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 _____	01/15/2020

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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Z 001	Initial Comments On 1/14/20 and 1/15/20, a recertification survey was completed at #3168- SBH Green Bay, LLC dba Willow Creek Behavioral Health. There were 28 deficiencies issued and a plan of correction is required. The program is certified for the following services: DHS 35- Outpatient Mental Health Clinic DHS 49- Mental Health Day Treatment for Children 3 DHS 61.71- Mental Health Inpatient DHS 61.75- Mental Health Day Treatment DHS 61.79- Mental Health Adolescent Inpatient Client files: 29 Staff files: 18	Z 001		
Z 012	50.065(2)(bm) OUT OF STATE BACKGROUND CHECKS If the person who is the subject of the search under par. (am) or (b) is not a resident of this state or if at any time within the 3 years preceding the date of the search that person has not been a resident of this state, or if the department or entity determines that the person's employment, licensing, or state court records provide a reasonable basis for further investigation, the department or the entity shall make a good faith effort to obtain from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search information that is equivalent to the information specified in par. (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each	Z 012		

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

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Z 012	Continued From page 1 bearing a complete set of the person's fingerprints. The department of justice may provide for the submission of the fingerprint cards to the federal bureau of investigation for the purposes of verifying the identity of the person fingerprinted and obtaining the records of his or her criminal arrests and convictions. This Rule is not met as evidenced by: Based on record reviews and interviews with staff, the provider did not attempt to obtain background check information from any state or other United States jurisdiction in which the person is a resident or was a resident within the 3 years preceding the date of the search for 5 of 7 staff (Director of Clinical Services-B, Psychiatrist-F, Advanced Practice Social Worker (APSW)- G, Licensed Professional Counselor (LPC)-H, and Physician-I) reviewed who documented living in other states at the time of hire. Findings include: On 1/14/20 and 1/15/20, surveyor reviewed staff files for background check information including the files of Director of Clinical Services-B, Psychiatrist-F, Advanced Practice Social Worker (APSW)- G, Licensed Professional Counselor (LPC)-H, and Physician-I as follows: Director of Clinical Services-B completed the BID (Background Information Disclosure) form on 7/19/19 and documented living in Pennsylvania prior to hire and no out-of-state background check was completed by the provider. Psychiatrist-F completed the BID form on 3/27/18 and documented living in Colorado from 2001-	Z 012		

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Z 012	Continued From page 2 present and no out-of-state background check was completed by the provider. APSW-G completed the BID form on 10/2/18 and documented living in Kansas until 2018 and no out-of-state background check was completed by the provider. Physician-I completed the BID form on 7/26/18 and documented living in Kentucky from 2014-2015 and no out-of-state background check was completed by the provider. On 1/14/20 at 2:10pm, surveyor interviewed Director of Human Resources-E and Human Resources (HR) Assistant- J who stated that s/he had "never been told to complete out-of-state background checks on any staff- Wisconsin is it." HR Assistant-J stated s/he would need training on how to complete out-of-state background checks. Director of Human Resources-E verified that out-of-state background checks were not completed.	Z 012		
X 227	DHS 40.06(2)(b)1 References and Validation An applicant for employment shall provide character references from at least 2 people and references from all previous employers within the last 5 years and verification from educational institutions of degrees obtained. This Rule is not met as evidenced by: Based on record reviews and interviews with staff, the provider did not obtain character references from at least 2 people and references from all previous employers within the last 5 years for 3 of 4 staff (RN (Registered Nurse)-K, Director of Clinical Services-D, LPC-IT (Licensed	X 227		

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X 227	Continued From page 3 Professional Counselor- In Training)-L) working under the DHS 40 service. Findings include: On 1/14/20, surveyor reviewed the staff files for character references from at least 2 people and references from previous employers within the last 5 years for RN (Registered Nurse)-K, Director of Clinical Services-D, and LPC-IT (Licensed Professional Counselor-In Training) -L and noted the following: RN-K was hired 1/2/2017 and there were no references within RN-K's employee file. Director of Clinical Services-D was hired 8/12/2019 and there was 1 reference within Director of Clinical Services-D's employee file. LPC-IT-L was hired 8/28/2018 and there was 1 reference within LPC-IT-L's employee file. On 1/15/20, surveyor reviewed the facility application for DHS 40 which asks the facility "for each program employee, do you have on file at least 2 character references?" and the facility checked the application box as "yes." The facility application for DHS 40 was signed by Director of Clinical Services-D and dated 11/27/2019. On 1/14/20 at approximately 4:00pm, surveyors met with CEO (Chief Executive officer)-A and Director of Quality and Risk -C and reviewed the findings and no additional information was provided.	X 227		
X 232	DHS 40.06(4)(a) Clinical Coordinator Qualifications	X 232		

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X 232	Continued From page 4 The clinical coordinator shall be a psychiatrist qualified under s. DHS 61.06 (2). A licensed psychologist listed or eligible to be listed in the national register of health service providers in psychology or a mental health professional. A mental health professional shall have a master's degree in psychology, clinical psychology, school psychology, counseling and guidance, counseling psychology, clinical social work, marriage and family counseling or mental health nursing, or a master's degree in a behavioral science or a related field from a graduate program that meets nationally recognized accreditation requirements approved by the department, with a minimum of 28 hours of graduate course credit in mental health theory and supervised clinical training; and have either 3,000 hours of supervised clinical experience in a practice where the majority of the clients are children with mental illness or severe emotional disturbance, or 1,500 hours of supervised clinical experience in a program certified under this chapter. This Rule is not met as evidenced by: Based on record review and interviews with staff, the provider did not employ a clinical coordinator who met the required qualifications to function as clinical coordinator under the mental health professional requirements for 1 of 1 staff files (Director of Clinical Services-D) reviewed. Findings include: On 1/14/20, surveyor reviewed the staffing lists for the DHS 40 program for the Clinical Coordinator position and Clinical Services Coordinator-D is identified as "Program Director" for DHS 40 program. Surveyor reviewed Clinical Services Director-D's employee file and s/he has	X 232		

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X 232	Continued From page 5 an APSW (Advanced Practice Social Worker) certification in Wisconsin which entails having a Master's degree in social work and passing the intermediate level national examination according to Wisconsin DSPS (Department of Safety and Professional Services). Per DHS 40, a clinical coordinator requires the Master's degree in social work: - "with a minimum of 28 hours of graduate course credit in mental health theory and supervised clinical training; -and have either 3,000 hours of supervised clinical experience in a practice where the majority of the clients are children with mental illness or severe emotional disturbance, -or 1,500 hours of supervised clinical experience in a program certified under this chapter." On 1/15/20 at 8:30am, surveyors met with CEO (Chief Executive Officer) -A and Director of Quality and Risk -C regarding the clinical coordinator position and CEO-A verified that Director of Clinical Services-D is responsible for the DHS 40 program and all clinical services at the location. On 1/15/20 at 10:15am ,surveyors interviewed Clinical Services Director-D and Director of Quality and Risk -C and Clinical Services Director-D verified that s/he obtained the APSW certification in August 2019 and began obtaining supervision hours in September 2019 from LCSW(Licensed Clinical Social Worker) -M who works outside the facility. Clinical Services Director-D verified that s/he did not have 1,500 hours of supervised clinical experience in another DHS 40 program and did not have 3,000 hours of supervised clinical experience due to beginning to obtain the required supervision hours in	X 232		

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X 232	Continued From page 6 September 2019.	X 232		
X 243	DHS 40.06(5)(b) Clinical Supervision Documentation Clinical supervision of individual program staff shall include direct clinical review and assessment of each staff person's performance in providing treatment services to children in the program, and letting the staff member know how well he or she is doing and what improvements are needed. This Rule is not met as evidenced by: Based on record review and interviews with staff, the facility did not ensure that clinical supervision of individual program staff shall include direct clinical review and assessment of each staff person's performance in providing treatment services to children in the program, and letting the staff member know how well s/he is doing and what improvements are needed for 1 of 1 staff (LPC (Licensed Professional Counselor-In Training)-IT-L) reviewed under the DHS 40 service. Findings include: On 1/15/20, surveyor reviewed the supervision hours provided by the facility for LPC (Licensed Professional Counselor-In Training)-IT-L. For 2019, LPC-IT-L had one meeting documented with LPC (Licensed Professional Counselor) -H dated 12/23/2019 with no indication that the supervision included direct clinical review and assessment of LPC-IT-L's performance in providing treatment services to children in the program, and letting LPC-IT-L know how well s/he is doing and what improvements are	X 243		

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X 243	Continued From page 7 needed. On 1/15/20 at 3:30pm, surveyor interviewed Director of Clinical Services-D and Director of Quality and Risk-C and Director of Clinical Services-D stated that LPC-IT was supervised by a former employee and there was no additional supervision documentation to review.	X 243		
X 246	DHS 40.06(5)(e) Minimum Clinical Supervision Hours A minimum of 2 hours per month of clinical supervision shall be provided for each mental health professional on staff providing services to clients or their families. This Rule is not met as evidenced by: Based on record review and interviews with staff, the facility did not provide a minimum of 2 hours per month of clinical supervision for each mental health professional on staff providing services to clients or their families for 1 of 1 staff (LPC (Licensed Professional Counselor-In Training)-IT-L) reviewed under the DHS 40 service. Findings include: On 1/15/20, surveyor reviewed the supervision hours provided by the facility for LPC (Licensed Professional Counselor-In Training)-IT-L. For 2019, LPC-IT-L had one meeting documented with LPC (Licensed Professional Counselor) -H dated 12/23/2019 with no amount of time of the supervision documented and no other supervision hours identified. On 1/15/20, the facility policy and procedure	X 246		

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X 246	Continued From page 8 entitled "Clinical Services: Plan Provisional Care Social Services" and dated reviewed 11/1/2019 documents "Therapy Services Department is staffed with Licensed Clinicians and Master's prepared clinicians who are supervised by a Licensed Clinician. All Therapy Services staff are supervised by the Director of Clinical Services, who is a licensed clinician with at least 3 years of experience. Supervision will take place in a group setting for a minimum of one hour per week." On 1/15/20 at 3:30pm, surveyor interviewed Director of Clinical Services-D and Director of Quality and Risk-C and Director of Clinical Services-D stated that LPC-IT-L was supervised by a former employee and there was no additional supervision documentation to review.	X 246		
X 265	DHS 40.07(1)(c)3 Level 3 Clinical Services-Therapy A program operating at Level III shall make available at least the following hours of direct clinical services provided either by program staff or professionals under contract to the program: Three hours per week of individual or family therapy by either a clinician or a clinical psychologist for each full-time client in the program. A program may select a particular type of professional or combination of professionals to provide those services based upon the specific needs of the clients served by the program. This Rule is not met as evidenced by: Based on record review and staff interview, the Level III program did not ensure that clients received 3 hours per week of individual or family therapy by either a clinician or clinical	X 265		

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X 265	Continued From page 9 psychologist for each full-time client in the program for 6 of 6 clinical charts reviewed (See Clients 15-20). Findings included: On 01/14/2020 the surveyor reviewed the clinical records for Clients 15-20 and the following was indicated: Clients 15-20 did not have documentation of 3 hours per week of individual or family therapy in their respective clinical records. On 01/14/2020, the surveyor interviewed Director of Nursing-B about individual and family therapy for clients receiving treatment under the DHS 40 certification. Director of Nursing-B stated with regards to the therapist "they always touch base" but clients "primarily talk to a therapist in a group setting." Director of Nursing-B also stated "they do group therapy in PHP and IOP." On 01/15/2020 CEO(Chief Executive Officer)-A stated one family session "is done prior to discharge" and this is "ideally in person but could be by phone." CEO-A also stated individual sessions with the therapist "are 30 minutes 1:1 weekly and as needed" and these sessions primarily focus on "coping." CEO-A also told the surveyor the program is designed to be a group therapy program.	X 265		
X 277	DHS 40.07(2)(d) Male and Female Staffing Levels At least one male staff member qualified under s. DHS 40.06 shall be present at a program when one or more male clients are present, and at least	X 277		

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X 277	Continued From page 10 one similarly qualified female staff member shall be present at a program when one or more female clients are present. This Rule is not met as evidenced by: Based on record reviews and interviews with staff, the program did not always have at least on male staff member present at the program when one or more male clients (clients 1-8) were present from August 2019- November 2019. Findings include: The program added DHS 40 services to its certificate on 9/1/2017 and began DHS 40 programming in July 2019 as adolescent PHP (partial hospitalization program) according to an interview with surveyors and CEO (Chief Executive Officer)-A and Director of Quality and Risk-C on 1/15/20 at 8:30am. Surveyor reviewed the DHS 40 staff list submitted with the renewal application and the updated staff listed provided onsite on 1/14/20, both of which listed all female staff members. Surveyors interviewed CEO-A and Director of Quality and Risk-C on 1/15/20 at 8:50am regarding male staff members and CEO-A stated that the DHS 40 program "had no male staff" and that the first male staff hired for DHS 40 was LPC (Licensed Professional Counselor)-N who was hired on 12/9/2019 (which hire date was verified by Director of Human Resources-E on 1/15/20). On 1/15/20, Director of Quality and Risk-C provided surveyor with a copy of all admissions to the DHS 40 program since opening in July 2019. Surveyor reviewed the DHS 40 admissions and noted the following male client admissions to programming when there was no male staff	X 277		

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X 277	Continued From page 11 member employed by the DHS 40 program: August 2019- client 1 attended the program. October 2019- client 2, client 3, client 4 client 5, and client 6 attended the program. November 2019- client 7 and client 8 attended the program.	X 277		
X 282	DHS 40.07(4)(c) Level 3 Minimum Operation Hours A Level III program shall be in operation and available to provide services to clients for a minimum of 8 hours a day, 5 days a week, and may suspend operations for no more than 4 weeks each year. This Rule is not met as evidenced by: Based on record review and staff interview, the Level III program did not operate and be available to provide services to clients for a minimum of 8 hours a day, 5 days a week. Findings included: On 01/14/2020 the surveyor reviewed the application for recertification of DHS 40 services received by the Division of Quality Assurance on 12/06/2019. The program responded "yes" to questions under all three levels of service-Level I, Level II, and Level III. On 01/15/2020, the surveyor consulted with the Section Chief who confirmed the certification granted to the program is for Level III DHS 40 services. On 01/14/2020 the surveyor reviewed the Youth Outpatient Schedule. According to that schedule, the program operated from 0845 until 1500 Monday through Friday for a total of 5.25 hours	X 282		

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X 282	Continued From page 12 per day including breaks and lunch. On 01/14/2020 the surveyor interviewed CEO(Chief Executive Officer)-A about the operating hours of the program. CEO-A confirmed that the program hours are 0845 until 1500 for a total of 5.25 hours.	X 282		
X 292	DHS 40.08(5) Admission Letter The program shall review a referral, make its decision whether to admit the child to the program, and report its decision by letter to the referral source within 30 days after the date of referral. This Rule is not met as evidenced by: Based on record review and staff interview, the program did not ensure that an admission letter was sent to the referral source within 30 days of the referral once the program reviewed the referral and made a decision about admission to the program for 6 of 6 clinical records reviewed (See Clients 15-20). Findings included: On 01/14/2020 the surveyor reviewed the clinical records of Clients 15-20 and the following was indicated: Client 15 was admitted to the program on 08/15/2019. Client 16 was admitted to the program on 12/27/2019. Client 17 was admitted to the program on 01/06/2020. Client 18 was admitted to the program on 01/13/2020. Client 19 was admitted to the program on 09/10/2019. Client 20 was admitted to the program on	X 292		

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X 292	Continued From page 13 11/14/2019. The clinical records for Clients 15-20 did not include an admission letter. On 01/14/2020 the surveyor reviewed the application for recertification received by the Division of Quality Assurance on 12/06/2019. On page 5 of the recertification application, the program answered "no" to the question "Do you notify the referring agency of your admission decision, by letter, within 30 days after the date of referral" under DHS 40.08(5) Admission Decision. On 01/14/2020 the surveyor asked Director of Nursing-B and CEO(Chief Executive Officer)-A if the program completed an admission letter to the referral source for clients in the DHS 40 program. Neither Director of Nursing-B nor CEO-A were able to provide evidence of an admission letter for Clients 15-20.	X 292		
X 294	DHS 40.08(7) Admission Summary Once a program has completed its screening of a child referred for services and has decided to admit the child, a designated staff member who is a qualified mental health professional shall prepare a written report summarizing the reasons for admission, identifying the services which will be offered while the initial assessment and treatment plan are prepared under ss. DHS 40.09 and 40.10, and setting the date on which the client may begin attending the program. This Rule is not met as evidenced by: Based on record review and staff interview, the program did not ensure a designated staff member who is a qualified mental health professional prepared written report summarizing the reasons for admission, identifying services to	X 294		

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X 294	Continued From page 14 be offered while the assessment and treatment plan are prepared, and setting the date the client will begin attending the program for 6 of 6 client records reviewed (See Clients 15-20). Findings included: On 01/14/2020 the surveyor reviewed the clinical records for Clients 15-20 and the following was indicated: The clinical records of Clients 15-20 did not include an admission summary meeting the requirements under DHS 40.08(7). On 01/14/2020 the surveyor reviewed the program's application for recertification received by the Division of Quality Assurance on 12/06/2019. On page 5 of the recertification application, the program answered "yes" to questions 1-3 under DHS 40.08(7) Admission Summary. Question 1 stated "When you have completed the screening and have decided to admit the child into your program, do you prepare a written report summarizing the reasons for admission?" Question 2 stated "If "yes" does the report identify services to be offered while the initial assessment and treatment plan are being prepared?" Question 3 stated "Does the report identify a date on which a client may begin attending the program?" This was not evidenced in the records reviewed by the surveyor for Clients 15-20. On 01/14/2020 the surveyor asked Director of Nursing-B and CEO(Chief Executive Officer)-A if the program completed an admission summary for clients in the DHS 40 program. Neither Director of Nursing-B nor CEO-A were able to provide evidence of an admission summary for	X 294		

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X 294	Continued From page 15 Clients 15-20.	X 294		
X 305	DHS 40.09(2)(c)1a-e Initial Assessment Status/DSM IV Diagnosis The initial assessment shall be carried out by appropriate professionals identified in s. DHS 40.06 (4) (a) to (h), and shall include completing an evaluation of the client's mental health status by a psychiatrist or a clinical psychologist and the clinical coordinator of the program, resulting in a diagnosis of the client on all 5 axes specified in DSM IV. Principal and secondary diagnoses shall be indicated as described in DSM IV if there are multiple diagnoses within axes I and II. The 5 axes in DSM IV are the following: a. Axis I: Clinical syndromes and V codes; b. Axis II: Developmental disorders and personality disorders; c. Axis III: Physical disorders and conditions; d. Axis IV: Severity of psychosocial stressors; and e. Axis V: Global assessment of functioning. This Rule is not met as evidenced by: Based on record reviews and interviews with staff, the program did not assure that initial assessments were carried out by appropriate professionals and included an evaluation of the client's mental health status by a psychiatrist or a clinical psychologist and the clinical coordinator of the program, resulting in a complete Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnosis for 6 of 6 records reviewed (See Clients 15-20). Findings included: On 01/14/2020, the surveyor reviewed the initial assessments for Clients 15-20 completed by an	X 305		

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X 305	Continued From page 16	X 305		

employee of the Assessment and Referral Department and the following was indicated:

1. Client 15's initial assessment dated 08/15/2019 contained no evaluation of the client's mental health status by a psychiatrist or a clinical psychologist and the clinical coordinator of the program resulting in a complete DSM diagnosis.

2. Client 16's initial assessment dated 12/26/2019 contained no evaluation of the client's mental health status by a psychiatrist or a clinical psychologist and the clinical coordinator of the program resulting in a complete DSM diagnosis.

3. Client 17's initial assessment dated 01/06/2020 contained no evaluation of the client's mental health status by a psychiatrist or a clinical psychologist and the clinical coordinator of the program resulting in a complete DSM diagnosis.

4. Client 18's initial assessment dated 01/13/2020 contained no evaluation of the client's mental health status by a psychiatrist or a clinical psychologist and the clinical coordinator of the program resulting in a complete DMS diagnosis.

5. Client 19's initial assessment dated 09/14/2019 contained no evaluation of the client's mental health status by a psychiatrist or a clinical psychologist and the clinical coordinator of the program resulting in a complete DSM diagnosis.

6. Client 20's initial assessment dated 11/14/2019 contained no evaluation of the client's mental health status by a psychiatrist or a clinical psychologist and the clinical coordinator of the program resulting in a complete DSM diagnosis.

On 01/14/2020 the surveyor interviewed Director

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X 305	Continued From page 17 of Nursing-B who stated clients admitted for treatment under the DHS 40 certification have the same assessment done as any other client or patient admitted to the facility. Director of Nursing-B stated all initial assessments are completed by an employee of the Assessment and Referral Department. In addition, Director of Nursing-B stated if the client is admitted as part of a step down from a higher level of care at the facility the client "will not have a comprehensive assessment done" at admission to treatment under DHS 40 certification. Director of Nursing-B stated "as long as there was not a lapse, they would not need a new comprehensive assessment." On 01/15/2020 the surveyor interviewed Director of Clinical Services-D who is identified as the Clinical Coordinator of the DHS 40 program. Director of Clinical Services-D reported s/he did not complete an assessment, mental status evaluation, or diagnosis on each new admission to the DHS 40 program. In addition, Director of Clinical Services-D confirmed s/he did not meet the minimum requirements for the position of Clinical Coordinator.	X 305		
X 325	DHS 40.10(2)(b) Treatment Plan-Service Summary The written treatment plan shall include a summary of services the client will receive from his or her school or other educational resource, including educational services provided by the program, and from any other agency that is or will be involved with the child and the family, and the process by which educational and other services provided from outside the program will be coordinated with services provided by the	X 325		

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X 325	Continued From page 18 program. This Rule is not met as evidenced by: Based on record review and staff interview, the program did not ensure that treatment plans included information on educational services for 6 of 6 clinical records reviewed (See Clients 15-20). Findings included: On 01/14/2020 the surveyor reviewed the clinical records of Clients 15-20 and the following was indicated: Client 15's treatment plan was dated 08/15/2019. Client 16's treatment plan was dated 12/27/2019. Client 17's treatment plan was dated 01/06/2020. Client 18's treatment plan was dated 01/13/2020. Client 19's treatment plan was dated 09/10/2019. Client 20's treatment plan was dated 11/14/2019. The treatment plans for Clients 15-20 indicated no information about educational services the client received from the client's school, the program, or other educational resources was included. In addition, there was no information about coordination of educational services between the program and outside educational resources including the client's school. On 01/14/2020 the surveyor interviewed Director of Nursing-B about including school and educational information on the treatment plans of clients receiving services under the DHS 40 certification. Director of Nursing-B was unable to provide any additional information to the surveyor to show this information was included with the treatment plans reviewed for Clients 15-20. In addition the surveyor interviewed Teacher-P who stated educational information is not part of the treatment plan. Teacher-P stated if a release of	X 325		

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X 325	Continued From page 19 information is in place, Teacher-P will make an attempt to obtain information from the client's home school but that information is not written on the treatment plan and Teacher-P did not attend typically attend the treatment plan meetings.	X 325		
X 330	DHS 40.10(2)(g) Medications The written treatment plan shall identify any medication the client will be receiving, the name of the physician prescribing the medication, the purpose for which it is prescribed and the plan for monitoring its administration and effects. This Rule is not met as evidenced by: Based on record review and staff interview, the program did not ensure that any medication the client is prescribed is identified on the treatment plan along with the name of the physician prescribing the medication, the purpose for the medication, and the plan for monitoring administration and side effects of the medication for 6 of 6 clinical records reviewed (See Clients 15-20). Findings included: On 01/14/2020 the surveyor reviewed the clinical records of Clients 15-20 and the following was indicated: Client 15's treatment plan was dated 08/15/2019. Client 16's treatment plan was dated 12/27/2019. Client 17's treatment plan was dated 01/06/2020. Client 18's treatment plan was dated 01/13/2020. Client 19's treatment plan was dated 09/10/2019. Client 20's treatment plan was dated 11/14/2019. There was no information about the medication the client was prescribed, the name of the	X 330		

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X 330	Continued From page 20 physician who prescribed the medication, the purpose for the medication, or the plan for monitoring administration and side effects of the medication included on the treatment plans for Clients 15-20. On 01/14/2020, the surveyor interviewed Director of Nursing-B who told the surveyor information about medication is not included on the treatment plans for clients receiving treatment in the program certified under DHS 40. Director of Nursing-B stated medication is referred to only with a goal about the doctor prescribing medication for the client.	X 330		
X 382	DHS 40.16(2)(a) Annual Operation Review In addition to the outcome evaluation under sub. (1), a program shall arrange for an annual review of its program operations to evaluate factors such as the appropriateness of admissions and clients' length of stay, the efficiency of procedures for conducting initial assessments and developing treatment plans, the effectiveness of discharge and aftercare services, the functionality of the program's interagency agreements and other factors that may contribute to effective use of the program's resources. This Rule is not met as evidenced by: Based on record reviews and interviews with staff, the program did not complete an annual review of its program operations to evaluate factors such as the appropriateness of admissions and clients' length of stay, the efficiency of procedures for conducting initial assessments and developing treatment plans, the effectiveness of discharge and aftercare services, the functionality of the program's interagency	X 382		

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agreements and other factors that may contribute to effective use of the program's resources for 2 of 2 years reviewed.

Findings include:

On 1/14/20 at the start of the survey, surveyors requested information on the DHS 40 program annual evaluations for 2018 and 2019 from CEO (Chief Executive Officer)-A and Director of Quality and Risk-C who stated that the adolescent PHP (Partial Hospitalization Program) program was the service provided under DHS 40.

On 1/15/20 at 8:30am, surveyors again requested information on the DHS 40 program annual evaluations for 2018 and 2019 from CEO-A and Director of Quality and Risk-C.

On 2:20pm on 1/15/20, Director of Quality and Risk-C met with surveyor and provided documents from the corporate office dated 2018 and 2019 for the facility, however, the documents provided did not include any information specific to DHS 40 program operations to evaluate factors such as the appropriateness of admissions and clients' length of stay, the efficiency of procedures for conducting initial assessments and developing treatment plans, the effectiveness of discharge and aftercare services, the functionality of the program's interagency agreements and other factors that may contribute to effective use of the program's resources. Director of Quality and Risk-C verified that the documents provided were not detail specific to DHS 40 programming for their adolescent PHP program which is the only program service provided under the DHS 40 service.

Surveyor reviewed the policy and procedure

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X 382	Continued From page 22 entitled "Program Evaluation PHP/IOP" dated effective 4/3/2017 which documents "The Program Evaluation process provides a means for assessment, evaluation, analysis, integration, and monitoring of Outpatient Programs", "program evaluation reports will occur monthly, quarterly, and annually", and "Outpatient Services will develop specific goals and objectives to be reviewed monthly, quarterly and annually. Supportive documentation is provided in conjunction with reviews." In addition, "Quality Program: The QI program defines plans and evaluates varying aspects of the program and its provisions of care. The outpatient services specific goals and objectives are detailed in the written plan."	X 382		
X1075	DHS 94.41(3)(b) Written Report When the inquiry under sub. (2) (c) is complete, the client rights specialist shall prepare a written report with a description of the relevant facts agreed upon by the parties or gathered during the inquiry, the application of the appropriate laws and rules to those facts, a determination as to whether the grievance was founded or unfounded, and the basis for the determination. This Rule is not met as evidenced by: Based on record review, policy review, and staff interview, the program did not ensure written follow up by the Client Rights Specialist as required under Wisconsin Administrative Code DHS 94.41, were completed for 3 of 3 complaints or grievances reviewed by the surveyor. Findings included: The facility's application for recertification	X1075		

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X1075	Continued From page 23 received by the Division of Quality Assurance on 12/06/2019 indicated the program received 215 complaints or grievances during the survey cycle. On 01/14/2019, the surveyor requested to review documentation of the complaints and grievances reported in the renewal application and selected 3 as a sample. The following was identified: A complaint dated 03/04/2019 reported confidentiality concerns and whether confidentiality of the patient was violated. The documentation provided to the surveyor did not have written follow up to the client from the Client Rights Specialist that included a determination made as to whether or not it was founded, the basis for the determination, and information to appeal the outcome. A complaint dated 05/21/2019 reported concerns that a nurse shared confidential patient information with employees at a different facility the nurse also works at. The documentation provided to the surveyor did not have written follow up to the client or complainant from the Client Rights Specialist that included a determination made as to whether or not it was founded, the basis for the determination, and information to appeal the outcome. A complaint dated 03/09/2019 reported concerns that staff did not respond to a patient's repeated request to see a nurse regarding neck pain. The documentation provided to the surveyor did not have written follow up to the client from the Client Rights Specialist that included a determination made as to whether or not it was founded, the basis for the determination, and information to appeal the outcome. The surveyor noted 3 written responses in the	X1075		

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X1075	Continued From page 24 documentation for the 215 complaints. There was a letter dated 04/17/2019 from Director of Quality and Risk-C regarding a complaint outcome including how to appeal. A letter was dated 02/01/2019 from Director of Quality and Risk-C regarding a complaint outcome including how to appeal. And, a letter was dated 02/26/2019 from Director of Quality and Risk-C regarding a complaint outcome including how to appeal. On 01/14/2020, the surveyor reviewed program policy on complaints and grievances titled "Patient/Client Grievance Complaint" and the following was indicated: On page 3 of this policy under "The Informal Resolution Process", letter D stated "The Client Rights Specialist shall prepare a brief report indicating the nature of the resolution and provide copies to the Hospital Administrator or designee, to the client and any person acting on behalf of the client." On page 4 of this policy under "The Formal Resolution Process, letter F stated "After review of the Grievance Committee, the inquiry is considered complete and the Client Rights Specialist shall prepare a written report with a description of the relevant facts agreed upon by the parties or gathered during the inquiry, the application of appropriate laws and rules to those facts, a determination as to whether the grievance was founded or unfounded, and the basis for the determination. A copy of the report shall be given to the Hospital Administrator, the grievant or person acting on behalf of the grievant and any relevant staff." The program did not follow the "Patient/Client Grievance Complaint" policy when responding to the 3 complaints selected as a sample. The surveyor reviewed the application the facility submitted for recertification received by the	X1075		

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X1075	Continued From page 25 Division of Quality Assurance on 12/06/2019. On page 3 of the DHS 94 Patient Rights and Resolution of Patient Grievances application, the facility answered "yes" under Section II DHS 94 -Grievance Resolution, question 6 "Does the program's grievance resolution procedure meet the standards of DHS 94.40-94.54?" This was not evidenced in the complaint and grievance records reviewed by the surveyor. On 01/14/2020 at 1110, the surveyor interviewed Director of Quality and Risk-C about the complaint and grievance process. Director of Quality and Risk-C stated "did not give them anything in writing" when asked how the outcome of the complaint was relayed to the client or person complaining on behalf of the client. Director of Quality and Risk-C stated communication with the client or person complaining on behalf of the client is verbal either in person or by phone. Director of Quality and Risk-C reported not being aware that a written response or follow up was required under DHS 94 and stated that was not part of the process developed in June or July by Director of Quality and Risk-C.	X1075		
X1839	DHS 61.71(1)(c) Required Personnel-Activity Therapy Each service shall employ at least one full-time registered occupational therapist and one certified occupational therapy assistant or a graduate of the division of mental hygiene's Activity Therapy Assistant Course. Where other health care services are located in the same or continuous property, one full-time occupational therapist may serve the other health care service as well as the inpatient mental health services.	X1839		

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X1839	Continued From page 26 The mental health inpatient service shall maintain a ratio of 1.6 hours of activity therapy staff time per patient per week. A registered music therapist or art therapist may fill the requirement for activity therapy positions after one registered occupational therapist has been employed. Where work therapy is utilized, each service shall designate the registered occupational therapist, unless the service has employed a vocational rehabilitation counselor. In this circumstance the vocational rehabilitation counselor shall be in charge of industrial therapy. This Rule is not met as evidenced by: Based on record reviews and interviews with staff, the facility did not employ at least one full-time registered occupational therapist and one certified occupational therapy assistant or a graduate of the division of mental hygiene's Activity Therapy Assistant Course who maintained a ratio of 1.6 hours of activity therapy staff time per patient per week for 3 of 3 years- 2017, 2018, and 2019- since opening in 2017. Findings include: On 1/14/20 and 1/15/20, surveyors reviewed the facility's renewal application staffing lists and the updated staff lists provided onsite by CEO (Chief Executive Officer)-A for the required staff working under DHS 61.71 program services and did not locate a full-time registered occupational therapist or a certified occupational therapy assistant or a graduate of the division of mental hygiene's Activity Therapy Assistant Course. The staffing lists for DHS 61.71 list CTRS (Certified Therapeutic Recreation Service) staff only. Surveyors interviewed CEO-A, Director of Quality Compliance-C, and Director of Nursing-B on	X1839		

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X1839	Continued From page 27 1/15/20 during the exit meeting and CEO-A stated that the facility did not have occupational therapy staff and that the facility "always had rec therapy staff since opening." The facility became certified for providing DHS 61.71- Mental Health Inpatient services effective 1/10/2017.	X1839		
X1840	DHS 61.71(1)(d) Required Personnel-Social Services Each service shall employ one full-time social worker and provide for a minimum of .8 hour a week social work time per patient under care. Social workers must have a master's degree from an accredited school of social work or a bachelor's degree in social work, or social science. The first social worker hired must have a master's degree in social work. This Rule is not met as evidenced by: Based on record review and interviews with staff, the facility was not able to verify the minimum of .8 hours per week of social work time per patient under the facility's care. Findings include: On 1/15/20, surveyors reviewed the staffing lists submitted with the renewal application dated 11/27/19 and signed by Director of Quality Compliance-C which lists "Social Services" staff as Director of Clinical Services-D, LPC(Licensed Professional Counselor) -H, APSW(Advanced Practice Social Worker)-Q, APSW-G, and Therapist-R. On 1/15/20, during the exit meeting at 4:15pm,	X1840		

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X1840	Continued From page 28 surveyors interviewed CEO (Chief Executive Officer)-A and Director of Quality and Risk-C regarding verifying the .8 hours of social work time per patient per week and CEO-A and Director of Quality and Risk -C stated that there are 2 case managers- BSW(Bachelor of Social Work)-S and BSW-T- who work with discharge planning and LCSW(Licensed Clinical Social Worker)-U and LCSW-V who do groups on the inpatient unit. Surveyors asked CEO-A and Director of Quality Compliance-C to verify the .8 hours of social work time per patient per week and no additional information was provided. In addition, BSW-S, BSW-T, LCSW-U and LCSW-V are not identified as staff listed on the renewal application signed by Director of Quality and Risk-C and also not on the updated staff listing which was provided to surveyors at entrance to the survey on 1/14/20.	X1840		
X1841	DHS 61.71(1)(e) Required Personnel-Psychological Services Each service shall employ or contract for the services of a clinical psychologist licensed in the state of Wisconsin to provide psychological testing, counseling and other psychological services. A minimum ratio of .8 hour per week psychology time per patient under care shall be provided. This Rule is not met as evidenced by: Based on record reviews and interviews with staff, the facility did not employ or contract for the services of a clinical psychologist licensed in the state of Wisconsin to provide psychological testing, counseling and other psychological services for a minimum ratio of .8 hour per week	X1841		

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X1841	Continued From page 29 psychology time per patient under care for 3 of 3 years- 2017, 2018, and 2019- since opening in 2017. Findings include: On 1/14/20 and 1/15/20, surveyors reviewed the facility's renewal application staffing lists and the updated staff lists provided onsite by CEO (Chief Executive Officer)-A for the required staff working under DHS 61.71 program services and did not locate a psychologist identified on the staffing lists provided. Surveyors interviewed CEO-A on 1/14/20 at 11:05am and CEO-A stated that the facility contracted with a psychologist for "neuropsych testing" and verified that the facility did not have a psychologist who worked onsite with patients. The facility became certified for providing DHS 61.71- Mental Health Inpatient services effective 1/10/2017.	X1841		
X1862	DHS 61.75(1)(c) Day Treatment-Required Personnel A psychiatrist shall be present at least weekly on a scheduled basis and shall be available on call whenever the day treatment service is operating. This Rule is not met as evidenced by: Based on record review and interviews with staff, the facility did not have a psychiatrist present at least weekly on a scheduled basis for 1 of 1 psychiatrists (Psychiatrist F) reviewed working under DHS 61.75 service for 2 of 2 years. Findings include:	X1862		

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X1862	Continued From page 30 On 1/14/20, surveyor reviewed the facility renewal application staffing list for DHS 61.75 services, there was no Psychiatrist listed as part of the required staff. Surveyor reviewed the facility renewal application for DHS 61.75 services and under Required Personnel, question 6- "do you have a psychiatrist present at least once a week on a scheduled basis?"- the facility answered "yes" and listed Psychiatrist-F and Monday thru Friday as available. Question 6c documents "a psychiatrist shall be present at least weekly on a scheduled basis and shall be available on call whenever the day treatment service is operating" and the facility answered "yes." On 1/14/20 at 11:05am, surveyor met with CEO-A regarding the staffing lists and CEO-A stated that for the DHS 61.75 service, Psychiatrist-F was the psychiatrist working in this program, however, Psychiatrist-F "is telehealth only." CEO-A stated that Psychiatrist-F lives in Colorado and "is available only by phone" Monday thru Friday. Surveyor reviewed Psychiatrist-F's employee record and Psychiatrist-F was hired 10/25/2017 and s/he has lived in Loveland. Colorado from 2001 to present according to background check information signed by Psychiatrist-F on 3/27/2018. The facility became certified for DHS 61.75 services effective 7/27/2017.	X1862		
X1866	DHS 61.75(2)(a) Day Treatment-Services A day treatment program shall provide services to meet the treatment needs of its patients on a long or short term basis as needed. The program shall	X1866		

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X1866	Continued From page 31	X1866		

include treatment modalities as indicated by the needs of the individual patient. Goals shall include improvement in interpersonal relationships, problem solving, development of adaptive behaviors and establishment of basic living skills.

This Rule is not met as evidenced by:
Based on record review and staff interview, the program did not establish problem solving, development of adaptive behaviors, and establishment of basic living skills goals as required for clients in the DHS 61.75 program for 4 of 4 client records reviewed (See Clients 11-14).

Findings included:

On 01/15/2020 the surveyor reviewed the clinical records of Clients 11-14 and identified the following:

Client 11 was admitted to the program on 12/06/2019. A treatment plan was developed for Client 11 on 12/06/2019 and then reviewed on 12/17/2019, 12/20/2019, and 12/27/2019. The goals on the treatment plan and in the clinical record did not include problem solving, adaptive behaviors, or basic living skills.

Client 12 was admitted to the program on 01/07/2020. A treatment plan was developed for Client 12 on 01/07/2020 and then reviewed on 01/14/2020. The goals on the treatment plan and in the clinical record did not include problem solving, adaptive behaviors, or basic living skills.

Client 13 was admitted to the program on 12/30/2019. A treatment plan was developed for Client 13 on 12/30/2019. The goals on the

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X1866	Continued From page 32 treatment plan and in the clinical record did not include problem solving, adaptive behaviors, or basic living skills. Client 14 was admitted to the program on 01/14/2020. A treatment plan was developed for Client 14 on 01/14/2020. The goals on the treatment plan and in the clinical record did not include problem solving, adaptive behaviors, or basic living skills. On 01/15/2020 the surveyor interviewed Director of Nursing-B about the goals developed for clients in the partial hospitalization program operated under the DHS 61.75 certification. Director of Nursing-B stated all the goals for clients are on the treatment plan. Director of Nursing-B stated there are not goals identified in other documentation for clients. The surveyor asked Director of Nursing-B if goals are developed for clients to address problem solving, adaptive behaviors and basic living skills. Director of Nursing-B was not able to locate these goals in the clinical records for Clients 11-14.	X1866		
X1882	DHS 61.79(1)(e) Required Personnel-Psychological Service Each service must provide a minimum of one hour per week of psychology time for each patient under care. This Rule is not met as evidenced by: Based on record reviews and interviews with staff, the facility did not provide a minimum of one hour per week of psychology time for each patient under care for 3 of 3 years- 2017, 2018, and 2019- since opening in 2017.	X1882		

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X1882	Continued From page 33 Findings include: On 1/14/20 and 1/15/20, surveyors reviewed the facility's renewal application staffing lists and the updated staff lists provided onsite by CEO (Chief Executive Officer)-A for the required staff working under DHS 61.79 program services and did not locate a psychologist identified on the staffing lists provided. Surveyors interviewed CEO-A on 1/14/20 at 11:05am and CEO-A stated that the facility contracted with a psychologist for "neuropsych testing" and verified that the facility did not have a psychologist who worked onsite with patients. The facility became certified for providing DHS 61.79- Child and Adolescent Inpatient services effective 9/1/2017.	X1882		
X2522	DHS 35.123(2)(a)-(c) Staffing requirements for clinics In addition to the clinic administrator, the clinic shall have a sufficient number of qualified staff members available to provide outpatient mental health services to consumers admitted to care. Except as provided in s. DHS 35.12 (2m), the clinic shall implement any one of the following minimum staffing combinations to provide outpatient mental health services: (a) Two or more licensed treatment professionals who combined are available to provide outpatient mental health services at least 60 hours per week. (b) One or more licensed treatment professionals who combined are available to provide outpatient mental health services at least 30 hours per week and one or more mental health practitioners or	X2522		

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X2522	Continued From page 34	X2522		

recognized psychotherapy practitioners who combined are available to provide outpatient mental health services at least 30 hours per week.
(c) One or more licensed treatment professionals who combined are available to provide outpatient mental health services at least 37.5 hours per week, and at least one psychiatrist or advanced practice nurse prescriber who provides outpatient mental health services to consumers of the clinic at least 4 hours per month.

This Rule is not met as evidenced by:
Based on record review and staff interview, the program did not ensure it met the minimum staff requirement to provide outpatient mental health services under DHS 35.123(2).

Findings included:

On 01/14/2020 the surveyor reviewed the application for recertification for DHS 35 received by the Division of Quality Assurance on 12/06/2019. The application included the Outpatient Mental Health Clinic Staff Roster. On the staff roster, the program identified 5 staff members as full time program staff members: Director of Clinical Services-D; RN(Registered Nurse)-K; LPC(Licensed Professional Counselor)-H; LPC-N; and LPC-IT(Licensed Professional Counseling In Training)-L.

On 01/14/2020, the surveyor interviewed CEO(Chief Executive Officer)-A about the DHS 35 certification and program. CEO-A stated the program that operates under the DHS 35 certification only includes an Intensive Outpatient Program in group format that is typically used as a step down from the inpatient program or partial hospitalization program. The program serves only

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adult clients and operates from 0830 until 1145 Monday through Friday. The program does not have medication management, individual psychotherapy appointments, or any other services in addition to the group schedule. CEO-A also stated clinical staff employed by the hospital serve all areas of the hospital and treat clients in different program areas. CEO-A confirmed that all 5 staff members listed on the staff roster of the recertification application for DHS 35 do not work full time in that program as listed on the application but full time for the hospital as a whole. CEO-A stated RN-K is the nurse for all outpatient programs which include the IOP, adult partial hospitalization program, and adolescent partial hospitalization program. CEO-A stated LPC-N is also the male staff required for the DHS 40 program.

On 01/15/2020 the surveyor interviewed Director of Clinical Services-D who stated LPC-H provides clinical supervision for staff in the DHS 35, DHS 40, DHS 61.71, and DHS 61.79 programs because Director of Clinical Services-D is not a fully licensed clinician. Director of Clinical Services-D stated LPC-H "has a small caseload" and "just returned to inpatient" where LPC-H was needed more. Prior to that LPC-H would "float between programs" according to Director of Clinical Services-D.

On 01/15/2020, the surveyor asked Director of Nursing-B about the staff for the program under DHS 61.75 certification. Director of Nursing-B stated LPC-IT-L and LPC-N are the therapists for that program and RN-K is the nurse for that program.

In addition, based on record reviews and staff interviews by the surveyors on 01/14/2020 and

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X2522	Continued From page 36 01/15/2020, LPC-IT-L completed evaluations in the Assessment and Referral Department and was identified as a staff person for the DHS 40 program. On 01/15/2020, the surveyor reviewed the Adult Outpatient Schedule provided by the program. The schedule identifies treatment hours for the Intensive Outpatient Program as 0830 until 1145 which equals 16.25 hours for the outpatient mental health program Monday through Friday. The program does not operate on weekends. Based on the above information, the program was not able to show how they met the minimum staff requirement as stated in DHS 35.123(2).	X2522		
X2541	DHS 35.14(2) Clinical supervision and collaboration Except as provided under sub. (4) (b), the clinic's policy on clinical supervision shall be in accordance with ch. MPSW 4, 12, or 16, or Psy 2, or for a recognized psychotherapy practitioner, whichever is applicable. The clinic's policy on clinical collaboration shall require one or more of the following: (a) Individual sessions, with staff case review, to assess performance and provide feedback. (b) Individual side-by-side session while a staff member provides assessments, service planning meetings or outpatient mental health services and in which other staff member assesses, and gives advice regarding staff performance. (c) Group meetings to review and assess quality of services and provide staff members advice or direction regarding specific situations or strategies. (d) Any other form of professionally recognized	X2541		

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X2541	Continued From page 37 method of clinical collaboration designed to provide sufficient guidance to assure the delivery of effective services to consumers by the staff member. This Rule is not met as evidenced by: Based on record review and interviews with staff, the facility policy on clinical supervision is not in accordance with MPSW 4 for 1 of 1 staff (APSW (Advanced Practice Social Worker)-G) reviewed receiving supervision under the DHS 35 service. Findings include: MPSW 4 states "Supervision of pre-certification or pre-licensure practice of social work under s. 457.08 (3) (c) and (4) (c), Stats., shall include the direction of social work practice in face-to-face individual or groups sessions of at least one hour duration during each week of supervised practice of social work. Such supervision may be exercised by a person other than an employment supervisor. The one hour per week supervision requirement may be averaged out over the course of the period of supervision. The supervisor may exercise discretion as to the frequency, duration, and intensity of the supervision sessions to meet an average of one hour supervised session per week during the supervision period. The person supervising the pre-certification or pre-licensure practice of social work shall have adequate training, knowledge and skill to competently supervise any social work service that a social worker undertakes. Supervision of the professional practice of social work in the applied skills of the profession may be exercised by a person other than an employment supervisor....." On 1/15/20, surveyor reviewed the facility policy	X2541		

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and procedure entitled "Clinical Services: Plan Provisional Care Social Services" which was dated "reviewed 11/1/2019" and documented "Therapy Services Department is staffed with Licensed Clinicians and Master's prepared clinicians who are supervised by a Licensed Clinician. All Therapy Services staff are supervised by the Director of Clinical Services, who is a licensed clinician with at least 3 years of experience. Supervision will take place in a group setting for a minimum of one hour per week."

On 1/15/20, surveyor reviewed the supervision hours provided by the facility for APSW (Advanced Practice Social Worker)-G who was hired on 10/8/2018. For 2019, APSW-G had supervision/collaboration completed by LPC (Licensed Professional Counselor) -H which included a one-on-one meeting between LPC-H and APSW-G on the following dates:

September 2019= 9/2, 9/3, 9/9, 9/16, 9/23, 9/30.
October 2019= 10/7, 10/14, 10/21, 10/28.
November 2019= 11/4, 11/11, 11/18, 11/25.
December 2019= 12/2, 12/9, 12/16.

The facility policy indicates supervision "will take place in a group setting for a minimum of one hour per week", however, MPSW 4 requires "face-to-face individual or groups sessions of at least one hour duration during each week of supervised practice of social work" and MPSW 4 states "the one hour per week supervision requirement may be averaged out over the course of the period of supervision."

The supervision hours provided for 2019 listed above did not contain the length of time LPC(Licensed Professional Counselor)-H met

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X2541	Continued From page 39 with APSW(Advanced Practice Social Worker)-G in each meeting from September 2019 to December 2019 in order to determine compliance with MPSW 4. There were no additional supervision hours provided for 2018 or 2019 to review for APSW-G. On 1/15/20 at 3:30pm, surveyor interviewed Director of Clinical Services-D and Director of Quality and Risk-C and Director of Clinical Services-D stated that APSW-G was supervised by a former employee and there was no additional supervision documentation to review.	X2541		
X2553	DHS 35.16(4) Diagnosis of Mental Illness Only a licensed treatment professional, or a recognized psychotherapy practitioner, may diagnose a mental illness of a consumer on behalf of a clinic. The licensed treatment professional, or recognized psychotherapy practitioner shall document, in the consumer file, the recommendation for psychotherapy specifying the diagnosis; the date of the recommendation for psychotherapy; the length of time of the recommendation; the services that are expected to be needed; and the name and signature of the person issuing the recommendation for psychotherapy. This Rule is not met as evidenced by: Based on record review and staff interview the program did not ensure that a licensed treatment professional or recognized psychotherapy practitioner documented a recommendation for psychotherapy specifying the diagnosis, the date of the recommendation, length of the	X2553		

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recommendation, the services that are expected to be needed, and the name and signature of the person issuing the recommendation for psychotherapy for 3 of 3 client receiving outpatient mental health services (see Clients 21-23).

Findings included:

On 01/14/2020 the surveyor reviewed the clinical records of Clients 21-23. The surveyor did not see evidence of a recommendation for psychotherapy with the required information documented by a licensed treatment professional or recognized psychotherapy practitioner in the clinical records of Clients 21-23.

On 01/14/2020 the surveyor reviewed the application the facility submitted for recertification received by the Division of Quality Assurance on 12/06/2019. On page 2 of the DHS 35 recertification application, the program answered "yes" to 35.16 under Policies and Procedures "Establish and implement written admission criteria. Maintain a written recommendation for psychotherapy documentation in the clinical record." This was not evidenced in the clinical record reviewed by the surveyor.

On 01/14/2020, the surveyor interviewed Director of Nursing-B and asked to see the recommendation for psychotherapy documented in the clinical records of Clients 21-23 by a licensed treatment professional or recognized psychotherapy practitioner. Director of Nursing-B stated "this would be in the admission orders." The surveyor then asked to see the admission orders for Clients 21-23. Director of Nursing-B stated then that there would not be admission orders for outpatient clients because the

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X2553	Continued From page 41 outpatient program does not have a psychiatrist. Director of Nursing-B stated the recommendation for psychotherapy was not part of the clinical record for outpatient mental health clients.	X2553		
X2559	DHS 35.17(1)(b)1.-5. Comprehensive assessment A comprehensive assessment shall be valid, accurately reflect the consumer's current needs, strengths and functioning, be completed before beginning treatment under the treatment plan established under s. DHS 35.19 (1), and include all of the following: 1. The consumer's presenting problems. 2. A diagnosis, which shall be established from the current Diagnostic and Statistical Manual of Mental Disorders, or for children up to age 4, the current Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood. 3. The recipient's symptoms which support the given diagnosis. 4. Information on the consumer's strengths, and current and past psychological, social, and physiological data; information related to school or vocational, medical, and cognitive functioning; 5. The consumer's unique perspective and own words about how the consumer views his or her recovery, experience, challenges, strengths, needs, recovery goals, priorities, preferences, values and lifestyle, areas of functional impairment, and family and community support. This Rule is not met as evidenced by: Based on record review and staff interview, the program did not ensure that a comprehensive assessment including information on consumer's strengths and a diagnosis established from the	X2559		

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X2559	Continued From page 42 current Diagnostic and Statistical Manual of Mental Disorders (DSM) was completed by a qualified mental health professional for clients receiving outpatient mental health treatment under DHS 35 for 3 of 3 records reviewed (see Clients 21-23). Findings included: On 01/14/2020 the surveyor reviewed the clinical records for Clients 21-23 and the following was indicated: Client 21 was admitted to the outpatient mental health program on 01/06/2020. Client 21 received an assessment from the Admissions and Referral (A and R) Department on 12/29/2019. The first part of Client 21's assessment that includes the DSM diagnosis was completed by a Registered Nurse who included a diagnosis of Major Depressive Disorder for Client 21. The second part of Client 21's assessment that identifies client strengths was completed by an APSW(Advanced Practice Social Worker) without the signature of the supervising licensed clinician. Client 22 was admitted to the outpatient mental health program on 12/11/2019. Client 22 received an assessment from the A and R Department on 12/10/2019. The first part of Client 22's assessment that includes the DSM diagnosis was completed by an A and R Department employee with credentials identified as MAC who included a diagnosis of Major Depressive Disorder for Client 22. The second part of Client 22's assessment that identifies client strengths was not completed. Client 23 was admitted to the outpatient mental health program on 12/27/2019. Client 23 received an assessment from the A and R Department on	X2559		

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X2559	Continued From page 43 12/23/2019. The first part of Client 23's assessment that includes the DSM diagnosis was completed by a LPC-IT(Licensed Professional Counselor In Training)-L without the signature of the supervising licensed clinician and included a diagnosis of Major Depressive Disorder for Client 23. In the second part of Client 23's assessment, there were no client strengths identified. On 01/14/2020, the surveyor reviewed the programs DHS 35 application for recertification submitted to the Division of Quality Assurance. On page 2 of the DHS 35 application under Clinical Documentation, the program indicated "yes" to "Comprehensive assessment is completed by a qualified clinical staff and a written assessment report is maintained in the clinical record." Clients 21-23 did not have the comprehensive assessment completed by a qualified clinical staff. On 01/14/2020, the surveyor interviewed Director of Nursing-B about the assessment process. Director of Nursing-B stated all patients admitted to any part of the facility have the same assessment completed by an employee of the A and R Department. Director of Nursing-B stated some of the employees in the A and R Department are nurses and some are therapists. Director of Nursing-B did not know what credentials MAC meant. On 01/15/2020, the surveyor interviewed Director of Clinical Services-D who stated clinicians in training are supervised by LPC(Licensed Professional Counselor)-H and LPC-H should be co-signing documentation for therapists under supervision and working toward full licensure.	X2559		

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X2592	Continued From page 44	X2592		
X2592	DHS 35.22(1)(b) Summary of services The discharge summary shall include a summary of the outpatient mental health services provided by the clinic, including any medications. This Rule is not met as evidenced by: Based on record review and staff interview, the program did not ensure that a client discharge summary included a summary of services provided as required under DHS 35 for mental health outpatient clients for 2 of 2 records reviewed (see Clients 9-10). Findings included: On 01/14/2020, the surveyor reviewed the clinical records for Clients 9-10 and the following was indicated: Client 9 was admitted to the program on 09/16/2019 and discharged on 10/17/2019. The discharge documentation dated 10/15/2019 did not include a summary of services provided to Client 9 while receiving treatment. Client 10 was admitted to the program on 08/16/2019 and discharged on 09/18/2019. The discharge documentation dated 09/18/2019 did not include a summary of services provided to Client 10 while receiving treatment. On 01/14/2020 the surveyor requested the policies and procedures for the facility's DHS 35 Mental Health Outpatient program. CEO(Chief Executive Officer)-A stated that the policies are for the whole outpatient program area and not developed for each certified program. The surveyor reviewed the policy information provided and did not see a program policy or procedure	X2592		

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X2592	Continued From page 45 that correlated to the required discharge documentation under DHS 35.22. On 01/14/2020, the surveyor interviewed Director of Nursing-B about discharge documentation for outpatient mental health clients. Director of Nursing-B stated the discharge documentation is the same for all of the programs at the facility. A nurse completes the discharge care plan and each discipline has some discharge documentation to complete. Director of Nursing-B was not able to find a summary of services provided to the client in the documentation identified to the surveyor as the discharge summary for Clients 9-10.	X2592		
X2593	DHS 35.22(1)(c) Discharge progress evaluation The discharge summary shall include a final evaluation of the consumer's progress toward the goals of the treatment plan. This Rule is not met as evidenced by: Based on record review and staff interview, the program did not ensure that a client discharge summary included a final evaluation of the progress toward goals of the treatment plan as required under DHS 35 for mental health outpatient clients for 2 of 2 records reviewed (see Clients 9-10). Findings included: On 01/14/2020, the surveyor reviewed the clinical records for Clients 9-10 and the following was indicated: Client 9 was admitted to the program on 09/16/2019 and discharged on 10/17/2019. The	X2593		

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X2593	Continued From page 46 discharge documentation dated 10/15/2019 did not include a final evaluation of the client's progress toward goals identified on the treatment plan. Client 10 was admitted to the program on 08/16/2019 and discharged on 09/18/2019. The discharge documentation dated 09/18/2019 did not include a final evaluation of the client's progress toward goals identified on the treatment plan. On 01/14/2020 the surveyor requested the policies and procedures for the facility's DHS 35 Mental Health Outpatient program. CEO(Chief Executive Officer)-A stated that the policies are for the whole outpatient program area and not developed for each certified program. The surveyor reviewed the policy information provided and did not see a program policy or procedure that correlated to the required discharge documentation under DHS 35.22. On 01/14/2020, the surveyor interviewed Director of Nursing-B about discharge documentation for outpatient mental health clients. Director of Nursing-B stated the discharge documentation is the same for all of the programs at the facility. A nurse completes the discharge care plan and each discipline has some discharge documentation to complete. Director of Nursing-B was not able to find a final evaluation of client progress toward treatment goals in the documentation identified to the surveyor as the discharge summary for Clients 9-10.	X2593		
X2762	DHS 94.40(2)(d) Written Policies - Client Rights Spec Trng	X2762		

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X2762	Continued From page 47 A program shall have written policies which provide that: (d) Staff who act as client rights specialists, or private individuals with whom the program contracts for this service, are trained in the procedures required by this subchapter, techniques for resolution of concerns and grievances and the applicable provisions of ch. 51, Stats., ch. DHS 92 and this chapter. This Rule is not met as evidenced by: Based on record review and staff interview, the program did not ensure the Client Rights Specialist completed the required training on techniques for resolution of complaints and grievances as well as the provisions of DHS 94 which outlines the complaint and grievance process the program and Client Rights Specialist is to follow. Findings included: On 01/14/2020, the surveyor reviewed facility records that identified Director of Quality and Risk-C as the Client Right Specialist for the facility. The surveyor reviewed the application the facility submitted for recertification received by the Division of Quality Assurance on 12/06/2019. On page 3 of the DHS 94 Patient Rights and Resolution of Patient Grievances application, the facility answered "yes" under Section II DHS 94 -Grievance Resolution, question 7 "Is the client rights specialist trained in compliance with DHS 94.40(2)(d); in the procedures required by subchapter III; techniques for resolution of concerns and grievances; and the applicable provisions of Chapter 51, Wis. Stats., and DHS	X2762		

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X2762	Continued From page 48 92 and 94?" This was not evidenced in records reviewed by the surveyor. On 01/14/2020 at 1110 the surveyor interviewed Director of Quality and Risk-C about the role of Client Rights Specialist. Director of Quality and Risk-C stated s/he started in the role of Client Rights Specialist about a year ago. Prior to that, there was no one in the role for about 4 months so the Director of Nursing responded to complaints. The surveyor asked Director of Quality and Risk-C for documentation of completion of the required training. Director of Quality and Risk-C stated the training was done. The surveyor then asked to see the certificate of completion. Director of Quality and Risk-C stated the certificate was not saved. Near the end of the survey day on 01/14/2020, Director of Quality and Risk-C showed the surveyor Certificate # 61749551 dated 01/14/2020 indicating completion of the on-line Client Rights Training. Director of Quality and Risk-C confirmed the required training was not done until 01/14/2020.	X2762		