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 12/20/2017

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 on-site Complaint investigation was conducted at Willow Creek Behavioral Health in Green Bay, WI from 12/18/2017-12/20/2017 for complaint #WI00031424. Willow Creek Behavioral Health was found to be in substantial compliance with Medicare Conditions of Participation for Hospitals, 42 CFR 482. Citations are issued at a standard level or below. Complaint #WI00031424 is substantiated, however the citations are not related to the complaint.	A 000		
A 396	NURSING CARE PLAN CFR(s): 482.23(b)(4) The hospital must ensure that the nursing staff develops, and keeps current, a nursing care plan for each patient. The nursing care plan may be part of an interdisciplinary care plan This STANDARD is not met as evidenced by: Based on record review and interview, staff at this facility failed to develop and/or update patient treatment plans related to falls in 3 out of 9 patients identified to be at risk for falls (Patient #4, 7, and 9), and failed to develop a goal for wound management in 1 of 1 patients identified to have an open draining wound on admission (Patient #5). Findings include: The facility's policy titled, "Fall Risk Precautions," #1000.51, dated 10/01/2016, was reviewed on 12/18/2017 at 12:59 PM. The policy does not indicate that patient's at risk for falls should have a falls problem, goals, and interventions added to	A 396		

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

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A 396	Continued From page 1	A 396		

their treatment plan. Per interview with Director of Nursing A on 12/18/2017 2:54 PM regarding treatment plans and falls, Director A stated that patients identified to have a moderate to high risk for falls should have a problem opened up in their treatment plan for them.

The facility's policy titled, "Treatment Plan Acute Inpatient," #1200.9, dated 10/1/2016, was reviewed on 12/19/ 2017 at 3:00 PM. The policy revealed in part, "Each patient admitted to the psychiatric unit shall have an individualized treatment plan which is based on interdisciplinary clinical assessments...The treatment planning process is continuous, beginning at the time of admission and continuing through discharge."

Falls:
Patient #9's closed medical record was reviewed on 12/18/2017 at 3:23 PM accompanied by Director of Nursing A who confirmed the following findings at the time of the record review: Patient #9 was admitted on 10/8/2017 and assessed to have a high risk for falls score of 26 on admission. There is no falls problem, goal or interventions identified in Patient #9's treatment plan. Per interview with Director A on 12/18/2017 at 3:23 PM, Director A stated, "No, there is no falls problem identified."

Patient #4's closed medical record was reviewed on 12/19/2017 at 8:02 AM accompanied by Director of Nursing A who confirmed the following findings at the time of the record review: Patient #4 was admitted on 11/14/2017 and was assessed to have a high risk for falls score of 24 on admission. A falls problem, goals and interventions were identified on the treatment

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A 396	Continued From page 2	A 396		

plan on 11/14/2017 and was updated on 11/15/2017 at 5:00 PM. Patient #4 had a fall on 11/15/2017 at 6:10 PM, 11/23/2017 at 12:30 PM and 11/23/2017 at 6:55 PM. There were no updates to the treatment plan after any of these falls to attempt to improve patient safety. Per interview with Director A on 12/19/2017 at 8:45 AM regarding Patient #4's interventions for falls, Director A stated, "We were continuing to use the interventions we have available to us." Director A stated that 1:1 observation status is primarily reserved for behavioral concerns, and not used for falls.

Patient #7's closed medical record was reviewed on 12/19/2017 at 10:12 AM accompanied by Director of Nursing A who confirmed the following findings at the time of the record review: Patient #7 was admitted on 11/7/2017 and assessed to have a falls risk score of 13 (low side of high risk). Patient #7's treatment plan has a falls problem identified with a start date of 11/7/2017, however there were no goals or intervention. Patient #7 had a fall on 11/14/2017 and the care plan was unchanged. Per interview with Director A on 12/19/2017 at 10:20 AM, Director A stated, "I was looking through the care plan last night and there were goals and interventions there, but now there are not." Review of the incident report filed on 11/14/2017 after Patient #7's fall, the previous risk manager identified that there was no falls treatment plan in place.

Wound:
Patient #5's closed medical record was reviewed on 12/19/2017 at 9:08 AM accompanied by Director of Nursing A who confirmed the following findings at the time of the record review: Patient #5 was admitted on 11/3/2017, and the nursing

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A 396	Continued From page 3 skin assessment on admission revealed that Patient #5 had a small skin tear on the anterior left leg that was leaking clear fluid. Patient #5 also had non-pitting edema and cellulitis (tissue inflammation) to both lower extremities. There are no goals or interventions related to Patient #5's draining wound on the treatment plan.	A 396		