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
	3114	A. BUILDING: ______ B. WING ______	02/20/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH WEST WISCONSIN COMPREHENSIVE TREAT	3440 OAKWOOD HILLS PKWY EAU CLAIRE, WI 54701

(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
Z 001	Initial Comments Surveyor: 15414 On 12/19/16, North West Wisconsin Comprehensive Treatment Center submitted renewal application materials and a fee of $800, via check #2578 to the Division of Quality Assurance for continued certification. This was a routine on-site survey conducted at North West Wisconsin Comprehensive Treatment Center on 2/20/17. The clinic recertification period shall be effective from 3/1/17 through 10/31/19 to correspond with CARF and SAMHSA approvals. Approved services: 1. Substance abuse outpatient services under DHS 75.13, Wisconsin Administrative Code. 2. Narcotic treatment services of opiate addiction under DHS 75.15, Wisconsin Administrative Code. Number of citations issued: 14 Clinical record sample size: 8 Staff record sample size: 6 Clinical supervision record sample size: 3	Z 001		
Z 005	50.065(2)(b)intro ENTITY BACKGROUND CHECK REQUIREMENTS Every entity shall obtain all of the following with respect to a caregiver of the entity: 1. A criminal history search from the records maintained by the department of justice. 2. Information that is contained in the registry under s. 146.40(4g) regarding any findings against the person. 3. Information maintained by the department of safety and professional services regarding the status of the person's credentials, if applicable.	Z 005		

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

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Z 005	Continued From page 1 4. Information maintained by the department regarding any final determination under s. 48.981(3)(c)5m. or, if a contested case hearing is held on such a determination, any final decision under s. 48.981(3)(c)5p. that the person has abused or neglected a child. 5. Information maintained by the department under this section regarding any denial to the person of a license, certification, certificate of approval or registration or of a continuation of a license, certification, certificate of approval or registration to operate an entity for a reason specified in sub. (4m)(a)1. to 5. and regarding any denial to the person of employment at, a contract with or permission to reside at an entity for a reason specified in sub. (4m)(b)1. to 5. If the information obtained under this subdivision indicates that the person has been denied a license, certification, certificate of approval or registration, continuation of a license, certification, certificate of approval or registration, a contract, employment or permission to reside as described in this subdivision, the entity need not obtain the information specified in subds. 1. to 4. This Rule is not met as evidenced by: Surveyor: 15414 Based on record review and interview, it was	Z 005		

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Z 005	Continued From page 2	Z 005		

determined that the licensee did not ensure that a complete criminal history and caregiver background check for each service provider was obtained and retained. This was evidenced in one of six employee records reviewed as indicated by the following:

1. On 2/20/17, the background information disclosure form and the background record findings for Staff B were requested. Staff B was hired on 11/28/16. No background information disclosure form was available for review to determine if an out-of-state background check, or discharge forms from the armed services, were needed. No criminal history search from the records maintained by the department of justice or caregiver background check were available for review.

Clinic Director A stated that she was not aware that staff were to complete a background information disclosure form, and that this form would alert her to the possible need of completing an out-of-state background check, or requesting documentation of discharge status from the armed forces. Clinic Director A stated she was not aware that the program needed to maintain a paper copy of the background information disclosure form, the criminal history search from the department of justice, or the caregiver background check on each employee.

The licensee did not obtain all caregiver background information as required. The licensee allowed employees without a completed background check, to work without supervision with clients.

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X 910	Continued From page 3	X 910		
X 910	DHS 94.03(1)(a)-(g) Informed Consent Document Any informed consent document required under this chapter shall include: (a) The benefits of the proposed treatment and services; (b) The way the treatment is to be administered and the services are to be provided; (c) The expected treatment side effects or risks of side effects which are a reasonable possibility, including side effects or risks of side effects from medications; (d) Alternative treatment modes and services; (e) The probable consequences of not receiving the proposed treatment and services; (f) The time period for which the informed consent is effective, which shall be no longer than 15 months from the time the consent is given; and (g) The right to withdraw informed consent at any time, in writing. This Rule is not met as evidenced by: Surveyor: 15414 Based on record review and interview, it was determined the program did not ensure that a medication consent was obtained when methadone or buprenorphine were prescribed. This was identified in 8 of the 8 records reviewed of clients being prescribed medications as evidenced by: No signed medication consents including side effects or risks of side effects from medications were found in the records. Staff indicated they were not aware that a signed consent for medications was required. The program did not ensure that a medication consent was obtained when medications were prescribed and administered by the program.	X 910		

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X1305	DHS 75.03(6)(a) Staff Training	X1305		

Each service shall have a written policy requiring each new staff person who may have responsibility for assessing or treating patients who present significant risks for suicide to do one of the following: 1. Receive documented training in assessment and management of suicidal individuals within two months after being hired by the service. 2. Provide written documentation of past training or supervised experience in assessment and management of suicidal individuals.

This Rule is not met as evidenced by:
Surveyor: 15414

Based on review of personnel records for staff providing substance abuse services and interview, it was determined the clinic did not have documentation that substance abuse treatment staff have received training in the assessment and management of suicidal individuals. Three of 3 substance abuse counselors hired in the past year did not have documentation of training available for review during the on-site survey. This was evidenced by:

1. Staff B holds a substance abuse counselor in-training certificate and was hired in the past year. No documentation of training in the assessment and management of suicidal individuals could be located or provided.

2. Staff C holds a substance abuse counselor certificate and was hired in the past year. No documentation of training in the assessment and management of suicidal individuals could be located or provided.

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X1305	Continued From page 5 3. Staff D holds a clinical substance abuse counselor certificate was hired in the past year. No documentation of training in the assessment and management of suicidal individuals could be located or provided. Clinic Director A confirmed that no documentation of training in the assessment and management of suicidal individuals could be located or provided for the three new counselors. The clinic did not ensure counseling staff received documented training in the assessment and management of suicidal individuals within two months after being hired by the service, if unable to provide at time of hire written documentation of past training or supervised experience in the assessment and management of suicidal individuals.	X1305		
X1325	DHS 75.03(8)(e)13 Patient Case Record A patient's case record shall include consent forms authorizing disclosure of specific information about the patient. This Rule is not met as evidenced by: Surveyor: 15414 Based on record review and interview, it was determined the clinic did not assure a release or request of information was obtained and retained in the patient's case record, including consent forms authorizing disclosure of specific information about the patient. This was evidenced by:	X1325		

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X1325	Continued From page 6 1. Client 3 was admitted on 9/9/16 and the treatment plan was updated to address mental health issues on 10/31/16. No releases or requests of information were completed to coordinate services with a mental health provider. 2. Client 7 identified Medical Director G as her primary care physician. Client 7 was referred from Medical Director G's private practice. No request or release of information was found in the record. Documentation in the record indicated the program had released information to the foodshare program. No release of information was found in the record authorizing disclosure of patient information to the foodshare program. The clinic did not assure a release or request of information was obtained and retained in the patient's case record authorizing disclosure of specific information about the patient.	X1325		
X1365	DHS 75.03(12)(b) Recommendations The counselor's recommendations for treatment shall be included in a written case history that includes a summary of the assessment information leading to the conclusions and outcomes determined from the counselor's evaluation of the patient's problems and needs. This Rule is not met as evidenced by: Surveyor: 15414 Based on record review and interview, it was determined the clinic did not assure assessments included the counselor's recommendations for treatment included a written case history including a summary of the assessment information	X1365		

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X1365	Continued From page 7 leading to the conclusion and outcomes of the client's problems and needs. This was evidenced in 5 of 8 sampled records. This was evidenced by: 1. Client 2 was admitted on 4/20/16. Client 2's assessment indicated he experienced depression and a history of suicidal ideation's. Client 2's assessment was incomplete and did not include a written case history including a summary of the assessment information leading to the conclusion and outcomes of the client's problems and needs. 2. Client 3 was admitted on 9/9/16. Client 3's history and physical indicated he was prescribed Flouxetine and Depakote. Client 3's assessment was incomplete and did not include a written case history including a summary of the assessment information leading to the conclusion and outcomes of the client's problems and needs. 3. Client 4 was admitted on 4/25/16. Client 4 indicated she was prescribed Flouxetine. Client 4's assessment summary did not identify depression or mental health needs. 4. Client 6 was admitted on 6/30/16. Client 6 indicated he was prescribed Effexor and Xanax. Client 6's assessment summary did not identify depression, anxiety or panic disorder or related mental health needs. A mental health assessment was completed on 8/16/16. 5. Client 8 was admitted on 4/19/16. Client 6 indicated she had a history of verbal, physical and sexual abuse. Client 8's mental health history was inconsistent between the history and physical and biopsychosocial assessment completed by the counselor. No mental health assessment or referral for mental health services was identified. Following the CARF accreditation review on 10/21/16, it was recommended that the organization utilize the information collected from	X1365		

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X1365	Continued From page 8 the assessment when preparing the person-centered plan. It was also recommended that when concurrent disorders or disabilities and/or conditions are identified, the person-centered plan address these conditions in an integrated manner. Staff reviewed the records and confirmed comprehensive assessments did not include a written case history including a summary of the assessment information leading to the conclusion and outcomes of the client's problems and needs, including mental health needs. Staff also confirmed that concurrent disorders were not addressed on the person-centered plans.	X1365		
X1369	DHS 75.03(13)(a) Treatment Plan Basis and Signatures A service shall develop a treatment plan for each patient. A patient's treatment plan shall be based on the assessment under sub. (12) and a discussion with the patient to ensure that the plan is tailored to the individual patient's needs. The treatment plan shall be developed in collaboration with other professional staff, the patient and, when feasible, the patient's family or another person who is important to the patient, and shall address culture, gender, disability, if any, and age-responsive treatment needs related to substance use disorders, mental disorders and trauma. The patient's participation in the development of the treatment plan shall be documented. The treatment plan shall be reviewed and signed first by the clinical supervisor and the counselor and secondly reviewed and signed by the patient and the consulting physician.	X1369		

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X1369	Continued From page 9	X1369		

This Rule is not met as evidenced by:
Surveyor: 15414

Based on record review and interview, it was determined the clinic did not ensure treatment plans were reviewed and signed by the patient, clinical supervisor, a mental health professional when there is a mental health diagnosis, and the consulting physician. This was identified in 5 of the 8 records reviewed as evidenced by:

1. Client 1 was admitted on 4/14/16. Client 1's treatment plan dated 4/18/16 was not reviewed and signed by the patient, clinical supervisor, and the consulting physician.
2. Client 2 was admitted on 4/20/16. Client 2's assessment indicated he experienced depression and a history of suicidal ideation's. Client 2's treatment plan dated 4/30/16 was not reviewed and signed by a mental health professional.
3. Client 3 was admitted on 9/9/16. Client 3's treatment plan dated 9/9/16 was not reviewed and signed by a mental health professional.
4. Client 4 was admitted on 4/25/16. Client 4's treatment plans dated 7/21/16 and 11/3/16 were not reviewed and signed by a mental health professional.
5. Client 6 was admitted on 6/30/16. Client 6 indicated he was prescribed Effexor and Xanax. Client 6's treatment plan dated 6/30/16 was not reviewed and signed by a mental health professional.

Staff reviewed the treatment plans and confirmed that treatment plans may not have been reviewed and signed by the clinical supervisor or a mental health professional.

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X1378	Continued From page 10	X1378		
X1378	DHS 75.03(14)(a) Staffing Schedule and Documentation Staffing shall be completed for each patient and shall be documented in the patient's case record as follows: 1. Staffing for patients in an outpatient treatment service who attend treatment sessions one day per week or less frequently shall be completed at least every 90 days. 2. Staffing for patients who attend treatment sessions more frequently than one day per week shall be completed at least every 30 days. This Rule is not met as evidenced by: Surveyor: 15414 Based on record review and interview, it was determined the program did not assure staffing for patients in an outpatient substance abuse treatment service was completed at least every 90 days for patients who attend treatment sessions one day per week or less frequently . This was identified in 2 of 8 substance abuse treatment records of clients receiving services over 90 days as evidenced by: 1. Client 4 was admitted on 4/25/16. Client 4 was staffed on 7/27/16 and 2/14/17. Client 4 has a history of depression and was suspected of diversion. Client 4 has not completed a urine test for illicit substances since October of 2016. Client 4 has not been staffed every 90 days or more frequently to address patient needs and staff concerns. 2. Client 6 was admitted on 6/30/16. Client 6 was staffed on 7/27/16 and the treatment plan was reviewed on 1/30/17. Client 6 has had 26 urine drug screens which were positive for illicit substances between 6/30/16 and 2/4/17. Client 6	X1378		

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X1378	Continued From page 11 has not been staffed every 90 days or more frequently to address noncompliance with program expectations of abstaining from other illicit substances. Client 6's continued use of other substances places Client 6's health and life at risk. No mental health professional was involved in client staffings between 11/22/16 and 2/14/17. No clinical supervisor was involved in staffings between 10/28/16 and 2/14/17. Treatment plans and staffing notes often lacked the signature of the clinical supervisor and mental health professional. Two of 8 records did not include documentation of case review at assessment or every 90 days with the counselor, clinical supervisor, mental health professional and medical director.	X1378		
X1381	DHS 75.03(14)(d) Dually Diagnosed Patient If a patient is dually diagnosed, the patient's treatment plan shall be reviewed by the counselor and a mental health professional and appropriate notation made in the patient's progress notes. This Rule is not met as evidenced by: Surveyor: 15414 Based on record review and interview, it was determined the program did not assure that at time of staffing dually diagnosed patients, the the patients' treatment plans were reviewed by the counselor and a mental health professional and appropriate notations were made in the patient's progress notes. This was identified in	X1381		

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X1381	Continued From page 12 five dually diagnosed client files as evidenced by: Clients 2, 3, 4, 6, 8 have a mental health diagnosis. Refer to Tag 1565. A mental professional did not assist in the development of the treatment plan and provide ongoing treatment services for the dually diagnosed clients. Refer to Tag 1737. Per interviews with Staff A and Staff D, no mental health professional was involved in client care or attended staffing's between 10/22/16 and 2/20/17. Staffing reports were not signed by a mental health professional in compliance with DHS 75.03(14)(e). Following the CARF accreditation review on 10/21/16, it was recommended that when concurrent disorders or disabilities and/or conditions are identified, the person-centered plan address these conditions in an integrated manner. The program did not assure that dually diagnosed patients' treatment plans were reviewed by the counselor and a mental health professional. Treatment plans did provide specific goals for treatment of dual diagnosis clients with input from a mental health professional in compliance with DHS 75.03(13)(b)5.	X1381		
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 functions delegated by the physician.	X1630		

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X1630	Continued From page 13 This Rule is not met as evidenced by: Surveyor: 15414 Based on staff interview, it was determined the clinic did not have a registered nurse (RN) on staff to supervise the dosing process during all times the treatment center provided dosing to patients. This was evidenced by: Staff E is the RN nursing supervisor. Staff E stated that a licensed practical nurse (LPN) will administer methadone on an average of one time per month when Staff E is ill or not working on a Saturday. Staff E stated there was no registered nurse (RN) in the building on those days. Time sheets were requested but available for review on 2/20/17. Clinic Director A confirmed that an RN was not always present to supervise staff and medication administration in the past year. Clinic Director A acknowledged that there are occasions when LPNs were the only nursing staff dosing patients without the registered nurse being present for supervision. The service did not have a registered nurse on staff and on-site at all times to supervise the dosing process and perform other functions delegated by the physician.	X1630		
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	X1669		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X1669	Continued From page 14 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: Surveyor: 15414 Based on record review and and interview, it was determined a service physicians did not sign all medical orders as required by federal and state law including initial medical orders and all subsequent medical order changes. This was evidenced by: Medication orders in the electronic medical records were not signed by the service physician. When questioned if medical orders were printed and signed by the service physician, RN E stated they were not. A Physician did not review, notate justification, and sign and date initial medical orders and all dosage changes as required by federal and state law.	X1669		
X1725	DHS 75.15(13)(d) Positive Test Results Service staff shall discuss positive test results with the patient within one week after receipt of results and shall document them in the patient's case record with the patient's response noted. 2. The service shall provide counseling, casework, medical review and other interventions when	X1725		

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	3114	A. BUILDING: ______ B. WING ______	02/20/2017

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X1725	Continued From page 15	X1725		

continued use of substances is identified. Punishment is not appropriate. 3. When there is a positive test result, service staff shall allow sufficient time before retesting to prevent a second positive test result from the same substance use. 4. Service staff confronted with a patient's denial of substance use shall consider the possibility of a false positive test. 5. Service staff shall review a patient's dosage and shall counsel the patient when test reports are positive for morphine-like substances and negative for the FDA-approved narcotic treatment.

This Rule is not met as evidenced by:
Surveyor: 15414

Based on the record review and interview, it was determined the clinic did not assure that staff discussed positive test results for illicit drugs with the clients within one week after the receipt of the results. This was evidenced in 5 of 5 clients who tested positive for illicit drugs out of the universal sample of 8 clients.

Examples included:

1. Client 1 tested positive for illicit substances on 4/13, 4/18, and 4/20/16. Positive results were not addressed with a counselor until 4/30/15. Client 1 tested positive for illicit substances on 5/20 and 6/9. Positive results were not addressed with a counselor until 6/23/16.
2. Client 3 tested positive for multiple illicit substances on 11/9, 11/17, 11/29, 12/6, 12/14, 12/27, 1/17, and 1/19. Positive results were addressed with a counselor once on 12/13/16.
3. Between 6/30/16 and 2/14/17, Client 6 has had 26 urine tests which were positive for illicit

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X1725	Continued From page 16 substances including benzodiazapines, opiates and cannabis. Client 6 did not discuss positive test results for illicit drugs within one week after the receipt of the results following the majority of the test results noted. 4. Client 7's positive drug screens for illicit substances were not discussed with 7 days of receiving the results. 5. Client 8's positive drug screens for illicit substances were not discussed with 7 days of receiving the results. Clinic staff reviewed some of the records and confirmed staff were not consistently discussing positive test results for illicit drugs with the clients within one week after the receipt of the results. The clinic did not assure that staff discussed positive test results for illicit drugs with the clients within one week after the receipt of the results. The service did not provide counseling, casework, medical review and other interventions when continued use of substances was identified.	X1725		
X1737	DHS 75.15(15)(c)2 Treatment Planning When a dual diagnosis exists, a service shall develop with the patient a treatment plan that integrates measures for treating all alcohol, drug and mental health problems. For the treatment of a dually-diagnosed patient, the service shall arrange for a mental health professional to help develop the treatment plan and provide ongoing treatment services. The mental health professional shall be available either as an employe of the service or through a written agreement.	X1737		

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X1737	Continued From page 17	X1737		

Continued From page 17

This Rule is not met as evidenced by:
Surveyor: 15414

Based on the record review and staff interview, it was determined the treatment center did not have a mental professional assist in the development of the treatment plan and provide ongoing treatment services for the dually diagnosed clients. This was evidenced by:

1. Client 2 was admitted on 4/20/16. Client 2's assessment indicated he experienced depression and a history of suicidal ideation's. Client 2's assessment was incomplete and did not include a written case history including a summary of the assessment information leading to the conclusion and outcomes of the client's mental health problems and needs. No treatment plan had been developed providing goals for the treatment of dual diagnosis.
2. Client 3 was admitted on 9/9/16. Client 3's history and physical indicated he was prescribed Flouxetine and Depakote. Client 3's assessment was incomplete and did not include a written case history including a summary of the assessment information leading to the conclusion and outcomes of the client's problems and needs in the area of mental health. No treatment plan had been developed providing goals for the treatment of dual diagnosis.
3. Client 4 was admitted on 4/25/16. Client 4 indicated she was prescribed Flouxetine. Client 4's assessment summary did not identify depression or mental health needs. No treatment plan had been developed providing goals for the treatment of dual diagnosis.
4. Client 6 was admitted on 6/30/16. Client 6 indicated he was prescribed Effexor and Xanax. Client 6's assessment summary did not identify

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X1737	Continued From page 18	X1737		

depression, anxiety or panic disorder or related mental health needs. A mental health assessment was completed on 8/16/16. No treatment plan had been developed providing goals for the treatment of dual diagnosis.
5. Client 8 was admitted on 4/19/16. Client 6 indicated she had a history of verbal, physical and sexual abuse. Client 8's mental health history was inconsistent between the history and physical and biopsychosocial assessment completed by the counselor. No mental health assessment or referral for mental health services was identified.

Following the CARF accreditation review on 10/21/16, it was recommended that when concurrent disorders or disabilities and/or conditions are identified, the person-centered plan address these conditions in an integrated manner.

Program staff reviewed the records and confirmed that assessments did not identify mental health diagnoses, and that treatment plans did not identify goals for the treatment of dually diagnosed clients. Staff also confirmed treatment plans had not been consistently signed by a mental health professional.

X1747 DHS 75.15(17)(a) TB Screening — X1747

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:
Surveyor: 15414

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X1747	Continued From page 19 Based on the record review, the narcotic treatment service for opiate addiction did not have documentation to verify that the service screened the patients immediately following the admission and annually thereafter for tuberculosis (TB), viral hepatitis, and sexually transmitted diseases. This was evidenced in 2 of 8 records reviewed as indicated by: 1. Client 7 was admitted on 5/10/16. No documentation was found indicating that a history and physical or TB test were completed at time of admission. 2. Client 8 was admitted on 4/19/16. No communicable disease screening beyond a TB test was found in the record. The narcotic treatment service for opiate addiction did not have documentation to verify that the service screened the patients immediately following the admission and annually thereafter for TB and other communicable illnesses.	X1747		
X2751	DHS 75.15 (4)(dm) Clinical Supervision - Narcotic Treatment (dm) A narcotic treatment services for opiate addiction shall provide for ongoing clinical supervision of the counseling staff. Ongoing clinical supervision shall be provided as required in s. SPS 162.01. Note: Section SPS 162.01(1) states that a clinical supervisor shall provide a minimum of: 1. Two hours of clinical supervision for every 40	X2751		

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X2751	Continued From page 20	X2751		

hours of work performed by a substance abuse counselor-in-training.
2. Two hours of clinical supervision for every 40 hours of counseling provided by a substance abuse counselor.
3. One hour of clinical supervision for every 40 hours of counseling provided by a clinical substance abuse counselor.
4. One in person meeting each calendar month with a substance abuse counselor-in-training, substance abuse counselor, or clinical substance abuse counselor. This meeting may fulfill a part of the
requirements above.

This Rule is not met as evidenced by:
Surveyor: 15414

Based on review of the clinical supervision log and staff interview, it was determined the narcotic treatment service for opiate addiction did not provide the minimum clinical supervision hours to substance abuse counseling staff. This was evidenced in 3 of 4 staff who were credentialed as substance abuse counselors as indicated by:

1. Staff B was hired on 11/28/16 and holds a substance abuse counselor in training (SAC-IT) certificate. Staff B is to receive 2 hours of supervision for every 40 hours of work performed. Staff B received no clinical supervision since time of hire.

2. Staff C holds a substance abuse counselor (SAC) certificate. Staff B is to receive 2 hours of supervision for every 40 hours of work performed. Staff C received 7.5 hours of supervision since 9/7/16, rather than the 40+ hours of supervision she was to receive.

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X2751	Continued From page 21 3. Staff D is a clinical substance abuse counselor (CSAC). Staff D is to receive one hour of clinical supervision for every 40 hours of counseling provided. Staff C received 5 hours of supervision since 8/29/16, rather than the 20+ hours of supervision she was to receive. Clinic Director A and Clinical Supervisor F stated no clinical supervision was provided to counseling staff after Staff F left for maternity leave on 10/28/16 until she returned to work in February of 2017. Staff did not receive required clinical supervision over a 10 week span of time. Staff did not receive adequate hours of supervision prior to Clinical Supervisor F being on maternity leave. The clinic has not assured that substance abuse counseling staff with a SAC-IT, or SAC credential have received at least two hours of clinical supervision for every 40 hours of work performed as a substance abuse counselor. The clinic did not assure that Staff D received at least one hours of clinical supervision for every 40 hours of work performed as a substance abuse counselor.	X2751		

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X 000	Initial Comments On 2/2/18, an on-site complaint investigation was conducted at North West Wisconsin Comprehensive Treatment Center located in Eau Claire. Six citations were issued, and a plan of correction is required. North West Wisconsin Comprehensive Treatment Center is approved to provide outpatient substance abuse and narcotic treatment services under DHS 75.13 and DHS 75.15. Clinical record sample size: 3 Number of citations: 6 Number of repeat citations: 4	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 functions delegated by the physician. This Rule is not met as evidenced by: REPEAT CITATION (Refer to SOD 7IZC11 issued 2/20/17) Based on staff interview and record review, it was determined the clinic did not have a registered nurse (RN) on staff to supervise the dosing process during all times the treatment center provided dosing to patients. This was evidenced by: Clinic Director A stated during interview that the clinic did not have a registered nurse (RN) on staff for a period of time between March of 2017 through May of 2017. The clinic was again without an RN for a period of time in August and September of 2017. During those times licensed practical nurses (LPNs) would administer methadone without an RN providing supervision.	X1630		

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

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X1630	Continued From page 1	X1630		

Staff schedules were requested but not readily available for review on 2/2/18. Review of individual weekly schedules indicated that LPNs dispensed methadone without an RN being onsite at least:
1. Eleven days in March of 2017.
2. Sixteen days in April of 2017.
3. Twenty-two days in May of 2017.
4. Six days in June of 2017.
5. Five days in August of 2017.
6. Twenty-six days in September of 2017.
7. Ten days in October of 2017.
8. Eleven days in November of 2017.
9. Fourteen days in December of 2017.

Review of staff schedules indicated the clinic did not have an RN on duty when LPNs were dispensing methadone on 119 days between March 1, 2017 and December 31, 2017.

Clinic Director A confirmed that an RN was not always present to supervise staff and medication administration in the past year. Clinic Director A acknowledged that there are occasions when LPNs were the only nursing staff dosing patients without the registered nurse being present for supervision.

The service did not have a registered nurse on staff and on-site at all times to supervise the dosing process and perform other functions delegated by the physician.

The clinic did not comply with the plan of correction submitted on 4/6/17 which stated: "The clinic shall have a Registered Nurse on staff to supervise the dosing process during dosing hours and to assist with other nursing duties as directed by the medical director.

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X1630	Continued From page 2 The Clinic Director and Nursing Supervisor will develop a nursing schedule that will be monitored on a monthly basis to ensure that a RN is on staff and offer direct supervision when dosing is occurring. Hiring another RN will ensure compliance of DHS 75.15" The correction date was identified as 2/28/17 and ongoing.	X1630		
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: REPEAT CITATION (Refer to SOD 7IZC11 issued 2/20/17) Based on record review and interview, it was determined that the physician did not review, sign and date all orders for the amount of narcotic drugs administered or dispensed. This was evidenced by: Client 1067 was suspected of selling or diverting methadone in September of 2017. On 9/28/17, the client was staffed and was to experience a loss of take home medications. The reduction in phase was not started until 11/2/17, after Client	X1669		

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X1669	Continued From page 3 1067 failed a call back. The signed physician order resulting in a loss of take homes/phase reduction could not be located on 2/2/18. Based on record review and interview during the complaint investigation conducted on 2/2/18, it was determined that the physician had approved cascading orders as evidenced by the MD order dated 1/30/2018 found in the record of Client 1218. The order states increase methadone by 8 mg every day until patient reports relief for 10-12 hours, then increase by 8 mg every day until patient reports relief for 24 hours. The order was not signed by the physician. The physician did not review, sign and date all orders for the amount of narcotic drugs administered or dispensed. The clinic did not comply with the plan of correction submitted on 4/6/17 which stated: "Medical Director will notate justification,and sign and date initial medical orders and all dosage changes as required. Audit tool was developed and will be completed by nursing supervisor on a weekly basis. Clinic Director will review to ensure compliance. IT department repaired programming issues for electronic signing. All orders will now show physician, nursing and counselor's signature and when appropriate the Mental Health Consultant." The correction date was identified as 2/28/17 and ongoing.	X1669		
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	X1723		

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X1723	Continued From page 4 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 record review and interview, it was determined the service did not determine a patient's drug levels in plasma or serum at the time the person is admitted to the service to determine a baseline, and 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 was evidenced by: 1. Client 1067 was readmitted to the program on 6/5/17. MD orders indicated he was to receive 140 mg which was increased to 150 mg on 6/6/17. Client 1067 remained in the program until 1/29/18 at which time he indicated he was leaving the program and that he did not desire to taper off the methadone. No documentation of testing for peaks or troughs were found in the record during this admission. 2. Client 1023 was admitted to the program on 4/12/16. MD orders indicated he was receiving 200 mg of methadone in August of 2017. No documentation of testing for peaks or troughs were found in the record. 3. Client 1218 was admitted on 11/25/16. An intake trough was obtained on 12/16/16. No further documentation of testing for peaks or troughs were found in the record.	X1723		

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X1723	Continued From page 5 The service did not assure that serum drug levels/peaks and troughs were determined at admission, and at 3 months, 6 months and annually thereafter. Peak and trough levels were not obtained or evaluated per physician orders.	X1723		
X1725	DHS 75.15(13)(d) Positive Test Results Service staff shall discuss positive test results with the patient within one week after receipt of results and shall document them in the patient's case record with the patient's response noted. 2. The service shall provide counseling, casework, medical review and other interventions when continued use of substances is identified. Punishment is not appropriate. 3. When there is a positive test result, service staff shall allow sufficient time before retesting to prevent a second positive test result from the same substance use. 4. Service staff confronted with a patient's denial of substance use shall consider the possibility of a false positive test. 5. Service staff shall review a patient's dosage and shall counsel the patient when test reports are positive for morphine-like substances and negative for the FDA-approved narcotic treatment. This Rule is not met as evidenced by: REPEAT CITATION (Refer to SOD 7IZC11 issued 2/20/17) Based on the record review and interview, it was determined the clinic did not assure that staff discussed positive test results for illicit drugs with the clients within one week after the receipt of the results. This was evidenced in 1 of 3 clients who tested positive for illicit drugs. This was	X1725		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIES (EACH DEFIC ENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENT FY NG INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X1725	Continued From page 6 evidenced by: Client 1218 tested positive for illicit substances on 5/31, 8/4, 11/30, 12/29, and 1/23/18. Positive results were not addressed with a counselor within 7 days of receiving the results. Clinic staff reviewed the record and confirmed staff were not consistently discussing positive test results for illicit drugs with the clients within one week after the receipt of the results. The clinic did not assure that staff discussed positive test results for illicit drugs with the clients within one week after the receipt of the results. The service did not provide counseling, casework, medical review and other interventions when continued use of illicit substances was identified. The clinic did not comply with the plan of correction submitted on 4/6/17 which stated: "All counselors will be retrained on policy to discuss positive test results with the patient within 7 days by their primary counselor after receipt of results. This will be documented in the Staff Training Binder. Clinical Supervisor will complete an audit specifically focusing on follow-up on positive urine drug screens. Counselors identified as non-complaint will have the expectation of compliance added to their individual staff development plan. Future evidence of non-compliance will result in progressive disciplinary action. Clinical records will be audited for compliance: Ongoing compliance will be monitored including monthly chart audits of a minimum of 5% of open active cases."	X1725		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3114	A. BUILDING: ______ B. WING ______	02/02/2018

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X1725	Continued From page 7 The correction date was identified as 2/28/17 and ongoing.	X1725		
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: REPEAT CITATION (Refer to SOD 7IZC11 issued 2/20/17) Based on the record review, the narcotic treatment service for opiate addiction did not have documentation to verify that the service screened the patients immediately following the admission and annually thereafter for tuberculosis (TB), viral hepatitis, and sexually transmitted diseases. This was evidenced in 2 of 8 records reviewed as indicated by: 1. Client 1067 was admitted on 4/26/16, and was readmitted 6/5/17. A TB test was completed on 10/17/17. No TB test completed for the 4/26/16 admission was found. The TB test completed on 10/17/17 was completed four months after admission. 2. Client 1023 was admitted on 4/12/16. A TB test was completed on 5/26/17. No TB test completed for the 4/12/16 admission was found. The TB test completed on 5/26/17 may have been completed as part of the correction plan following issuance of an SOD on 2/20/17.	X1747		

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X1747	Continued From page 8 3. Client 1218 was admitted on 11/25/16, and was discharged on 12/30/16 when incarcerated. Client 1218 was readmitted on 2/16/17. No TB test following either admission was found. The narcotic treatment service for opiate addiction did not have documentation to verify that the service screened the patients immediately following the admission and annually thereafter for TB and other communicable illnesses. The clinic did not comply with the plan of correction submitted on 4/6/17 which stated: "TB testing will be done on all new patients upon admission and annually thereafter. The TB test results will be recorded in Methasoft by RN under "Health Screen and in patient case notes. The Nurse Supervisor will monitor compliance through 5% of monthly chart audits to ensure completion of initial and annual TB tests per DHS 75.15(17)(9a)" The correction date was identified as 2/28/17 and ongoing.	X1747		
X1759	DHS 75.15(19)(a) Diversion Control Each staff member of the narcotic treatment service for opiate addiction is responsible for being alert to potential diversion of narcotic medication by patients and staff. This Rule is not met as evidenced by: Based on record review and staff interview, it was determined that the narcotic treatment service is not effectively monitoring diversion of narcotic medication. This was evidenced by:	X1759		

Wisconsin Department of Health Services

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X1759	Continued From page 9 A client reported in January that Client 1218 was not ingesting her methadone at the clinic. Upon investigation, the clinic learned that a licensed practical nurse (LPN) B was reportedly giving the methadone to some clients and allowing them to take the methadone with them. It was also reported that LPN B may be providing or selling urine to clients if a urine drug screen was required. Upon investigation, conducting interviews, and review of the video monitoring tapes, the clinic determined that LPN B was providing Client 1218, Client 1067, and Client 1023 with methadone and that they were allowed to take that day's methadone as well as take homes with them when they left the clinic and were not required to ingest the methadone in front of staff. Each of the clients was receiving in excess of 115 mg of methadone daily. Interviews with Client 1218 and Client 1023 conducted by clinic staff indicated that this practice had been ongoing for a few months prior to staff becoming aware of the diversion. Client 1067 was to be reduced to Phase 1 in September of 2017 for suspicions of diverting or selling methadone. Refer to Tag 1672. When questioned in January, Client 1067 denied diversion activities and indicated he would be discontinuing services and did not desire to be tapered from his dose of 150 mg daily at time of discharge. Other medical staff having worked with LPN B indicated that they were not aware that LPN B was allowing patients to leave the clinic without ingesting that day's methadone dose. The narcotic treatment service was not effectively monitoring administration to prevent diversion of narcotic medication. The narcotic treatment	X1759		

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X1759	Continued From page 10 service did not assure supervision from an RN as required. Refer to Tag 1630.	X1759		