STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	524041	A. BUILDING _____ B. WING _____	C 02/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILLOW CREEK BEHAVIORAL HEALTH	**1351 ONTARIO RD GREEN BAY, WI 54311**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
A 000	INITIAL COMMENTS An unannounced onsite federally authorized complaint investigation of complaint #WI 00036673 was completed at Willow Creek Behavioral Health in Green Bay, Wisconsin on 2/06/2020 through 2/10/2020. The hospital was found to be in substantial compliance with Medicare Conditions of Participation 42 CFR 482 for Hospitals. Complaint #WI00036673 was unsubstantiated with standard citations issued.	A 000		
A 131	PATIENT RIGHTS: INFORMED CONSENT CFR(s): 482.13(b)(2) The patient or his or her representative (as allowed under State law) has the right to make informed decisions regarding his or her care. The patient's rights include being informed of his or her health status, being involved in care planning and treatment, and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate. This STANDARD is not met as evidenced by: Based on interview, the facility failed to inform patients of their rights by failing to disclose to their patients that there is not a medical doctor (MD) or doctor of osteopathic medicine (DO) present in the hospital at all times. Findings include: On 2/08/2020 at 4:17 PM during interview with Director of Quality Director H, Quality Director H	A 131		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 02/10/2020

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A 131	Continued From page 1 stated the physicians work clinic hours and there was not a physician at this facility 24 hours a day, 7 days a week. Quality Director H confirmed patients did not get written notice that the hospital did not have a physician at this facility at all times.	A 131		
A 286	PATIENT SAFETY CFR(s): 482.21(a), (c)(2), (e)(3) (a) Standard: Program Scope (1) The program must include, but not be limited to, an ongoing program that shows measurable improvement in indicators for which there is evidence that it will ... identify and reduce medical errors. (2) The hospital must measure, analyze, and track ...adverse patient events ... (c) Program Activities ..... (2) Performance improvement activities must track medical errors and adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospital. (e) Executive Responsibilities, The hospital's governing body (or organized group or individual who assumes full legal authority and responsibility for operations of the hospital), medical staff, and administrative officials are responsible and accountable for ensuring the following: ... (3) That clear expectations for safety are established. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure an ongoing program that shows measurable improvement to identify and reduce medication errors in one of one Quality Performance Plans.	A 286		

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A 286	Continued From page 2	A 286		

Findings include:

Review of "Medication Discrepancies and Medication Errors" policy #1700.30 reviewed date 1/2020, #4 revealed "Medication Variance (Incident) reports shall be reviewed ... and acted upon as appropriate."

Review of record titled "List of Performance Indicators & Scope of Services" for 2020 did not list the Pharmacy Department or medication variances.

Review of "QUALITY/PERFORMANCE IMPROVEMENT REPORT" dated December 19, revealed indicators collected for the Pharmacy Department included "Medication Error Rate%(calculated based on total doses dispensed) between 0.013 and 0.057, Adverse drug reaction rate (calculated based on total doses dispensed) between 0 and 0.0532 and "Medication error rate attributed to pharmacy error" 0.006 and 0, all were below their standard of "5" and threshold of "6" requiring continued follow-up.

On 2/06/2020 at 3:07 PM during interview with Quality Director H, Quality Director H stated that the standards and thresholds for the pharmacy indicators are "corporate decisions". Director H stated that when there was nothing that was above the standard or threshold, no further performance improvement with these indicators was done "at this time."

On 2/06/2020 at 3:13 PM during interview with Pharmacy Director J, Pharmacist J stated variance numbers are collected and given to

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A 286	Continued From page 3 Quality Director H . Pharmacist J confirmed his follow-up of the medication incident reports was complete once these monthly variance numbers were reported to H.	A 286		