Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	123	A. BUILDING: ______ B. WING ______	C 05/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEATON FRANCISCAN HEALTHCARE ALL S	**3801 SPRING ST RACINE, WI 53405**

(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) COMPLETE DATE
R 000	INITIAL COMMENTS Based on the findings of an unannounced complaint investigation survey 25999 conducted 05/11/2015 through 05/12/2015, Wheaton Franciscan All Saints in Racine was found to be out of compliance with requirements of Chapter DHS 124 for Hospitals, this complaint is substantiated and citations related to patient rights and nursing services were issued.	R 000		
R 236	124.05(3)(a)1.a. GOVERNING BODY - POLICIES Patient rights and responsibilities. Every hospital shall have written policies established by the governing board on patient rights and responsibilities which shall provide that: A patient may not be denied appropriate hospital care because of the patient's race, creed, national origin, ancestry, religion, sex, sexual orientation, marital status, age, newborn status, handicap or source of payment; This Rule is not met as evidenced by: Based on record review and interview the hospital failed to ensure all patients were admitted without prejudice. This deficiency has the potential to affect all patients served by the hospital. Findings include:	R 236		7/2/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE 05/22/15

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R 236	Continued From page 1 Per interview with Staff A on 05/04/15 at 9:30 AM the facility keeps a book of names of people who are not to be admitted. Per Interview with RN M on 05/12/15 at 11:45 AM a "Seek Alternative Placement book" exists to screen patients who may be violent or injurious to others. Per interview with RN S on 05/12/15 at 12:20 PM a "Seek Alternate Book" exists to provide guidelines for patients who should not be admitted for medical reasons, sexual acting out or violence. S stated that pt.s should be re-evaluated in the "here and now". VP I was asked about the "Seek Alternate Placement" book and produced it for review on 05/12/15 at 3:00 PM. The book contains 204 names of individuals (child/adolescent/adult/geriatric) with varied reasons attached to each name why alternate placement should be sought. The reasons range from medical complexity, destruction of property, violence, acting out sexually or the "need for a state hospital". According to I this book is to be used as a guideline only, however there is no policy on how the information is to be used by admitting providers.	R 236		
R 252	124.05(3)(a)2. GOVERNING BODY - POLICIES Patient rights and responsibilities. A patient who receives treatment for mental illness, a developmental disability, alcohol abuse or drug abuse shall be recognized as having, in addition, the rights listed under s. 51.61, Stats., and ch. HFS 94.	R 252		7/2/15

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R 252	Continued From page 2	R 252		

This Rule is not met as evidenced by:
Based on record review, interview and observation, the facility failed to ensure a safe environment in 5 of 5 areas observed (3 Adult units and 2 Child/Adolescent units), in 1 of 1 body check reviewed and in 1 of 1 security checks reviewed. This deficiency has the potential to affect all patients served by the hospital.

Findings include:

Facility policy entitled; "Patient (pt.) Belongings and Searches" dated March 2012 was reviewed on 05/12/2015 at 11:00 AM, it states under procedure; "Document all contraband found and the disposition of such."

Pt. #1 was admitted on 01/21/2015 with a diagnosis of chronic depression and anxiety per record review on 05/11/15 at 12:30 PM. Pt. #1 was found on the afternoon of 01/22/15 in bed. According to nursing notes on 01/22/15 at 2:57 PM; "pt in bed lethargic, search done of pt. room, travel jar full of yellow rock substance found in night stand in pt. room, search done of pt. clothing syringe and tourniquet found in pt. scrub pocket, pt also had bag full of multiple pills in bra. security called. pt bag full of pills contained xanax and unknown white pills."

A "Belongings Inventory" in pt. #1's medical record (MR) was found to be completed but was

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R 252	Continued From page 3	R 252		

lacking a staff signature with date and time. The inventory documented that medications had been secured in med drawer but did not indicate which med's they were.

Facility policy entitled; "Patient Checks (Unit Checks) dated 03/15 was reviewed on 05/12/15 at 3:30 PM, it states; ......"Values of Respect and Integrity require us to ensure knowledge of the location and safety of patients on a 24-hour basis."...."Associates are assigned to do patient checks" on "Adult Inpatient Every 30 minutes".

Pt. #3's MR was reviewed on 05/11/15 at 2:00 PM, nursing notes from 02/03/15 at 10:17 PM state: "Pt. was in room rest when staff did rounds, when staff did next set of rounds, pt. was no where to be found. staff found pt. in the ceiling. he had removed tile and was crawling around trying to 'escape' 'They are trying to kill me, I need to get out of here' staff was able to convince pt to come down from the ceiling. Md notified. order obtained for 1:1 for patient safety."

According to documentation reviewed on 05/11/15 at 2:00 PM pt. #6 eloped from an adult inpatient treatment unit. The hospital performed a root cause analysis (RCA) which revealed that staff were unaware of pt. #6's absence between the hours of 12:13 PM and 3:00 PM. At that time it was determined that pt. #6 had been taken home by a spouse. The RCA revealed that staff had not properly identified pt. #6 during security rounds mistaking another pt. for pt. #6.

During a tour of pt. care units (3 Adult units and 2 Child/Adolescent units) on 05/11/15 at 2:30 PM with VP I the layout of the units was observed. The situation of all the nursing stations did not allow for direct visualization of hallways by

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R 252	Continued From page 4 staff. Per interview with I on 05/12/15 at 1:00 PM cameras are to be installed in the hallways to increase vigilance.	R 252		
R 399	124.13(1)(b)1. NURSING SERVICES - NURSING SERVICE Administration. The nursing service shall be directed by a registered nurse with appropriate education and experience to direct the service. A registered nurse with administrative authority shall be designated to act in the absence of the director of the nursing service. Appropriate administrative staffing of the nursing service shall be provided on all shifts. This Rule is not met as evidenced by: Based on observation, interview and record review, the nursing service failed to have an organized nursing staff with authority and oversight for 1 of 6 off site locations (mental health unit). This deficiency has the potential to affect all patients served by the hospital. Findings include: On 05/12/15 at 9:15 AM during an interview about Pt #6's elopement, RN (Registered Nurse) P stated P #6, was able to leave the unit because of multiple practice breakdowns. RN P state P left the unit with Pt #6 hanging out near the locked door and did not check the door to ensure it was locked after exiting. RN P stated of these actions did not followed unit policies. Patients are not to hang out near the locked doors, safety rounding did not see Pt #6 in a location prohibited to patient. Nursing staff logged #6 as safe and in the	R 399		7/15/15

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facility for about 3 hours after #6 eloped.

RN P was asked about knowledge of sexual assaults on any of the mental health units, RN P stated it happens a lot at night, stating the Psychiatric Intensive Care (PIC) unit does accept known sexual offenders. RN P acknowledged nursing administration is aware the sexual assault issues, incident reports are filed.

On 05/12/15 between 9:33 AM -11:05 AM during an interview Director of Medical Services (DMS) K stated there are many areas in the facility that nursing staff cannot visualize from the nursing unit. DMS K stated the nurses "huddle" at the nursing station and do not go out on the floor.

DMS K stated "search" procedures are lax, and nursing policy not followed.

Example #1 provided by DMS K, nursing staff have been conducting one-person searches, the policy requires 2-person search, and at least one of the nursing staff must be of the same sex as the patient being searched.

Example #2 provided by DMS K, all patients admitted to the locked psychiatric unit are to remove all their clothes, for a physical assessment and search for contraband. DMS K stated that a Pt. #1 was not searched per P&P, and brought in a drug assumed to be heroin, and other pills, needles, and a tourniquet. Pt.#1 was using the drugs on the unit. (see A-144)

Example #3 on the child/adolescent unit a Pt. # 3 was able to remove a ceiling tile, at the end of a hallway near a window, crawled up into the ceiling, and hid without staff seeing or hearing the incident. (See A-144)

Example #4 a patient (#6) eloped from our locked unit and never came back, and staff were still marking the patient in the unit after the patient eloped. (See A 144)

A review of the incident and hospitals investigation identified Pt. #6 eloped and the staff

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conducting rounding incorrectly identify Pt #6, for 2 hours and 57 minutes.

DMS K confirmed the nursing staff lacks clear direction and support.

When asked about patient sexual assaults and sexual misconduct, DMS K stated I won't lie and say it doesn't happen, but the unit set up doesn't help. There are blind spots, no cameras except by the locked exit, and with staff huddling in the nursing station, not all areas can be seen. Look at the end of B hall. You have to physically walk down there to see into the rooms and visualize the end of the hall.

On 05/12/15 at 8:35 AM a tour, with Clinical Therapy N, confirmed without staff walking down the hall of patient rooms on Unit B, staff could not visualize rooms or the end of the hall.

Nursing staff Q, O, P M and S were asked, "Who is the overall Director of Nursing (DON) responsible for nursing service?"

On 05/12/15 at 11:16 AM during an interview RN Q stated, we have no current manager, so I guess, VP of Operation I, or a supervisor.

On 05/12/15 at 11:17 AM, during an interview behavioral health associate (BHA) O stated, we have no manager and no director, so BHA O would refer to VP of Operation I.

On 05/12/15 at 11:17 AM, during an interview RN P stated, we have no director of nursing, I guess supervisor M or VP of Operation I.

On 05/12/15 at 11:57 AM, during an interview Supervisor M stated, nursing services has no manager or director for the service. Supervisor M stated, currently VP of Operation I is the "interim everything".

Supervisor M stated that the expectation is that when staff round, they walk through the halls.

Review of Patient Checks (Unit Checks) Policy, Effective Date: March 2012, date of last revision 3/15 related to unit elopements, does not

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R 399	Continued From page 7 address the steps staff should take to identify patients to ensure the correct patient is documented on during safety rounds, or the hospital expectation for how to conduct safety rounds. On 05/12/15 at 12:27 PM, RN S stated, "I think" Chief Nursing Office T is the one at the main campus, but we have never seen T. Maybe the VP of Service (I) is functioning as the DON. RN S stated, it has been a revolving door with managers and director here (offsite mental health unit). When RN S was asked about the patients that are known sexual offenders, RN S stated those patients would go to the psychiatric intensive care unit (PIC). RN S stated that nursing staff is not always provided the patient history and then known sexual offenders are placed on the open units with 30 minute checks, instead of the 1:1 or 15 minute checks. On 05/12/15 at 2:50 PM during a telephone interview with Anonymous staff E stated, E wants to feel safe, and have it safer for the patients. E stated difficult to handle adolescents are sometime sent to the adult PIC unit. E stated this is where the violent offenders and sexual predators are treated. E stated, on numerous occasions E has taken these concerns to the unit supervisor and managers, without any changes. As a part of the complaint, a rape incident was reviewed during this survey. The history noted in 2012 Pt #8 was found Not Guilty by Reason of Insanity (NGRI) from charges of a 2nd degree sexual assault. Pt #8 was admitted on 03/09/14 to open behavior unit and placed on standard 30 minute checks, on 03/11/14 Pt. #8 sexually assaulted Pt. #4 On 05/12/15 at 1:57 PM during a telephone interview Chief Nursing Office (CNO) T, when	R 399		

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R 399	Continued From page 8 asked if CNO T, knew what was happening at this mental health off site location, CNO T explained WF has the line control model, and line control staff (for services) identifying VP of Operations I as the Director of Nursing at the mental health locations, who reports to CNO T. CNO T's oversight is the "the market". When asked, if CNO T had been to this off site location to see what is going on? CNO stated, no, the mental health program "service line" reports through quality council annually. CNO T stated T's responsibility along with VP Chief Operating Officer (COO) G is to provide resources, labor, performance, benchmarks and safe staffing. When asked if annual oversight of this mental health off site service was enough?, CNO T stated the Executive Team meets weekly, to look at operational issues, but does not look at all services, but some services are looked at; there is safety committees, environmental rounds and regulatory rounds. A request for Executive Team meeting minutes, or any leadership meeting minutes, along with any of the safety, regulatory or environmental rounds for the past year that would identify issues unique to this off site mental health unit, be brought for review. Concerns shared with CNO T, that the nursing unit staff and supervisors at this offsite mental health location did not understand, or know the line of nursing authority, and could not identify their overall nursing director responsible for all nursing services and that there was no communication between this off site mental health unit and the main hospital campus services. On 05/12/15 at 2:25 PM during an interview VP of Operations I stated, the VP of Operations is responsible for the day-to-day operations of the	R 399		

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mental health unit, I stated was not the nursing director.

A review of two current organizational charts for nursing services were provided and reviewed with VP of Operations I. The organization chart for WF titled "CNO matrix" revised 4/17/15, shows Chief Nursing Office T as the head of nursing services.

There was no nurse authority on the CNO matrix, between CNO T and 6 off site services (Inpatient Rehab, Cancer Center, Lakeshore Manor, Mental Health Services Adult Inpatient, Mental Health Service Child/Adolescent, and WF Clinics). This was noted with a dash line between Chief Nursing Office T and 6 offsite services (Inpatient Rehab, Cancer Center, Lakeshore Manor, Mental Health Services Adult Inpatient, Mental Health Service Child/Adolescent, and WF Clinics).

A second organization chart was presented by VP of Operations I and reviewed was not specific to nursing. The chart titled "Mental Health Organization Chart". This Organization Chart was not dated. VP of Operations I, stated the title "Administrative Director" on this flow of authority chart, is their hospitals title for the unit specific RN director. The "Administrative Director" position as vacant. VP of Operations confirmed this offsite mental health unit has not current director of nursing.

When asked, are you the Director of Nurses, VP or Operations I, stated, "as of today, I guess I am".

On 05/12/14 at 3:00 PM VP of Operations I provided the following documents on behalf of Chief Nursing Officer T, to show the nursing authority and oversight to this offsite mental health unit. The documents were reviewed with VP of Operations I and Director of Quality U:

"Medical Executive Committee" meeting

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R 399	Continued From page 10 minutes were provided and reviewed with VP of Operations I and Director of Quality U, for the following period: July 16-2014 - August 19, 2014, September 17, 2014 - October 21, 2014, January 21, 2015 - February 17, 2015. No meeting minutes were provided for Nov-Dec 2014, "Medical Executive" meeting minutes for the January - February 2015 stated, the "search policy" was discussed and sent to physicians for review and feedback. The December 3, 2014 "Operating Council" meeting minutes were provided and reviewed with VP of Operations I and Director of Quality U, no information was identified specific to this offsite mental health unit. The February 4, 2015 "Management Council" were provided and reviewed with VP of Operations I and Director of Quality U noted a policy update for "Utilization of a Companion Providing Direct 1:1 Observation for the Non-Suicidal Patient." November 11, 2014 "Nursing Practice Council" meeting minutes were provided and reviewed with VP of Operations I and Director of Quality U, noting behavior health personnel attended. A Joint Commission (TJC) tool dated 12/02/2014 based on (TJC) survey was provided, that included two areas for monitoring behavioral health; patient suicide, and patient assessments, but no data collection or monitoring provided. Director of Quality U stated, U understood the off site locations were disconnected from the main campus hospital. Director of Quality U stated, U sees this same issue with the off site clinics billed under the hospital number. VP of Operations I stated the flow of nursing authority and oversight to this mental health unit is confusing.	R 399		

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R 411	Continued From page 11	R 411		
R 411	124.13(1)(c)2. NURSING SERVICES - NURSING SERVICE Staffing. The number of nursing personnel for all patient care services of the hospital shall be consistent with nursing care needs of the hospital's patients. This Rule is not met as evidenced by: Based on interviews and record reviews, the nursing service failed to 1 of 1 nurse staffing policy and procedure, that defined acuity or minimum staffing for consistent staffing patterns for 22 of 22 days reviewed (12/21/14 - 01/03/15 and 03/29/15 - 04/05/15). Findings include: On 05/12/15 at 8:25 AM during an interview with VP of Operations I, and review of Policy, that was not, titled: "Staff Plan-Nursing", effective date March 2012, last revised 6/14. I. "Child/Adolescent Inpatient/Partial and Outpatient Programs" A. 2. " Days, PM and NOC: 1 RN & 1 Support Associate " A. 3. "Daily staffing decisions are based upon acuity of the patients, the ratio for children and adolescent patients, the census and the admitting and discharge activities that are occurring". II. "Adult Inpatient and Outpatient Programs" A. 2. Day, PM, NOC: 1 RN & 1 Support Associate A. 3. "Daily staffing decisions are based upon acuity of the patients, the census of the service, the ration of the patients in intensive treatment unit vs. the step-down unit, the census and the	R 411		7/10/15

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admitting and discharge activities that are occurring."
During the interview VP of Operations I stated, acuity was not defined in policy and the hospital had no matrix for consistent application when determining staffing patterns.
VP of Operations I acknowledged the policy minimum staffing patterns did not address patient census.
When asked what "acuity" meant, VP of Operations I stated, "Admissions, Alcohol scales and medical concerns".
VP of Operation I said it is left up to the nursing supervisor on that shift to make acuity judgments.
On 05/12/15 between 9:33 AM and 10:30 AM, when asked what acuity meant, when determining staffing levels, Director of Medical Services (DMS) K, asked "what type of acuity medical and psychiatric?" DMS K stated, this is a behavior health unit, but we accept patients with medical conditions.
DMS K, stated there are no acuity matrix to guide supervisor for consistent application, right now the supervisors rely on the staff nurses, and staff nurse base acuity of workload, not patient specific acuity, such as, aggressive behaviors, medical needs, sexual inappropriateness or clinical withdrawals.
On 05/12/15 between 8:00 AM and 4:15 PM, interviews conducted via telephone and in-person with unit staff that wish to remain anonymous A, E, RN P and RN S admitted the patient safety rounding documents were filled in by unit staff including themselves or observed firsthand unit staff or supervisors documenting work they had not completed by filling in the safety rounding sheets because of being short staffed.
Anonymous staff A, E, RN P and RN S, stated it was going on so long, it was the expectation and unit culture, "to make it look good".

Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	123	A. BUILDING: ____ B. WING ____	C 05/12/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WHEATON FRANCISCAN HEALTHCARE ALL S	3801 SPRING ST RACINE, WI 53405

(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) COMPLETE DATE
R 411	Continued From page 13	R 411		

Continued From page 13

RN P stated, RN Supervisor V (terminated from hospital employment) gave nursing staff directive to complete safety rounds even if nursing staff were shorthanded and could not complete the work. RN Supervisor V was terminated and could not be interviewed to support or refute or support the statement.
Anonymous E stated E was on the unit and observed firsthand Supervisor M fill in safety check sheets that were incomplete.
On 05/12/15 at 11:57 AM, RN Supervisor M stated I (M) did not fill in the safety rounds, and stated, I (M) "told them no, don't chart what you don't do." RN Supervisor acknowledged as the supervisor, M was aware of the practice.
Supervisor M stated determining a patient ' s acuity is up to each supervisor.
On 05/12/15 at 2:00, VP of Operations I denied knowledge of safety round records being falsified, or that it was the unit culture to falsify records.
On 05/12/15 between 3:45 PM and 4:15 PM Resource Management Assistant and Staffing Scheduler W provided and reviewed two staffing models (adults and child/adolescent) used for staffing schedulers to us. The two staffing models are not a part of the policy. Also reviewed were time off logs, and staffing logs for December 21, 2014 through January 3, 2015 and March 29 through April 5 2015 (22 days total).
On 12/21/14 on the evening shift based on the "staffing model", the evening shift (PM) was 1 staff under minimum on the adult unit and 1 staff under minimum for the second half of the PM shift on the child/adolescent unit.
On 12/22/14 on the evening shift based on the staffing model, the PM shift was 1 staff under minimum on the adult unit and 1 staff under minimum for the second half of the shift. On the child/adolescent unit, the PM shift was down ½ staff the entire shift.

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On 12/23/14, the child/adolescent unit-staffing log shows two staff (1 RN and 1 LPN) on the night shift. Reviewing the time off log, on this date the RN is listed as "off". Leaving the night shift of 8 child/adolescent patients on that unit, 1 under minimum and without an RN on the unit.
On 12/24/14, the child/adolescent unit was 1 staff under minimum for the first half of the PM shift.
On 12/29/14 the adult unit was 1 staff below minimum for the first half of the PM shift.
On 03/29/15, the child/adolescent unit was 1 staff below minimum on the second half of the PM shift.
On 03/30/15, the child/adolescent unit was 1 staff below minimum on the second half of the PM shift.
On 04/03/15, the child/adolescent unit was 2 staff below minimum on the first half of the PM shift, and 1 staff below minimum on the second half of the PM shift.
For dates 12/25, 12/26, 12/27, 12/30, 12/31 2014 and 3/30, 3/31, 4/1, 4/2, 4/3, 4/4 and 4/5 2015 the census is below 22, the staffing model for the adult unit provides guidance for patient censuses of 22-54. In an interview about how to determine the staffing for levels below 22, Staffing Scheduler W stated, they would staff minimum and leave it up to the supervisor on duty, if they needed extra staff.
Staffing logs for both the adult and child/adolescent unit failed to include the census for all three shifts 1/1/2015 through 1/3/2015.
Staffing Scheduler W was asked to provide the census for the dates as soon as possible today (5/12/15, but no later than tomorrow via email).
No census for all three shifts between the dates of 1/1/2015 through 1/3/2015 was provided as of 4:30 PM, 5/13/15.
On 05/12/15 at 4:30 PM, in a review of staffing findings with VP of Operations I, without a clear

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R 411	Continued From page 15 definition of what acuity levels the mental health unit uses, and no consistent definition of patient acuity, Staffing Scheduler W used the two "staffing models" for the adult and adolescent unit, used by the staffing schedulers: 12 of the 22 days went below the staffing model census guidelines. No determination could be made if the staffing met policy, because the model did not provide guidance for the census levels below 22, and the policy does not define minimum or acuity. Of the remaining 11 days reviewed for staffing levels, 3 of 11 days did not have a census available to make a determination. The remaining 8 days had below minimum requirements 8 of 8 days with 7 of the 8 days being the PM shift. On 05/12/15 at 4:30 PM, VP of Operations I stated, with the introduction of the EPIC electronic health records, a staffing matrix is being built in. VP of Operations I stated, we have some more work to do, since that does not happen until November or December, and that electronic record system does not have a matrix for the child and adolescent population.	R 411		
R 433	124.13(6)(e) DOCUMENTATION,STAFF MEETINGS\EVALUATION The nursing service director shall ensure that there is ongoing review and evaluation of the nursing care provided for patients and shall ensure that nursing care standards and objectives are established and met.	R 433		7/2/15

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R 433	Continued From page 16 This Rule is not met as evidenced by: Based on interview and record review, the nursing service failed to accurately document 1 of 1 safety rounding document for Pt. #6. Pt. #6 eloped and did not return to the facility. Findings include: Facility policy entitled; "Patient Checks (Unit Checks) dated 03/15 was reviewed on 05/12/15 at 3:30 PM, it states; ......"Values of Respect and Integrity require us to ensure knowledge of the location and safety of patients on a 24-hour basis."...."Associates are assigned to do patient checks" on "Adult Inpatient Every 30 minutes". According to a medical record reviewed on 05/11/15 at 2:00 PM Pt. #6 eloped from an adult inpatient treatment unit. The safety rounds sheets was completed as if Pt. #6, was present and accounted for after Pt #6 eloped. On 05/12/15 between 8:00 AM and 4:15 PM, interviews conducted via telephone and in-person with unit staff that wish to remain anonymous A, E, RN P and RN S admitted the patient safety rounding documents were filled in by unit staff including themselves or observed firsthand unit staff or supervisors documenting work they had not completed by filling in the safety rounding sheets "to make it look good." Anonymous staff A, E, RN P and RN S, stated when the units are short staffed that was the expectation and unit culture. RN P stated, RN Supervisor V (terminated from employment) gave nursing staff directive to complete safety rounds sheets even if nursing staff were shorthanded and could not complete the work. Nursing Supervisor V was terminated and could not be interviewed to support or refute the statement.	R 433		

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R 433	Continued From page 17 On 05/12/15 at 11:57 AM RN Supervisor M stated I (M) did not fill in the safety rounds, and stated, I (M) "told them no, don't chart what you don't do." RN Supervisor confirmed M was aware of the practice. On 5/12/15 at 2:00 PM, VP of Operations I denied knowledge of safety rounding sheets being falsified or that it was the culture on the unit.	R 433		

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STATE OF WISCONSIN
Division of Quality Assurance
F-00344 (12/10)

PLAN OF CORRECTION

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Wheaton Franciscan Healthcare All Saints Inc	
Street Address/City/Zip Code:	
3801 Spring St, Racine, WI 53405	
License/Certification/ID Number (X1):	**123**
Survey Date (X3):	**05/12/2015**
Survey Event ID Number:	**B0QI11**

ID Prefix Tag (X4)	Provider's Plan of Correction (Each corrective action must be cross-referenced to the appropriate deficiency.)	Completion Date (X5)
R236	What will be Corrected: Removal and destruction of patient list book known as BH2 book which contained patient names and notes on patients that needed to Seek Alternative Placement, PIC only, and Assess Carefully. This book was turned over to Risk Management on 5/26/15 for destruction in compliance with HIPPA guidelines. Who will be responsible for corrections & monitoring future compliance: Director of Risk Management and Vice-President of Operations How will the corrections be made: 1. The BH2 book will be destroyed. 2. The Admission Criteria Departmental Policy will be revised to reflect admission criteria that will include exclusion criteria for all patients needing admission to the Mental Health and Addiction Care Unit, as well as guidance (chain of command) if there is a question regarding the ability to safely meet the patient's needs. 3. All inpatient mental health and addiction care staff will be educated on the policy revisions. 4. Compliance to policy will be monitored by reviewing all incidences of implementation of the chain of command starting June 15th to ensure compliance to new policy standards. Weekly monitoring will continue until 100% compliance is reached for 90 days. Results will be reported to the hospital's Quality Council (QAPI program oversight). When will the corrections be completed?	
	1. The BH2 book will be destroyed by Director of Risk Management by 5/29/15.	**05/29/2015**
	2. The Admission Criteria Departmental Policy will be revised before 06/01/2015.	**06/01/2015**
	3. All inpatient mental health and addiction care staff will be educated on the	**06/15/2015**

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	policy revisions by 6/15/15. **4.** Compliance to all policies will be monitored starting the week of 06/15/2015. **5.** Compliance monitoring results will be reported to the hospital's Quality Council starting 07/02/2015.	 **06/15/2015** **07/02/2015**
R252	**What will be corrected:** The following policies have been updated to meet patient safety standards as required per Wisconsin Administrative Code Chapter DHS 94, PATIENT RIGHTS AND RESOLUTION OF PATIENT GRIEVANCES: 1. Patient Belongings and Searches 2. Patient Belongings-Restricted and Controlled 3. Patient Check (Unit Checks) **Who will be responsible for corrections & monitoring future compliance:** Vice-President of Operations is responsible for corrections & monitoring future compliance. **How will the corrections be made:** 1. Patient Belongings and searches policy will be revised to reflect detailed gown search procedure. 2. Patient Belongings-Restricted and Controlled policy will be revised to reflect listing of restricted and controlled patient belongings. 3. Patient Check (Unit Checks) policy revised to include staff presence in patient care areas to ensure patient safety at all times on the inpatient units. This policy also outlines the process of correct patient identification standards for staff to ensure correct patient is present and safe on the unit. 4. All inpatient staff will be educated on the policy revisions. 5. Compliance to all policies will be monitored. Each week. Starting June 15th, 20 observations will be completed to ensure compliance to new policy standards. Weekly monitoring will continue until 100% compliance	

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	is reached for 90 days. Results will be reported to the hospital's Quality Council (QAPI program oversight). **When will the corrections be completed?** 1. Patient Belongings and searches policy will be revised by 05/29/2015. 2. Patient Belongings-Restricted and Controlled policy will be revised by 05/29/2015. 3. Patient Check (Unit Checks) policy will be revised by 05/29/2015. 4. Staff will be education on the policy revisions by 6/15/15. 5. Compliance to all policies will be monitored starting the week of 06/15/2015. 6. Compliance monitoring results will be reported to the hospital's Quality Council starting 07/02/2015.	**05/29/2015** **05/29/2015** **05/29/20105** **06/15/2015** **06/15/2015** **07/02/2015**
R399	**What will be Corrected:** The structure, delegation of authority, and oversight of nursing practice in the Mental Health departments will be evaluated and re-clarified by the Chief Nursing Officer for Wheaton Franciscan Healthcare-All Saints. **Who will be responsible for corrections & monitoring future compliance:** The Chief Nursing Officer will oversee the changes in the organized structure, plan of correction, and ongoing compliance through direct oversight and through designated nursing leaders. The Vice-President of Operations is responsible for monitoring compliance to policies. The Chairperson(s) of the Hospital's Quality Council (QAPI Program Oversight), and the President, is responsible for monitoring the Nursing Services compliance to regulatory standards. **How will the corrections be made:** 1. The CNO will evaluate and identify designated nursing leader for Mental Health Services who will function as a direct report for nursing practiced in designated Mental Health departments. The organizational chart will be updated to reflect those changes. 2. An identification of priorities and action plans for the immediate time period and upcoming fiscal year will be completed for each Mental Health	

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	Nursing Unit. This will be completed to include an assessment of alignment with state and federal regulatory requirements, the current state nursing practice needs, high-risk patient care issues, nursing staffing/resource needs, and other challenges confronting each department. The evaluation of policies, procedures, practice, and documentation relating to safety rounding, elopement, safety precautions relating to known sex offenders, search procedures, and visualization of patients on the unit will be included at a minimum. Priorities and specific initiatives to address identified needs and timeframes to be completed will be developed as well as metrics to measure process or outcome measures. This will be completed by the designated Mental Health Nursing leader and reviewed by the CNO. Nursing Services resources will be deployed to support priority initiatives as required. Ongoing performance to plan will evaluated at minimum of monthly by the CNO and Nursing Service leaders deployed to support the plan.	
	3. The Mental Health inpatient departments will implement standard leader work and tools to support daily operations and a clear process for elevation of unresolved concerns through to senior leadership and the CNO to include: Daily quality/safety huddles, use of a production board to identify high-risk issues of the day, participation in Nursing Services bed/resource daily meetings and monthly staffing/scheduling processes, participation in the market leadership safety huddle.	
	4. Compliance to processes will be monitored once weekly for completion. Weekly monitoring will continue until 100% compliance is reached for 90 days. Results will be reported to the hospital's Quality Council (QAPI program oversight).	
	When will the corrections be completed:	
	1. Nursing Leader identified and designated by 5/26/15.	**05/26/2015**
	2. Priorities and Actions plan to be completed by 6/5/15.	**06/052015**
	3. All action plan items relating to the evaluation of policies, procedures, practice, and documentation relating to safety rounding, elopement, safety precautions relating to known sex offenders, search procedures, and visualization of patients on the unit, as identified in the SOD, will be	**07/10/2015**

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	completed by 7/10/2015. 4. Implementation of department standard leader work, tools, and operational processes to be in place by 7/10/2015.	**07/15/2015**
R411	**What will be Corrected:** The nursing staffing planning and daily staffing process on Mental Health departments will be corrected to ensure full implementation and alignment with Nursing Services policies, procedures, and daily operational processes for scheduling, staffing, and deployment of staff. The process will support the matching of staffing resources to identify patient care needs on an ongoing basis. **Who will be responsible for corrections & monitoring future compliance:** The V.P. of Operations is the designated nursing leader for Mental Health nursing department and will be responsible for corrections and monitoring of compliance and reviewed monthly by the Chief Nursing Officer and Director of Operations Support. **How will the corrections be made:** 1. The Mental Health staffing and scheduling practices will be evaluated against the Nursing Services Staffing and Scheduling Policies and Procedures. Recommendations for improvements will be made to ensure alignment with organizational policy and addressing needs that may be unique to the Mental Health environment. This will be completed by the designated nursing leader for Mental Health and the Director of Operations Support. 2. The planned hours of nursing care and accompanying staffing plan will be evaluated against national benchmarks for like-departments to ensure alignment. The nursing staffing plan will also be evaluated in relation to patient activity. Recommendations to ensure alignment with benchmarks or patient need will be made by the designated nursing leader for Mental Health and Director of Operations Support and incorporated into a revised staffing plan that will be presented to the Chief Nursing Officer. Resources will be aligned to support a revised staffing plan and the scheduling of staff needs that result.	

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	3. The Mental Health inpatient departments will implement standard leader work and tools to support daily operations and a clear process for elevation of unresolved concerns through senior leadership and the CNO to include: Daily quality/safety huddles, use of a production board to identify high-risk issues of the day and related staffing resource needs, participation in Nursing Services bed/resource daily meetings, participation in Nursing Services monthly staffing/scheduling processes, and participation in the market leadership daily safety huddle. 4. A process for measuring staffing effectiveness of the Mental Health nursing department will be developed and implemented to include the correlation of defined measures of staffing with documented safety events. 5. Compliance to processes will be monitored once weekly for completion. Weekly monitoring will continue until 100% compliance is reached for 90 days. Results will be reported to the hospital's Quality Council (QAPI program oversight).	
	When will the corrections be completed:	
	1. Evaluation of current staffing and scheduling practices and recommendations for improvements to be completed by 6/5/15.	**06/05/2015**
	2. Evaluation of nursing hours and planned staffing to be evaluated with corresponding recommendations to be completed by 6/5/15.	**06/05/2015**
	3. Implementation of department standard leader work, tools, and operational processes to be in place by 7/10/2015.	**07/10/2015**
	4. A process for measuring staffing effectiveness in Mental Health nursing departments and monitoring on an ongoing basis will be completed by 7/10/15.	**07/10/2015**

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	5. Compliance to all processes will be monitored starting the week of 06/15/2015 6. Compliance monitoring results will be reported to the hospital's Quality Council starting 07/02/2015	**05/15/2015** **07/02/2015**
R433	**What is corrected:** Staff knowledge, understanding and compliance with the expectations regarding the accuracy and timeliness of documentation. **Who will be responsible for corrections & monitoring future compliance:** Director of Risk Management and Vice-President of Operations **How will the corrections be made:** **1.** Education will be provided to all inpatient staff regarding expectations of the accuracy and timeliness of documentation. **2.** A Statement of Understanding will be signed by Mental Health and Addiction Care Inpatient Associates that acknowledges that falsification of any documentation is not an allowable practice and will be grounds for immediate disciplinary action. All Associates will have signed form completed and placed into Associate File. **When will the corrections be completed** 1. Education will be provided to all inpatient staff regarding expectations of the accuracy and timeliness of documentation completed by 6/15/15. 2. A Statement of Understanding will be signed by Mental Health and Addiction Care Inpatient Associates that acknowledges that falsification of any documentation is not an allowable practice and will be grounds for immediate disciplinary action. All Associates will have signed form completed and placed into Associate File. as evidenced by 100% of inpatient associates will have signed letter in their file completed 06/15/2015 3. Compliance monitoring to accurate documentation of safety rounds will occur as addressed in R252 starting 07/02/2015	**06/15/2015** **06/15/2015** **07/02/2015**