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State Of Wisconsin
Before The Nursing Home Administrator Board

In The Matter Of Disciplinary Proceedings Against	:	
	:	FINAL DECISION AND ORDER
MARK C. RADMER, Respondent	:	LS0406174NHA

Division of Enforcement Case #00 NHA 002

The parties to this action for the purposes of Wis. Stats. §. 227.53 are:

Mark C. Radmer
3403 Mediterranean Avenue
West Bend, WI 53090

Wisconsin Nursing Home Administrator Board
P. O. Box 8935
Madison, WI 53708-8935

Department of Regulation and Licensing
Division of Enforcement
P. O. Box 8935
Madison, WI 53708-8935

The Wisconsin Nursing Home Administrator Board received a Stipulation submitted by the parties to the above-captioned matter. The Stipulation, a copy of which is attached hereto, was executed Mark C. Radmer personally and by his attorney, Burton A. Wagner, and by Claudia Berry Miran, attorney for the Department of Regulation and Licensing, Division of Enforcement. Based upon the Stipulation of the parties, the Wisconsin Nursing Home Administrator Board makes the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Mark C. Radmer was born January 28, 1970. Mr. Radmer's latest address on file with the Department of Regulation and Licensing is 3403 Mediterranean Avenue, West Bend, WI 53090.

2. Mr. Radmer is licensed to practice in the state of Wisconsin as a nursing home administrator pursuant to license #2959. This license was first granted on June 16, 2000, and is current through June 30, 2004.

3. Mr. Radmer was administrator for Northwest Health Care Center located in Milwaukee, WI, from December 30, 1997, through July 27, 1999.

4. Sometime after August 4, 1999, Northwest Health Care Center self-reported a resident death to the Bureau of Quality Assurance (BQA). On or about August 26, 1999, BQA performed an announced complaint survey, and followed up with a revisit survey on September 8, 1999. In the September 8, 2003, survey, BQA made a finding of immediate jeopardy because the facility did not provide adequate supervision and assistance devices to prevent accidents in 26 of 26 residents who use side rails.

5. BQA determined the facility used side rails not specifically manufactured for the beds which left a 10 and 7/8" gap between the headboards and the top end of the side rail. The gap created a danger whereby residents could become entrapped.

6. On August 4, 1999, a cognitively impaired resident with a history of moving about in bed was found pulseless and not

breathing with his head resting on the floor between the dresser and bed and his feet tangled in the side rail. The resident had attempted to exit his bed between the side rail and headboard and became entrapped.

7. Even though Radmer had left the employ of Northwest Health Care Center on July 27, 1999, the BQA survey found that appropriate systems were not in place during the time Radmer was the administrator to ensure that the facility was administered in manner that enabled it to effectively and efficiently use its resources to attain or maintain the highest practicable well-being of each resident. BQA found the following systems problems:

- Caring for resident's pressure sores, lack of turning and repositioning and failure to follow physician's orders.
- Facility did not weigh residents as ordered and did not provide residents with ordered diets and supplements.
- No resident assessments regarding the side rails.
- The administrative staff had not conducted quality assurance activities since November of 1998. On September 1, 1999, there was no currently functioning quality assurance committee and BQA surveyors were not able to locate quality assurance material for the previous administration.
- BQA surveyors were not able to locate in-service records and current performance evaluations for staff kept by the previous administration.
- The facility did not complete a performance review of every nurse aide at least once every 12 months and did not provide regular in-service education.
- There was no evidence that the facility had a system in place to verify that nurse aides were certified to work in a federally certified nursing home.

CONCLUSIONS OF LAW

1. The Nursing Home Administrator Board has jurisdiction in this matter pursuant to § 456.10, Stats.

2. The Nursing Home Administrator Board has authority to enter into this stipulated resolution without an evidentiary hearing pursuant to § 227.44 (5), Stats.

3. Respondent **Mark C. Radmer** has violated Wis. Admin. Code § NHA 5.02(1), (2) and (6), by violating in a negligent manner, by an act or acts of omission or commission, a law substantially relating to the practice of nursing home administration and by engaging in any practice as a nursing home administrator which constitutes a substantial danger to the health, welfare, or safety of patient or public.

ORDER

NOW, THEREFORE, IT IS ORDERED that the stipulation of the parties is approved.

IT IS FURTHER ORDERED that the license of **Mark C. Radmer** (license # 65 2959) to practice as a Nursing Home Administrator in the State of Wisconsin **SHALL BE LIMITED** AS FOLLOWS:

Practice Limitations

1. Within thirty (30) days from the effective date of this Order, Mr. Radmer shall be mentored by another licensee acceptable to the Board. Thereafter, and until otherwise ordered by the Board, Respondent shall also practice only under the supervision of a designated professional approved by the Board.

2. The mentor shall be the individual responsible for supervision of Respondent's responsibilities as a nursing home administrator for one year. Supervision shall include weekly review of duties preformed by the Respondent, monthly

meetings, and any other actions deemed appropriate by the mentor to determine that Respondent is practicing in a professional and competent manner.

a. The mentor may designate another qualified person acceptable to the Board to exercise the duties and responsibilities of the mentor in an absence of more than three weeks.

b. In the event that the mentor is unable or unwilling to continue to serve as Respondent's mentor, the Board may in its sole discretion select a successor mentor.

Reporting

3. Respondent shall arrange for both his mentor and his immediate supervisor to provide formal written reports to the Department Monitor in the Department of Regulation and Licensing, Division of Enforcement, PO Box 8935, Madison, Wisconsin 53708-8935 on a quarterly basis, as directed by the Department Monitor. These reports shall assess Respondent's work performance.

4. Respondent's mentor or immediate supervisor shall immediately report to the Department Monitor any conduct or condition of the Respondent which may constitute unprofessional conduct, a violation of this Order, or a danger to the public or patients.

5. It is the responsibility of Respondent to promptly notify the Department Monitor of any suspected violations of any of the terms and conditions of this Order, including any failures of the mentor or immediate supervisor to conform to the terms and conditions of this Order.

6. Respondent shall report to the Board any change of employment status, residence, address or telephone number within five (5) days of the date of a change.

Summary Suspension

7. If the Board determines that there is probable cause to believe that Respondent has violated any term of this Final Decision and Order, the Board may, pursuant to §456.10, Wis. Stats., order that the license of Respondent be summarily suspended pending investigation of the alleged violation.

Costs

8. Respondent shall be responsible for all costs incurred in his compliance with the terms of this Order.

IT IS FURTHER ORDERED, that file # 00 NHA 002 is hereby closed.

Dated this 17th day of June, 2004.

WISCONSIN NURSING HOME ADMINISTRATOR EXAMINING BOARD

Jerry Schallock
A Member of the Board