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A 000	INITIAL COMMENTS An unannounced on site complaint survey was conducted at Winnebago Mental Health Institute in Winnebago, WI 12/12-12/13/17 for complaints #WI00031402, WI00031229 & WI00031218, Winnebago Mental Health Institute was found to be out of compliance with the Code 42 CFR 482 for Hospitals. 42 CFR 482.22: Condition of Participation for Medical Staff is NOT MET. Complaints #WI00031402, #WI00031229, and #WI00031218 were substantiated with citations.	A 000		
A 144	PATIENT RIGHTS: CARE IN SAFE SETTING CFR(s): 482.13(c)(2) The patient has the right to receive care in a safe setting. This STANDARD is not met as evidenced by: Based on record review and interview, facility staff failed to implement interventions designed to protect patient safety in 1 of 12 patients reviewed (Patient #3). Findings include: Review of facility policy "202.19 Safety-Security Precautions" dated 1/2016 revealed: "All patients are entitled to receive treatment in an environment that is safe and secure. At times, some patients require an increased level of supervision and intervention to prevent self-injurious behavior, ...or harm due to a patient's vulnerability... Responsibilities: A. Physician or Designee Responsibilities: ...4. Determines the type of monitoring needed for	A 144		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE 12/14/2017

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patient's safety and security. 5. Provides an order whenever there is a change... B. Registered Nurse Authority and Responsibility: d. Supervises, evaluates, and assigns the nursing care needed for the safety/security of the patient to PCT staff in accordance with the patient's needs... f. May implement or upgrade Safety-Security Precautions to a 1:1..."

Review of facility policy "216.07 Adaptive/Protective Equipment, Security Restraint, Staff-Directed Quiet Time" dated 10/2016 revealed: "II. Protective Equipment: A. Protective equipment is a device used for the protection of the patient. These include helmets..."

Review of Patient #3's medical record revealed nursing progress note dated 10/14/2017 at 9:10 PM "Patient was noted to be in room lying on bed with left side of face on the mattress. Dry blood spots were noted by the patient's head and there were 2 fresh blood spots...[Patient #3] was alert and oriented x4 and responding appropriately to writer's questions and conversation. ...A laceration was present to the patient's left cerebrum...there was dry blood present...at the time [Patient #3] had a Band-Aid above left eyebrow." When asked how the wound was obtained, Patient #3 responded "Falling." "Patient told writer that [#3] was falling intentionally to hurt self. ...MOD [Medical Doctor on call] was notified of blood and patient's claims of cause." Labs and safety precautions were ordered on 10/14/2017 at 9:25 PM, including: "KIV (keep in view) and SIV (sleep in view) for self-injurious behavior." An admission nursing progress note dated 10/14/2017 at 9:25 PM revealed "Behavior: intentionally falling down and hitting head to hurt

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self." An admission nursing progress note dated 10/15/2017 at 6:15 AM revealed "Patient had appeared agitated and was purposefully falling out of bed onto floor. No signs of injury or change in mental status. Staff moved mattress to floor for safety." An admission nursing progress note dated 10/15/2017 at 2:16 PM revealed "Cooperated with precautions. Intentionally fell x 4 by 10:00 [AM]. Hit head (witnessed) on last fall on floor. VS (vital signs) unremarkable. Lab drawn -- MOD update. No further orders. [Layed] 'sleeping' in dayroom floor since last fall." Review of Patient #3's "Safety-Security Responsibility Log" on 10/15/2017 revealed Patient #3 was ordered to be "keep in view" status due to "risk for self-injurious behavior." There was no evidence that precautions were effective in preventing Patient #3's intentional falls, or that the precautions were modified in response to the continued behavior.

During an interview on 12/14/2017 at 2:10 PM, Supervisor H stated that on 10/15/2017 "the staff called me to the unit [when Patient #3 was unresponsive on the floor] for help trouble shooting. They told me [Patient #3] was running into chairs in the dayroom, I went and looked for a helmet and weighted blanket." Supervisor H was unable to call the times at which staff called or when H went to the unit. When asked why H went to look for a helmet when Patient #3 was non-responsive, H stated "I had previous knowledge of the patient, I didn't think lying on the floor was different than previous behaviors...I was getting them [the blanket and helmet] for when [#3] woke up [to prevent similar behavior]." Supervisor H was unable to state why alternative interventions were not implemented after fall #2 or fall #3 where staff witnessed patient #3s head

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A 144	Continued From page 3 hit the floor.	A 144		
A 166	PATIENT RIGHTS: RESTRAINT OR SECLUSION CFR(s): 482.13(e)(4)(i) The use of restraint or seclusion must be-- (i) in accordance with a written modification to the patient's plan of care. This STANDARD is not met as evidenced by: Based on observation, record review and interview the facility failed to ensure that the use of a restraint was on the "Interdisciplinary Treatment Plan" in 1 of 1 medical records reviewed (Patient #1). Findings include: The facility policy titled "Seclusion or Restraint" last reviewed 05/2017 reviewed on 12/13/17 at 9:00 AM. This document revealed on page 2 under "POLICY" item C. #2 "When the patient's Individual Treatment Plan (ITP) or Nursing Care Plan (NDP) is reviewed. The NCP is reviewed and modified (as needed) following the resolution of each incident of restraint or seclusion. The ITP is reviewed and modified (as needed) at each staffing or sooner as necessary to address the use of seclusion or restraint and methods to prevent its use in the future. 3. Modifications to the ITP or NCP are documented." On page 3 under "PROCEDURE" A. #2. "During staffing, treatment team will identify newly diagnosed medical risk factors or other physical conditions that require special consideration during the use of seclusion or restraint. a. Treatment team will ensure special considerations identified are added to individual's ITP/NCP."	A 166		

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A 166	Continued From page 4 Patient #1's medical record was reviewed on 12/12/17 at 12:07 PM. State of Wisconsin Department of Health Services for F-21678 "SECLUSION OR RESTRAINT INCIDENT DOCUMENTATION" was filled out on 9/17/17 at 1:55 PM documented "ASSESSED RISK FOR SECLUSION/RESTRAINT TO PREVENT :" and an "X" marked in the box next to "Harm to others". Patient #1 was documented to have been physically aggressive with a peer and was "hitting peer in face and pulling hair. Peer stood up and began hitting back. Staff attempted verbal (unable to read) with 0 eff [zero effect]. Patient was taken to ground via 3 man take down, pt (patient) placed on transboard and taken to seclusion room via gurney." Patient #1 is documented to have remained in restraints until 3:35 PM. Review of Patient #1's "INDIVIDUALIZED TREATMENT PLAN" (ITP) initiated 9/13/17 did not have documentation of a problem addressing restraints when initiated on 9/17/17 and "NURSING CARE PLAN-ROLE RELATIONSHIP" (NCP) goals include making needs known, verbalizing thoughts of hurting self/committing suicide and seek help from staff and to verbalize the measures necessary to achieve weight reduction within 2 weeks. There was no documentation on ITP or NCP addressing the use of restraints. An interview was conducted with Director of Nursing B on 12/13/17 at 8:20 AM who stated "I guess they [restraints] really don't get put on care plans."	A 166		
A 338	MEDICAL STAFF CFR(s): 482.22	A 338		

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A 338	Continued From page 5 The hospital must have an organized medical staff that operates under bylaws approved by the governing body, and which is responsible for the quality of medical care provided to patients by the hospital. This CONDITION is not met as evidenced by: Based on record review and interview, the facility failed to provide medical staff oversight and ensure medical staff accountability for 1 of 1 medical staff (Physician M). The lack of medical assessment directly affected Patient #3. The Cumulative effect of the medical staff deficiencies prevents the hospital from having an organized medical staff with clear direction and delineation of privileges. Findings include: The medical staff failed to ensure oversight 1 of 1 new appointed medical staff (M). See tag A-340. The facility failed to ensure medical staff is accountable for discharge summaries in 4 of 7 discharge summaries reviewed (Patient #1, Patient #3, Patient #4 & Patient #8). See tag A-347.	A 338		
A 340	MEDICAL STAFF PERIODIC APPRAISALS CFR(s): 482.22(a)(1) The medical staff must periodically conduct appraisals of its members. This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure effective oversight in 1 of 1 newly appointed medical staff (Physician M). Findings include:	A 340		

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Review of "101.04 Medical Staff Bylaws" dated 4/2017 revealed: "Article VII Medical Staff Appointment and Reappointment: ...Section 2 Proctoring Requirements. 1. All initial appointments shall be subject to a period of proctoring pursuant to Article VIII, Section 11. Each initial appointee shall be assigned a proctor at the discretion of the Medical Director, whose responsibility it shall be to observe and evaluate the appointee's practice and monitor performance indicators or aggregate data. During this period the newly appointed Medical Staff member shall have her/his clinical work reviewed by a physician designee. ...Article VIII Determination of Clinical Privileges: Section 11 Focused Professional Practice Evaluation. Focused Professional Practice Evaluation is a process whereby the Medical Staff more closely evaluates the competency and professional performance of a practitioner for a time-limited period."

Review of Physician M's application for delineation of privileges does not include "general initial and emergency care."

Review of Physician M's credentialing files revealed that Physician M was granted privileges in general initial and emergency care and internal medicine on 7/21/2017.

Review of Physician M's recommendation for medical privileges reveal former Medical Director O as Physician M's supervisor, with "moderate" intensity supervision of MDB (Medical Database) reviews.

An interview was conducted on 12/13/2017 at 8:45 AM, Medical Staff Coordinator W stated

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Physician M was hired as a locum/temporary provider and "this is a new process, we just started using locum/temporary staff." W stated "they are used for weekend coverage, they get a 2 day orientation. We start them with admissions only--they come in and do the admission H and P's [history and physicals]." When asked about the proctoring and oversight of Physician M and review of Physician M's medical database records, Coordinator W stated "that is done every 3 months, unfortunately that review didn't happen." Per W, former Medical Director O did an informal review, "I think he [former Medical Director O] looked at 4 of his charts in early November."

Per medical record review, Patient #3 became unresponsive after a fall in which Patient #3's head was witnessed hitting the floor on 10/15/2017 at approximately 10:00 AM. Patient #3 was sent to the Emergency Department on 10/16/2017 at 12:30 AM. Patient #3 was diagnosed with a brain bleed and underwent surgery on 10/16/2017. Patient #3's medical record does not contain any documentation of assessment performed by Physician M on 10/15/2017.

An interview was conducted with Physician N on 12/13/2017 at 10:00 AM, N stated "we don't come in when we are the weekend call doctor, staff will call if they have a medical concern and we advise them, but don't come in [to the facility]." Physician N stated received a call about Patient #3 on 10/15/2017 regarding concerns about a change in Patient #3's condition and "I advised them to have the rounding doc [Physician M] take a look." Per N, they called again and at some point "later in the day or evening" I said to send [Patient #3] to

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A 340	Continued From page 8 the ED (emergency department)." An interview was conducted on 12/13/2017 at 11:40 AM, Registered Nurse J stated on 10/15/2017 "[Physician M] checked on [Patient #3] and talked with us [Registered Nurse I and Registered Nurse J] in the nursing station. [Physician M] said to not send [Patient #3] out and that there were no concerns." An interview was conducted on 12/13/2017 at 12:00 PM, Registered Nurse I stated "[Physician M] came to assess [Patient #3] twice [on 10/15/2017]. The first time [M] said [M] didn't have any immediate concerns. When I paged again, [Physician M] made me feel like I was wasting [M's] time...said it wasn't a brain bleed and to continue monitoring [Patient #3] and that we needed to wake the patient up." Registered Nurse I was unable to receall the times at which Physician M assessed Patient #3. An interview was conducted on 12/13/2017 at 8:45 AM, Facility Director D stated that former Medical Director O stated that Physician M "should have documented" the assessments of Patient #3. Facility Director D stated former Medical Director O retired as of 12/1/2017 and was currently out of the county and unavailable for interview.	A 340		
A 347	MEDICAL STAFF ORGANIZATION & ACCOUNTABILITY CFR(s): 482.22(b)(1), (2), (3) The medical staff must be well organized and accountable to the governing body for the quality of the medical care provided to the patients.	A 347		

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(1) The medical staff must be organized in a manner approved by the governing body.

(2) If the medical staff has an executive committee, a majority of the members of the committee must be doctors of medicine or osteopathy.

(3) The responsibility for organization and conduct of the medical staff must be assigned only to one of the following:
(i) An individual doctor of medicine or osteopathy.
(ii) A doctor of dental surgery or dental medicine, when permitted by State law of the State in which the hospital is located.
(iii) A doctor of podiatric medicine, when permitted by State law of the State in which the hospital is located.

This STANDARD is not met as evidenced by:
Based on record review and interview, the facility failed to ensure discharge summaries are completed by medical staff in 4 of 7 discharge summaries (Patient #1, Patient #3, Patient #4 & Patient #8) and failed to ensure medical staff accountability for the patient status and at discharge in 1 of 7 patients (Patient #1).

Findings include:

Review of "101.04 Medical Staff Bylaws" dated 4/2017 revealed: "Article XVIII Adoption: ...8. The attending physician shall be responsible for preparing or causing to be prepared a complete medical record for each patient. ...The medical record shall include...final summary which is to be completed within 30 days..., condition at

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discharge..."

Review of facility policy "Documentation Guidelines (Formerly POMR Manual)" dated 6/2017 revealed: "Psychiatry Services:
...Discharge Summary: The Discharge Summary, F-25819, will be completed and signed by the physician or by the physician and LIP or physician and psychologist within 30 days of discharge."

An interview was conducted on 12/13/2017 at 3:35 PM, when asked about the discharge summary process, Facility Director D stated "we have a couple of nurses who we detail to do that work. They put together all the notes and the physician signs off, the process was initiated by former [Medical Director O]. It was started because we had gotten behind on discharge summaries."

A telephone interview was conducted on 12/14/2017 at 11:00 AM with Registered Nurse X and Facility Director D, Registered Nurse X stated the process of using nursing staff [primarily RN X and RN R] to dictate the discharge summaries started in May 2014. Per X, "we receive the chart from HIM (health information management) and there are certain parts we copy and paste into the [discharge summary] template. When asked if there was any documentation of the guidance or protocols the nurses followed in creating the discharge summaries, X stated there was no documented records of the former Medical Director O's direction, and that it was "informal guidance" received when the facility started the process over 3 years ago. Facility Director D stated that the goal of having nursing staff prepare the discharge summaries was to streamline the

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process and cut down on waste for the physician staff. When asked if the facility had any documentation, in the form of policies or bylaws, that addressed the process, Facility Director D stated former Medical Director O "was a pretty informal guy" and there was no documentation. Facility Director D was unable to show how the facility was able to ensure that nurses were working within their nursing scope of practice and only copying and pasting information into the discharge summary "shell." No review of the summaries had been done to determine which portions of the discharge summaries were dictated by the nursing staff and which were dictated by the physician staff.

Per medical record review, Patient #3 was discharged from the facility on 10/16/2017 after being transferred to the Emergency Department of another facility. Patient #3's discharge summary was dictated and transcribed on 11/2/2017, signed by Registered Nurse R on 11/2/2017 and by the physician on 11/3/2017. Under: "Hospital Course and Response to Treatment: ...[Patient #3] was then placed on safety/security precautions for keep-in-view, sleep-in-view, escort-to-bathroom and shower, dayroom restricted 0700-2200 secondary to suicidal ideation and patient intentionally throwing self on ground in attempts to hurt self." The discharge summary then noted under "Final Assessment: [Patient #3] was not deemed to be an imminent danger of harm to self..."

Per medical record review, Patient #4 was discharged from the facility on 8/14/2017. Patient #4's discharge summary was dictated on 9/6/2017 at 11:21 AM, transcribed on 9/7/2017 at 12:18 PM, signed by Registered Nurse X on

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9/7/2017 at 2:19 PM and signed by the physician on 9/8/2017 at 2:54 PM. The discharge summary revealed "Following careful discussion of risks, benefits, alternatives and possible side effects, consent was given to start [medication]. [Patient #4] was compliant and tolerated this well with no side effects noted. Medications were monitored and adjusted as symptoms warranted. We discontinued [medication]..." It unclear if summary of medication adjustment and tolerance was dictated by the nurse upon review of the chart, copy and pasted from the medical record or dictated by the physician.

Per medical record review, Patient #8 was discharged from the facility on 8/14/2017. Patient #8's discharge summary was dictated on 9/5/2017, transcribed on 9/6/2017 and signed by Registered Nurse X on 9/7/2017 at 7:04 AM and by the physician on 9/7/2017 at 3:54 PM. The discharge summary revealed "Outpatient medication [sic] was resumed. We monitored for any symptoms that warranted dose adjustments. ...Following careful discussion of risks, benefits, alternatives and possible side effects, consent was given to start [medication]." It is unclear if this summary of medication adjustment and tolerance was dictated by the nurse upon review of the chart, copy and pasted from the medical record or dictated by the physician.

Per medical record review, Patient #1 was discharged from the facility on 09/18/2017 after being transferred to home with parents. Patient #1's discharge summary was dictated and transcribed on 10/09/2017, signed by Registered Nurse X on 10/09/2017 and by the physician on 10/12/2017. Under: "Hospital Course and Response to Treatment: ...[Patient #1] was

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A 347	Continued From page 13 monitored on standard unit precautions. Some ongoing suicidal ideation. [Patient #1] was cooperative with unit rules and guidelines." Patient #1 had a documented positive Columbia Suicide Screening on day of discharge (9/18/17) with documentation of a suicide plan that was not addressed prior to discharge. "[Patient #1] did not display any aggressive or self-harm behaviors." Patient #1 was physically aggressive to a peer on 9/17/17 requiring placement of wrist and ankle restraints. Under "FINAL ASSESSMENT [Patient #1] was not deemed to be an imminent danger of harm to self or others. [Patient #1] denied suicidal or homicidal ideation, intent or plan." Patient #1 had a positive Columbia Suicide Screening on day of discharge 9/18/17 documents intent and plan verbalized to facility staff to jump out of father's car after discharged from facility. Patient #1 did run from father's car after discharge and was readmitted to facility on the same day. There was no documented progress of Patient #1's suicidal ideations or aggressive behavior from date of admission to date of discharge.	A 347		
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 the facility failed to ensure care plans were individualized and complete to meet patient needs and failed to document progress toward goals in 6 of 12 patients reviewed (Patient #1, Patient #2, Patient	A 396		

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#3, Patient #4, Patient #7, Patient #9).

Findings include:

Review of the facility policy titled "Documentation Guidelines" policy id #3727208 last reviewed on 06/2017 document on page 9 under "Individualized Treatment Plan (ITP)/Nursing Care Plan" "An individualized Treatment Plan will also be completed and filed in the medical record within 8 hours of admission and includes information gathered collaboratively with the physician related to patient goals, and treatment methods. The Initial Treatment Plan may be revised to reflect changes occurring with the patient prior to the first treatment planning staffing. The Nursing Care Plan directs care provided by nursing and these plans of care also reflect the nursing goals and treatment methods that are incorporated into the patients multi-disciplinary Individualized Treatment Plan. RN's (registered nurses) develop Nursing Care Plans to direct nursing care provided by PCT's (psychiatric care technician). These NCPs (nursing care plans) that are not addressing active issues identified in the ITP (initial treatment plan) may be stand-alone documents to direct patient care and do not require a corresponding ITP."

Review of facility policy "Individualized Treatment Plan (ITP)" dated 9/2017 revealed: "10. Goals AND methods should be updated as frequently as needed but at a minimum of each ITP session. When a goal is met or discontinued, follow the Date Key for the appropriate letter (M = Met, D = Discontinued) and highlight the goal, along with any corresponding method(s). Sometimes a method is met or discontinued, but not the entire

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goal. ALL goals must be stated in measurable, achievable and time specific terms and related to the patient outcomes."

Patient #3's medical record review revealed Patient #3 was admitted to the facility on 10/14/2017 after jumping from a 2 story building with a history of psychosis, aggression, drug use, paranoid schizophrenia and previous attempt of suicide. The initial medical database, performed by Physician M on 10/14/2017, revealed: "[Patient #3] jumped out of the second story window and landed on his back. Later that day he walked into the river in an attempt to drown himself."

An admission nursing progress note dated 10/14/2017 at 2:00 PM revealed "At 0730 patient [#3] dropped self to floor." A nursing progress note dated 10/14/2017 at 9:10 PM documents "Patient told writer that he was falling intentionally to hurt himself. ...MOD [Medical Doctor on call] was notified..." Labs and safety precautions were ordered, including: "KIV (keep in view) and SIV (sleep in view) for self-injurious behavior." An admission nursing progress note dated 10/14/2017 at 9:25 PM revealed "Behavior: intentionally falling down and hitting head to hurt self." Patient #3's orientation was documented as oriented to "Person, Place, Time, Role." An admission nursing progress note dated 10/15/2017 at 6:15 AM revealed "Patient had appeared agitated and was purposefully falling out of bed onto floor. ...Staff moved mattress to floor for safety." An admission nursing progress note dated 10/15/2017 at 2:16 PM revealed "Cooperated with precautions. Intentionally fell x 4 by 1000. Hit head (witnessed) on last fall on floor."

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Patient #3's Columbia-Suicide Severity Rating Scale, dated 10/14/2017 at 1:00 AM, answers "No" to the following risk questions: "Suicidal Thoughts with Method; Suicidal Intent (without specific plan); Suicidal Intent with Specific Plan; Have you ever done anything, started to do anything or prepared to do anything to end your life?" Per the assessment, standard accountability procedures were implemented and "N/A" checked under "Physician Notified (if suicide precautions indicated)." On 10/14/2017 nursing care plan for "Risk for Suicide" related to ineffective coping skills, impulsive behavior and threat of killing self prior to admission was initiated goals of "patient will not hurt self" and "Pt will verbalize thoughts of hurting self/committing suicide and seek help from staff." The care plan was not individualized to reflect Patient #3's attempts of self-harm within the facility.

A Morse Fall Assessment Scale on admission scored Patient #3's risk for falling at 25 (standard risk) due to a history of falling. A nursing care plan for "Risk for Falls Standard" related to altered mobility and fatigue was initiated on 10/14/2017 with a goal "The patient will relate fewer falls and less fear of falling within 30 days." Methods identified to meet the goal include "Under the direction of [primary RN], unit RNs will assess the patient's fall risk/factors using the Morse Fall Assessment Scale or Humpty Dumpty Fall Assessment Scale as follows: -After a new fall; -Change in mental status; -Change in medical condition." There was no documentation in the care plan that Patient #3 was using falls as a means to harm self and that the falls were intentional and not accidental or due to other risk factors known to contribute to falls.

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Patient #3's ITP documents "Method--For Nursing Goals/Methods, See NCP(s): Disturbed Personal Identity; Risk for Suicide." Goals include "Patient will remain free from harm to self..." and "Patient will not hurt self." Patient #3 was transferred to the Emergency Department on 10/16/2017 for injuries sustained from an intentional fall. Patient #3 was discharged on 10/16/2017, there was no documentation that the goals were not met or that any progress had been made toward the goals during the hospitalization. There was no documentation that interventions to meet goals were re-evaluated after interventions failed to protect patient after each attempt to harm self.

Patient #4 was admitted to the facility on 8/3/2017 with a diagnosis of psychosis. Patient #4's ITP includes a goal that "Patient will have 2 or fewer episodes of seclusion or restraint related to dangerous behaviors associated with psychosis..." Patient #4 was discharged from the facility on 8/14/2017. There was no documentation that the goal was met or discontinued, or what progress had been made toward the goals at the time of discharge.

Patient #7 was admitted to the facility on 9/5/2017 for self harm and aggressive behaviors. Patient #7 ITP goals include "Patient will have 2 or fewer self-harm threats per week; Patient will have 2 or fewer self-harm attempts/acts per week; Patient will have 2 or fewer episodes of restraint use/seclusion per week; Patient will respond to changes in routine or environment without signs or symptoms of anxiety, agitation, or temper tantrums within 1 month." Patient #7 was discharged on 12/4/2017. There was no documentation that the goals were met or discontinued, or what progress had been made

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A 396	Continued From page 18 toward the goals at the time of discharge. Patient #1's medical record was reviewed 12/12/17 at 12:07 PM. The document "NURSING CARE PLAN-ROLE-RELATIONSHIP" dated 6/18/17 under "Methods" has designated lines for "Trigger:, Response:, Interventions:" and "If the patient's behavior indicates the patient is actively losing control such as:". There was no documentation by staff in any of the above areas (lines are left blank). Patient #2's medical record was reviewed 12/12/17 at 2:14 PM. The document "NURSING CARE PLAN-ROLE-RELATIONSHIP" dated 6/18/17 under "Methods" has designated lines for "Trigger:, Response:, Interventions:" and "If the patient's behavior indicates the patient is actively losing control such as:". There was no documentation by staff in any of the above areas (lines are left blank). Patient #9's medical record was reviewed on 12/13/17 at 10:55 AM. The document "NURSING CARE PLAN-ROLE-RELATIONSHIP" dated 6/18/17 under "Methods" has designated lines for "Trigger:, Response:, Interventions:" and "If the patient's behavior indicates the patient is actively losing control such as:". There was no documentation by staff in any of the above areas (lines are left blank). An interview was conducted with Director of Nursing B on 12/13/17 at 8:35 AM when asked if it would be expected for the above listed items to be filled in Director of Nursing B stated "it sure would be expected."	A 396		
A 397	PATIENT CARE ASSIGNMENTS	A 397		

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A 397	Continued From page 19 CFR(s): 482.23(b)(5) A registered nurse must assign the nursing care of each patient to other nursing personnel in accordance with the patient's needs and the specialized qualifications and competence of the nursing staff available. This STANDARD is not met as evidenced by: Based on record review and interview, facility staff failed to provide nursing staff to meet patient needs in 1 of 3 patient incidents reviewed (Patient #3). Findings include: Review of facility policy "202.19 Safety-Security Precautions" dated 1/2016 revealed: "All patients are entitled to receive treatment in an environment that is safe and secure. At times, some patients require an increased level of supervision and intervention to prevent self-injurious behavior, ...or harm due to a patient's vulnerability... Responsibilities: B. Registered Nurse Authority and Responsibility: d. Supervises, evaluates, and assigns the nursing care needed for the safety/security of the patient to PCT staff in accordance with the patient's needs... f. May implement or upgrade Safety-Security Precautions to a 1:1..." Per medical review review, Patient #3's nursing progress note dated 10/15/2017 at 9:53 PM documented "Patient slept all shift after fall, around 10:00 [AM], without responding to verbal stimuli. ...Patient then was incontinent of urine. ...hygiene needs were unable to be addressed immediately due to limited staffing. ...Nursing supervisor updated. Staff was obtained to assist	A 397		

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patient with hygiene needs and transfer patient to bedroom."

Review of the facility's staffing log and census reveal the unit was staffed per protocol on 10/15/2017.

An interview was conducted on 12/13/2017 at 12:00 PM with Registered Nurse I, when asked about examples in which patient care was affected by staffing shortages, I stated "the most recent example is probably [Patient #3]." Per I, on 10/15/2017, "I contacted the house supervisor [Supervisor H] for extra staff and [H] said we didn't have the staff to do that." Patient #3 was lying on the floor in the day room and per I, Patient #3 was incontinent of urine at approximately 7 PM. I stated "we needed 2 additional staff to transfer the patient to [#3's] room." I stated "we got extra staff from the children's unit after 9 PM and then could keep [Patient #3] in [#3's] room after 10 PM because the day room closes then so that PCT [that is assigned to the day room] can watch the patient."

An interview was conducted on 12/13/2017 at 11:40 AM, Registered Nurse J stated Patient #3 was incontinent in the day room at "8-ish" and was moved to bed at "10-ish." When asked why there was a delay in moving and providing cares to Patient #3, J stated "we didn't have enough staff to have [Patient #3] in [#3's] room and change [#3]."

An interview was conducted on 12/12/2017 at 10:45 AM, Director of Nursing B stated "staff claimed the delay in cleaning [Patient #3] up after incontinence was due to being short staffed. We talked to them, they can borrow staff from other

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A 397	Continued From page 21 units. They are capable of getting anything done." An interview was conducted on 12/14/2017 at 2:10 PM, Supervisor H stated "between 7 and 9 [RN I] called asking for help to transport patient. I called that unit and was able to send staff over to help." When asked if H had at any point told RN I that no additional staff were available, H stated "no."	A 397		
A 449	CONTENT OF RECORD CFR(s): 482.24(c) The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. This STANDARD is not met as evidenced by: Based on record review and interview the facility failed to ensure nursing progress notes were completed for 3 of 12 patients reviewed (Patient #1, Patient #2 & Patient #3). Findings include: Review of facility policy "Documentation Guidelines (Formerly POMR Manual)" dated 6/2017 revealed: "Progress Notes: Progress notes shall be completed by the RN (registered nurse) every shift for the first 72 hours for new admissions or transfers from another unit (include the time and date the note was written). ...Progress Notes must be completed immediately for all significant incidents, including, but not limited to: -Injury; -Medical issues; -Self-injurious behavior."	A 449		

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Patient #1's medical record was reviewed on 12/12/17 at 12:07 PM. Patient #1 was admitted on 9/13/17, physician dictation documented time was 8:55 AM, "INITIAL NURSING ASSESSMENT" signed by registered nurse at 1:32 AM and discharged on 9/18/17 at 3:38 PM. There was no nursing progress notes documented for 9/14/17 evening shift.

An interview was conducted with Director of Nursing B on 12/13/17 at 8:35 AM who stated "yes, it is missing a progress note for 9/14/17 evening shift [Patient #1's nurses notes]."

Patient #2's medical record was reviewed on 12/12/17 at 2:14 PM. Patient #2 was admitted on 6/18/17, physician dictation documented time 9:30 PM "INITIAL NURSING ASSESSMENT" signed by registered nurse at 6:00 PM, and discharged on 6/20/17 at 10:52 AM. There was no documented "progress note" completed from 6/19/17 8:23 PM until discharge on 6/20/17 at 10:52 AM (missing 2 shifts).

An interview was conducted with Director of Nursing B on 12/13/17 at 8:35 AM who stated "yeah, there should have been notes for nights and day shift before (Patient #2) discharged."

Per medical record review, Patient #3 was admitted to the facility on 10/14/2017. A nursing progress note dated 10/15/2017 at 2:16 PM revealed "Intentionally fell x 4 by 1000. Hit head (witnessed) on last fall on floor." There was no other documentation, under additional significant information "Pt. slept all shift." A nursing progress note dated 10/15/2017 at 9:53 PM documented "Patient slept all shift after fall, around 10:00 [AM], without responding to verbal stimuli." There

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A 449	Continued From page 23 was no documentation of nursing assessments or the time at which Patient #3 was assessed. The documentation does not include times at which Patient #3 was noted to be incontinent or what time the patient was moved and hygiene performed. Review of Patient #3's neurochecks flowsheet reveal neurochecks were initiated on 10/15/2017 at 11:10 PM, more than 12 hours after Patient #3's witnessed fall. An interview was conducted on 12/12/2017 at 1:10 PM, Service Nursing Coordinator G stated "there was a lack of documentation" regarding staff assessments and interventions for Patient #3. Per G, "we've interviewed about 26 staff members" trying to get an accurate timeline of the events that occurred on 10/15/2017 related to Patient #3. An interview was conducted on 12/14/2017 at 2:10 PM, Supervisor H stated H didn't discuss with staff their documentation of events on 10/15/2017. Per H, "I just expect that they are going to document--that is something a prudent nurse would do." Patient #3's medical record did not contain any documentation of assessment performed by Physician M on 10/15/2017. An interview was conducted on 12/13/2017 at 8:45 AM, Director D stated that former Medical Director O stated that Physician M "should have documented" the assessments of Patient #3.	A 449		
A 821	REASSESSMENT OF A DISCHARGE PLAN CFR(s): 482.43(c)(4) The hospital must reassess the patient's	A 821		

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discharge plan if there are factors that may affect continuing care needs or the appropriateness of the discharge plan.
This STANDARD is not met as evidenced by:
Based on record review and interview the facility failed to update discharge plans based on significant changes in patient condition in 1 of 8 discharged patients (Patient #1).

Findings include:

The facility policy titled "Discharge Planning" #203.04 last reviewed on 01/2016 was reviewed on 12/12/17 at 2:30 PM. This document revealed on page 3 under C. "The psychiatrist shall complete a comprehensive discharge summary that will include the patient's medical, psychiatric, and drug history, and an assessment of the patient's readiness for discharge including overall response to medication and other treatment, general progress, length of treatment, unresolved problems, and discharge recommendations." Continued on page 5 under F. "General Guidelines for Discharging Patients under the Provisions of the WSS 51.15/51.20-Involuntary Civil Admission. 1. When treatment staff in conjunction with the patient, county contacts, family/guardians as appropriate, determine that the patient is ready for discharge, aftercare arrangements are finalized that address the patient's needs."

Patient #1's medical record was reviewed on 12/12/17 at 12:07 PM. Patient #1 was admitted on 9/13/17 on 72 hour hold for attempted suicide. "PROGRESS NOTE-NURSING" on 9/13/17 stated "Pt (patient) coop (cooperative) with admission process and continued with SI (suicidal ideations); pt did state "not here" when attempting

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to obtain verbal contract for safety. Columbia (suicide risk screening) indicating Severe S/P-plan to OD (overdose) or hang self; placed on S/S precautions for no tieables, no sheets, no pillowcases, brown blankets only." Columbia suicide severity rating scale completed on 9/13/17 documented under "Recent Clinical Status" an "X" marked in boxes for hopelessness, major depressive episode, highly impulsive behavior, substance abuse or dependence, anxiety, aggressive behavior towards others and sexual abuse. On page 2 Patient #1 answered "yes" to 6 out of 6 questions (wish to be dead, suicidal thoughts, suicidal thoughts with method, suicidal intent, suicide intent with specific plan and suicide behavior). "PROGRESS NOTE-NURSING" dated 9/13/17 at 2:00 PM "Needed redirection regarding object aggression." "PROGRESS NOTE-NURSING" dated 9/14/17 at 1:00 PM "Punched wall several times.....threatening to harm peer." Patient #1's 72 hour hold was up on 9/15/17, discharge was canceled due to Patient #1's ongoing suicidal ideation's. On 9/17/17 Patient #1 "got into a verbal altercation with peer. Patient started attacking peer, hitting peer in face and pulling hair" patient was physically taken down by staff and place in bilateral wrist and ankle restraints from 1:50 PM to 3:35 PM. Columbia suicide screening completed on day of discharge, 9/18/17, documented under "Recent Clinical Status and "X" marked in boxes for hopelessness, agitation, aggressive behavior towards others and refuses or feels unable to agree to safety plan. In box titled "Describe any suicidal, self-injuries or aggressive behavior" registered nurse documented "Tonight pt (patient) stated that [#1] intends to jump out of [#1] father's vehicle on the way home, take a bunch of pills

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WINNEBAGO MENTAL HEALTH INSTITUTE	1300 SOUTH DRIVE WINNEBAGO, WI 54985

(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 821	Continued From page 26	A 821		

when [#1] gets home and pt (patient) also stated that [#1] will not make it to supper time." On page 2 Patient #1 answered "yes" to the following: wish to be dead, suicidal thoughts, suicidal thoughts with method, suicidal intent, suicide intent with specific plan and suicide behavior. On 9/18/17 at 4:00 PM Physician P was documented as being informed of Patient #1's above statement of suicidal intent and of positive Columbia suicide screening by registered nurse. "PROGRESS NOTE-PHYSICIAN" dated and signed by Physician P on 9/18/17 at 5:00 PM under "Current Mental Status:" hand written "ongoing SI [suicidal ideation]", under "Self-Harm Risk:" hand written "ongoing SI [suicidal ideation]", under "Aggressive Behavior Risk" hand written "assaulted another pt" and under "Current Estimated Length of Stay" hand written "2 day. D/C [discharge] soon". "PROGRESS NOTE-NURSING" dated 9/18/17 at 6:40 PM and signed by registered nurse stated "Pt was d/c [discharge] this shift. Pt's Columbia was positive for SI [suicidal ideation] and pt (patient) stated that [#1] wants to jump out of the car on the way home or swallow a bunch of pills when gets home. And pt also stated that was not going to make it to supper. (Physician P) was notified of pt's positive Columbia and ordered to d/c pt with positive Columbia and to alert pt's father of [Patient #1's] statements and instruct him to lock the car and call the police with any problems. Pt was cooperative with admission (error should be discharge) and walked to father's vehicle." Patient #1 ran out onto a highway while father put gas in car and needed to be physically restrained by father and community people and was taken into police custody and readmitted to facility the same date as discharge.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	524002	A. BUILDING _____ B. WING _____	C 12/14/2017

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A 821	Continued From page 27	A 821		

Patient #1's "DISCHARGE SUMMARY" was reviewed on 9/12/17 at 2:40 PM. Dictated on 10/9/17 by Registered Nurse X and electronically signed by X on 10/9/17 and by Physician P on 10/12/17 stated under "HOSPITAL COURSE AND RESPONSE TO TREATMENT" "Some ongoing suicidal ideation, chronic, no active planning... [Patient #1] contracted for safety and was monitored on standard unit precautions...[Patient #1] was cooperative with unit rules and guidelines. [Patient #1] did not display any aggressive or self-harm behaviors. [Patient #1] responded favorable to the structure and support of the milieu on the units. The patient was not a behavioral management problem. [Patient #1] denied suicidal/homicidal ideation or plan." Under "FINAL ASSESSMENT" "[Patient #1] was not deemed to be an imminent danger of harm to self or others. [Patient #1] denied suicidal or homicidal ideation, intent or plan and no psychotic symptoms were noted."

An interview was conducted with Physician P on 12/13/17 at 3:30 PM when asked Physician P about positive COLUMBIA-SUICIDE form and physician progress note for 9/18/17 that was positive for suicidal ideations and Patient #1 was discharged that same day Physician P responded "Is this the first time someone has been sent home with a positive Columbia on the day of discharge? No, we do it all the time." Questioned Physician P as to how it is decided in that situation who is kept in facility based on positive suicide screening and who is allowed to go home Physician P replied "It's a judgement call. Borderlines usually get worse on prolonged hospitalizations. We believe that (Patient #1) had a hidden agenda to be suicidal and that this is all retaliation to neglect allegations...There was a

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A 821	Continued From page 28 meticulous discharge and outpatient follow up plan with the county. If I had to do the whole thing over again the only thing I would have done differently is to tell them to have 2 people in the car driving home."	A 821		