Report 19-14
August 2019

STATE OF WISCONSIN
Legislative Audit Bureau
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BRIEFING SHEET

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

Conducted by the Department of Health Services from 2012 through 2016

Background

The Department of Veterans Affairs operates the Wisconsin Veterans Home at King (King). The Department of Health Services (DHS) may conduct unannounced investigations based on complaints it receives and on certain incidents that King is required to report to it. We did not include information about such investigations in our evaluation of King (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 the federal Centers for Medicare & Medicaid Services 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. We analyzed the information we were provided in 2019 but performed no other audit work related to report 17-14.

Key Findings

We found:

- 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, according to information we were provided. 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.