Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	3340		C 10/27/2022

NAME OF PROVIDER OR SUPPLIER
SBH MADISON LLC DBA MIRAMONT BEHAV HLTH

STREET ADDRESS, CITY, STATE, ZIP CODE
3169 DEMING WAY
MIDDLETON, WI 53562

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X 000	INITIAL COMMENTS On 10/19/2022, an onsite complaint investigation was conducted . The provider holds certification under Wisconsin Administrative Code(s): DHS 61.71 Community Mental Health Inpatient DHS 61.75 Mental Health - Day Treatment DHS 61.79 Community Mental Health Adolescent Inpatient Six (6) patient records and 1 personnel record were reviewed. Three (3) deficiencies were identified. The survey was conducted in conjunction with an Acute Care Compliance Sections (ACCS). On 10/11/2022 the Department received 2 complaints alleging concerns regarding patient rights. Complaint #WI00045707 was found to be substantiated. Compliant #WI00045709 was found to be substantiated.	X 000		
X9416	DHS 94.08 PATIENT RIGHTS PROMPT AND ADEQUATE TREATMENT All patients shall be provided prompt and adequate treatment, habilitation or rehabilitation, supports, community services and educational services as required under s. 51.61(1)(f), Stats., and copies of applicable licensing and certification rules and program manuals and guidelines. Note: Educational requirements for school-age patients in inpatient facilities can be found under	X9416		

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

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X9416	Continued From page 1 chs. 115 and 118, Stats. This Rule is not met as evidenced by: Based on record review and interview, 3 of 6 patients did not receive medications in a prompt or adequate manner. On 10/11/2022 the department received 2 complaints alleging delays in medication administration. Findings include: According to the facility's policy titled, "Medication Administration" BID is defined as twice daily, TID is defined as three times daily, and QID is defined as four times daily. Surveyor emailed Chief Nursing Officer (CNO) A and Director of Quality/Risk Management D on 11/09/2022 for clarification on the facility's medication order documentation using Patient 1's medication order and medication administration record (MAR) for cyclobenzaprine 10 mg as an example. Director D replied via email on 11/10/2022 and identified that medication orders signed by Family Nurse Practitioner (FNP) M on 08/01/2022 at 3:20 PM did not include a start date and time. Director D also identified that because Psychiatrist L later entered and signed the same medication order on 08/01/202 at 8:02 PM, which was after the facility's latest medication administration time of 8 PM, that the system defaulted to the next medication administration time the following day, 08/02/2022 at 8 AM. This response from Director D can be applied to all medication orders, hereafter, that were entered without a start date and time and for medication orders entered and signed after the facility's latest medication administration time of 8 PM. Patient 1 was admitted on 08/01/2022 at 12:19	X9416		

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X9416	Continued From page 2 PM. Patient 1 had been transferred via ambulance following an overnight stay at a medical hospital. On 08/01/2022 at 10:27 AM Patient 1's transfer records were received via fax. The transfer records documented, in part, the patient's last medication administrations on 08/01/2022 as follows: gabapentin 800 mg at 10:22 AM, oxycodone-acetaminophen 5 mg - 325 mg at 9:50 AM; and buspirone 15 mg at 10:22 AM. On 08/01/2022 signed at 11:25 AM, Patient 1 completed the Patient Self-Report form answering "yes" to pain with a score of "9" in the "back and neck". On 08/01/2022 at 3:00 PM, FNP M documented the following on Patient 1's H & P Examination (History & Physical): on page 3, under Current Home Medications, includes buspirone 15 mg, cyclobenzaprine 10 mg, gabapentin 800 mg, oxycodone-acetaminophen 5 mg-325 mg; on page 7 under Pain Scale, as having "aching" pain in the "back" at a scale of "7"; on page 8-9 under Physical Exam, as having "limited ROM [range of motion] due to back pain."; on page 10 under Reflexes, Gait - "Abnormal walking with limp d/t back pain" and Balance - "Abnormal poor balance d/t back pain" On 08/01/2022 at 3:20 PM, within Patient 1's medication orders, FNP M signed orders for the following Routine Medications: cyclobenzaprine (for back pain) 10 mg BID, oxycodone-acetaminophen (for back pain) 5 mg - 325 mg PRN, and gabapentin (for back pain) 800 mg QID. On 8/01/2022 at 6:11 PM, following the H & P and	X9416		

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X9416	Continued From page 3 orders for home medications, RN P documented on the Nursing Admission Assessment that Patient 1 reported pain at a level of "8 pain" and at 6:20 PM, RN P documented on the Nursing Physical Assessment the patient reported "back pain" at a level of "7 pain". On 08/01/2022 at 8:02 PM, within Patient 1's medication orders, Psychiatrist L signed orders for the following Routine Medications : cyclobenzaprine (for back pain) 10 mg BID, buspirone 15 mg (for bipolar) BID, oxycodone-acetaminophen (for back pain) 5 mg - 325 mg PRN, and gabapentin (for back pain) 800 mg QID. On 08/01/2022, Patient 1's MAR documented the patient receiving the following medications: acetaminophen 650 mg at 6:07 PM by RN P, gabapentin 800 mg by RN Q, diazepam 5 mg by RN R, and oxycodone-acetaminophen 5 mg-325 mg at 9:59 PM by RN R. On 08/01/2022, FNP M and Psychiatrist L did not promptly order and start Patient 1's pain and psychiatric medications. Patient 2 was admitted to the facility on 09/09/2022 at 10:29 AM. On 09/09/2022 at 12:10 PM, DNP Y completed Patient 2's H & P Examination with the following diagnoses: Major Depressive Disorder recurrent without psychotic features. On 09/10/2022 at 10:00 AM, Psychiatrist X completed Patient 2's Psychiatric Evaluation. Initial Plan of Care to include "Medications: as ordered."	X9416		

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X9416	Continued From page 4 On 09/11/2022 at 12:30 PM, Psychiatrist X completed Patient 2's Psychiatric Evaluation. Medication Adjustments to include: Continue current meds and treatment, monitor meds..." On 09/11/2022 between 3:33-3:40 PM, within Patient 2's medication orders, Psychiatrist X signed orders for the following Routine Medications: atomoxetine 25 mg daily (for ADD/ADHD), guanfacine 2 mg daily (for anxiety), and escitalopram 40 mg daily (for depression). These medications were ordered with a start time of 8:00 AM on 09/12/2022. On 09/12/2022, Patient 2's MAR documented the patient receiving the following medications from RN J: atomoxetine 25 mg at 9:34 AM, escitalopram 40 mg at 9:35 AM, and guanfacine 2 mg at 9:44 AM. Psychiatrist X did not promptly order and start Patient 2's psychiatric medications following admission. Patient 3 was admitted to the facility on 05/25/2022 at 3:44 PM. On 05/26/2022 at 1:15 PM, within Patient 3's medication orders, Psychiatrist U signed orders for the following Routine Medications: divalproex 500 mg (for mood) to start on 05/26/2022 at 2:00 PM. On 05/26/2022, Patient 3's MAR documented the patient receiving divalproex 500 mg at 6:16 PM by RN Z. A Nursing Progress Note signed by RN C on 05/26/2022 at 5:20 PM did not identify a reason for delayed medication administration and no other supporting documentation could be located in Patient 3's record.	X9416		

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X9416	Continued From page 5 On 05/26/2022, nursing staff did not promptly administer Patient 3's psychiatric medication.	X9416		
X9447	DHS 94.23 PATIENT RIGHTS DISCHARGE OF VOLUNTARY PATIENT (1) When a voluntary inpatient requests a discharge, the facility director or designee shall either release the patient or file a statement of emergency detention with the court as provided under ss. 51.10 (5), 51.13 (7) (b) and 51.15 (10), Stats., and this section. (2) If a voluntary inpatient requests a discharge and he or she has no other living quarters or is in need of other services to make the transition to the community, the following actions shall be taken by the facility director or designee prior to discharge: (a) Counsel the patient and, when possible, assist the patient in locating living quarters; (b) Inform the applicable program director, if any, of the patient's need for residential and other necessary transitional services; and (c) If no living arrangements have been made by the time of discharge, refer the patient to an appropriate service agency for emergency living arrangements. This Rule is not met as evidenced by: Based on record review and interview, 2 of 6 voluntary patients were not released within a	X9447		

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X9447	Continued From page 6 timely manner following their request for discharge. On 10/11/2022 the department received 2 complaints alleging that voluntary patients were not discharged at the patient's request. Findings include: Patient 1 was admitted on 08/01/2022 at 12:19 PM and discharged on 08/04/2022 at 1:44 PM. Patient 1's record contained a "Nursing Progress Note" dated 08/02/2022 and signed by RN R at 6:47 AM stating in part, "[S/he] denies suicidal ideation stated 'I want to get out of here. This place will keep me from wanting to try it again. [S/he] denies self harm or homicidal ideation." The note later states, "Patient stated [s/he] is going to sign [his/her] self out of the hospital tomorrow because [s/he] is voluntary and she signed [him/her] self in, patient was educated about the AMA process." Patient 1's record contained a "Psychiatry Progress Note" dated 08/02/2022 with the time of examination at 10:00 AM and signed by Psychiatrist L at 11:15 PM. Under Diagnosis/Impressions Psychiatrist L wrote, "Patient remains unable to safely navigate in community and plan for food shelter and clothing." Between 08/02/2022 at 6:47 AM when Patient 1 requested AMA discharge and 08/03/2022 at 10:00 AM when Psychiatrist L determined the patient was unstable for discharge, Psychiatrist L failed to place the patient on a director's hold and sign and/or file emergency detention paperwork with the courts in order to legally hold the patient.	X9447		

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X9447	Continued From page 7 Patient 6 was admitted on 07/04/2022 at 1:41 PM and discharged on 07/15/2022 at 1:50 PM. Patient 6's record contained a "REQUEST FOR AMA DISCHARGE" form that was signed by Patient 6 on 07/12/2022 at 11:02 AM with a witness signature by RN T at 11:03 AM. RN T also signed as the RN notifying physician. Patient 6's record contained a "Psychiatry Progress Note" dated 07/12/2022 with the time of service at 2:12 PM and signed by Psychiatrist U at 2:17 PM. The note stated in part, "Apparently [s/he] has put an AMA request and hence placed on a director's hold. Will attempt to see [him/her] again today or tomorrow." On 11/01/2022 Director D provided surveyor via email a "Statement of Emergency Detention by Treatment Director" signed by Psychiatrist U and filed with Dane County Circuit Court on 07/12/2022; a "Notice of Hearing" filed with the court on 07/12/2022 scheduling Patient 6 for court on 07/13/2022 at 3:30 PM via Zoom; a "Motion for Dismissal" filed with the court on 07/13/2022 signed by Corporation Counsel V citing the reason for dismissal as "Other: Subject under current Order of Commitment through [County Name]."; and an "Order on Motion For Dismissal" signed and filed with the court on 07/13/2022 citing, "This matter is dismissed.". Patient 6's record contained a discharge order under "Final Ancillary Orders" entered and e-signed by Psychiatrist U on 07/15/2022 at 10:55 AM. A "Nursing Progress Note" dated 07/15/2022 and signed by RN P at 2:00 PM stated in part, "Pt got discharged to home at 1350 [1:50 PM] today." The facility failed to discharge Patient 6 within	X9447		

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X9447	Continued From page 8 reasonable time following the court order for dismissal on 07/13/2022.	X9447		
X9450	DHS 94.24(2)(d) PATIENT RIGHTS BODY SEARCHES Only inpatients may be subjected to a body search. All body searches shall be conducted as follows: 1. A personal search of an inpatient may be conducted by any facility staff member: a. Before a patient leaves or enters the security enclosure of maximum security units; b. Before a patient is placed in seclusion; c. When there is documented reason to believe the patient has, on his or her person, objects or materials which threaten the safety or security of patients or other persons; or d. If, for security reasons, the facility routinely conducts personal searches of patients committed under ch. 971 or 975, Stats., patients residing in the maximum security facility at the Mendota mental health institute or a secure mental health unit or facility under s. 980.065, Stats., and persons transferred under s. 51.35(3) or 51.37, Stats.; 2. A strip search of an inpatient may be conducted: a. Only in a clean and private place; b. Except in an emergency, only by a person of	X9450		

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X9450	Continued From page 9 the same sex; c. Only when all less intrusive search procedures are deemed inadequate; and d. Only under circumstances specified under subd. 1. a. to c.; 3. A body cavity search of an inpatient may be conducted: a. Only in a clean and private place; b. Only by a physician and, whenever possible, by a physician of the same sex; c. Only when all less intrusive search procedures are deemed inadequate; and d. Only under circumstances specified under subd. 1. a. to c. This Rule is not met as evidenced by: Based on interview and record review, 6 of 6 patients were strip searched without a documented reason to justify that a personal search would not be sufficient. On 10/11/2022 the department received a complaint alleging that strip searches were conducted without prior patient knowledge and in a manner that was not comfortable for the patient. Findings include: As defined by DHS 94.02(33): "Personal search" means a search of the patient's person, including the patient's pockets, frisking his or her body, an examination of the patient's shoes and hat and a visual inspection of the patient's mouth.	X9450		

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X9450	Continued From page 10 As defined by DHS 94.02(43): "Strip search" means a search in which the patient is required to remove all of his or her clothing. Permissible inspection includes examination of the patient's clothing and body and visual inspection of his or her body cavities. During an interview on 10/19/2022 at 10:03 AM with Chief Nursing Officer (CNO) A, Surveyors asked about body searches done on admission. CNO A stated "Skin checks are done upon admission with two staff members in a private room. Patients are asked to remove their top for a contraband check, they put their top back on-then remove their bottoms for contraband check and then pull up; then staff check their feet. They have scrubs or sweats on at this time." Surveyors asked if patients remove their undergarments to full nudity and are touched by staff and buttocks separated, CNO A stated, "They are not asked to take their underpants off, they are asked to take their under-wire bra off if they have one on-they are asked to move undergarments over to look at buttocks, we never touch any orifice or separate the buttocks." During an interview with Director of Quality/Risk Management D on 10/19/2022 at 10:13 AM, Director D stated, "Skin checks are done in the seclusion bathroom, there are no cameras in there." During an interview with Mental Health Tech (MHT) G on 10/19/2022 at 11:59 AM, MHT G stated, "[Searches are done with] 2 people, if they [the patients] have on undergarments they take them off too." Patient 1 voluntarily transferred to the facility from a medical hospital via ambulance following an	X9450		

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X9450	Continued From page 11	X9450		

overnight stay for medical clearance. Patient 1's record indicated the patients had been searched upon admission. The facility's search of Patient 1 met the definition of a strip search in s. DHS 94.02(43).

Patient 2 voluntarily admitted self. Patient 2's record indicated the patients had been searched upon admission. The facility's search of Patient 2 met the definition of a strip search in s. DHS 94.02(43).

Patient 3 voluntarily admitted self. Patient 3's record indicated the patients had been searched upon admission. The facility's search of Patient 3 met the definition of a strip search in s. DHS 94.02(43).

Patient 4 was voluntarily transferred to the facility from a medical hospital via ambulance following an overnight stay for medical clearance with law enforcement present. Patient 4's record indicated the patients had been searched upon admission. The facility's search of Patient 4 met the definition of a strip search in s. DHS 94.02(43).

Patient 5 voluntarily transferred to the facility from a medical hospital via ambulance following an overnight stay for medical clearance. Patient 5's record indicated the patients had been searched upon admission. The facility's search of Patient 5 met the definition of a strip search in s. DHS 94.02(43).

Patient 6 voluntarily transferred to the facility from a medical hospital via ambulance following an overnight stay for medical clearance. Patient 6's record indicated the patients had been searched upon admission. The facility's search of Patient 6 met the definition of a strip search in s. DHS

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X9450	Continued From page 12 94.02(43). Patient 1-6's records did not contain any additional documentation to justify the need for a strip search.	X9450		