WISCONSIN DEPARTMENT OF REGULATION & LICENSING

Wisconsin Department of Regulation & Licensing
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Regulation & Licensing website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Regulation and Licensing from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Regulation and Licensing data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Regulation and Licensing, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Regulation and Licensing is shown on the Department's Web Site under "License Lookup." The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca .
- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DRL website: An individual who believes that information on the website is inaccurate may contact the webmaster at web@drl.state.wi.gov

STATE OF WISCONSIN
BEFORE THE NURSING HOME ADMINISTRATOR EXAMINING BOARD

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	**FINAL DECISION AND ORDER**
SCOTT L. MYERS,	:	LS0708093NHA RESPONDENT. :

Division of Enforcement Case #06 NHA 25

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

Scott L. Myers
W282 Madison Ave.
Oconomowoc, WI 53066

Wisconsin Nursing Home Administrator Examining 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

PROCEDURAL HISTORY

The parties in this matter agree to the terms and conditions of the attached Stipulation as the final decision of this matter, subject to the approval of the Board. The Board has reviewed this Stipulation and considers it acceptable.

Accordingly, the Board in this matter adopts the attached Stipulation and makes the following:

FINDINGS OF FACT

1. Scott L. Myers (D.O.B. 8/18/63) is duly licensed in the state of Wisconsin as a nursing home administrator (license # 3125). This license was first granted on 9/26/00. From February, 2003, through May, 2006, Respondent was the administrator of the Columbus Rehabilitation and Nursing Center, Columbus, Wisconsin, where all of the events described below took place.

2. In July, 2005, the Medicare program implemented a new form for use when benefits were exhausted and thus would be denied. This new form contained required information regarding the appeal process, which the former version did not have, and the use of this new form was made mandatory immediately. Notwithstanding this requirement, Respondent's facility issued a notice to resident M.J., on 2/3/06, that she had exhausted her benefits, on the obsolete version of the form. An attempted review of other cases to determine if the obsolete form had been used, resulted in the DHFS-BQA surveyor being told by Respondent that Respondent was unable to locate the requested information.

3. On eight occasions, resident G.N., who suffered from an organic brain syndrome and cerebrovascular disease, struck other residents without apparent reason, within a seven month period following his admission in July, 2005. There is no evidence that the facility developed any plan to deal with this behavior. When the DHFS-BQA surveyor requested information on what the facility had done to deal with the resident's behavior, Respondent was unable to provide any information.

4. An inspection by DHFS-BQA staff showed that all of the facility's Certified Nursing Assistants had failed to meet the required 12 hour in-service training requirements for the year 2005.

5. On 4/5/05, resident C.F. was admitted to the facility with a high risk of fall assessment. On 12/2/05, the patient fell twice, but no incident reports could be located. The patient climbed out of bed on 1/23/06; no incident report could be located. On 2/6/06, the resident fell out of bed; the incident report states that the bed alarm had not sounded, although it had apparently been activated. There is no indication that any steps were taken to deal with the non-working alarm; Respondent personally signed the incident report. On 2/7/06, the resident again fell out of bed and was sent to the hospital on 2/8/06; a hip fracture was diagnosed and treated. The incident report for the 2/7/06 fall again stated that the bed alarm was not working properly; there is no indication that steps were taken to repair or replace the equipment.

6. In March and April, 2006, surveyors from the DHFS-BQA noted six incidents of injuries of unknown origin to residents of the facility. In none of these cases could incident reports be located.

7. Since the above incidents, Respondent has taken and successfully completed 8 credit hours of continuing education in the area of supervision and management of staff, including methods of assuring that policies and procedures are followed. The course of study was pre-approved by the Case Advisor in this matter.

CONCLUSION OF LAW

By the conduct described in pars. 2-6, above, respondent is subject to disciplinary action against his license to practice as a nursing home administrator in the state of Wisconsin, pursuant to Wis. Stats. §456.10(1)(b), (bm), and (d), and Wis. Adm. Code §§ NHA 5.02(2) and (6).

ORDER

NOW, THEREFORE, IT IS HEREBY ORDERED that Scott L. Myers is REPRIMANDED for his unprofessional conduct in this matter.

IT IS FURTHER ORDERED that respondent shall pay the costs of investigating and prosecuting this matter, in the amount of $600, within 90 days of this Order.

WISCONSIN NURSING HOME ADMINISTRATOR EXAMINING BOARD

By: David Egan
A Member of the Board

August 9, 2007
Date