

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X 000	<p><b>Initial Comments</b></p> <p>The Behavioral Health Certification Section received notification of client diversion of methadone on or around 05/15/2017 involving QAM, Inc. d.b.a. Waukesha Comprehensive Treatment Center (#1748). An initial onsite visit was conducted with the State Opioid Treatment Authority on 06/29/2017. Formal complaint 2017-C-014 was opened on 12/07/2017. An onsite complaint investigation was conducted on 01/04/2018.</p> <p>The clinic is certified under Wisconsin Administrative Code Ch. DHS 75.15 for provision of Narcotic Treatment Services for Opiate Addiction and Ch. DHS 75.13 for provision of Substance Use Treatment Services. Four violations were cited as a result of the investigation. A plan of correction is required.</p>	X 000		
X1302	<p><b>DHS 75.03(4)(f) Qualified Mental Health Professionals</b></p> <p>All staff who provide mental health treatment services to dually diagnosed clients shall meet the appropriate qualifications under appendix B.</p> <p>This Rule is not met as evidenced by: Based on staff interview, review of Counselor B's personnel record, and documentation of mental health supervision, all staff who provide mental health treatment services to dually diagnosed clients do not meet the qualifications under Wisconsin Administrative Code Ch. DHS 75 Appendix B.</p> <p>Findings include:</p> <p>Based on interview with Clinic Director A, the clinic contracts with Mental Health Supervisor</p>	X1302		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (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
--------------------	--	--------------	---	--------------------

X1302	<p>Continued From page 1</p> <p>(MH Suprv) C to provide mental health supervision of mental health professionals in-training for the purpose of building hours of experience for mental health licensure. MH Suprv C provides onsite supervision of Counselor B and other mental health professionals in-training through case staffings. Clinic Director A stated, MH Supervisor C does not conduct clinical record review to verify verbal information reported or for the purpose of assessing professional development needs related to documentation of mental health services provided. Director A stated MH Suprv C provides approximately 4-8 hours of supervision per week at the clinic. Surveyor requested documentation of mental health supervision provided to mental health professionals in-training. Director A told Surveyor that MH Suprv C and the trainees, not the clinic, maintain documentation of MH supervision provided and received.</p> <p>According to Director A, mental health professionals in-training "monitor" dual diagnosed clients and the clinic refers out all mental health services. Director A also stated the clinic is not billing for mental health services provided. Director A acknowledged he/she was not aware that mental health professionals in-training did not meet the qualifications established under DHS 75 Appendix B.</p> <p>Surveyor reviewed Counselor B's personnel record. Counselor B's was hired on 6/08/2015 as a "Dual-Credentialed Counselor/Case Manager." B holds an Advanced Practice Social Worker (in-training) certification issued by the Department of Safety and Professional Services on 06/17/2015. An email dated 01/04/2018 from Clinic Director A to Surveyor indicated that Counselor B reported completing 82 hours of</p>	X1302		
-------	--	-------	--	--

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (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
X1302	<p>Continued From page 2</p> <p>supervised mental health experience under the supervision of MH Suprv C while employed at the clinic. Counselor B provided a record of supervision sessions attended for the purpose of earning hours for mental health licensure. The documentation does not identify the mental health supervisor, does not provide a narrative description of what occurred during the session and does not provide an evaluation of professional development.</p> <p>Similarly, Counselor E holds an Advanced Practice Social Worker (in-training) certification issued by the Department of Safety and Professional Services on 04/11/2016. An email dated 01/04/2018 from Clinic Director A to Surveyor indicated that Counselor E reported completing 61.5 hours of supervised mental health experience while employed at the clinic.</p> <p>Staff member F holds a professional Counselor Training License issued by the Department of Safety and Professional Services on 01/12/2017. An email dated 01/04/2018 from Clinic Director A to Surveyor indicated that Counselor F reported completing 60 hours of supervised mental health experience while employed at the clinic.</p> <p>Although Clinic Director A reported that mental health professionals in-training are "monitoring" dual diagnosed clients, the trainees are recordings hours of mental health treatment provided for the purpose of professional licensure.</p>	X1302		
X1391	<p>DHS 75.03(17)(c) Discharge Summary</p> <p>The discharge summary shall include all of the following: 1. Recommendations regarding care</p>	X1391		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(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
X1391	<p>Continued From page 3</p> <p>after discharge. 2. A description of the reasons for discharge. 3. The patient's treatment status and condition at discharge. 4. A final evaluation of the patient's progress toward the goals set forth in the treatment plan. 5. The signature of the patient, the counselor, the clinical supervisor and, if the patient is dually diagnosed, the mental health professional, with the signature of the consulting physician included within 30 days after the discharge date.</p> <p>This Rule is not met as evidenced by: Based on review of Client 1's clinical record and staff interview, Client 1's discharge summary did not describe coordination of care and discharge planning activities consistent with Physician G's order to discharge to "a higher level of care." Client 1's discharge summary did not provide a final evaluation of Client 1's progress toward the goals set forth in the treatment plan. The discharge summary was not signed by Client 1.</p> <p>Findings include:</p> <p>On 5/15/2017, law enforcement reported to the clinic that Client 1 diverted his/her methadone resulting in dangerous consequences requiring intervention by emergency responders for another individual.</p> <p>On 5/15/2017, Physician G's written order stated in part, "Start Admin Detox" and "Discharge to a higher level of care. Non-opioid treatment recommended."</p> <p>According to the document titled "Patient Discharge," Client 1 was admitted to the clinic on 6/20/2013 and discharged on 6/14/2017 following an involuntary taper as a result of methadone</p>	X1391		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X1391	<p>Continued From page 4</p> <p>diversion with dangerous consequences. The "Follow-up Plans" section of the document stated, "Non-opioid treatment. Follow-up with PCP if withdrawals become severe. Engage in recovery oriented supports, engage in community support groups." There was no information in the follow-up plan indicating a formal referral or client transfer to a higher level of care was discussed or completed as ordered by Physician G. The client did not sign the discharge document and there was no explanation noted for Client 1's missing signature. Client 1's clinical record did not include a separate aftercare plan document.</p> <p>A progress note dated 6/5/2017 provided information about Client 1's status just prior to discharge noting "Patient reports [he/she] smoked before coming to her counseling appointment. [Client 1] reports 'I probably won't quit now,'" referring to use of THC. Client 1 also reported he/she "has nothing in place but is interested in counseling." Client 1 reported he/she had an appointment scheduled with his/her primary care physician, however there was no indication the information was verified. Counselor B noted a recommendation to abstain from all mood altering substances. There was no information indicating a formal referral or client transfer to a higher level of care was discussed or completed as ordered by Physician G. Telephone numbers for two agencies were provided to Client 1.</p> <p>The "Treatment Summary" section of the discharge document stated, "[Client 1] struggled with continued THC use despite education regarding risks and consequences of continued use. Patient completed Ateam on 3/21/2017 regarding non-compliance with counseling attendance and continued THC use." There is no</p>	X1391		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X1391	<p>Continued From page 5</p> <p>additional narrative describing treatment provided or Client 1's response to interventions during the past four years.</p> <p>The Goal Description table on page 2 of the discharge document indicated in part that as of 7/9/2017 "Patient has met all goals under all problems in their treatment plan" and "Patient will develop an aftercare plan." There was no "Outcome Status" for goals reported within the Goal Description table on the discharge document. The document was signed by Counselor B on 6/14/2017, Mental Health Supervisor C on 06/23/2017, Clinical Supervisor on 6/28/2017 and Physician G on 06/21/2017. Client 1's signature was not captured on the document. Client 1's clinical record did not include a separate aftercare document.</p>	X1391		
X1702	<p>DHS 75.15(11)(i) Deny or Rescind Take-home Privileges</p> <p>A service shall deny or rescind approval for take-home privileges for any of the following reasons: 1. Signs or symptoms of withdrawal. 2. Continued illicit substance use. 3. The absence of laboratory evidence of FDA-approved narcotic treatment in test samples, including serum levels. 4. Potential complications from concurrent disorders. 5. Ongoing or renewed criminal behavior. 6. An unstable home environment.</p> <p>This Rule is not met as evidenced by: Based on review of Client 1's clinical record, review of relevant clinic policies and interview with Clinic Director A, the service did not deny or rescind approval of Sunday take-home privileges while Client 1 continued illicit use of THC and had missed counseling appointments.</p>	X1702		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (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
X1702	<p>Continued From page 6</p> <p>Findings include: A progress note dated 5/15/2017 documented law enforcement notification to the clinic that Client 1 diverted his/her methadone resulting in dangerous consequences requiring intervention by emergency responders for another individual. A law enforcement report received by this Surveyor confirmed this fact.</p> <p>Based on an email dated 01/04/2018, Clinic Director A reported that on 07/08/2015, Client 1 was lowered from Phase 4 status to Phase 1. "Physician Orders - Phase Status Form" dated 7/08/2015 indicated phase reduction was a result of Client 1's continued THC use resulting in positive urine drug screens. Phase reduction resulted in reducing take-home privileges to one time per week (Sundays).</p> <p>Clinic policy titled "Take-Home Medication Call-Backs (WI)" stated in part, "Patients who are at level one will have call-backs as needed when there is suspicion of diversion." Based on review of Client 1's clinical record, a progress note dated 12/22/2015 reveals Client 1 was known to have diverted a Sunday take home dose. A progress note dated 12/27/2015 documents a failed Sunday call back with a plan for an additional call back "the next Sunday the clinic is open." No further call backs were documented in Client 1's record.</p> <p>Documentation of Client 1's annual physical dated 6/20/2016 noted "ongoing THC use" and "[Client 1] wants to taper." Client 1 had been on Phase 1 for 11 months. Client 1's treatment plan dated 06/27/2016 maintained the same (required) "Withdrawal Planning" goal. The goal was not amended to capture Client 1's expressed desire</p>	X1702		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X1702	<p>Continued From page 7</p> <p>to taper.</p> <p>Documentation in Client 1's clinical record reveals he/she had at least 23 positive urine drug screens between January 2016 and May 2017. Client 1 continued to receive Sunday take home doses. Clinic policy titled "Diversion Control Plan" stated in part, "The results of these drug tests are monitored by the primary counselor and are one tool utilized to determine eligibility for take-home medication."</p> <p>Clinic policy titled "Response to Patient Drug Screen Analysis Results (WI)" stated in part, "staff must remain vigilant in responding to patients' DSA [drug screen analysis] results." The policy also stated, "If a patient's drug screen analysis result is positive for an illicit substance, take-home privileges will be suspended immediately." Treatment plans dated between 06/27/2016 and 04/10/2017, remained unchanged, despite Client 1's ongoing noncompliance with treatment goals/expectations. Client 1 continued to receive Sunday take home doses.</p> <p>Client 1's clinical record indicated Client 1 missed at least 5 counseling appointments between December 2016 and February 2017, including 12/21/2016, 1/17/2017, 1/30/2017, 2/16/2017, and 2/27/2017. Client 1 continued to receive Sunday take home doses.</p> <p>Physician Order dated 3/08/2017, indicated Physician G began a voluntary taper "as tolerated."</p> <p>A progress note dated 3/21/2017 documents an "A-team" meeting as a result of poor attendance for counseling appointments and continued THC</p>	X1702		



Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(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
X1702	<p>Continued From page 8</p> <p>use. Client 1 voiced his/her feeling that an A-team should have been done months ago due to continued noncompliance. The A-team discussed the importance and benefits of engaging in a program of recovery and having healthy coping skills and positive supports. Client 1 reported he/she was not interested in AA-type meetings. As a result of the A-team meeting, there were no changes to Client 1's treatment plan to meet Client 1's individual needs, including treatment noncompliance, and provide support to achieve established treatment goals [reference treatment plan dated 4/10/2017].</p> <p>Physician Order dated 4/03/2017, indicated Physician G continued the voluntary taper "against medical advise." There was no change Client 1's treatment plan or documentation of coordination of care for anticipated discharge.</p> <p>On 5/15/2017, Client 1 diverted his/her Sunday dose resulting in dangerous consequences requiring intervention by emergency responders for another individual.</p> <p>Clinic Director A told Surveyor that following the initial site visit on 06/29/2017 by another Surveyor and the State Opioid Treatment Authority, the clinic's Diversion policy was reviewed with all staff. The clinic also implemented a call back procedure focusing on phase 1 clients with Sunday take home doses. Director A reported the call back policy was not updated with the new procedure.</p> <p>Cross Reference X1721 DHS 75.15(13)(a)2 Treatment Approaches</p>	X1702		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (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
X1721	Continued From page 9	X1721		
X1721	<p>DHS 75.15(13)(a)2 Treatment Approaches</p> <p>A service shall use the results of a drug test or analysis on a patient as a guide to review and modify treatment approaches and not as the sole criterion to discharge the patient from treatment.</p> <p>This Rule is not met as evidenced by: Based on review of Client 1's clinical record, request for clinic policy and interview with Clinic Director A, the service did not use results of drug test or analysis on Client 1 as a guide to review and modify treatment approaches.</p> <p>Findings include:</p> <p>In an email dated 01/04/2018, Clinic Director A reported that on 07/08/2015, Client 1 was lowered from Phase 4 status to Phase 1. "Physician Orders - Phase Status Form" dated 7/08/2015 indicated the phase reduction was a result of Client 1's continued THC use resulting in positive urine drug screens.</p> <p>Clinic policy titled "Diversion Control Plan" stated in part, "The results of these drug tests are monitored by the primary counselor and are one tool utilized to determine eligibility for take-home medication."</p> <p>Documentation in Client 1's clinical record revealed Client 1 had at least 23 positive urine drug screens between January 2016 and May 2017. A sample of additional findings included: Client 1's annual physical dated 6/20/2016 noted "ongoing THC use;" Staffing Review Form dated 09/15/2016 stated "Continues to smoke THC despite education on cross addiction and dangers of continued drug use;" ASI (Addiction Severity Index) completed on 1/31/2017 indicated client</p>	X1721		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X1721	<p>Continued From page 10</p> <p>self-reported cannabis use 20 of the past 30 days; and Staffing Review Form dated 4/10/2017 stated in part "ongoing THC use." The clinic did not use positive urine drug results to inform treatment planning and modify interventions. Review of Client 1's treatment plan during this timeframe revealed no modification to treatment approaches.</p> <p>Client 1's treatment plan dated 06/27/2016 included the goal "Cessation of marijuana use." Methods for achieving the goal were "patient responsibility" and included the following:</p> <ul style="list-style-type: none"> <li>&gt; "Patient will engage in healthy leisure activities"</li> <li>&gt; "Set a 'Quit Date' for cessation of cannabis use"</li> <li>&gt; "Patient will develop healthy coping skills as alternatives to illicit use"</li> </ul> <p>Treatment plans dated 9/30/2016, 1/23/2017, and 4/10/2017 revealed that positive drug test results did not lead to changes in treatment goals or modification of treatment approaches. The "Cessation of marijuana use" goal remained unchanged. No additional treatment goals were established and there was no modification to treatment methods/approaches.</p> <p>A progress note dated 3/21/2017 documented an "A-team" meeting as a result of poor attendance for counseling appointments and continued THC use. Client 1 voiced his/her feeling that an A-team should have been done months ago due to continued noncompliance. The A-team discussed the importance and benefits of engaging in a program of recovery and having healthy coping skills and positive supports. Client 1 reported he/she was not interested in AA-type meetings. As a result of the A-team meeting, there were no changes to Client 1's treatment plan to meet</p>	X1721		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>06/29/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(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
X1721	<p>Continued From page 11</p> <p>Client 1's individual needs, including treatment noncompliance with illicit drug use resulting in positive urine drug screens[reference updated treatment plan dated 4/10/2017]. Review of Client 1's treatment plan revealed no modification to treatment methods/approaches.</p> <p>DHS 75.15(13)(a)3 states, "A service's policies and procedures shall integrate testing and analysis into treatment planning and clinical practice." In an email dated 01/23/2018 from Clinic Director A to Surveyor, Director A stated "We don't have anything specific in our policies of how positive results should be used to inform treatment planning. I've already reached out to our teams to make this connection in the policies."</p> <p>Client 1 did not progress beyond Phase 1 between 7/9/2015 and discharge on 06/09/2017 due to continued illicit use of THC resulting in positive urine drug screens. Client 1 was administratively discharged from the program following an incident of methadone diversion which resulted in dangerous consequences requiring intervention by emergency responders for another individual on 5/15/2017.</p> <p>Cross Reference X1702 DHS 75.15(11)(i) Deny or Rescind Take-Home Privileges.</p>	X1721		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCES (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
X 000	<p><b>Initial Comments</b></p> <p>On 11/22/2017, the Behavioral Health Certification Section received notification of water damage and mold at QAM d.b.a. Waukesha CTC (#1748) which occurred on or around 09/26/2017. An initial onsite visit was conducted on 11/30/2017 with the State Opioid Treatment Authority. Formal complaint 2017-C-013 was opened on 12/01/2017. A second site visit occurred on 12/06/2017, with a verification visit completed on 01/04/2018.</p> <p>The clinic is certified under Wisconsin Administrative Code Ch. DHS 75.15 for provision of Narcotic Treatment Services for Opiate Addiction and Ch. DHS 75.13 for provision of Substance Use Treatment Services. Two violations were cited as a result of the investigation. A plan of correction is required.</p>	X 000		
X 560	<p><b>DHS 92.03(1)(k) Record Security</b></p> <p>All treatment records shall be maintained in a secure manner to ensure that unauthorized persons do not have access to the records.</p> <p>This Rule is not met as evidenced by: Based on Surveyor observation and staff interview, the clinic did not maintain all treatment records in a secure manner.</p> <p>Findings include:</p> <p>The Behavioral Health Certification Section was notified on 11/22/2017, via email from the State Opioid Treatment Authority (SOTA), of a flooding incident at QAM d.b.a. Waukesha CTC (#1748) which occurred on 09/26/2017. In an email dated 11/22/2017, Clinic Director F stated, "It resulted in mold in our dispensing area that still needs to be</p>	X 560		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(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
X 560	<p>Continued From page 1</p> <p>treated." The SOTA responded that she was not aware the clinic had flooded.</p> <p>On 11/30/2017, an unannounced onsite visit was conducted with the SOTA. During a tour of the facility with Clinic Director F, Surveyor learned that damaged areas of the clinic included the client waiting area, dosing stations, phlebotomy room, one or more counseling offices, and administrative area. As a result of the flooding incident, some confidential client records were relocated to other areas of the clinic. Director F reported the clinic census was 409 clients.</p> <p>Upon arrival at the facility on 11/30/2017, the SOTA conducted an independent walk-through of the clinic. The SOTA reported observing a client walk through an upstairs common area where confidential clinical records were exposed in an unlocked file cabinet with the drawer face left open. Surveyor requested to see the area. Surveyor observed room #203 was unlocked. The room included a common area used to walk through to access two counselor's offices. An unlocked file cabinet was located in the common area of the unlocked room with the drawer face open, exposing client names and leaving confidential client records accessible to unauthorized persons.</p> <p>This Surveyor also observed purged client record packets stacked on top of another file cabinet in the same common area. The purged client record packets had client names written on the outside of the large envelope in large black ink and were visible to anyone who walked through the common area.</p> <p>While continuing the tour of the second floor of the clinic with Director F, Surveyor observed an</p>	X 560		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (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
X 560	<p>Continued From page 2</p> <p>unlocked file cabinet in the common area of room #201. Clients receiving counseling services in room #201 were required to walk through a common area to access the two counselor's offices. Surveyor easily pulled the unlock drawer open and found confidential client records accessible to unauthorized persons. While in the common area of room #201, Surveyor could hear a counseling session occurring in a counselor office located adjacent to the common area, permitting disclosure of protected health information.</p> <p>While continuing the tour, Surveyor discovered 2 unlocked file cabinets containing confidential client records in the walk through common area of room #202.</p> <p>On 12/06/2017, an unannounced onsite visit was conducted with the SOTA. Surveyor checked in at the reception window and then immediately went upstairs to check the security of confidential client records. Surveyor found the file cabinet in the common area of room #201 to be locked with the keys hanging from the lock. Surveyor unlocked the drawer with the key and found confidential client records accessible to unauthorized persons who would use the key to unlock the cabinet. Surveyor locked the cabinet and removed the key. The key was returned to Director F during the entrance conference.</p>	X 560		
X1753	<p>DHS 75.15(18)(c) Facility Physical Environment</p> <p>A service shall provide a setting that is conducive to rehabilitation of the patients. (c) Dosing stations and adjacent areas shall be kept sanitary and ensure privacy and confidentiality.</p>	X1753		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCIAS (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
X1753	<p>Continued From page 3</p> <p>This Rule is not met as evidenced by: Based on staff interviews, documentation review and Surveyor observations, the clinic did not maintain a setting that was kept sanitary and ensured privacy and confidentiality.</p> <p>Findings include:</p> <p>The Behavioral Health Certification Section was notified on 11/22/2017, via email from the State Opioid Treatment Authority (SOTA), of a flooding incident at QAM d.b.a. Waukesha CTC (#1748) which occurred on 09/26/2017. In an email dated 11/22/2017, Clinic Director F stated, "It resulted in mold in our dispensing area that still needs to be treated." The SOTA responded that she was not aware the clinic had flooded.</p> <p>On 11/30/2017, an unannounced onsite visit was conducted by the Division of Quality Assurance (DQA) with the SOTA. During the entrance interview, Clinic Director F reported he/she was on leave from 9/19/2017 through 11/20/2017. On 9/26/2017 the clinic was flooded following a hot water tank failure. On 12/06/2017, Regional Director D acknowledged during interview that he/she assumed responsibility for clinic operations while Director F was on leave. Director D acknowledged he/she did not notify the DQA or the SOTA of the event.</p> <p>On 11/30/2017, a facility tour was conducted with Director F. During the tour, Surveyor learned that damaged areas on the first floor of the clinic included the client waiting area, dosing station, phlebotomy room, one or more counseling offices, and administrative area. Also during the tour, Surveyor, SOTA and Director F observed the client waiting room to be overcrowded, permitting standing room only, making it difficult to move</p>	X1753		



Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(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
--------------------	--	--------------	---	--------------------

X1753	<p>Continued From page 4</p> <p>about the waiting area freely. The waiting area contained 21 chairs in the main area; 4 chairs in the counselor office walkway; and 6 chairs in the waiting cove near dosing window 2 (counts occurred on 12/06/2017). Director F later reported that the clinic census was 409 clients with dosing hours established from 5:00 a.m. to 10:30 a.m.. During interview with Contractor BP on 12/01/2017, BP stated there were 60-70 people in the waiting area every time he/she was onsite to conduct remediation work.</p> <p>On 11/30/2017, Surveyor observed both dosing windows in operation in the client waiting area. Clients receiving dosing were in full view of clients waiting to be dosed. Standing in front of a seated client within a few feet of the dosing window, Surveyor could hear information exchanged between the dosing nurse and the client being dosed. The dosing windows did not have side privacy panels or other privacy protections to ensure privacy and confidentiality of protected health information was not disclosed. Client capacity exceeded the waiting area space at times throughout the dosing hours of 5:00 a.m. to 10:30 a.m..</p> <p>On the date of the flooding incident (9/26/2017), Nurse H and Counselor J reported during interview that the waiting area was found not usable and the area was blocked off with chairs because staff speculated the flooding may be sewage following a plumbing service call the previous day. Staff described the presence of 2-4 inches of standing water in the dosing station, client waiting area and adjacent areas. The clinic proceeded to open for business in lieu of implementing a flood disaster plan. Nursing staff reported standing in water during dosing on day 1. Clients were instructed to line up at the clinic</p>	X1753		
-------	---	-------	--	--

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (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
X1753	<p>Continued From page 5</p> <p>side door for dosing. The line of clients waiting for dosing extended outside the clinic. Staff H reported that clients walked through water to dose, describing the flooring as "squishy."</p> <p>The clinic proceeded to reopen for business the days immediately following the flooding incident as initial remediation efforts were underway. Staff members J and H reported, and Director D acknowledged, that on day 2 he/she took down barriers established by the remediation contractor in an effort to open dosing window 1. Staff J reported putting the barrier back in place after a short time. On day 2, clients were lined up in a hallway of the clinic due to a change in outdoor temperature from the previous day. Based on interviews, Staff and clients were exposed to remediation measures, including the operation of large heated fans, chemical application of mold retardant, and adhesive application to re-glue tile flooring. Staff reported sustained high temperatures in the clinic during drying and reported illness or irritation symptoms due to chemical treatments of the physical property. Staff K reported to the SOTA, it "felt like a hundred" in the clinic. Staff H and J reported to this surveyor that staff members complained of headaches and dizziness, with one or more staff members leaving their work shift early.</p> <p>On 12/01/2017, Surveyor consulted with PH, WI DHS/Division of Public Health. PH advised that with reports of illness or irritation, avoiding use of the space by closing off the area until remediation is completed is recommended.</p> <p>The clinic reported that: &gt; 265 clients were dosed on 9/26/2017 &gt; 288 clients were dosed on 9/27/2017 &gt; 277 clients were dosed on 9/28/2017</p>	X1753		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	D PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
X1753	<p>Continued From page 6</p> <p>Per undated Assessment &amp; Course of Action report submitted by the remediation contractor, mold was identified in the dosing station on 10/10/2017 and a plan for remediation and restoration was proposed. In an email dated 10/11/2017 from Staff B to the U.S. Drug Enforcement Administration (DEA), restoration of the nursing station was anticipated over the weekend. As of 11/30/2017, the restoration was not completed.</p> <p>According to multiple staff members, the clinic continued to operate while restoration efforts were delayed. Contractor BP stated during interview, "patient dosing seemed more important" to Director D than completing restoration of the area. Director F reported that 279 clients (on average) received daily dosing in September, October, and November.</p> <p>The Moisture Mapper Project Report dated 12/07/2017 for the timeframe of 9/26/2017-9/30/2017 stated, "[Contractor] was not allowed to get into the nurses station where medication was kept and dispersed per Director of Waukesha Comprehensive Center even though there are area were saturated with water."</p> <p>On 11/30/2017, the following observations were made by this Surveyor and the SOTA:</p> <ul style="list-style-type: none"> <li>&gt; Dosing station remained in use following the discovery of mold behind lower cabinets in the dosing station. An exposed flooring seam in a high traffic area of the dosing station was covered by worn duck tape. Restoration was not completed.</li> <li>&gt; Client waiting area baseboards remained</li> </ul>	X1753		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(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
X1753	<p>Continued From page 7</p> <p>removed from walls and stacked behind waiting room chairs under the windows. Restoration was not completed.</p> <p>&gt; Phlebotomy room was closed off and not in use. Baseboards and tile flooring were removed. Phlebotomy chair and supplies were set up in the group room. Blood draw supplies were found in an unlocked drawer in the group room. Phlebotomy services were not available when the treatment group was in session. Restoration was not completed.</p> <p>&gt; Counseling room adjacent to the waiting area was closed off and not in use. Baseboards were removed. Director F reported the carpet was "not dried." An unidentifiable odor was present in the room. Restoration was not completed.</p> <p>&gt; Waiting area wall across from the phlebotomy room and counseling room had an estimated 3 foot by 3 foot area of drywall removed to allow repair of the water tank. The area was covered with a black plastic tarp taped to the wall. Restoration was not completed.</p> <p>On 11/30/2017 Surveyor requested a copy of the clinic's emergency management plan. Director F provided a copy of the clinic's policy titled Emergency Action Plan - Natural Disaster. The policy addressed flooding due to a natural disaster. The policy identified a plan to "initiate procedures for alternative treatment locations." No action was taken to implement an alternative treatment location following the water tank failure resulting in clinic flooding. According to Director F, WM was identified as an alternate treatment location. The policy did not include notification to DQA or SOTA.</p>	X1753		

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC ENCS (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
--------------------	--	--------------	---	--------------------

X1753	<p>Continued From page 8</p> <p>On 11/30/2017 Surveyor requested a copy of clinic's security video from 9/26/2017. On 12/01/2017 Director F notified Surveyor via email that the clinic did not maintain a copy of the video beyond the required DEA requirement of 30 days. On 12/06/2017, Director D verified there was no video of the event maintained. Director F informed Surveyor that no photographs of the flooded areas were taken by clinic staff members. Staff members J and B reported that emails related to the event were lost after 30 days due to the entity's auto-delete process.</p> <p>Review of documentation of security alarm testing revealed the alarm was not retested immediately following the flood. The alarm underwent routine monthly testing on 9/18/2017 (prior to the flood) and 10/16/2017 (20 days post flood). Director D acknowledged on 12/06/2017 there was no additional alarm testing and the alarm company did not come to the facility in response to the flood. On 12/13/2017, Staff B confirmed that routine monthly checks were conducted. Staff B also stated that door alarm wiring is located in the ceiling and would not have been impacted by the flood event.</p> <p>On 11/30/2017, Medical Director A stated he/she was not informed of the "details" of the flooding incident resulting in mold in the dosing station. Director A was not involved in remediation or restoration activities.</p> <p>On 12/06/2017, an unannounced onsite visit was conducted with the SOTA. Director F reported restoration work completed in the client waiting area included patching the water tank access hole, repainting, and re-installed baseboards. Restoration work not completed included carpet replacement in the counselor office, tile flooring</p>	X1753		
-------	--	-------	--	--

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROV DER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>1748</b>	(X2) MULT PLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/30/2017</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>QAM, INC DBA WAUKESHA COMPREHENSIVE TX CT</b>	STREET ADDRESS CITY STATE ZIP CODE <b>2422 N. GRANDVIEW BOULEVARD WAUKESHA, WI 53188</b>
--	---

(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
X1753	<p>Continued From page 9</p> <p>replacement in the phlebotomy room, tile flooring and baseboard replacement in the client bathroom, and mold remediation in the dosing station. During interview Director D acknowledged that clients were not advised of the presence of mold in the dosing station.</p> <p>On 12/08/2017, Director F submitted a written request to the SOTA, DQA, and SAMHSA to close the clinic from 12/16/2017 to 12/18/2017 for clinic restoration and mold remediation. The plan was accepted.</p> <p>On 01/04/2018, a verification visit was conducted to verify dosing station restoration was completed. Director F confirmed during interview that mold was found on the back wall and around the corner behind the cabinets.</p>	X1753		