Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2408	A. BUILDING: ______ B. WING ______	04/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MHSS, LLC DBA WAUSAU COMPREHENSIVE TX CTR	210 WASHINGTON STREET WAUSAU, WI 54403

(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) COMPLETE DATE
X 000	Initial Comments Surveyor: X0120 New ownership and new location necessitated a name change and location change on Certificate #2408. An on-site verification survey was conducted on 4/11/16. Certification approval is as follows: Approved Services: 1. Substance abuse day treatment service under DHS 75.12, Wisconsin Administrative Code. 2. Substance outpatient treatment service under DHS 75.13, Wisconsin Administrative Code. 3. Narcotic treatment service for opiate addiction under DHS 75.15, Wisconsin Administrative Code. Change of certificate name and location with specified certification period: From 3/1/16 to 5/1/16 Milwaukee Health Services System, LLC dba Wausau Comprehensive Treatment Center was approved to provide all three services at 209 W. Washington Street, Wausau, WI 54403. From 5/2/16 to 10/31/16 Milwaukee Health Services System, LLC dba Wausau Comprehensive Treatment Center was approved to provide all three services at 210 Washington Street, Wausau, WI 54403. # of Citations issued: 1	X 000		
X1630	DHS 75.15(4)(b) Required Personnel The service shall have a registered nurse on staff to supervise the dosing process and perform other	X1630		

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X1630	Continued From page 1 functions delegated by the physician. This Rule is not met as evidenced by: Surveyor: X0120 Based on the staff roster review and staff interview, the treatment center did not have a registered nurse on staff to supervise the dosing process on Saturdays at least in the past two years. Examples included: The treatment center was open for methadone dosing everyday from Mondays through Saturdays. Staff roster showed that a full-time Registered Nurse C was the only registered nurse who work Mondays through Fridays, not Saturdays when the treatment center was open in the morning for methadone dosing. According to the federal and state regulations, Saturday dosing is required for patients who were newly admitted to the treatment center during an induction phase or non-compliant patients who required a closer monitoring to receive methadone dose. Staff interview was conducted with Clinic Director A and Clinical Supervisor B during the exit conference on 4/11/16. Both Director A and Supervisor B acknowledged that in the past two years licensed practical nurse was the only nursing staff dosed patients on Saturdays without the registered nurse being present for supervision.	X1630		

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X 000	Initial Comments Surveyor: X0120 This report is the result of an unannounced death investigation of Death Report #3110 conducted on 5/31/17 at Milwaukee Health Services System, LLC dba Wausau Comprehensive Treatment Center using the State Administrative Codes DHS 75.03, 75.13 and 75.15 for substance abuse outpatient clinic and narcotic treatment services for opiate addiction. # of citations issued: 3 # of clinical record: 1 # of staff interview: 3	X 000		
X1368	DHS 75.03(12)(e) On-going Assessment Process Initial assessment shall be conducted for treatment planning. The service shall implement an ongoing process of assessment to ensure that the patient's treatment plan is modified if the need arises as determined through a staffing at least every 30 days. This Rule is not met as evidenced by: Surveyor: X0120 Based on the record review and staff interview, the clinic did not have the following evidence to demonstrate compliance with this standard. Examples included: 1. Initial assessment was not completed for treatment planning. Client #1's clinical record revealed that only 8 of 18 pages of the biopsychosocial assessment form were completed upon admission in 8/2016. The last 10 pages were blank when the record was reviewed during the death investigation on 5/31/17.	X1368		

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X1368	Continued From page 1 2. Client #1's clinical record revealed that the treatment plan was not completed. There were no treatment objectives, no treatment interventions specified, no signatures from the clinical team and Client #1 to illustrate agreement and approval for treatment delivery. 3. Despite the team's concern for Client#1's continuing with her anti-anxiety prescription which was contra-indicated with the methadone prescription to treat her narcotic addiction, on-going process of assessment was not evidenced to ensure Client #1's treatment plan was modified. 4. On-going minimum monthly staffing documentation was not evidenced in Client #1's record. Based on Client #1's treatment period from 8/2016 to 5/2017, a minimum of 9 monthly staffings were expected. However, no staffing notes were evidenced in Client #1's clinical record. Staff interviews with Clinic Director A, Clinical Supervisor B and Counselor C were conducted during the death investigation on 5/31/17. Clinic Director A acknowledged that initial assessment and treatment plan were not completed. Clinical Supervisor B acknowledged that she did not remember Counselor C brought this case to her review during the clinical supervision meetings. Counselor C acknowledged that on-going assessment and counseling were limited by infrequent and irregular attendance of the counseling sessions.	X1368		
X1390	DHS 75.03(17)(b) Discharge Summary	X1390		

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X1390	Continued From page 2 A discharge summary shall be entered in the patient's case record within one week after the discharge date. This Rule is not met as evidenced by: Surveyor: X0120 Based on the record review, the clinic did not have a discharge summary on file in 4/2016. Clinical record revealed that besides the most recent admission to the clinic on 8/4/16, Client #1 was previously admitted to the clinic on 10/15/14 to receive narcotic treatment for her opiate addiction. Record revealed that Client #1 requested discharge from the clinic on 1/27/16. Per clinical record 2016, it showed Client #1's treatment period began on 10/15/14 through 4/15/16. However, clinical record showed no discharge summary in 4/2016.	X1390		
X1580	DHS 75.13(5)(b) Treatment Plan Completion A service shall complete a patient's treatment plan within two visits after admission. This Rule is not met as evidenced by: Surveyor: X0120 Based on the record review and staff interview, the substance abuse outpatient clinic did not complete Client #1's treatment plan within two visits after admission. Example included: Client #1 completed a screening on 7/19/16 and an intake on 8/4/16 for admission. Review of Client #1's clinical record was conducted during the death investigation on 5/31/17. Clinical record revealed an attempt was initiated on 8/9/16 to establish a treatment plan, few words were	X1580		

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X1580	Continued From page 3 written on the treatment plan; however, the treatment plan was never completed. Since admission, Client #1 was placed on Phase 1 requiring Client #1 to be present in person at the clinic to receive the daily dose of methadone to treat her opiate addiction. Medication record revealed that Client #1 received her daily dose in person 243 times from 8/4/16 to 5/25/17, yet a treatment plan was not established over a period of 290 days when Client #1 was in treatment. Staff interviews were conducted with Clinic Director A and Clinical Supervisor B during the death investigation on 5/31/17, both acknowledged the finding.	X1580		

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X 000	Initial Comments This report is the result of an unannounced complaint investigation of Complaint Report 2017-C-012 conducted on 12/14/17 at Milwaukee Health Services System, LLC dba Wausau Comprehensive Treatment Center using the State Administrative Codes DHS 75.03 and 75.15 for narcotic treatment services for opiate addiction. # of citations issued: 6 # of clinical record: 2 # of staff interview: 3	X 000		
X1311	DHS 75.03(8)(c) Compliance with Federal Standard Patient case records shall be safeguarded as provided in sub. (7) and maintained with the security precautions specified in 42 CFR Part 2. This RULE: is not met as evidenced by: Based on the surveyor observation, facility tour and staff interview, the opioid treatment program did not safeguard or maintain the patient case records with the security precautions as specified in 42 CFR Part 2 section 2.16 (a)(1)(iii). During the facility tour conducted on 12/14/17 around noon, multiple patient case records from 2015 to 2017 were found inside 1 unlocked wood standard wall cabinet and 4 unlocked wood standard base cabinets in the nursing station. Staff interviews were conducted during the facility tour. Nurse Manager C confirmed that those patient case records found in the unlocked cabinets were placed there after the clinic moved to the current location in 5/2016, more patient case records kept piling inside the unlocked cabinets since then. Clinic Director A confirmed that she was not aware of patient case records	X1311		

If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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X1311	Continued From Page 1 were placed in those unlocked cabinets until it was uncovered during the complaint investigation on 12/14/17.	X1311		
X1669	DHS 75.15(9)(b)6 Medical Director's Responsibilities The medical director of a service is responsible for signing or countersigning all medical orders as required by federal or state law, including all of the following: a. Initial medical orders and all subsequent medical order changes. b. Approval of all take-home medications. c. Approval of all changes in frequency of take-home medication. d. Prescriptions for additional take-home medication for an emergency situation. This RULE: is not met as evidenced by: Based on the record review, the opioid treatment program did not ensure all medical orders were signed by the ordering physician. It was evidenced in Patient #2's treatment record. Medical orders 10/22/15, 10/8/15, 8/10/15, 8/8/15, 7/31/15 and 7/1/15 on the hard copy record showed Physician F's stamped signature which was not an ink or a handwritten signature. Signature stamp was not acceptable in treatment record because it did not reflect or signify its author's originality and authenticity.	X1669		
X1707	DHS 75.15(11)(k)1 Change of Take-home Privileges or Visits A service may reduce a patient's take-home privileges or may require more frequent visits to the service if the patient inexcusably misses a scheduled appointment with the service, including an appointment for dosing, counseling, a medical review or a psychosocial review or for an annual physical or an evaluation.	X1707		

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X1707	Continued From Page 2 This RULE: is not met as evidenced by: Based on the record review and staff interview, the opioid treatment program did not have annual phy ical examination re ult to determine if patients meeting the criteria for take-home privileges and/or increased need for more visits to the service. It was evidenced in 2 of 2 patients in this complaint investigation. (See Patients #1 and #2) Examples included: Patient #1's treatment record consisted of 3 volumes showed that he had annual physical examination on 9/23/09, 5/2/11 and 5/25/17. Annual physical examination was not evidenced in 2010, 2012, 2013, 2014, 2015 and 2016. Patient #2 treatment record showed that she had annual physical examination on 12/21/05, 1/22/07, 4/29/08, 9/22/09, 12/14/10, 2/5/12, 3/18/13, 4/1/14, 7/8/15 and 4/6/17. Annual physical examination was not evidenced in 2011 and 2016. Staff interview was conducted during the complaint investigation on 12/14/17. The opioid treatment program was given time to locate the missing information. On 12/15/17 Clinic Director A confirmed that the annual physical examination for Patients #1 and #2 were not completed in 2016.	X1707		
X1716	DHS 75.15(12)(d)1 Additional Approval Any exception to the take-home requirements exceeding 2 times the amount in that phase is subject to approval of the designated federal agency and the state methadone authority. The following is the amount of additional take-home doses needing approval: Phase 1 = 2 additional	X1716		

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X1716	Continued From Page 3 (excluding Sunday); phase 2 =4 additional; phase 3 = 6 additional; phase 4 = 12 take home doses required for approval. Thi RULE i not met a evidenced by Based on the record review and staff interview, the opioid treatment program did not obtain the required prior approval of the designated federal agency and the state methadone authority to grant the exception to the take home requirement It was evidenced in 2 of 2 patients in this complaint investigation. (See Patients #1 and #2.) Examples included: According to the patient treatment records, both Patients #1 and #2 were on treatment level 3 which allowed them to receive 6 additional take-home doses only. Any exception to the additional take-home dose would require a request made to the designated federal agency and the state methadone authority for their review and final official approval. According to the medication record, Patient #1 was given 13 take-home doses of methadone from 6/16/17 to 6/28/17 to allow Patient #1 to traveling out of state to visit his family; it was 7 additional take-home doses over Patient #1's treatment level allowed. On 10/17/17 Patient #1 once again was given 11 take-home doses of methadone from 10/20/17 to 10/30/17 for traveling out of state to visit his family; it was 5 additional take-home doses over Patient #1's treatment level allowed. According to the medication record, On 6/15/17 Patient #2 was given 13 take-home doses of methadone from 6/16/17 to 6/28/17 for traveling out of state to visit her family; it was 7 additional take-home doses over Patient #2's treatment level	X1716		

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X1716	Continued From Page 4	X1716		

allowed. Patient #2 was once again given 10 take-home doses of methadone from 10/21/17 to 10/30/17 to allow Patient #2 to traveling out of state to visit her family; it was 4 additional take-home doses over Patient #2's treatment level allowed.

According to the medication log for both Patients #1 and #2, nursing staff typed "State approved" for those additional take-home doses in June and October 2017. However, the opioid treatment program never received the approval from the federal agency and the state methadone authority.

Written corre pondence 11/20/17 from the tate methadone authority to Clinic Director A confirmed that the opioid treatment program was denied to allow Patients #1 and #2 to have take-homes more than their treatment level allowed in October 2017 becau e the facility turned in the exception requests close to one month late. According to the response from Clinic Director A to the state methadone authority on 11/20/17, Clinic Director A confirmed that both Patients #1 and #2 were given additional take-home doses without the proper final approval from the state methadone authority.

Staff interview was conducted during the complaint investigation on 12/14/17. Clinic Director A confirmed the following survey findings:
1. The opioid treatment program did not obtain necessary prior approval from the designated federal agency and the state methadone authority to grant the exceptions to the take-home requirements for both Patients #1 and #2 in 6/2017 and 10/2017.
2. Counseling Staff D did not sign the staff meeting/training record 11/21/17 to verify the training completion on the exception request approval policy and procedure.
3. Counseling Staff E did not receive the latest

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X1716	Continued From Page 5 training on the exception request approval policy and procedure. 4. The Take-Homes Exceptions policy and procedure did not specify or clearly illustrate each staff's role and responsibility in handling the exception requests and verifying the final approval from designated federal and state authorities.	X1716		
X1723	DHS 75.15(13)(b) Blood Tests A service shall determine a patient's drug levels in plasma or serum at the time the person is admitted to the service to determine a baseline. The determinations shall also be made at 3 months, 6 months and annually subsequently. If a patient requests and receives doses above 100 milligrams, serum levels shall be drawn to evaluate peak and trough determinations after the patient's dose is stabilized. This RULE: is not met as evidenced by: Based on the record review and staff interview, the opioid treatment program did not obtain patient's methadone drug level in serum at a required interval of 3 months, 6 months and annually to medically determine if the patient received the most appropriate dose of methadone. It was evidenced in 2 of 2 patients in this complaint investigation. (See Patients #1 and #2.) Examples included: Patient #1's treatment record showed the serum level results were obtained on 4/4/11, 7/16/15 and 9/27/16. Patient #2's treatment record showed the serum level results were obtained on 1/23/07, 2/13/08, 4/30/08, 8/26/09, 9/24/09, 12/14/10, 12/15/11, 9/9/14 and 11/2/16.	X1723		

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X1723	Continued From Page 6 Staff interview was conducted during the complaint investigation on 12/14/17. The opioid treatment program was given time to locate the mi ing information On 12/15/17 Clinic Director A confirmed that the serum level for Patients #1 and #2 were not completed in 2017.	X1723		
X1747	DHS 75.15(17)(a) TB Screening A narcotic treatment service for opiate addiction shall screen patients immediately following admission and annually thereafter for tuberculosis (TB). Tuberculosis treatment may be provided by referral to an appropriate public health agency or community medical service. This RULE: is not met as evidenced by: Based on the record review and staff interview, the opioid treatment program did not screen patients annually for tuberculosis (TB). It was evidenced in 2 of 2 patients in this complaint investigation. (See Patients #1 and #2.) Examples included: Patient #1's treatment record showed that physician orders for TB were issued on 6/17/08, 9/23/09 and 2/5/10. However, there were no results found for those orders from 2008 to 2010. There was no annual TB screen results found from 2011 to 2016. Patient #1's annual physical examination 5/25/17 showed a positive PPD reading and a physician order was written to request a chest x-ray; however, there was no information to verify if Patient #1 followed the physician order to have a chest x-ray done. Patient #2's treatment record showed that she was screened for TB on 1/22/07, 9/24/09,	X1747		

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X1747	Continued From Page 7 12/17/10, 12/15/11, 1/31/13 and 10/27/16. The opioid treatment program did not have TB screen results in 2008, 2012, 2014, 2015. Staff interview wa conducted during the complaint investigation. Clinic Director A acknowledged the investigation findings.	X1747		

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(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) COMPLETE DATE
X 000	Initial Comments This report is the result of an unannounced complaint investigation of Complaint Report #31659 conducted on 2/22/2018 at Milwaukee Health Services System, LLC dba Wausau Comprehensive Treatment Center using the State Administrative Codes DHS 75.03 and 75.15 for narcotic treatment services for opiate addiction. # of citations issued: 2 # of clinical record reviewed: 8 # of admission: 7 # of admission denial: # of observed dosing: 7 # of staff interview: 7	X 000		
X1368	DHS 75.03(12)(e) On-going Assessment Process Initial assessment shall be conducted for treatment planning. The service shall implement an ongoing process of assessment to ensure that the patient's treatment plan is modified if the need arises as determined through a staffing at least every 30 days. This Rule is not met as evidenced by: Based on the record review and staff interview, the service did not have the following evidence to demonstrate compliance with this standard, initial assessment was not completed for treatment planning. It was evidenced in 4 of 4 clients who returned to substance abuse counseling out of the universal sample of 7 admissions. (See Clients #2, #3, #5 and #7.) Examples included: Client #2 was admitted to the service on 3/22/17, later the client was discharged on 5/14/17. Record showed that only 2 of 17 pages of the	X1368		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	2408	A. BUILDING: ______ B. WING ______	C 02/22/2018

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X1368	Continued From page 1	X1368		

biopsychosocial assessment form was completed, the rest of the pages were blank, no assessment summary was evidenced.

Client #3 was admitted to the service on 7/6/17. Record showed that Client #7 returned to attend his one-on-one counseling on 7/14/17 and 7/17/17. However there was no assessment summary found on file.

Client #5 was admitted to the service on 12/5/17. Record showed that Client #5 returned to attend his one-on-one counseling on 12/5/17, 12/7/17, 12/11/17, 12/19/17 and 12/22/17. However there was no complete assessment summary on file.

Client #7 was admitted to the service on 2/8/18. Record showed that the intake was completed on 2/8/18 to begin his first dose of methadone. Per progress notes, Client #7 returned to attend his one-on-one counseling on 2/13/18 and 2/16/18. However the biopsychosocial assessment form was blank, no assessment summary was evidenced.

Staff interview was completed with Program Director A during the complaint investigation on 2/22/18. Clinic Director A confirmed the survey findings. This was the 2nd time the service received the same citation following the unannounced death investigation completed on 5/31/17. The service continued to be substantially incompliant with this standard.

X1644 DHS 75.15(5)(j)1 Written Admission Protocol — X1644

The service shall have a written admissions protocol that accomplishes all of the following: 1. identifies the person on the basis of appropriate

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X1644	Continued From page 2 substantiated documents that contain the individual's name and address, date of birth, sex and race or ethnic origin as evidenced by a valid driver's license or other suitable documentation such as a passport. This Rule is not met as evidenced by: Based on the service's self report 1/25/18, clinical record review, surveyor observation and staff interview during the complaint investigation conducted on 2/22/18, the service did not meet this standard as follows: 1. The service did not obtain a copy of a newly admitted client's valid driver license, an example of acceptable photo document required from this state standard and Wisconsin Opioid Treatment Program Patient Reference Handbook to prove the client's identity. It was evidenced in 1 of 7 new admissions. (See Client #1.) 2. The service did not follow the service's own policy and procedure to take and upload the newly admitted client's photo onto the electronic medical record allowing nursing staff to verify the person's identity at the initial dosing and ongoing dosing. It was evidenced in 2 of 7 new admissions. (See Client #2 and #7.) Examples included: On 1/24/18 the State Opioid Treatment Authority H contacted the service to inquire information the service collected related to Client #1's admission. On 1/25/18 Clinical Supervisor B confirmed that the service did not have a copy of Client #1's photo identification card (photo ID) on file upon admission. On 1/31/18 Clinical Supervisor B submitted the correction plan to the State Opioid Treatment Authority H to correct the deficient practice of missing the required photo ID.	X1644		

Wisconsin Department of Health Services

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X1644	Continued From page 3 On 2/22/18 Surveyor observed 7 patients receiving their medication doses from 10:35 am to 10:45 am. Based on the observation, prior to each dosing, both Nurses C and D retrieved the patient's electronic health record by comparing the patient's photo from the electronic health record and the patient who was standing in front of the counter to verify the patient identity. If there was a match, the medication would be dispensed to the patient. Staff interviews with Nurses C and D revealed that, per service policy and procedure, the service was to take a photo of all new clients on Day 1 upon admission, and then uploaded the new photo onto the electronic health record for all involved staff to view to verify patient identity. However, Client #7 who was newly admitted to the service on 2/8/18 did not have a photo on the electronic health record for verification. Staff interview with Nurses C and D confirmed surveyor observation that the service did not have a current photo of Client #7 on the electronic health record. On 2/22/18 random sample record review of new admissions revealed that 2 of 7 new admissions (Clients #2 and #7) did not have photos taken on Day 1 upon admission, no photos were uploaded onto the electronic health record. Staff interview with Program Director A confirmed the survey findings.	X1644		