Report 19-14
August 2019

Wisconsin Veterans Home at King: Investigations of Incident Reports and Complaints

Conducted by the Department of Health Services from 2012 through 2016

State of Wisconsin



Legislative Audit Bureau

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Joe Chrisman
State Auditor

August 28, 2019

Senator Robert Cowles and
Representative Samantha Kerkman, Co-chairpersons
Joint Legislative Audit Committee
State Capitol
Madison, Wisconsin 53702

Dear Senator Cowles and Representative Kerkman:

In August 2017, we released an evaluation (report 17-14) of the Wisconsin Veterans Home at King (King) without including information related to incident reports and complaints that the Wisconsin Department of Health Services (DHS) investigated. In 2017, DHS indicated that it could not provide us with such information because it acts on behalf of the federal government when conducting investigations of King, which is overseen by the Wisconsin Department of Veterans Affairs (DVA).

In March 2017, we submitted a Freedom of Information Act request to the federal Centers for Medicare & Medicaid Services for data on such investigations of King. In February 2019, nearly two years later, we were provided information in the form of partially redacted paper reports.

We analyzed the information we were provided in 2019, which is limited to only the incident reports and complaints investigated by DHS from 2012 through 2016. Our analyses may now be considered in conjunction with information in report 17-14 for the same time period, including citations DHS issued to King as a result of routine inspections, citations the federal Department of Veterans Affairs issued to King, complaints made to King, complaints made to the Long Term Care Ombudsman program, and complaints made directly to the Legislative Audit Bureau. We performed no other audit work related to report 17-14 since it was issued.

According to the information we were provided in 2019, DHS conducted a total of 90 investigations based on incident reports and complaints that it received from 2012 through 2016 involving the four skilled nursing facilities at King. Most of these investigations involved allegations of resident abuse (41.1 percent) or the quality of care (32.2 percent). DHS substantiated allegations in 40 of the 90 investigations (44.4 percent) it conducted. DHS issued 22 citations to address deficient King practices or policies that it had identified in 11 investigations.

A response from the DVA Secretary follows the Appendix.

Respectfully submitted,

Joe Chrisman
State Auditor

JC/DS/ss

Investigations Conducted by the Department of Health Services ■

The Wisconsin Veterans Home at King (King), which opened in 1887 and is located in Waupaca County, is operated by the Wisconsin Department of Veterans Affairs (DVA). King provides nursing care to eligible veterans and their spouses, including surviving spouses. In 2016, King provided nursing care to an average of 685 veterans and their spouses each day.

The Department of Health Services (DHS) separately licenses each of King's four residence halls as skilled nursing facilities, including:

- Ainsworth Hall, which had 205 licensed beds;
- Olson Hall, which had 200 licensed beds;
- Stordock Hall, which had 200 licensed beds; and
- MacArthur Hall, which had 116 licensed beds.

Of the 205 licensed beds in Ainsworth Hall, 99 beds (48.3 percent) were located within two secured units for providing memory care services to residents with Alzheimer's disease, dementia, and other types of memory issues. However, not all residents requiring memory care services resided within these secured units. DVA indicated that it prioritized placing residents in the least-restrictive care setting available and allowed them to "age in place." This practice allowed residents to make one move into a residence hall where they received a continuity of care in a familiar, personal environment for the remainder of their time at King.

DHS conducts unannounced routine inspections to ensure compliance with state requirements, as well as with federal requirements on behalf of the federal Centers for Medicare & Medicaid Services (CMS). We included information about these routine inspections in our evaluation of King, which we published as report 17-14 in August 2017.

DHS may also conduct unannounced investigations based on complaints it receives directly and on certain incidents that King is required to report to it, such as allegations of resident abuse and neglect, misappropriation of resident property, or injuries of unknown origin. We did not include information about such investigations in report 17-14. DHS indicated in 2017 that it could not provide us with this information because it acts on behalf of the federal government when conducting investigations of King.

In March 2017, we submitted a Freedom of Information Act request to CMS for data on such investigations of King from 2012 through 2016. In February 2019, nearly two years later, we were provided information in the form of partially redacted paper reports.

Our analyses of the information we were provided in 2019 is limited to only the incident reports and complaints investigated by DHS from 2012 through 2016. These analyses may now be considered in conjunction with other information we presented in report 17-14 for the same time period, including:

- citations DHS issued to King during routine inspections;
- citations the federal Department of Veterans Affairs issued to King;
- complaints made to King;
- complaints made to the Long Term Care Ombudsman program; and
- complaints made directly to the Legislative Audit Bureau.

We performed no other audit work related to report 17-14 since it was issued in August 2017.

Investigating Incident Reports and Complaints

DHS conducted 90 investigations based on incident reports and complaints that it received from 2012 through 2016 involving King.

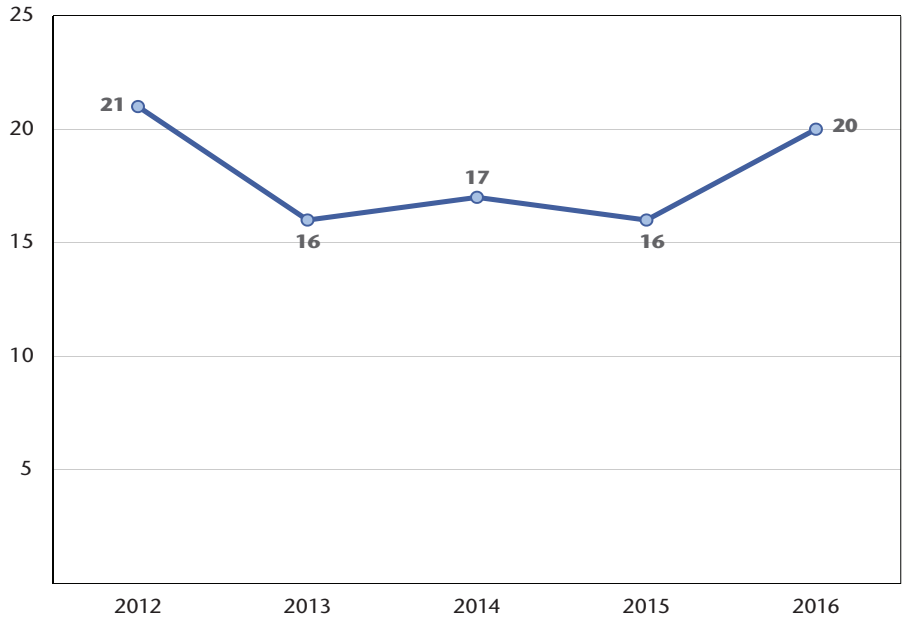
According to the information we were provided in 2019, DHS conducted 90 investigations based on incident reports and complaints that it received over the five-year period from 2012 through 2016 involving King. DHS conducted:

- 29 investigations that pertained to Ainsworth Hall;
- 29 investigations that pertained to Olson Hall;
- 18 investigations that pertained to Stordock Hall; and
- 14 investigations that pertained to MacArthur Hall.

As shown in Figure 1, the number of investigations ranged from a high of 21 in 2012 to a low of 16 in both 2013 and 2015.

Figure 1

DHS Investigations of Incident Reports and Complaints Involving King[1]



[1] Based on the year that DHS received an incident report or complaint.

Most of the 90 investigations conducted by DHS involved allegations of resident abuse or the quality of care.

As shown in Table 1, most of the 90 investigations conducted by DHS involved allegations of resident abuse (41.1 percent) or the quality of care (32.2 percent). Resident abuse was allegedly committed by other residents and King employees. Allegations about the quality of care were diverse and included concerns such as a failure to use proper procedures when transferring a resident from a bed to a wheelchair, inconsistency of resident care because of high turnover among certified nursing assistants, and delayed follow-up on a doctor's written orders. The Appendix shows the number of incident reports and complaints pertaining to each of the four residence halls at King.

Table 1

Incident Reports and Complaints Investigated by DHS, by Type of Allegation
2012 through 2016[1]

Type of Allegation	Incident Reports	Complaints	Total	Percentage of Total
Resident Abuse	36	1	37	41.1%
Quality of Care	15	14	29	32.2
Accidents	5	1	6	6.7
Resident Neglect	3	1	4	4.5
Resident Services[2]	1	3	4	4.5
Death of Resident	2	1	3	3.3
Misappropriation of Property	3	–	3	3.3
Physical Environment	–	2	2	2.2
Quality of Life	1	–	1	1.1
Resident Rights	–	1	1	1.1
Total	**66**	**24**	**90**	**100.0%**

[1] Based on the year that DHS received an incident report or complaint.

[2] Includes pharmaceutical services, rehabilitation services, and "other services."

Of the 90 investigations, DHS initially determined that:

- 46 (51.1 percent) involved alleged noncompliance with one or more requirements that may cause limited harm and do not significantly impair a resident's mental, physical, or psychosocial status;

- 23 (25.6 percent) involved alleged noncompliance with one or more requirements that may harm a resident's mental, physical, or psychosocial status and are significant enough that a rapid response is indicated; and

- 21 (23.3 percent) involved the potential for immediate jeopardy, which means that there is the potential for serious injury, harm, impairment, or death of a resident and that there continues to be an immediate risk unless immediate corrective action is taken.

During an investigation, DHS determines whether an allegation can be substantiated by the available evidence. When an allegation is substantiated, DHS determines whether the actions and policies of the skilled nursing facility were deficient and, if so, issues citations for failure to comply with applicable rules and regulations.

DHS substantiated allegations in 40 of the 90 investigations (44.4 percent) it conducted.

As shown in Table 2, DHS substantiated allegations in 40 of the 90 investigations (44.4 percent) it conducted as a result of incident reports and complaints it received from 2012 through 2016. DHS identified deficient practices or policies by King as the cause for 11 of the 40 substantiated allegations, and it issued citations of federal deficiencies. DHS did not substantiate allegations in 47 investigations because of insufficient evidence to confirm that the alleged events occurred and in 3 investigations because it concluded that the alleged events did not occur. The Appendix shows the number of allegations pertaining to each of the four residence halls at King.

Table 2

Findings of DHS Investigations of Incident Reports and Complaints, by Type of Allegation
2012 through 2016[1]

Type of Allegation	Allegations Substantiated		Allegations Not Substantiated		Percentage Substantiated
	Federal Deficiencies Cited	No Federal Deficiencies Cited	Insufficient Evidence	Alleged Events Did Not Occur	
Resident Abuse	5	13	19	–	48.6%
Quality of Care	3	10	15	1	44.8
Accidents	–	4	2	–	66.7
Resident Neglect	–	2	1	1	50.0
Resident Services[2]	1	–	3	–	25.0
Death of Resident	2	–	–	1	66.7
Misappropriation of Property	–	–	3	–	0.0
Physical Environment	–	–	2	–	0.0
Quality of Life	–	–	1	–	0.0
Resident Rights	–	–	1	–	0.0
Total	**11**	**29**	**47**	**3**	44.4

[1] Based on the year that DHS received an incident report or complaint.

[2] Includes pharmaceutical services, rehabilitation services, and "other services."

We reviewed allegations of resident abuse more closely because they were the most-common type of allegation, and DHS conducted 37 of the 90 investigations as a result of them. CMS guidelines categorize abuse into three types:

- physical abuse, which includes actions such as hitting, slapping, punching, biting, kicking, and any type of corporal punishment;
- sexual abuse, which includes actions such as unwanted intimate touching, forced observation of sexual activity or pornography, and all types of sexual assault; and
- mental/verbal abuse, which is the use of verbal or nonverbal actions that cause or have the potential to cause a resident to experience humiliation, intimidation, fear, shame, agitation, or degradation, such as harassment, mocking, yelling, and threatening.

As shown in Table 3, 18 of 37 investigations (48.6 percent) conducted by DHS involved allegations of residents abusing other residents, including 11 investigations (29.7 percent) involving allegations of sexual abuse. In addition:

- 13 investigations (35.1 percent) involved allegations of King employees abusing residents; and
- 6 investigations (16.2 percent) involved allegations of unknown perpetrators.

Fourteen of the 18 substantiated allegations (77.8 percent) involved residents abusing other residents.

Table 3

DHS Investigations of Incident Reports and Complaints Related to Resident Abuse, by Type of Allegation
2012 through 2016[1]

Type of Allegation	Allegations Substantiated		Allegations Not Substantiated[2]	Total
	Federal Deficiencies Cited	No Federal Deficiencies Cited		
Committed by Another Resident				
Sexual Abuse	2	7	2	11
Physical Abuse	1	3	2	6
Mental/Verbal Abuse	–	1	–	1
Subtotal				18
Committed by a King Employee				
Mental/Verbal Abuse	1	–	4	5
Physical Abuse	1	1	2	4
Sexual Abuse	–	–	4	4
Subtotal				13
Committed by an Unknown Perpetrator				
Sexual Abuse	–	1	5	6
Total	**5**	**13**	**19**	**37**

[1] Based on the year that DHS received an incident report or complaint.

[2] There was insufficient evidence to confirm that the events occurred.

Citations Issued to King

As indicated in report 17-14, DHS issued a total of 184 citations to King from 2012 through 2016. King's four residence halls averaged 9.2 citations per year during this period, which was less than the average number of citations DHS issued to other Wisconsin Veterans Homes, to other skilled nursing facilities in DHS's Northeastern Region with 100 or more licensed beds, or to all skilled nursing facilities statewide.

From 2012 through 2016, 22 of the 184 citations DHS issued to King resulted from incident reports and complaints.

The 184 citations issued to King included 162 citations (88.0 percent) issued as a result of routine inspections and 22 citations (12.0 percent) issued as a result of incident reports and complaints investigated by DHS. These 22 citations resulted from 11 investigations in which DHS identified deficient King practices or policies.

As shown in Table 4, DHS issued 8 of the 22 citations as a result of investigations pertaining to Stordock Hall, which was the most citations among the four residence halls. DHS issued 4 of the 22 citations as a result of investigations pertaining to Olson Hall, which was the least citations among the four resident halls.

Table 4

Citations Issued by DHS for Incident Reports and Complaints Investigated, by Residence Hall
2012 through 2016

Residence Hall	Licensed Beds	Incident Reports and Complaints Investigated	Citations Issued	Percentage of Total Citations Issued
Stordock Hall	200	18	8	36.4%
Ainsworth Hall	205	29	5	22.7
MacArthur Hall	116	14	5	22.7
Olson Hall	200	29	4	18.2
Total	**721**	**90**	**22**	**100.0%**

DHS grouped the 22 citations into seven broad categories. It issued:

- 8 citations (36.4 percent) for freedom from restraints and abuse standards, which include prohibitions against employing individuals who have abused residents and requirements for investigating all alleged resident abuse;

- 7 citations (31.8 percent) for quality of care standards, such as prevention of pressure sores, which promote resident well-being;

- 3 citations (13.6 percent) for resident services standards, which include development of a comprehensive care plan for each resident and supervision of each resident's medical care by a physician;

- 2 citations (9.1 percent) for administrative standards, which include maintaining complete, readily accessible clinical records on each resident; and

- 2 citations (9.1 percent) for resident rights standards, which include the right to self-administer drugs and the right to send and promptly receive mail that is unopened.

None of the 22 citations was for life safety code standards, which establish standards for fire prevention and other building safety requirements, or quality of life standards, which include providing a pleasant, homelike atmosphere and food that is palatable, attractive, and served at the proper temperature.

DHS also grouped citations by scope and severity. Since December 2011, and as required by 2011 Wisconsin Act 70, DHS no longer issues citations under state law if it issues a federal citation for the same violation for which it would have also issued a state citation. All 184 citations DHS issued to King from 2012 through 2016 were federal citations. The federal citations issued by DHS were grouped into three categories based on their scope and severity:

- "substandard quality of care," which includes the most severe or widespread violations of certain regulations, such as incidents resulting in serious harm to residents;

- "noncompliance," which includes isolated incidents resulting in actual harm to residents and incidents resulting in no actual harm to residents but having the potential for more than minimal harm; and

- "substantial compliance," which includes incidents resulting in no actual harm to residents but having the potential for minimal harm.

From 2012 through 2016, only 1 of the 22 citations issued as a result of incident reports and complaints investigated by DHS was an "immediate jeopardy" citation.

From 2012 through 2016, only 1 of the 22 citations issued as a result of incident reports and complaints investigated by DHS was for King providing a "substandard quality of care." This citation was further classified as "immediate jeopardy," which means a deficient practice caused or was likely to cause serious harm or death to a resident and required immediate corrective action. The "immediate jeopardy" citation was issued to Olson Hall because King employees did not provide cardiopulmonary resuscitation or arrange for emergency transportation for a 94-year-old resident who was found not breathing and without a pulse. The remaining 21 citations were for "noncompliance."

■ ■ ■ ■

Appendix ■

Appendix

Findings of DHS Investigations of Incident Reports and Complaints, by Residence Hall

2012 through 2016[1]

Residence Hall	Licensed Beds	DHS Investigations Based On:			Allegations		
		Incident Reports	Complaints	Total	Substantiated	Not Substantiated	Total
Ainsworth	205	28	1	29	15	14	29
Olson	200	19	10	29	8	21	29
Stordock	200	11	7	18	11	7	18
MacArthur	116	8	6	14	6	8	14
Total	**721**	**66**	**24**	**90**	**40**	**50**	**90**

[1] Based on the year that DHS received an incident report or complaint.

Response ■

Wisconsin Department of Veterans Affairs

Tony Evers, Governor | Mary M. Kolar, Secretary

August 23, 2019

Mr. Joe Chrisman, State Auditor
Legislative Audit Bureau
22 E. Mifflin Street, Suite 500
Madison, WI 53703

Dear Director Chrisman,

Thank you for the opportunity to comment on the supplement to Report 17-14, now reported by the Legislative Audit Bureau as the result of fulfillment earlier this year of a request made to the Centers for Medicare and Medicaid Services (CMS) in 2017.

While this supplement covers activities that occurred from 2012-2016, I have reviewed the information with an eye towards ensuring policy and other continuous improvements and am confident that policy changes have occurred that address the issues that arose during that time period.

Since my appointment in January, the department has renewed its focus on the operations of all the Veterans Homes, and particularly King. The agency's Division of Veterans Homes Administrator, a crucial oversight and management position, had been kept vacant for nearly two years until we filled the position in April 2019.

The federal Five-Star Quality Rating System objectively evaluates nursing homes to enable consumers to make informed comparisons regarding the quality of care delivered to patients living in the licensed nursing homes across the country.

As the Bureau noted in Report 17-14, from 2012 through 2016, "on average, the Department of Health Services (DHS) issued King fewer citations for violations of federal nursing home regulations than it issued to other skilled nursing facilities in Wisconsin." (Report 17-14, page 4.) This is significant because King is comprised of four separately licensed facilities that in totality, as a campus, are one of the largest veterans skilled nursing homes in the country.

While the data you evaluate is from several years ago, the department is proud of King's ratings. Currently, all four of King's homes exceed local and state averages in Overall Quality as determined by this federal rating system. All four licensed skilled nursing facilities at King are rated above average by CMS, with Ainsworth, MacArthur, and Olson achieving ratings at the highest, 5-star, rating, and Stordock above average at 4 stars.

Sincerely,

Mary M. Kolar
Secretary-designee

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