STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	3168	A. BUILDING: _____ B. WING _____	C 07/20/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SBH GREEN BAY, LLC DBA WILLOW CREEK BEHAV	1351 ONTARIO RD GREEN BAY, WI 54311

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X 000	Initial Comments Between 07/15/2020 and 07/20/2020, 1 virtual complaint investigation was conducted (#38134). Willow Creek Behavioral Health holds certification under Wisconsin Administrative Codes: DHS 35 Mental Health Outpatient Clinic; DHS 61.79 Mental Health Adolescent Inpatient; DHS 61.71 Mental Health Inpatient; DHS 61.75 Mental Health Day Treatment; and DHS 40.11(2)(c) Mental Health Day Treatment for Children 3. Two client records were reviewed. The complaint was substantiated. One deficiency was identified. This was a joint survey with the hospital section.	X 000		
X1000	DHS 94.24(2)(a) Safe Physical Environment Staff shall take reasonable steps to ensure the physical safety of all patients. This Rule is not met as evidenced by: Based on closed record review, virtual facility tour, policy review, and staff interviews, the facility did not ensure staff took reasonable steps to provide for the physical safety of all patients (Clients 1 and 2) in the Assessment and Referral (A&R) Department when multiple patients were being assessed at the same time. Findings include: On 07/10/2020, the Department received a complaint that an adult and a juvenile were left without supervision in the A&R Department and the juvenile performed oral sex on the adult. Per closed record review by surveyor, Client 1 arrived at the A&R Department of Willow Creek Behavioral Health (WCBH) on 07/08/2020 at	X1000		

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

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approximately 2250 via law enforcement detained under a Statement of Emergency Detention and was placed in an assessment room. Client 1 had been admitted to WCBH before and the clinical record documented a history of Attention Deficit Hyperactivity Disorder (ADHD), Oppositional Defiant Disorder (ODD), and depression. Client 1 remained in the A&R Department to complete assessments and paperwork until being brought to the inpatient unit at 0038 on 07/09/2020.

Per closed record review by surveyor, Client 2 arrived at the A&R Department of WCBH on 07/08/2020 at approximately 2217 via law enforcement detained under a Statement of Emergency Detention and was placed in an assessment room. Client 2 was also previously admitted to WCBH and the clinical record documented a history of Schizophrenia, Schizoaffective Disorder, and Cannabis Dependence. Client 2 remained in the A&R Department to complete assessments and paperwork until being brought to the inpatient unit at 0020 on 07/09/2020.

Surveyors viewed the assessment rooms area of the A&R Department during a virtual tour conducted on 07/15/2020 at 1030.The assessment rooms are located in a hallway and are located 2 on each side of the hallway, basically across from each other. There was not a staff person monitoring the hallway during the virtual tour. The A&R Department also has a large workroom for staff to use while completing assessment and admission paperwork that is behind closed doors and not directly within view of the clients who are located inside individual rooms outside the staff workroom. This workroom includes the camera feed to a video screen for staff in the large workroom area to monitor clients

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in the A&R Department. There was not a staff person assigned to monitor the camera feed video screens during the virtual tour.

According to facility records reviewed by the surveyors, Client 1 and Client 2 first encounter each other at 2342 on 07/08/2020 as Client 2 returns to an assessment room and Client 1 exits an assessment room. The A&R Department completed 15 minute checks per policy. Client 1 and Client 2 were re-directed to remain in separate assessment rooms 5 times by different staff between 2303 on 07/08/2020 and 0013 on 07/09/2020. In addition, the A&R Department received 2 phone calls from an inpatient unit to inform of 2 incidents of suspicious movement observed on the camera feed by the unit Registered Nurse (RN) between Client 1 and Client 2. Facility records do not indicate any action taken by A&R Department staff from the time Client 1 and Client 2 first encounter each other until they are transferred to inpatient units to permanently separate both clients or to increase the supervision and/or monitoring of the assessment room area either using direct staff observation or observation via the camera feed video screens.

The facility records indicated contact described as "suspicious movements and gestures" between Client 1 and Client 2 in the A&R Department of WCBH at approximately 0014 on 07/09/2020. Staff at WCBH were alerted to the incident by a phone call from the parent of the Client 1 according to review of Client 1's clinical record that included a nursing progress note signed by the Unit RN at 0431 on 07/09/2020. There is no documentation that staff were aware before this. The phone call was received at approximately 0135 on 07/09/2020. The Green

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Bay Police Department was contacted at approximately 0145 on 07/09/2020. An officer responded and an investigation was started. Client 2 was discharged on 7/13/2020 to the police and charged with two counts of 2nd Degree Sexual Assault of a Child- a felony.

Review of facility policy and procedure 1300.10 titled "Staffing Plan for Provision of Care" stated on page 1 under Definition of Nursing Practice "Direct and indirect patient care services ensure the safety, comfort, personal hygiene, protection of patients and the performance of disease prevention and restorative measures by providing adequate nursing staff." On evening of 07/08/2020 and the early morning hours of 07/09/2020, the A&R Department did not have adequate staff supervision to ensure the safety of Client 1 and Client 2.

Review of facility policy and procedure 1800.30 titled "Application of Minor Patient Rights" stated on page 2, letter g "Minors will receive inpatient services in an area separated from adults receiving services." The A&R Department did not provide separate assessment areas for minors and adults.

On 7/16/2020 at 10:35am, surveyors interviewed Director of Admissions and Referral-A who stated that 15 minute checks are completed where staff physically look at the patients and document those checks on paper on patients when the patients are in the Admission and Referral area and the 15 minute checks are completed electronically once the patient is admitted. Director of Admissions and Referral-A stated that there are cameras located in the Admissions and

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Referral department and staff can see the patients. Director of Admissions and Referral-A verified that there is "no one person who watches the cameras" and that the units have access to the cameras in the Admissions and Referral department, however, s/he is unsure of what the unit staff have access to on the cameras. Regarding client 1 and client 2 on 7/8/20, Director of Admissions and Referral-A verified that clients 1 and 2 "did not listen to redirection" provided by staff. Director of Admissions and Referral-A stated the Admissions and Referral staff "could have called for extra staff but it didn't cross my mind honestly." Regarding clients 1 and 2 on 7/8/20, Director of Admissions and Referral-A stated s/he did not notice anything else unusual between clients 1 and 2 and that s/he did not assess client 2. Director of Admissions and Referral-A verified that the House Supervisor, RN (Registered Nurse) -B did receive a call from the unit about what unit staff had viewed on the camera between clients 1 and 2.

On 7/16/2020 at 11:01am, surveyors interviewed House Supervisor, RN-B who verified that s/he helped in the Admissions and Referral department to review paperwork for admissions. House Supervisor, RN-B stated on the night of 7/8/20, it was"extremely busy" in Admissions and Referral. House Supervisor, RN-B stated that RN-C called the unit to give report and the unit staff told her about "the pocket thing." House Supervisor, RN-B stated that originally, the unit called and said clients 1 and 2 were "slipping something in someone's pocket" and that staff said something to clients 1 and 2 and staff put clients 1 and 2 back in their Admissions and Referral rooms. House Supervisor, RN-B stated staff had clients 1 and 2 "empty their pockets." Regarding the sexual assault between clients 1

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and 2 which occurred, House Supervisor, RN-B indicated that "typically, a single person may act out, but (clients 1 and 2) kept talking to each other" and that "we could have had someone stand in the hallway." House Supervisor, RN-B verified that 15 minute checks were completed on client 1 by RN-C for client 2 and by Director of Admissions and Referral-A on client 1. House Supervisor, RN-B stated that there was a tv on the wall inside the Admission and Referral office showing the cameras and that staff "scan as we go" and that "we rely on the 15 minute checks." House Supervisor, RN-B verified that there was no one dedicated to watching the cameras only and that Admissions and Referral staff had "little time to watch the cameras that night as busy as it was." House Supervisor, RN-B stated that "staff have been pulled to do 1:1's in the past to watch patients" and that there weren't behavior indicators "at the moment" and that staff "should have tried to get someone over there." House Supervisor, RN-B stated that the incident between clients 1 and 2 was "told to the (unit) nurse and then back to me" how client 1 stated that client 2 "grabbed his hair and forced him to give oral sex." House Supervisor, RN-B stated "we were out there non-stop" and staff reviewed the camera recorded tapes and "saw two different incidents." House Supervisor, RN-B stated that there was "contact between clients 1 and 2 around 11:00pm and after midnight and that staff couldn't see exactly, but verified gestures... and that (client 1's) arm went into (client 2's) room." House Supervisor, RN-B stated that the second incident on camera, the staff could "definitely tell that something was going on" and the first incident, client 1's "arm went into the room." House Supervisor, RN-B verified that there are "blind spots if you're in the door area and it's hard to see" on camera.

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X1000	Continued From page 6 On 7/16/2020 at 11:02am, Director of Quality and Compliance-G stated that the blind spot "isn't necessarily a blind spot, if closing the door- it blocks the camera. (Client 2) put his body between the door and blocked the camera- (client 2) knew what he was doing, (client 2) was blocking the camera." On 7/16/2020 at 11:13am, surveyors interviewed RN-C stated that she was going to do the admission assessment on client 2 and verified that s/he completed the 15 minute check form on client 2. RN-C stated s/he called back to the unit asking the unit to come and get client 2 and the unit staff said that "one patient was giving the other patient something in a pocket." RN-C stated s/he reported that to House Supervisor, RN-B and Director of Admissions and Referral-A and Director of Admissions and Referral-A and Intake Coordinator- D walked out into the hallway and checked client 1's pockets and redirected both clients 1 and 2. RN-C stated frequent checks were being made due to "continual redirection" for clients 1 and 2. RN-C was asked about facility training on when patients are not redirectable and RN-C stated "redirect as we need to" and that clients 1 and 2 were "redirectable, but kept coming out of their rooms." On 7/16/2020 at 11:15am, Director of Quality Compliance-G stated "we didn't know about the incident (between clients 1 and 2) until after (client 1's) mother called" the facility. On 7/16/2020 at 11:23am, surveyors interviewed Intake Coordinator-D who stated that the evening of 7/8/20 was "high volume" in the Admissions and Referral department and that "at some point, RN-C got a call about (client 2) passing	X1000		

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something to (client 1) and Director of Admissions and Referral-A and I went out to (client 1) and checked pockets. (Client 1) was not wearing a shirt and came to us not wearing a shirt. (Clients 1 and 2) were told to stay in their rooms a couple of times and don't socialize between 11pm and 12am. I left at 12:30am." Intake Coordinator-D stated if patients are not following redirection given from staff "typically, we call the House Supervisor or Administrator On-Call and ask for further direction."

On 7/16/2020 at 11:40am, surveyors interviewed RN-E who works on the children's inpatient units and on 7/8/20 worked 6:00pm to 6:00am. RN-E stated s/he completed the admission for client 2 and went back to the children's unit to complete charting for client 2 there and client 1 was on the phone and client 1 told RN-E "that caused his distress." RN-E reported the information to RN-F who was the nurse for client 1, Admissions and Referral was notified, and RN-E stated s/he tried to "comfort (client 1) and tried to get client 1 to calm down." RN-E stated safety measures in place were a secured unit and 15 minute checks were completed. RN-E stated the police came for a DNA swab and we brought (client 1) to the Admissions and Referral department to see the police. RN-E stated there are cameras on the inpatient unit in the hallways, day room, and in the medication room and that the Admission and Referral department cameras were observed the night of 7/8/20 on the unit. RN-E stated that there are staff assigned to the cameras and that RN-E and RN-F observed clients 1 and 2 interacting on 7/8/20. RN-E stated RN-F spoke with Admissions and Referral staff and asked inpatient unit staff to "take clothes to (client 1)." RN-E stated that there were two incidents that were observed on camera on the inpatient unit from

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the cameras in Admissions and Referral- "the first incident there was no physical contact- they were talking" and the second incident, "(client 1) went to (client 2's) door and we called Admissions and Referral department staff." RN-E stated Director of Admissions and Referral-A came out of the office and "checked clients 1 and 2 and sent them back to their rooms." RN-E stated there was "no physical contact on the first incident and there was physical contact on the second incident" and that RN-F called up to Admissions and Referral department staff on two occasions where Admissions and Referral staff did respond. RN-E stated that RN-F spoke with client 1's mother that night.

On 7/16/2020 at 12:02pm, RN-F was interviewed and stated that the camera feed from Admissions and Referral was viewed where client 1 had no shirt on and was going down the hall, crying, talking to the guy (client 2) across the hall, and walking around." RN-F called Admissions and Referral department and reported that client 1 was talking to client 2 and Director of Admissions and Referral-A "went out and put clients 1 and 2 back in their rooms." RN-F stated that client 1 "kept walking to (client 2's) door and it looked like client 2 stuffed something into client 1's back pocket. Intake Coordinator-D went out of the Admissions and Referral office and checked client 1's pockets and did not find anything." RN-F stated "we found out later that (client 2) grabbed (client 1's) butt." RN-F stated s/he "had never seen a minor talking to an adult in the Admissions and Referral area." RN-F stated client 1 did not mention the incident between client 1 and client 2 during the assessment or when RN-F drew client 1's blood, but when client 1 called his mother, client 1 was "screaming into the phone" and RN-E talked to client 1 and client

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X1000	Continued From page 9 1 reported that "a man touched me, he's 29 years old." Per RN-F, client 1's mother called and was referred to Admissions and Referral department staff where the cameras were reviewed and the police were called. On 7/20/2020 between 9:15am and 9:23am during the exit meeting with facility staff and surveyors, CEO (Chief Executive Officer) -H stated that when Willow Creek staff completed a root cause analysis of the incident involving clients 1 and 2 on 7/8/20, "we came to the same conclusion- we could have adjusted the approach to care."	X1000		