverse action. Such requirements are not referenced at the COP citation. They are included at the appropriate tag number and corresponding CFR reference in the HCFA-2567.

## CONCLUSION:

All requirements are binding. The structures, processes and outcomes required by the regulations are necessary for the entity to provide quality care, prevent negative outcomes, and facilitate positive outcomes. Failure of the entity to provide any of the required services or to meet required conditions constitutes evidence of noncompliance regardless of the presence of outcomes. The purpose of these Principles of Documentation is to provide structure and consistency to the construction of a citation.

Correctly documenting the Statement of Deficiencies (HCFA-2567) is the key to the success of the survey and certification process. Effective documentation of the survey signals the provision or denial of financial participation in the Medicare/Medicaid program, as well as the provision of or lack of quality care in health care settings.

Keep in mind that one of the roles of the surveyor is to ensure that quality health care is provided by those entities participating in the Medicare/Medicaid program. It is the surveyor•s knowledge of the regulations and how to interpret and apply these regulations in a consistent manner during the survey that will produce a clear description of the entity•s deficient practice. When the deficient practices are resolved by the entity, quality of care and quality of life can be a reality in health care settings.

# Appendix B
# Enforcement Report

# Assisted Living Facility Citations with Enforcements

**SAMPLE**

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **North View Manor II** | 2/28/03 | 50.065(2)(b) | and 50.065(3)(b), 50.065(4m)(c)<br>Criminal background checks.<br><br>Order: Pursuant to 50.03(5g)3 and 50.03(5g)6, the facility will comply with criminal background requirements as specified by chpts. 50, 83, and 12 and will maintain records onsite for review by the department upon request. Personnel records, including caregiver background evaluations, for staff C and E, shall be complete and available onsite within 14 days.<br><br>The facility had not met criminal background requirements for two employees. | Order | Event ID: H5HH12 |
| Portage | | 83.14(1)(c) | 2nd cite. Universal Precautions<br><br>The facility was issued a repeat violation for failing to ensure an employee received training in universal precautions prior to working with residents. | $400 | |
| Columbia | | 83.14(1)(d) | Fire Safety, First Aid, & Choking<br><br>One employee had not received required training. | $200 | |
| Southern | | 83.41(5)(d)2 | 2nd cite. Hot Water Temperatures<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will ensure that hot water in all areas accessible to residents does not exceed 110 degrees. The facility will install mixing valves or anti-scald devices at each hot water fixture accessible to residents that cannot otherwise be maintained at acceptable levels.<br><br>Although cited previously, the facility did not ensure that hot water temperatures at sinks used by residents were kept at a safe temperature of 110 degrees or less. Temperatures were recorded at 130 degrees. Residents with dementia have access to the sinks. | $100<br>Order | |
| | | 83.42(2)(a) | Evaluation of Resident Evacuation Limits<br><br>Order: Pursuant to 50.03(5g)3 and 50.03(5g)6, the facility will complete written evacuation assessments for resident 1 and resident 2 within 3 days of receipt of this notice and will update residents' ISPs, as appropriate, to ensure the safety needs of residents will be met in the event of emergency.<br><br>The facility did not complete, update, or retain evacuation assessments for two residents with cognitive or physical limitations. | Order | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **Tradewinds Residence** | 2/27/03 | 83.14(1)(a) | Client Related Training<br><br>One employee did not meet all requirements for client-related training. | $200 | Event ID: 6CJV11 Paid. |
| Superior | | 83.14(2) | Dietary<br><br>One employee did not complete dietary training. | $200 | Paid. |
| Douglas<br>Western | | | | | |
| **Evergreen Terrace LLC** | 2/26/03 | 50.065(2)(b) | Background Checks<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will ensure that complete criminal background checks have been conducted for all current employees within 14 as required by Chpts. 50 and 12. Pursuant to 50.03(5g)(b)3, the facility will maintain compliance with criminal background requirements for all new employees. Records of background checks will be maintained in employee personnel files at the facility and will be made available to Department representatives upon request.<br><br>The facility had not conducted complete background checks for two staff. | Order | |
| Antigo | | 83.14(1)(d) | Fire Safety, First Aid & Choking<br><br>Five employees did not complete all requirements for fire safety, first aid, and procedures to alleviate choking within 90 days of hire. Up to six months elapsed between hire dates and training completion dates. | $250 ($50 per 5 employees - training was completed late) | |
| Langlade<br>Northern | | | | | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **Learning Services of Middleton (cont.)** | 2/26/03 | 83.14(1)(c) | 3rd cite. Universal Precautions<br><br>Repeat violation. Three caregivers had not received training. | $1,000 (3 caregivers @$400, max $1000) | |
| Middleton | | 83.14(1)(d) | 4th cite. Fire Safety, First Aid & Choking<br><br>3 caregivers did not complete all required training. Fourth citation. Facility does not ensure that caregivers have met minimum training requirements to ensure the health, safety, and welfare of residents. | $1,000 | |
| Dane | | 83.14(2) | 3rd cite. Dietary Training<br><br>3 caregivers had not completed training. | $1000 | |
| Southern | | 83.42(3)(e) | 2nd cite. Quarterly Fire Drills<br><br>Order: Pursuant to 50.03(5g)(b)(3), the facility will comply with requirements to conduct quarterly fire drills and will maintain documentation as specified by 83.42(3)(e). | $50<br>Order | |
| | | 83.43(3)(a) | Smoke Detection System & Heat Detectors.<br><br>Order: Pursuant to 50.03(5g)(b)(3), the facility will comply with requirements to test the interconnected smoke detection system at least quarterly and will maintain documentation as specified by 83.43(a). | Order | |
| **Learning Services of Middleton (cont.)** | 2/26/03 | 83.43(3)(b)1 | 2nd cite. Testing by a Service Company<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will have the smoke and heat detection system inspected, cleaned and tested by a reputable service company within 10 days. The facility will submit a copy of the inspection report to the Department and will follow-through will all recommendations made by the inspector.<br><br>The facility had not had the smoke detection and heat detection system inspected, tested, or cleaned since 1/18/01. | $100<br>Order | |
| Middleton | | 83.43(7)(b) | Installation and Maintenance<br><br>Order: Pursuant to 50.03(5g)(b)4, the facility will submit a written plan of correction to the Department within 10 days addressing the replacement of sprinkler heads.<br><br>Sprinkler heads were recalled and the facility was notified via an inspection report on 4/9/02 but has taken no steps to replace the faulty parts. | Order | |
| Dane<br>Southern | | | | | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| | | 88.10(3)(p) | Adequate Treatment<br><br>Order: Pursuant to 88.03(6)(g)2b, the facility will comply with requirements specified under 88.10(3)(p) to ensure that resident needs are met.<br><br>The facility did not provide personal cares for a respite resident. Hygiene needs were not met. The resident was sent to a day program with dirty hair and clothing, poor oral hygiene, and peri-area odor. | Order | |
| **Sun Valley East 2** | 2/26/03 | 50.065(2)(b) | 2nd cite. Background Checks<br><br>Background checks had not been completed for one employee, repeat violation.<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will ensure that complete criminal background checks have been conducted for all current employees within 14 as required by Chpts. 50 and 12. Pursuant to 50.03(5g)(b)3, the facility will maintain compliance with criminal background requirements for all new employees. | $100<br>Order | Event ID: 8ZCH12 |
| Beloit | | 50.065(4m)(c) | Background Information Disclosure Forms<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will ensure that all current employees have completed Background Information Forms as required by 50.065(4m)(c) within 5 days. Completed forms for current employees shall be maintained in personnel records, onsite, and shall be made available to Department representatives upon request.<br><br>Personnel records for two employees did not contain Background Information Disclosure Forms. | Order | |
| Rock | | 83.13(4)(a) | 2nd cite. Communicable Disease Control<br><br>The facility did not ensure that 4 employees had been screened for communicable disease (previously cited). | $100 | |
| Southern | | 83.14(1)(d) | 2nd cite. Fire Safety, First Aid & Choking<br><br>Two staff had not completed required training. | $800 ($400 per untrained staff) | |
| | | 83.21(4)(h) | Privacy<br><br>Order: Pursuant to 50.03(5g)(b)4, the facility will submit a plan of correction to the Department within 10 days addressing measures to ensure the privacy of resident 3, including that the personal activities of the resident will not be inappropriately overhead by others through a monitoring device.<br><br>The facility placed a baby monitor from a resident's bedroom to the kitchen area where the resident's daily activities could be overhead by others. | Order | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **Triangle House** | 2/26/03 | 83.11(3)(a) | Licensee Responsibilities<br>Order: Pursuant to 50.03(5g)(b)7, the licensee will admit no new residents until compliance with all regulations is attained and verified by the department and this order is rescinded in writing.<br><br>Nineteen deficiencies were issued, including five repeat violations. | Order: see note | Event ID: Y48Y12 |
| Milwaukee | | 12.10 | Criminal Background Checks<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will complete background checks on all current employees and those included in the SOD within 10 days. Documentation of background checks will be retained in personnel files, onsite, and will be made available to Department representatives upon request.<br><br>The facility did not have records verifying that criminal background checks had been completed for five employees. | Order: see note | |
| Milwaukee | | 83.14(1)(c) | 2nd cite. Universal Precautions<br><br>Repeat violation. Three employees had not received training in universal precautions. | $1,000 (3 employees @ $400 per employee, max $1000) | |
| Southeastern | | 83.14(1)(d) | Fire Safety, First Aid & Choking<br><br>Two employees had not received training within 90 days of employment. | $400 | |
| | | 83.33(2)(c) | Activities<br>The facility did not provide activity programs for three residents. One resident was observed to spend the full day in her room during survey, talking to herself. Two other residents were in bed from 10:05 a.m. until 5:00 p.m. Residents expressed an interest in activities and indicated "there is not much to do around here." The facility did not have an activity schedule and the house manager confirmed that the facility does not offer activities to residents. | $400 | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **Triangle House (cont.)** | 2/26/03 | 83.21(4)(p) | and 83.33(2)(h)1 Medical Services/ Prompt and Adequate Treatment<br><br>The facility did not call the physician and did not provide the proper diet based on the resident's condition. There was no physician's order for a modified diet. There was physician input for the blood sugar parameters, but the facility did not follow the orders. The resident's blood sugar was 62 and the facility did not recheck the blood sugar level or contact the physician as specified by the order. Instead, staff prepared a breakfast of pancakes and syrup for the resident. Following breakfast the resident's blood sugar was 426.<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will obtain consultation and assistance from a qualified professional to develop and implement a written policy addressing services for residents with diabetes. Pursuant to 50.03(5g)(b)8, the facility will ensure all staff receive inservice training by a qualified professional on diabetic care and monitoring within 45 days. | $100<br>Order: see note | |
| Milwaukee | | 83.41(5)(d)2 | 2nd cite. Hot Water Temperatures<br><br>The facility had been cited for the same violation previously. Water temperatures in the water heater measured 89 degrees, significantly below the required, safe range of 131-140 degrees. The facility had not installed a functional automatic mixing valve. Residents complained that baths and showers were | $100 | |
| Milwaukee | | 83.41(9) | 2nd cite. Cleanliness of Rooms<br><br>The facility was not maintained in a clean and homelike manner. Carpeting had several cigarette burns, floors were discolored and stained. Toilet seats had brown and yellow stains. Bathtubs had black and brown stains in and around. There was a pervasive odor of urine and cigarette smoke. The kitchens were not well-kept. | $100 | |
| Southeastern | | 83.41(10(a) | 2nd cite. Building Maintenance<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will repair or replace damaged furnishings, such as living room furniture, will repair or replace damaged flooring, and will install functional sink fixtures in apartment 6 within 30 days.<br><br>The sink fixtures had no knobs and residents in the apartment were unable to use the sink. Flooring was detached and worn. Upholstry was torn. | $100<br>Order: see note | |
| | | 83.42(6)(a)1 | Annual Fire Inspection<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will obtain a fire inspection as specified by 83.42(6)(a)1 within ten days of receipt of this order.<br><br>The facility has not had a fire inspection since 2000. Several residents smoke and the smoke detection system in the facility is not interconnected. | Order: see note | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **The Avenue** | 2/21/03 | 83.11(3)(h) | and 12.07(2)<br>Not permit a condition of risk.<br><br>The executive director has been charged with 3 felony counts including intentional abuse, negligent abuse of a resident, and reckless injury. The licensee has not conducted an impartial investigation or taken action to protect the health, safety, and welfare of residents.<br><br>Effective immediately, pursuant to 50.03(5g)(b)6, employee A will have no direct contact with residents or access to facility premises (The Avenue, Crossroads I and Crossroads II) pending final disposition of the criminal complaint filed against employee A on 1/21/02 for 3 felony charges.<br><br>Order also applies to Crossroads I and Crossroads II | Order (see note) | |
| Gilman<br>Taylor<br>Northern | | | | | |
| **Encore Sr. Villa Fitchburg East 2** | 2/20/03 | 50.065(2)(bb) | Criminal Background Checks<br><br>The facility did not complete background checks for an employee with an arrest who had previously resided out-of-state.<br><br>Order: Pursuant to 50.03(5g)(b)3 and 50.03(5g)(b)6, the facility is ordered to immediately suspend the employment of (Employee D). (Employee D) may not work in the facility or have contact with residents until criminal background evaluations have been completed as specified by 50.065(2)(bb), 50.065(2)(bm), and HFS Chpt. 12. | Order (see note) | Event ID: DBBU12 |
| Madison | | 50.065(2)(bm) | Out of State Back Ground Checks<br>(noted above) | Order | |
| Dane | | 83.14(8) | Documentation<br><br>The facility did not have employee training records available onsite to verify that minimum training requirements had been met.<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will obtain training records for all current employees within 14 days. Training records for current employees will be maintained onsite and will be made available to Department representatives upon | Order | |
| Southern | | | | | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
| --- | --- | --- | --- | --- | --- |
| **Clark Place Riverside**<br>Burlington<br>Racine<br>Southeastern | 2/17/03 | 88.03(6)(g)2.c. | The facility has not provided plans of correction as requested by the Department for past violations.<br><br>Order: Pursuant to 88.03(6)(g)2.c., the facility is hereby ordered to submit a plan of correction for SOD# 1000588, dated 3/14/02, and SOD# [ ], dated 2/7/03, within ten days of receipt of this notice. | Order (see note) | Event ID: P9UC11 |
| **Hillcrest Home**<br>West Allis<br>Milwaukee<br>Southeastern | 2/17/03 | 83.43(4)(b)3 | Smoke Detectors<br>Three smoke detectors had not been integrated with the facility's interconnected smoke detection system. | $200 | Paid |
| **Rock Valley Community Programs**<br>Janesville<br>Rock<br>Southern | 2/17/03 | 83.14(1)(a) | Client related training<br>Three employees had not completed client-related training within six months of starting employment. One untrained employee was hired in 1999, another was hired in August 2001. | $600 | Event ID: XPF111 |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **Ain Dah Ing (cont.)** | 2/11/03 | 83.33(3)(e)6 | 2nd cite. Medical Record Documentation<br>The facility had not documented numerous incidents when four residents did not receive medications, including psychotropic medications, as ordered or had refused medications. Client 7, for example, did not receive (or refused) 26 doses of Depakote and 7 doses of Seroquel in December 2002.<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will obtain consultation from a qualified professional to develop and implement a written policy and procedure addressing appropriate, effective documentation of medications administered to residents. The written procedure will be submitted to the Department for review within 30 days. All staff responsible for administering medications will receive inservice training regarding the written procedure within 45 days.<br>Order: Pursuant to 50.03(5g)(b)3, the facility will immediately comply with requirements specified by 83.33(3) to ensure residents receive necessary medications. | $200<br>Order (see note) | Paid |
| Spooner | | 83.41(10) | 2nd cite. Building Maintenance<br>Although cited during a previous survey, several observations were made of poor repair in the interior and exterior of the building. | $100 | Paid |
| Washburn | | 83.43(3)(b) | 2nd cite. Testing by Service Company<br>The facility did not have the smoke and heat detection system inspected and cleaned.<br>Order: Pursuant to 50.03(5g)(b)6, the facility will have the smoke and heat detection system inspected, cleaned, and tested by a reputable service company within 10 days. | Order (see note) | |
| Western | | | | | |
| **Old Times**<br><br>Westby<br>Vernon<br>Western | 2/11/03 | 83.21(4)(o) | Medications<br>A resident with a history of stroke did not receive a blood-thinning medication (Coumadin) as ordered by the physician. The facility documented that the medication had been administered although the pills remained in the unit dose package. A second resident did not receive Coumadin or a second medication the resident needed to alleviate anxiety. | $100 ($25/day for 1/15/03, 1/16/03, 1/21/03, and 1/23/03) | Event ID: 0HQ711. Paid |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **Sun Valley** | 2/10/03 | 83.33(2)(g)3 | Arrange Health Visits<br>A resident showed a decline in appetite on 1/9/03 and was sleeping at the table on 1/10, 1/11, and 1/12/03. Symptoms of illness (weakness, fatigue, refusing meals, agitation) persisted until the resident was hospitalized on 1/20/03. Facility records indicate the physician was not contacted until 1/17/03. | $100 | Event ID: ZEJY12 Paid |
| Beloit | | 83.41(9) | 2nd cite. Cleanliness of rooms<br>Surveyors noted strong urine odors in a resident room. Facility staff indicated the odor originated from the carpet and was "aware that the facility had been cited previously for the urine odor" but thought it was better. The facility permitted a resident to reside in a room with persistent urine odors. | $100 | Paid |
| Rock | | 83.42(3)(3) | Quarterly Fire Drills<br>The facility did not conduct all required fire drills. When drills were conducted, the facility did not document evacuation times.<br>Order: Pursuant to 50.03(5g)(b)3, the facility will comply with the requirements of 83.42(3)(e) and conduct quarterly fire drills, with written documentation of the date and evacuation time for | Order (see note) | |
| Southern | | 83.42(3)(f) | Sleeping Hours Evacuation<br>The facility had not conducted a simulated night-time fire drill, a failure in emergency preparedness that poses a safety risk to physically and cognitively impaired residents. | $100 | Paid |
| | | 83.43(3)(a) | 2nd cite. Smoke Detection System and Heat Detectors<br>Despite a previous citation, the facility did not conduct tests of the smoke and heat detection system as required. | $50 | Paid |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **WestHill Adult Family Home**<br><br>Rhinelander<br>Oneida<br>Northern | 2/10/03 | | 2nd cite. Documentation of Training for 15 hours within 6 months...the training shall include first aid and fire safety. The facility did not have documentation to verify that two employees had completed required training in first aid and that one employee had completed training in fire safety.<br><br>Order: Pursuant to 88.03(6)(g)2b and 88.03(6)(g)2e, the facility will comply with the requirements of 88.04(5)(a) and shall obtain all required training, document training, and maintain training records onsite for review by the Department upon request. Within 30 days, the licensee will submit documentation to the Department verifying the completion of fire safety training and first aid training for Staff C and Staff I. | Order (see note) | Event ID: 88.04(5)(a) |
| **White Birch Terrace** | 2/10/03 | 83.41(5)(d)2 | 2nd cite Hot water temperatures<br>Facility did not maintain water temperatures at 110 degrees or less. The facility had been cited previously for high water temperatures. Temperatures during this survey ranged from 116-119 degrees. | $100 | Event ID: J2UL12. Paid |
| Bayside<br><br>Milwaukee<br>Southeastern | | 83.43(4)(b)2.e. | Smoke Detectors<br>The facility had not installed a smoke detector in a required location.<br>Order: Pursuant to 50.03(5g)(b)3, the facility will comply with requirements to have smoke detectors installed as specified by HFS chpt 83. | Order (see note) | |
| **Bothne House**<br><br>Coon Valley<br>Vernon<br>Western | 2/7/03 | 83.33(3)(a) | The facility did not ensure that a resident received prescribed medications. Medications were not administered on a weekend, 10/12 and 10/13 even though the pharmacy offers a 24 hour service. The daughter brought medications to the resident, but the facility did not know which medications had been provided by the daughter, with the exception of Lorazepam, a medication that was not included among those the resident was to receive according to hospital discharge | $200 ($100 per day 10/12 and 10/13) | Paid |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **New Century Adult Living (cont.)** | 2/7/03 | 88.05(4)(b)1 | Smoke detectors<br>The facility did not have smoke detectors installed in three required locations.<br>Order: Pursuant to 88.03(6)(g)2b, the facility will immediately install smoke detectors in all locations required by HFS chapter 88. | Order | |
| Wausau | | 88.05(4)(b)2 | Testing Smoke Detectors.<br>Monthly testing of smoke detectors had not been done since 5/25/02.<br>Order: Pursuant to 88.03(6)(g)2b, the facility will immediately conduct required tests of smoke detectors and will resume monthly testing as required by 88.05(4)(b)2. The facility will maintain documentation of smoke detector testing and maintenance. | Order (see note) | |
| Marathon | | 88.05(4)(d)2.b | Resident Evacuation Assessment<br>The facility had not completed an evacuation assessment for resident #1 since 1999. Resident #1 is developmentally disabled, elderly, and susceptible to falls.<br><br>Order: Pursuant to 88.03(6)(g)2b, the facility will complete an evacuation assessment for resident #1 within 3 days. | Order (see note) | |
| Northern | | 88.05(4)(d)2.c | The facility had not conducted a fire drill since 2/18/02. | | |
| | | 88.07(2)(b)(5) | Monitoring Health<br>A developmentally disabled resident with Leukemia was punched in the face twice by resident of the same day program while in the transport van. The resident sustained a bloody nose and cut lip. Facility did not contact the resident's physician. Incident was reported to resident's guardian, but not caseworker. | | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **Harbor Suites** | 2/6/03 | 50.065(2)(bb) | Determine Final Disposition of Charges<br>Facility did not complete criminal background evaluation as required for an employee who had an arrest and conviction within the past five year.<br>Order: Pursuant to 50.03(5g)(b)3 and 50.03(5g)(b)6, the facility is ordered to immediately suspend the employment of (Employee D). (Employee D) may not work in the facility or have contact with residents until criminal background evaluations have been completed as specified by 50.065(2)(bb) and HFS Chpt. 12. | Order (see note) | Event ID: YOYZ12 |
| Madison | | 83.33(2)(a) | Supervision<br>A resident with dementia and an unsteady gait who required "constant supervision" wandered from the facility on two occasions. The second elopement occurred in November at 7:00 a.m. The resident was not wearing a cap or overcoat. He had bedroom slippers on his feet. The resident fell prior to being located and a passerby contacted emergency medical services. | $500 (assessed for incident 11/7/02. Facility did not prevent recurrence of incident of 10/7/02.) | Paid |
| Dane<br>Southern | | | | | |
| **Inncare of Minocqua I** | 2/6/03 | 83.16(1) | 2nd cite. Admissions Agreement. Admissions documents and ISP for a resident who had not been adjudicated incompetent or deemed incapacitated were not authorized by the resident. The resident's admissions documents and ISP were signed by a family member who was not a legal representative (guardian or POA-HC, activated). | $50 | Paid |
| Minocqua<br>Oneida/Vilas<br>Northern | | 83.32(3) | 2nd cite. ISP. See note above. | $50 | Paid |
| **Inncare of Minocqua I (cont.)** | 2/6/03 | 83.32(2)(a)1 | Physical Health<br>A developmentally disabled resident was admitted to the facility without a preadmission assessment. | $50 | |
| Minocqua | | 83.35(5)(b) | Accurate thermometer<br>Refrigerator temperature was above acceptable limits. Thermometers were not available to monitor temperatures.<br>Order: Pursuant to 50.03(5g)(b)6, the facility will comply with requirements to have an accurate thermometer in each refrigeration unit. | Order (see note) | |
| Oneida/Vilas<br>Northern | | | | | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
| --- | --- | --- | --- | --- | --- |
| **Alterra Clare Bridge Brookfield** | 2/5/03 | 13.05(2) | Investigating Injuries of Unknown Origin<br>Residents sustained injuries of unknown origin including cuts, a black eye, and bruising on the lower back, buttocks, and hip areas. The facility did not investigate or report.<br>Orders: Pursuant to 50.03(5g)(b)6, the facility will develop and implement a written policy on investigating injuries of unknown origin. The policy will incorporate reporting requirements specified under Chapter 13. In addition, the facility will investigate the injuries sustained by residents #1 and #2 and will comply with requirements specified by HFS chpts. 13 and 83. Pursuant to 50.03(5g)(b)8, the facility will ensure all staff receive training within 45 days on the topics of abuse and neglect, including investigating injuries of unknown origin, preventing abuse, and meeting reporting requirements. | Order (see note) | Event ID: TWH912 |
| Brookfield | | 83.13(4)(b) | Communicable Disease<br>A caregiver went to work while ill. Within days, three residents contracted the Norwalk virus and were hospitalized.<br>Orders: Pursuant to 50.03(5g)(b)6, the facility will obtain consultation and assistance from a qualified professional to develop and implement a written policy on infection control practices. The facility will comply with requirements specified by 83.13(5)(a) and 83.13(5)(b). Pursuant to 50.03(5g)(b)8, the facility will ensure all staff receive inservice training on infection control practices within 45 days. | Order (see note) | |
| Waukesha | | 83.35(7)(a) | Clean and safe work habits.<br><br>The facility did not employ safe handwashing and use of gloves during meal preparation and serving.<br><br>Order: Pursuant to 50.03(5g)(b)6, the facility will obtain consultation and assistance from a qualified professional to develop and implement a written policy on infection control practices and the prevention of foodborne illnesses. The written policy will address food preparation and sanitary dishwashing practices. Pursuant to 50.03(5g)(b)8, the facility will ensure all staff receive inservice training on infection control practices within 45 days. | Order (see note) | |
| Southeastern | | | | | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **Hammersley House (cont.)** | 2/5/03 | 83.32(4)(a) | Persons in Respite Care<br>The facility did not ensure that two residents had service plans while receiving respite care.<br><br>Order: Pursuant to 50.03(5g)(b)(6), the facility will maintain complete, accurate records (including assessments and service plans) for current residents, including respite residents, onsite, and will make records available for review by the Department upon request. | Order (see note) | |
| Madison<br>Dane<br>Southern | | | | | |
| **Harbor House II**<br>DeForest<br>Dane<br>Southern | 2/5/03 | 83.14(1)(d) | Two staff had not received training in Fire Safety and First Aid. | $400 ($200 per untrained staff) | Event ID: MI0R11 |
| **Inncare of Minocqua West** | 2/5/03 | 83.14(1)(a) | 83.14(1)(a)2 and 83.14(1)(a)3 Block I training,<br>Two staff had not completed training in resident rights, dealing with challenging behaviors, or client-specific training within six months of employment. Staff F worked in the facility nearly two years prior to receiving training. | $400 | Event ID: DX8N11 |
| Minocqua | | 83.14(1)(c) | One staff did not have standard precautions training prior to assuming responsibilities for direct care of residents. | $200 | |
| Oneida/Vilas | | 83.14(d) | One staff did not complete fire safety training within 90 days of employment. | $200 | |
| Northern | | 83.14(3) | Medication Training<br>One staff did not receive initial training in medication management prior to assuming responsibilities for administering medications to residents. | $200 | |

| Facility Name, City, County, Region | Citation Date | Codes | Descriptions | Remedies | Outcomes |
|---|---|---|---|---|---|
| **Heavenly Care Group Home** | 2/3/03 | 83.05(2)(a) | 2nd cite. Class A Ambulatory<br>This Class AA facility retained a semi-ambulatory resident despite having received a citation regarding the same resident in the past.<br>Order: Discharge resident #1 or comply with an appropriate class of licensure within 45 days. Pending discharge, the facility shall immediately develop a plan to ensure the evacuation needs of resident #4 can be accomplished safely in the event of an emergency. | $100<br>Order (see note) | Event ID: KY2P12 |
| Milwaukee | | 83.07(4) | Community Advisory Committee.<br>Despite repeat requests, the facility did not provide evidence of establishing a community advisory committee.<br>Order: Within ten days, the facility will provide evidence that a good faith effort has been made to establish a community advisory committee. | Order: see note | |
| Milwaukee | | 83.07(10)(a) | Plan of Correction<br>The facility did not submit plans of correction as directed.<br>Order: Within ten days, the facility will submit plans of correction addressing SOD # 100005977. | Order: see note | |
| Southeastern | | | | | |

## Asbjornson, Karen

**Subject:** MADISON Meeting w/ Rep. Jeskewitz, LAB, and DHFS

**Start:** Tue 08/19/2003 8:15 AM
**End:** Tue 08/19/2003 10:15 AM

**Recurrence:** (none)

re: assisted living audit
here
Need to call LAB back,
Diane said 8am would work better
Gary Radloff- yes
Sue Schroeder- yes SS told her 9am-10:30am
Sue is bringing 3 people with
Jan- yes
Joe- yes
LAB coming at 8:15, everyone else at 9am
330 SW

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## Assisted Living/Nursing Home Audit

Give brief overview that you had a good Audit committee meeting and that the Co-chairs have asked the department to respond by July 1, 2003. You look forward to working on this issue after the budget deliberations conclude.

- February 5, 2002 Joint Audit Committee, which I co-chair with Representative Jeskewitz, held a hearing on the regulations of nursing homes and assisted living facilities.

- The Audit hearing focused on regulatory oversight to ensure quality care in assisted living facilities and nursing homes.

- All of those testifying concurred that quality of care has to be the most important focus of all long term care facilities, however those working in the field cited frustrations over inconsistencies in inspections.

- We directed the department to further address the recommendations of the audit and the committee members concerns. Further, we directed DHFS to meet with providers and advocates and report back to the Audit Committee in July with suggestions for improvement.

**Highlights of letters to DHFS asking for more information:**

1. **Share best practices:** during inspections of nursing homes and long term care facilities that some of the time be spent documenting what the home does well and then share those best practices with other facilities. Is there a way for the industry to do sharing of best practices? If not, does the Department have any plans for implementation of best practice sharing?
2. **Number of unsubstantiated cases:** Seeing as there are a large number of unsubstantiated complaints, is there a way to better "weed out" some of these so as to save the time and money of the Department?
3. **No medical professional on assisted living inspector team**: Why aren't the qualifications of the nursing home inspectors and the assisted living inspectors the same? Why shouldn't the inspectors of the assisted living facilities include a medical professional? Why are the inspection schedules different?
4. **Citations - increased and disproportionate around state:**
   - Why is it that the number of citations issued increases when the federal regulators accompany state inspectors?
   - Why are the numbers of citations disproportionate around the state?
   - Do we need to put more time in the failing facilities and ease up on the facilities that are having little or no deficiencies?
   - The Department's position on maintaining both state and federal regulations for nursing homes;
   - Is there a timeline for establishing written procedures to guide the assessment process for assisted living facilities?

Implementation of Best Practice sharing

Double jeopardy

Portion of Assessments to Dept. not all to Common School Fund

LTC FC.7

- Has the Department been working to change the timeline for appeals and compliance? Could this decrease costs because more issues could be resolved before they entered the court system?
- Does the Department support sending some fine money back for administrative costs? How can this be done without creating an incentive for the Department to fine?

5. Other:
    - What is the difference in cost breakdown for subsidies to assisted living facilities as opposed to nursing homes?
    - Does the Department support expanding the Board on Aging and Long Term Care's Ombudsman services into the residential care apartment complexes?
    - What can be done to increase the retention of trained employees in nursing homes and long-term care facilities?
    - Is there a timeline for establishing written procedures to guide the assessment process for assisted living facilities?

Bureau of Quality Assurance
Provider Enforcement Data
August 19, 2003

| | 2002 | 2003 |
|---|---|---|
| **Total Nursing Home Class A, B, C, Chapter 50 Cited** | 313 | 168 |
| **Number of Nursing Home Citations Already Issued Forfeitures (Completed)** | 218 | 44 |
| **Total Hospice State Citations Issued** | 61 | 2 |
| **Number of 2002 Hospice Citations Already Issued Forfeitures** | 2 | 0 |

| | | |
|---|---|---|
| Outstanding 2002 Nursing Home Citations | 95 | |
| Outstanding 2003 Nursing Home Citations | 124 | |
| Outstanding 2002 Hospice Citations | 59 | |
| Outstanding 2003 Hospice Citations | 2 | |
| Total | 280 | As of July 31st |

statistical run.

An Evaluation
**Regulation of Nursing Homes and Assisted Living Facilities**
Department of Health and Family Services
(Report 02-21)

| **RECOMMENDATIONS** | **STATUS** |
|---|---|
| *We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by March 1, 2003, on:*<br>• *the number and percentage of FY 2000-01 and FY 2001-02 state nursing home citations eligible for forfeiture and awaiting review; and*<br>• *the percentage of a forfeiture that represents a reasonable estimate of the Department's administrative costs related to assessing a forfeiture.* (page 46) | **Completed**<br><br>Department filed detailed reports with Joint Audit Committee on February 28, 2003 and July 1, 2003. |
| *We recommend the Department of Health and Family Services establish a written procedure to guide the assessment of forfeitures for assisted living facilities.* (page 48) | **Partially completed** |
| *We recommend the Legislature amend s.50.04(4)(d), Wis. Stats., to allow the Department of Health and Family Services to restrict nursing home admissions in a more timely manner.* (page 50) | **Not completed** |
| *We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by July 1, 2003, on:*<br>• *the effect on timeliness of returning responsibility for informal dispute resolution decision-making to regional managers;*<br>• *the number of cases resolved through informal dispute resolution; and*<br>• *the number of cases resolved through informal dispute resolution that were subsequently appealed.* (page 60) | **Partially completed**<br><br>July 1, 2003 follow-up report contains information on the timeliness of informal dispute resolution and the number of cases resolved.<br><br>July 1, 2003 follow-up report does **not** contain information on the number of informal dispute resolution cases appealed. |
| *We recommend the Legislature modify ch. 50, Wis. Stats., to create a 60-day time frame for providers to file appeals after receiving statements of deficiency for state violations.* (page 63) | **Not completed** |

| OPTIONS | STATUS |
| --- | --- |
| We suggested that if the Legislature is not satisfied with the current regulatory process for assisted living facilities, a number of options are available. For example, if it wishes to comprehensively review assisted living facility regulations, the Legislature could request the Joint Legislative Council to study the issue and make recommendations to improve regulatory oversight that could better ensure quality care. | **Not completed** |

Alternatively, the Legislature could:

- establish standards for the frequency with which assisted living facilities should be inspected;
- establish minimum qualifications for assisted living facility inspectors;
- increase the number of staff assigned to inspect assisted living facilities by seeking additional federal funds, increasing facility licensure fees, or directing the Department to reallocate its existing resources; or
- direct the Department to develop technical assistance training programs to better enable assisted living facilities to comply with regulations. (page 37)

An Evaluation
**Regulation of Nursing Homes and Assisted Living Facilities**
Department of Health and Family Services
(Report 02-21)

*Follow-up Questions for the Department of Health and Family Services*
*August 19, 2003*

## I. Assisted Living Facility Survey Process

- The Department made strides in modifying the survey process for assisted living facilities, and interest group participation in the Assisted Living Forum is considerable. When will the new process be fully implemented?

- Does the Department believe the steps taken to develop guidelines for assisted living facility forfeiture assessment are adequate to ensure consistency?

- How does the Department's effort to rewrite the administrative code for community-based residential facilities (HFS 83) relate to implementation of the revised assisted living facility survey process? When will the rewrite of the code be completed?

## II. Quality of Care Issues

- The federal government has clarified a greater level of flexibility for the state in using civil money penalties collected from nursing homes. Does the Department expect to implement additional technical assistance or best practices-sharing activities as a result of this new flexibility?

- The Department's February 2003 report indicates that $1.4 million in civil money penalties was available on 12/31/01. Has the amount available increased?

## III. Enforcement Activities

- The Department has attempted to reduce the backlog of forfeitures for nursing homes, yet the size of the backlog remains between 275 and 300. When will the backlog be eliminated?

- Does the Department plan to take no further action on retaining a portion of the forfeiture assessment for its administrative costs?

- In an effort to target its enforcement actions, the Department has identified a list of "problem" nursing home facilities. What is the Department's plan for further developing the criteria used to identify these facilities?

## IV. Use of Department Resources

- In its February 2003 report, the Department indicated its employment of 114.5 full-time equivalent (FTE) nursing home facility regional staff and 40.5 FTE assisted living facility regional staff. In light of budget constraints, how many regional regulatory staff does the Department currently employ? How many central office staff?

- At the Joint Audit Committee hearing on February 5, 2003, the Department testified that it would continue to pursue federal funding for additional assisted living facility regulators. Did the Department indeed receive these funds and what additional federal funding does it expect to receive?

- Is it reasonable to assume that fewer staff will be devoted to the informal dispute resolution process under the proposed model incorporating an option for external review?

An Evaluation

**Regulation of Nursing Homes and Assisted Living Facilities**

Department of Health and Family Services

(Report 02-21)

| RECOMMENDATIONS | STATUS |
| --- | --- |
| *We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by March 1, 2003, on:*<br>• *the number and percentage of FY 2000-01 and FY 2001-02 state nursing home citations eligible for forfeiture and awaiting review; and*<br>• *the percentage of a forfeiture that represents a reasonable estimate of the Department's administrative costs related to assessing a forfeiture.* (page 46) | **Completed**<br><br>Department filed detailed reports with Joint Audit Committee on February 28, 2003 and July 1, 2003. |
| *We recommend the Department of Health and Family Services establish a written procedure to guide the assessment of forfeitures for assisted living facilities.* (page 48) | **Partially completed** |
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| *We recommend the Department of Health and Family Services report to the Joint Legislative Audit Committee by July 1, 2003, on:*<br>• *the effect on timeliness of returning responsibility for informal dispute resolution decision-making to regional managers;*<br>• *the number of cases resolved through informal dispute resolution; and*<br>• *the number of cases resolved through informal dispute resolution that were subsequently appealed.* (page 60) | **Partially completed**<br><br>July 1, 2003 follow-up report contains information on the timeliness of informal dispute resolution and the number of cases resolved.<br><br>July 1, 2003 follow-up report does **not** contain information on the number of informal dispute resolution cases appealed. |
| *We recommend the Legislature modify ch. 50, Wis. Stats., to create a 60-day time frame for providers to file appeals after receiving statements of deficiency for state violations.* (page 63) | **Not completed** |

| **OPTIONS** | **STATUS** |
|---|---|
| We suggested that if the Legislature is not satisfied with the current regulatory process for assisted living facilities, a number of options are available. For example, if it wishes to comprehensively review assisted living facility regulations, the Legislature could request the Joint Legislative Council to study the issue and make recommendations to improve regulatory oversight that could better ensure quality care.<br><br>Alternatively, the Legislature could:<br><br>• establish standards for the frequency with which assisted living facilities should be inspected;<br>• establish minimum qualifications for assisted living facility inspectors;<br>• increase the number of staff assigned to inspect assisted living facilities by seeking additional federal funds, increasing facility licensure fees, or directing the Department to reallocate its existing resources; or<br>• direct the Department to develop technical assistance training programs to better enable assisted living facilities to comply with regulations. (page 37) | **Not completed** |

Tommy G. Thompson
Governor

Joe Leean
Secretary

State of Wisconsin

Department of Health and Family Services

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# CIVIL MONEY PENALTY FUND USE

Effective February 1, 2000

Written and developed in conjunction with Bureau of Quality Assurance (BQA) Manual Code #2556 – Civil Money Penalty Determination

Pursuant to federal requirements, 488.442 Civil Money Penalties: Due date for payment of penalty, "penalties collected by the State must be applied to the protection of the health or property of residents of facilities that the State or HCFA finds deficient such as:

(1) Payment for the cost of relocating residents to other facilities;
(2) State costs related to the operation of a facility pending correction of deficiencies or closure; and
(3) Reimbursement of residents for personal funds or property lost at a facility as a result of actions by the facility or by individuals used by the facility to provide services to residents."

Monies collected by or returned to the State of Wisconsin as a result of provider CMP payments are deposited in a general revenue account, and therefore disbursement of funds from this account must comply with Department of Health and Family Service fiscal procedures. This procedure establishes parameters by which the State of Wisconsin, Division of Supportive Living, Bureau of Quality Assurance will expend CMP funds.

Fifty percent of the Civil Money Penalty Fund will be reserved by BQA and applied toward the Department's costs for monitoring a facility while under a state imposed monitor remedy or in the event that the Department is appointed the receiver of a facility under Chapter 50, Wis. Stats. A petition for receivership occurs when:

- A facility is operating without a license.
- The department has suspended or revoked the existing license of the facility.
- The department initiates revocation procedures and determined that lives, health, and safety or welfare of residents cannot be adequately assured.
- The facility is closing or intends to close and adequate resident relocation initiatives are not in place.

The remaining fifty percent of the Civil Money Penalty Fund will be utilized for the purpose of funding projects that improve the health and safety and quality of care provided to residents, pursuant to item (4), s. 49.499 Wis. Stats. Expenditure of CMP funds received by the State of Wisconsin, per s. 49.499 Wis. Stats., may be utilized for the following:

(1) Relocating residents to other facilities.
(2) Reimbursement for state costs related to operating a facility pending correction of deficiencies or closure.
(3) Reimbursement to residents for funds or property lost as a result of a facility's action or inaction.
(4) Innovative projects that improve the health and safety and quality of care provided to residents.

CMP funds are not intended to be a patient/resident compensation fund, unless the Department is the receiver or operator of the facility pursuant to s. 50.05(4), Wis. Stats. Facilities are responsible for establishing mechanisms to handle resident claims.

File: m:/do/CMPuse.doc

**Facilities, Beds, and Average Bed Capacity by Region as of December 31**

**2001**

| | NERO | NRO | SERO | SRO | WRO | State |
|---|---|---|---|---|---|---|
| SNF/NF Facilities | 101 | 39 | 112 | 76 | 90 | 418 |
| SNF/NF Beds | 10557 | 4244 | 14967 | 7235 | 8096 | 45099 |
| **Average SNF/NF Beds** | **105** | **109** | **134** | **95** | **90** | **108** |
| FDD Facilities | 15 | 0 | 8 | 8 | 9 | 40 |
| FDD Beds | 597 | 0 | 1054 | 969 | 571 | 3191 |
| **Average FDD Beds** | **40** | **0** | **132** | **121** | **63** | **80** |
| Total Facilities | 116 | 39 | 120 | 84 | 99 | 458 |
| Total Beds | 11154 | 4244 | 16021 | 8204 | 8667 | 48290 |
| **Average Bed Capacity** | **96** | **109** | **134** | **98** | **88** | **105** |

**2000**

| | NERO | NRO | SERO | SRO | WRO | State |
|---|---|---|---|---|---|---|
| SNF/NF Facilities | 104 | 39 | 116 | 75 | 91 | 425 |
| SNF/NF Beds | 10922 | 4265 | 15332 | 7245 | 8383 | 46147 |
| **Average SNF/NF Beds** | **105** | **109** | **132** | **97** | **92** | **109** |
| FDD Facilities | 14 | 1 | 8 | 8 | 9 | 40 |
| FDD Beds | 479 | 125 | 1061 | 975 | 623 | 3263 |
| **Average FDD Beds** | **34** | **125** | **133** | **122** | **69** | **82** |
| Total Facilities | 118 | 40 | 124 | 83 | 100 | 465 |
| Total Beds | 11401 | 4390 | 16393 | 8220 | 9006 | 49410 |
| **Average Bed Capacity** | **97** | **110** | **132** | **99** | **90** | **106** |

**1999**

| | NERO | NRO | SERO | SRO | WRO | State |
|---|---|---|---|---|---|---|
| SNF/NF Facilities | 104 | 39 | 118 | 76 | 91 | 428 |
| SNF/NF Beds | 11060 | 4274 | 16084 | 7528 | 8447 | 47393 |
| **Average SNF/NF Beds** | **106** | **110** | **136** | **99** | **93** | **111** |
| FDD Facilities | 14 | 2 | 8 | 8 | 9 | 41 |
| FDD Beds | 481 | 165 | 1094 | 997 | 668 | 3405 |
| **Average FDD Beds** | **34** | **83** | **137** | **125** | **74** | **83** |
| Total Facilities | 118 | 41 | 126 | 84 | 100 | 469 |
| Total Beds | 11541 | 4439 | 17178 | 8525 | 9115 | 50798 |
| **Average Bed Capacity** | **98** | **108** | **136** | **101** | **91** | **108** |

*Correlation analysis suggests that average facility bed capacity explained about 42% of the variation in federal cites across regions for FY 2001, 52% for FY 2000, and 33% for FY 1999.*

**Facilities, Beds, and Average Bed Size**
**by Region as of December 31**

**2001**

| | NERO | NRO | SERO | SRO | WRO | State |
|---|---|---|---|---|---|---|
| SNF/NF Facilities | 101 | 39 | 112 | 76 | 90 | 418 |
| SNF/NF Beds | 10557 | 4244 | 14967 | 7235 | 8096 | 45099 |
| Average Bed Size | **105** | **109** | **134** | **95** | **90** | **108** |
| FDD Facilities | 15 | 0 | 8 | 8 | 9 | 40 |
| FDD Beds | 597 | 0 | 1054 | 969 | 571 | 3191 |
| Average Bed Size | **40** | **0** | **132** | **121** | **63** | **80** |
| Total Facilities | 116 | 39 | 120 | 84 | 99 | 458 |
| Total Beds | 11154 | 4244 | 16021 | 8204 | 8667 | 48290 |
| Average Bed Size | **96** | **109** | **134** | **98** | **88** | **105** |

**2000**

| | NERO | NRO | SERO | SRO | WRO | State |
|---|---|---|---|---|---|---|
| SNF/NF Facilities | 104 | 39 | 116 | 75 | 91 | 425 |
| SNF/NF Beds | 10922 | 4265 | 15332 | 7245 | 8383 | 46147 |
| Average Bed Size | **105** | **109** | **132** | **97** | **92** | **109** |
| FDD Facilities | 14 | 1 | 8 | 8 | 9 | 40 |
| FDD Beds | 479 | 125 | 1061 | 975 | 623 | 3263 |
| Average Bed Size | **34** | **125** | **133** | **122** | **69** | **82** |
| Total Facilities | 118 | 40 | 124 | 83 | 100 | 465 |
| Total Beds | 11401 | 4390 | 16393 | 8220 | 9006 | 49410 |
| Average Bed Size | **97** | **110** | **132** | **99** | **90** | **106** |

**1999**

| | NERO | NRO | SERO | SRO | WRO | State |
|---|---|---|---|---|---|---|
| SNF/NF Facilities | 104 | 39 | 118 | 76 | 91 | 428 |
| SNF/NF Beds | 11060 | 4274 | 16084 | 7528 | 8447 | 47393 |
| Average Bed Size | **106** | **110** | **136** | **99** | **93** | **111** |
| FDD Facilities | 14 | 2 | 8 | 8 | 9 | 41 |
| FDD Beds | 481 | 165 | 1094 | 997 | 668 | 3405 |
| Average Bed Size | **34** | **83** | **137** | **125** | **74** | **83** |
| Total Facilities | 118 | 41 | 126 | 84 | 100 | 469 |
| Total Beds | 11541 | 4439 | 17178 | 8525 | 9115 | 50798 |
| Average Bed Size | **98** | **108** | **136** | **101** | **91** | **108** |

8-19-03 DHFS — Josh
— Kate

- thank Sec. Nelson
- Assted Living
  # of enforcement people
  use fed $ to enhance their activit

enforcement
  reg - how ensure quality of car

N. Home - too prescriptive
A. Liv - very few regulated / visite

more flexibility w/ civil penalty
(of care N Home) what in mind for those

(*) addl fed $ - what using that
$ for?

- when implemented
- forfeiture backlog reduced

1. another followup mtg (comm.)
   issue press release

2.
   if new survey finish CBRF -
   fall not make changes

3 P Buff - gd. idea?

1) how many staff
did fed $ used
- civil $ penalties → N. Home
best practice/fed
- how $ fed dollars came in
Feb. 2003 114.5 FTE N Home
40.5 FTE A Liv.
now? regional & central office?

90 day time period

State $ generate

DHFS

2yrs — Otis (13 yrs.) — Deputy BQA
1 yr. — Kevin — Sec. Chief Ast. Liv.
4 yrs — Sue S. — Dir BQA state survey agen.
— Gary — DHFS Leg. Lais.

LAB

Ast. Liv. now ensure consistency
backlog - N. Homes Otis
forfeitures for A. Liv. - Kevin
new Ast. Liv. FO3
development of a manual
criteria based on process
cannot have a backlog —
280 citations N. Homes & hospice
backlog

HFS 101 Hospice
medication
do spot surveys 17% sample 1/2 pos on
State side designated
50 hospice statewide
expanding role for hospice - fed.
prognosis 6 mos or less
cms incr. threshold - to incr.
pain management

Feb. 03 started process follow manual
procedure
b/c audit info in Nov.

A. Living
- manual has been printed
  - March 19, 2003 official date manual completed
  - seeing some trends -
    - increased complaints
    - " staff
    - substantiating at a higher rat

1500 complaints in '03
1300 " in '02
740 " in '01

more compliance
- new survey Jan 2004 hope to roll out abbreviated survey for compliance places
- disproportionate amt of complaints in Milw. - some unique issues
  complaints more egregious, work retention & recruitment.
- provider - just decided need to hire RN's
  for waiver must meet N. home level of care
-

N. Home - over 50% dimentia
Asstd Liv - more developing
- hospice + ast. liv. partnering
- S term stay - N. Home - medicare funded

• 40 position ast. liv.

•

177 pos. N Home / A. Liv.
→ 32/33 Ast Liv.
RN's →

capture some new fed $
coord. comm. w/ medicaid - agency
to conduct survey & certific.
b/c of the waiver

since July 2002
• 30% of the entire program
• offset to current
want site visit target zone of
• every 12-18 mos now 2½-3 yrs.

When target zone reach - date what goal ???

how reach - more staff?

— reg. reform for N. Home but marginal
"use us"

Nat. Coal. for Citizens N. Home reform - NCCNHR

CMS not have authority to allow state to pilot

ctr. for medicare/medicaid services

don't

ck asked for long ① Sen Grassley influenced - Iowa
- from above not changing N Home

② Sen Waxman CA now approp. comm.
③ Sen. Braux

What other states

- Pilot another ast liv. survey
George Petrowski - direct link to advocate Link

1.3 - civil penalty funds
1/2 - reg.
1/2 proj's include quality
only N. Homes no DD.
medistar receive fed $ this yr. expand to home health + next yr. hospital
grant $ to ombudsman - use the $ for quality improvement w/ deficiencies
facility poor care - new owners from out of state - advisor there to provide feedback, training + how to succeed in W?
certain qualif. - exp. as surveyor + a clinician so can do
SMQT

N. Home - fed constraints

adm. costs
civil penalty funds

backlog 280 was 375
$ go to school fund
- implement new efficient policy
- batching forfeitures in similar nature
- ongoing workload - had hoped

95↓ in 6mos period b/c of
org
added 2 add'l LTE indiv. - take
on backlog w/i 6mos.
focusing on 95
shorten review process

retirement in dept. - indiv. filling

informal dispute resol - new process & structure
advocates +
3rd review
CMS approved
ready to implement
industry is pleased
partial privation through bureau or pay
for it + have a private review

reg. side

asst. lil. set new model
significant Δ
if put stat. changes in now
& had a year from now
are we getting to them more
frequently
if say now many times then
back to the old - everyone
the same
rec. for Δ but need confidence
possible changes
package of ideas ā coming
keep informed of ↻

enforcement procedure
choose to be 1st hearing

— 60 day timeframe
— min. qual for inspectors
resp. & qual. - change qual.
to N. home assessor
levels
change classification - relevant
group reallocation - 25 people
grandfathered
1 in all 5 regions - 5

probs. can't have masters degree -
but could require enough
stuff to need Masters & # of yrs.
of experience
outcome oriented

ave. 2 1/2 - 3 so some 5
rep
2 Jan. - 3 mos. training
2nd quarter some improvement

survey - advance backlog

Match new fed $ - through budget office -
resource needs do they have
quantify to see. authority
legisl. or internal alloc.
GOV. see fit 16.5% request
IDR what happens there will
determine if appeal goes forward
fed appeals take about 2 years.

Of the IDR decisions how many are
done
both of those

IDR is a fed process - state takes settled
but allow state enforcement
activity

tell Jan 04 - focus
over 600 outstanding complaints
no work done
manageable - so
complaint -> substant -> enforcement
as incr. frequency add nursing expertise
enforcement go up then down — 2-5 yrs

Olmstead
reg structure has to keep up
tech ast. as important as?
abbreviated ast. liv. survey