STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 000	Initial Comments On 01/31/2025 to 02/13/2025, Surveyor conducted 3 complaint investigations, standard survey, and verification visit at Wellington Place at Biron. Sixteen deficiencies were identified. One of 16 deficiencies was a repeat violation. See Statement of Deficiency (SOD) #F9O311,dated 10/12/2022. Two complaints were substantiated. One complaint was unsubstantiated. Per state statutes a $200.00 re-visit fee is assessed. Census: 22	N 000		
N 196	83.14(2)(a) Licensee ensures facility complies with laws The licensee shall ensure the CBRF and its operation comply with all laws governing the CBRF. This Rule is not met as evidenced by: Based on record review and interview, the licensee did not ensure the CBRF and its operation complied with all laws governing the CBRF. From 10/12/2022 to 02/13/2025, the provider did not comply with all the laws governing the CBRF as evidenced by 33 deficiencies identified and 13 complaints substantiated. The current survey included investigation of 3 complaints, a	N 196		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 196	Continued From page 1 verification visit, and standard survey. As a result, 16 deficiencies were identified. Findings include: Example 1: Obtain and maintain compliance with laws governing the CBRF: On 10/12/2022, Surveyor conducted 9 complaint investigations and standard survey. As a result of the survey 8 deficiencies were identified in Statement of Deficiency (SOD) #F9O311. Six of 9 complaints were substantiated. On 06/20/2023, Surveyor conducted 8 complaint investigations and a verification visit. As a result of the survey 9 deficiencies were identified in SOD #F9O312. Four of 8 complaints were substantiated. On 10/31/2023, Surveyor conducted 6 complaint investigation and a verification visit. As a result of the survey 0 deficiencies were identified. Six of 6 complaints were unsubstantiated. On 02/16/2024, Surveyor conducted 2 complaint investigations. As a result of the survey 3 deficiencies were identified in SOD #4O8811. 1 of 2 complaints was substantiated. On 04/25/2024, Surveyor conducted 3 complaint investigations. As a result of the survey 0 deficiencies were identified. Three of 3 complaints were unsubstantiated. On 02/13/2025, Surveyor conducted 3 complaint investigations, standard survey, and verification visit. As a result of the survey 16 deficiencies were identified. Two of 3 complaints were substantiated.	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 196	Continued From page 2 Example 2: Repeat violations of laws governing the CBRF. 1) 83.12(3)(a) Investigate Injuries Of Unknown Source SOD #F9O311,dated 10/12/2022 and SOD #F9O312, dated 06/20/2023. 2) 83.32(3)(h) Rights Of Residents: Receive Medication SOD #F9O311,dated 10/12/2022 and SOD #F9O312, dated 06/20/2023. 3) 83.38(1)(g) Health Monitoring SOD #F9O311, dated 10/12/2022 and SOD #4O8812, dated 02/13/2025. 4)83.43(1) Environment Safe, Clean, And Comfortable SOD #F9O311,dated 10/12/2022 and SOD #F9O312, dated 06/20/2023. Example 3: Number of Complaints Substantiated 1) SOD #F9O311, dated 10/12/2022, 6 complaints substantiated. 2) SOD #F9O312, dated 06/20/2023, 4 complaints substantiated. 3) SOD #4O8811, dated 02/06/2024, 1 complaint substantiated. 4) SOD #4O8812, dated 02/13/2025, 2 complaints substantiated. On 02/13/2025 at 3:00 PM, Surveyor conducted an exit conference and shared findings with VP of Operations (VPO) B. VPO B acknowledged an	N 196		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 196	Continued From page 3 understanding of the concerns and reported the provider is aware of areas needed for improvement. VPO B stated s/he was unaware of the non-compliance issues dating back to 2022 and the high number of complaints investigated and substantiated. VPO B stated s/he needed to absorb the Surveyor's findings before moving forward with plans of corrections. Summary: The licensee did not ensure the facility and its operation complied with all laws governing the CBRF.	N 196		
N 220	83.17(2)(a) Employees screened for communicable disease. The CBRF shall obtain documentation from a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse indicating all employees have been screened for clinically apparent communicable disease including tuberculosis. Screening for tuberculosis shall be conducted using centers for disease control and prevention standards. The screening and documentation shall be completed within 90 days before the start of employment. The CBRF shall keep screening documentation confidential, except the department shall have access to the screening documentation for verification purposes. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure documentation was obtained from a physician, physician assistant, clinical nurse practitioner, or licensed registered nurse indicating 2 of 2 employees (Caregiver D	N 220		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 220	Continued From page 4 and Caregiver E) reviewed was screened for clinically apparent communicable disease including tuberculosis (TB). Findings include: On 01/31/2025, Surveyor reviewed employee records and identified the following: -Caregiver D was hired on 05/17/2024. His/her record did not include a baseline TB test. -Caregiver E was hired on 05/29/2024. His/her record did not include a baseline TB test. On 01/31/2025 at 2:00 PM, Surveyor interviewed Regional Director A. Regional Director A acknowledged an understanding of the concern and confirmed s/he could not find evidence of TB tests for Caregiver D and Caregiver E. Regional Director A reported a previous administrator hired the above staff. Regional Director A acknowledged an understanding of the concern and stated both staff would get new testing completed.	N 220		
N 247	83.22(1)-(4) Task specific training. The CBRF shall provide, obtain or otherwise ensure adequate training for employees performing job duties in all of the following: Assessment of residents. All employees responsible for resident assessment shall successfully complete training in the assessment of residents prior to assuming these job duties. Specific training topics shall include: assessment methodology, assessment of changes in condition, sources of assessment information, and documentation of the assessment.	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 247	Continued From page 5 Individual service plan development. All employees responsible for service plan development shall successfully complete training in individual service plan development prior to assuming these job duties. Specific training topics shall include: identification of the resident ' s needs and desired outcomes, development of goals and interventions, service plan evaluation and review of progress. Provision of personal care. All employees responsible for providing assistance with activities of daily living shall successfully complete training prior to assuming these job duties. Specific training topics shall include, as appropriate: bathing, eating, dressing, oral hygiene, nail and foot care, toileting and incontinence care, positioning and body alignment, and mobility and transferring. Dietary training. All employees performing dietary duties shall complete dietary training within 90 days after assuming these job duties. Specific training topics shall include: determining nutritional needs, menu planning, food preparation and food sanitation. This Rule is not met as evidenced by: Based on staff interview and record review, the provider did not ensure 2 of 2 employees obtained all task specific training. Caregiver D and Caregiver E, who perform dietary duties, did not have training in dietary services within 90 days after assuming these job duties. Findings include:	N 247		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 247	Continued From page 6 On 01/31/2025, Surveyor conducted a review of 2 employees to verify compliance with task specific training requirements. Surveyor requested training records from Regional Director A for Caregiver D and Caregiver E. Dietary Training On 01/31/2025 at approximately 12:00 PM, Surveyor observed staff preparing meals. The record for Caregiver D, hired 05/17/2024, did not contain evidence of training or evidence of meeting an exemption for dietary training. The record for Caregiver E, hired 05/29/2024, did not contain evidence of training or evidence of meeting an exemption for dietary training. On 02/13/2025 at 3:00 PM, Surveyor conducted an exit conference and shared findings with VP of Operations (VPO) B. VPO B acknowledged an understanding of the concern. VPO B stated s/he would ensure dietary training is completed going forward.	N 247		
N 277	83.25 Continuing education The administrator and resident care staff shall receive at least 15 hours per calendar year of continuing education beginning with the first full calendar year of employment. Continuing education shall be relevant to the job responsibilities and shall include, at a minimum, all of the following: (1) Standard precautions; (2) Client group related training; (3) Medications; (4) Resident rights; (5) Prevention and reporting of abuse, neglect and	N 277		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 277	Continued From page 7 misappropriation; (6) Fire safety and emergency procedures, including first aid. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 1 employee (who required continuing education) completed at least 15 hours of continuing education in 2024. Findings include: On 01/31/2025, Surveyor reviewed Caregiver F's record and identified the following: Caregiver F was hired 03/13/2023. Caregiver F's record did not include any hours of continuing education training in 2024. On 02/13/2025 at 3:00 PM, Surveyor conducted an exit conference and shared findings with VP of Operations (VPO) B. VPO B acknowledged an understanding of the concern. VPO B reported Former Administrator H was in charge of ensuring training was completed.	N 277		
N 387	83.35(3)(b) Service plan development: parties involved Development. The CBRF shall involve the resident and the resident ' s legal representative, as appropriate, in developing the individual service plan and the resident or the resident ' s legal representative shall sign the plan acknowledging their involvement in, understanding of and agreement with the plan. If a resident has a medical prognosis of terminal	N 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 387	Continued From page 8	N 387		

illness, a hospice program or home health care agency, as identified in s. HFS 83.38(2) shall, in cooperation with the CBRF, coordinate the development of the individual service plan and its approval under s. HFS 83.38 (2) (b). The resident ' s case manager, if any, and any health care providers, shall be invited to participate in the development of the service plan.

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not ensure 6 of 6 individual service plans (ISP) reviewed were developed with involvement from the resident and resident's legal representative.

Findings include:

On 01/31/2025, Surveyor reviewed resident records and identified the following:

Resident 2 was admitted on 08/18/2022. Resident 2 had a legal guardian. Resident 2's most recent ISP dated 09/26/2023 did not contain a signature from his/her guardian.

Resident 3 was admitted on 12/10/2021. Resident 3 had a legal guardian. Resident 3's most recent ISP dated 01/11/2024 did not contain a signature from his/her guardian.

Resident 5 was admitted on 01/25/2021. Resident 5 had a legal guardian. Resident 5's most recent ISP with an unknown date did not contain a signature from his/her guardian.

Resident 10 was admitted on 01/13/2022.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 387	Continued From page 9 Resident 10 had an activated healthcare power of attorney. Resident 10's most recent ISP dated 02/22/2024 did not contain a signature from his/her legal representative. Resident 11 was admitted on 04/08/2020. Resident 11 had a legal guardian. Resident 11's most recent ISP dated 09/21/2023 did not contain a signature from his/her guardian. Resident 13 was admitted on 01/05/2024. Resident 13 had an activated healthcare power of attorney. Resident 13's most recent ISP dated 03/06/2024 did not contain a signature from his/her legal representative. On 02/13/2025 at 3:00 PM, Surveyor shared findings with VP of Operations (VPO) B. VPO B reported after looking through records, the provider did not have evidence resident care plans were reviewed and signed at care conferences. VPO B noted the gaps identified from previous findings were beyond his/her control, but the provider recognized where improvements needed to be done.	N 387		
N 389	83.35(3)(d) Service plans updated annually or on changes Individual service plan review. Annually or when there is a change in a resident ' s needs, abilities or physical or mental condition, the individual service plan shall be reviewed and revised based on the assessment under sub. (1). All reviews of the individual service plan shall include input from the resident or legal representative, case manager, resident care staff, and other service providers as appropriate. The resident or resident ' s legal representative shall sign the	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 389	Continued From page 10 individual service plan, acknowledging their involvement in, understanding of and agreement with the individual service plan. This Rule is not met as evidenced by: Based on observation, record review, and interview, the individual service plan (ISP) was not updated for 3 of 3 resident record reviewed when there was a change in resident needs and abilities. Resident 2's, Resident 5's and Resident 11's ISP were not updated to include the use of adaptive equipment to aid in transferring in and out of bed. According to the U.S. Food & Drug Administration's Hospital Bed Safety Workgroup, "...Strangling, suffocating, bodily injury, or death can occur when patients or parts of their bodies are caught between rails or between the bed rails and mattresses...Regardless of the purpose for which bed rails are being used or considered, a decision to utilize or remove those in current use should occur within the framework of an individual patient assessment...3. Use of bed rails should be based on patients' assessed medical needs and should be documented clearly...Bed rail effectiveness should be reviewed on a regular basis...The patient's chart should include a risk-benefit assessment that identifies why other care interventions are not appropriate or not effective if they were previously attempted and determined not to be the treatment of choice for the patient. 4. Bed rail use for treatment of a medical symptom or condition should be accompanied by a care plan (treatment program) designed for that symptom or condition. The plan should present clear directions for further	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 389	Continued From page 11	N 389		

investigation of less restrictive care interventions. The documentation should describe the attempts to use less restrictive care interventions and, if indicated, their failure to meet patients' assessed needs...The care plan should: include educating the patient about possible bed rail danger to enable the patient to make an informed decision; and address options for reducing the risks of the rail use..." (Source: "Clinical Guidance For the Assessment and Implementation of Bed Rails In Hospitals, Long Term Care Facilities, and Home Care Settings" https://www.fda.gov/media/88765/download (retrieval date 02/17/2025)).

Findings include:

Example 1: Resident 2

On 01/31/2025 9:38 AM, Surveyor observed Resident 2's bedroom and observed a half-length side rail attached to the right side of Resident 2's hospital bed.

On 01/31/2025, Surveyor reviewed Resident 2's record. Resident 2 was admitted to the provider on 08/18/2022 with diagnoses including pervasive developmental disorder and seizures. Resident 2's most recent individual service plan (ISP) dated 09/26/2023 identified him/her as a fall risk, required assistance with all activities of daily living (ADLs), at risk for pressure sores, and displayed behaviors such as refusing cares and verbal/physical aggression. Documented under the falls section: "Staff will assist [Resident 2] with all transfers. Staff will ensure they are using the floor/fall mat in [Resident 2's] suite when [s/he] is in [his/her] bed. [Resident 2] is at risk for pressure ulcer due to bedfast/mobility. Staff will turn and reposition every 2 hours and PRN." The ISP did

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 389	Continued From page 12 not address the use of half-length side rail. Example 2: Resident 5 On 01/31/2025 at 9:54 AM, Surveyor observed Resident 5's bedroom and observed quarter-length side rails attached to each side of Resident 5's hospital bed. On 01/31/2025, Surveyor reviewed Resident 5's record. Resident 5 was admitted to the provider on 01/25/2021 with diagnoses including history of hemiplegia affecting right dominant side, reduced mobility, and chronic pain syndrome. Resident 5's most recent ISP dated 09/21/2023 documented: "[Resident 5] is able to ambulate in [his/her] wheelchair without assistance. [S/he] has right side paralysis post stroke. [Resident 5] need assistance with transferring. Staff will use a gait belt with transferring. Resident is at risk for falls and pressure ulcers." The ISP did not address the use of quarter-length side rails. Example 3: Resident 11 On 01/31/2025 at 9:47 AM, Surveyor observed Resident 11's bedroom and observed half-length side rails attached to each side of Resident 11's hospital bed. On 01/31/2025, Surveyor reviewed Resident 11's record. Resident 11 was admitted to the provider on 09/22/2020 with diagnoses including epilepsy, history of falls/convulsions, and moderate intellectual disabilities. Resident 11's most recent ISP dated 09/21/2023 identified him/her as a fall risk, required assistance with ADL's and documented the following under Transferring: "[Resident 11] is unable to transfer by [his/herself]. [S/he] requires assistance from 2	N 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 389	Continued From page 13 staff. Hospice ordered a sit-to-stand for [Resident 11]." The ISP did not address the use of half-length side rails. On 01/31/2025 at 2:00 PM, Surveyor interviewed Regional Director A regarding the above concerns. Regional Director A acknowledged an understanding of the concerns and stated when side rails are used, the ISP should reflect that. Regional Director A reported concerns with Former Administrator H not updating care plans. Regional Director A stated the new administrator had just started and s/he would work with him/her to ensure ISP's are updated in the future.	N 389		
N 431	83.38(1)(g) Health monitoring. As appropriate, the CBRF shall teach residents the necessary skills to achieve and maintain the resident ' s highest level of functioning. In addition to the assessed needs as determined under s. DHS 83.35(1), the CBRF shall provide or arrange services adequate to meet the needs of the residents in all of the following areas: Health monitoring. 1. The CBRF shall monitor the health of residents and make arrangements for physical health, oral health or mental health services unless otherwise arranged for by the resident. Each resident shall have an annual physical health examination completed by a physician or an advanced practice nurse as defined in s. N 8.02(1), unless seen by a physician or an advanced practice nurse as defined in s. N 8.02(1) more frequently. 2. When indicated, a CBRF shall observe residents ' food and fluid intake and acceptance of diet. The CBRF shall report significant deviations from normal food and fluid intake patterns to the resident ' s physician or dietician. 3. The CBRF shall document	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 431	Continued From page 14 communication with the resident ' s physician and other health care providers, and shall record any changes in the resident ' s health or mental health status in the resident ' s record. This Rule is not met as evidenced by: Based on interview and record review, the provider did not ensure Resident 10's health was monitored to meet Resident 10's needs in relation to a change in condition. On 06/04/2024-06/18/2024, Resident 10 sustained falls, a fracture, a UTI, and a change in condition that was not documented or communicated to their legal representative and his/her physician in a timely manner. The findings include: On 06/20/2024 and 07/09/2024, the Department received complaints alleging concerns with resident's health not being monitored or communicated. On 01/31/2025, Surveyor reviewed Resident 10's record and identified the following: Example 1: Fall and fracture concerns Resident 10 admitted to the facility on 01/13/2022 with diagnosis including dementia, psychotic disturbance, and anxiety. Resident 10 had an	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 431	Continued From page 15	N 431		

activated healthcare power of attorney.

Resident 10's individual service plan (ISP) dated 02/23/2024 documented:
"Fall Risk: [Resident 10] is a high risk of failing due to [his/her] diagnosis, history of falls, and medications. Increased staff supervision with intensity based on resident need. Staff will check on resident frequently while [s/he] is in [his/her] suite when [s/he] is experiencing increased confusing or appears unsteady. Staff will offer [Resident 10] a wheelchair or walker when [s/he] appears weak or unsteady.
Mood & Behaviors: [Resident 10] has a diagnosis of dementia. [Resident 10] will at times be confused, sad, and withdrawn and is an elopement risk. Since being at [provider], [Resident 10] has displayed some confusion and exit seeking behavior. [Resident 10] has also smoked cigarettes in suite. [Resident 10] has displayed some physically aggressive behavior with staff while they assisted with personal cares. [S/he] will hit, bite, kick, yell, and lower [him/herself] to the floor."

Resident 10's incident reports documented:
"06/04/2024: Resident had an un-witnessed fall in the dining room. It was not witnessed when writer was notified by staff that resident was on the floor, resident was sitting on the floor in the center of the dining room with [his/her] legs crossed, sitting in front of [his/her] wheelchair Resident was not able to relay what happened leading up to [his/her] sitting on the floor, more confusing on getting into [his/her] chair, and seemed overwhelmed of all the people standing around [him/her]. Once [s/he] got back into [his/her] chair, [s/he] seemed to clam down much more and staff was able to attain vitals. Pain observations: resident stated several times that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 431	Continued From page 16	N 431		

[s/he] was not in pain, but it did appear as if [s/he] might have been as [s/he] was leaning slightly to one side which is abnormal for [him/her]. Writer notified med passer of this. Physician notified: No.

06/08/2024: Writer and staff went into residents' room to do morning cares and while changing [his/her] shirt noticed some light bruising and asked resident if that area hurt or was sore and resident stated no. Staff asked if [s/he] was sure there was no pain in the area and resident again stated no. Staff proceeded with morning cares as normal and noticed no signs of pain in resident. Staff then brought resident to dining room for breakfast. Resident ate as normal." (This was not reported to the physician or legal representative.)

06/09/2024: "RN notified via telephone by staff, that resident had a quarter sized bump and bruise to [his/her] neck. No open areas noted. RN recommended a PRN Tylenol and ice pack for resident comfort. RN will continue to monitor." (This was not reported to the physician or legal representative.)

06/11/2024: "Update on resident's shoulder. Shoulder seems to be swollen more and bruising remains. Writer will contact RN about concerns ....Writer contacted RN about resident's left shoulder and left arm swelling and bruising. RN suggested that writer send resident down to the ER. Writer called resident's guardian and spoke with [him/her] at 9:20 and explained concerns and what RN had suggested ....Residents left shoulder blade appears to be swollen and resident's left shoulder downwards appears to be dark red, purple, and black in color. Resident did not have any complaints of pain in the affected area however writer noticed during transfers that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 431	Continued From page 17	N 431		

resident was using [his/her] right arm and grabbing the neck/shoulder blade area ....Resident's family came down to the facility to look at resident ....Writer observed that resident's upper left shoulder blade area appears to be protruding and felt extremely hard to the touch. Family initially stated that they were going to take [him/her] down to the ER however decided that a transport via ambulance would be better for [him/her].

06/12/2024: Resident came back from emergency room and was incontinent when dropped off ...Applied arm sling to resident via ambulance drivers request because at the time resident was combative."

Resident 10's progress noted documented: "06/09/2024: Writer and staff went to change and put resident to bed and when we were changing residents shirt we noticed a quarter size bump on the back of residents left side of neck and shoulder, it is about as tall as quarter also and has bruising on and around it. On call was notified and so was the RN, we will keep an eye on it." (This was not reported to the physician or legal representative.)

"06/13/2024 written by Former Administrator H: "Resident's palliative provider was notified of the fall on 6/4, resident had no complaints of pain or discomfort at that time and did not appear to have injury. Resident's primary care provider was notified of [his/her] fall and ER visit. [S/he] has a follow-up appointment scheduled for Monday 6/17." Resident 10's physician was not notified until 9 days after the initial fall on 06/04/2024 and subsequent findings of bruising/change in condition.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 431	Continued From page 18	N 431		

06/14/2024 at 11:55 PM: "Staff went down to resident and notice that resident was on the floor and not for sure if the resident fell or sat down on the floor. Staff came and told writer and staff went back down with the vital kit that time was 11:15 PM and resident wouldn't get off the floor or have staff help them get off the floor ....Writer did call the [son/daughter] to help get the resident off the floor ....the [son/daughter] thinks that there [mother/father] might be in pain because [s/he] is getting kinda [sic] upset with [him/her] and most of the time the resident don't with the [son/daughter].

06/15/2024 at 5:42 AM: Resident has been checked on thru out the night and is still on the floor. Resident refuses to let anyone help [him/her] and wants to stay on the floor, so writer put a blanket over resident, resident has been dry all night." (This was not reported to the physician or legal representative.)

06/18/2024 at 12:20 AM: Writer went down and checked on resident, resident is sitting in bed and is dry and is refusing to wear their sling for their arm. Staff told writer that resident wasn't looking very well and felt hot and went and took vitals and told writer that residents temp was 104.6. When writer went down and checked on residents temp it was not high it was 97.6. Resident does feel a little clammy and cool though. Resident didn't want writer to check residents temp again but writer able to do it. 2:52 AM: Resident refused being changed and being assisted with laying down. Resident is still sitting on the edge of their bed, resident seems to be in pain, but is refusing taking anything. At 4:28 AM: Resident is refusing to be changed and assisted with laying down in bed. Resident is still sitting on the edge of their bed and is also refusing to wear their arm sling,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 431	Continued From page 19	N 431		

and refusing to take anything for pain. Resident is still saying "ow." At 6:01 AM: Resident has been at the edge of their bed all night and refusing and being combative with writer and staff and will not let either of us change them and still refusing to take anything for pain and resident is still saying "ow" and looking like they are in a lot of pain. (This was not reported to the on-call, the physician, or legal representative.)
06/18/2024 at 2:21 PM: RN at facility for routine visit. Rn notified that resident had rolled out of bed around 9:00am this morning ...Around 2:00pm resident fell out of [his/her] wheelchair onto the dining room floor. Resident was resistive to vitals being taken and was also combative when EMS arrived to get resident on the stretcher. Resident was transported to Riverview Hospital by Wisconsin Rapids EMS for further evaluation."

Surveyor requested Resident 10's medical record from the provider multiple times and got limited documentation:
"06/11/2024: After visit summary, Reason for visit-Shoulder injury, Diagnoses-Ecchymosis, Clavicular fracture. Instructions-Keep the left arm in a sling. Follow up with orthopedic surgery. Follow up with primary care physician. Chief complaint: Patient has shoulder bruising and deformity, staff states for a few days. Patient is not in pain." (This was not reported to the physician until 2 days later on 06/13/2024).

06/18/2024: "After visit summary, Reason for visit-Trauma 3, Falls. Instructions: I discussed with you the results of your physical exam and imaging. I discussed with the patient's POA that they do no want to have surgical intervention performed for this fracture."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 431	Continued From page 20 On 02/10/2025 at 2:54 PM, Surveyor interviewed Legal Representative I regarding the above concerns. Legal Representative I reported Resident 10 had advanced dementia and thought I was his/her mother. Legal Representative I reported s/he was contacted after 9pm on 06/11/2024 and was told about Resident 10's injuries and the provider's RN wanted him/her sent out. Legal Representative I reported s/he went to the facility and observed a contusion to Resident 10's head and lump on his/her left shoulder. Legal Representative I reported s/he met Resident 10 at the hospital, and s/he was diagnosed with a clavicle fracture. Legal Representative I stated the doctor at the hospital said per their observations the clavicle injury happened 3-4 days prior to being brought in. Legal Representative I stated the physician was starting to get mad with him/her and s/he had to tell the physician s/he was just notified Resident 10's condition tonight. Legal Representative I reported s/he was unaware Resident 10 had a change in condition since their fall on 06/04/2024. Legal Representative I stated s/he would had Resident 10 sent out sooner if s/he had known injuries were that bad. Surveyor asked Legal Representative I if s/he was made aware of additional falls on 06/14/2024 and morning of 06/18/2024 per Resident 10's record. Legal Representative I stated s/he was not made aware until the afternoon of 06/18/2024 after Resident 10 had their second fall of the day and was being sent to the ER. Legal Representative I reported a historical concern with the provider's ability to communicate medical concerns and when they did, it's multiple days after the injuries are occurring. Example 2: UTI concerns	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 431	Continued From page 21 On 07/09/2024, the Department received a complaint alleging concerns a resident was sent to a medical appointment alone via a taxi. Resident 10's ISP dated 12/12/2023 in the Toileting section documented: "[Resident 10] is incontinent and needs assistance with changes and reminders to use the bathroom. Personal Cares section: [Resident 10] requires assistance from 1 staff and queuing to complete personal cares. [S/he] is often resistant to cares and assistance. Communication section: [Resident 10] is able to speak clearly. [S/he] is not always able to communicate [his/her] wants and needs due to [his/her] dementia diagnosis. [Resident 10] no longer has a cellphone and does not know how to use a phone without assistance." Resident 10's progress notes documented: "06/13/2024 written by Former Administrator H: Resident's palliative provider was notified of the fall on 6/4, resident had no complaints of pain or discomfort at that time and did not appear to have injury. Resident's primary care provider was notified of [his/her] fall and ER visit. [S/he] has a follow-up appointment scheduled for Monday 6/17. 06/17/2024 written by Former Administrator H: Resident went out to a scheduled follow up appointment today to (primary care physician). The appointment was scheduled for Friday but the hospital called and rescheduled. While at the appointment, we received a call stating that [s/he] was being sent to the ER for confusion. Resident has a diagnosis of UTI." Surveyor requested Resident 10's medical record from the provider multiple times and got limited documentation:	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 431	Continued From page 22 "06/17/2024: After visit summary, Reason for visit-Altered mental status, Diagnosis-Urinary tract infection. Instructions: I discussed with you the results of your labs and imaging. I discussed with you that I will treat you with antibiotics for the urinary tract infection. Discussed with you the consult for social services. I discussed with you the patient will likely need to continue to see ortho for follow up regarding left should and clavicle fracture. The patient does not describe any [pain to [his/her] left should and clavicle today." On 02/10/2025 at 2:54 PM, Surveyor interviewed Legal Representative I regarding the above concerns. Legal Representative I reported all care coordination for medical appointments was supposed to go through him/her due to Resident 10's dementia. Legal Representative I reported someone at the provider had scheduled a follow up appointment with Resident 10's primary care physician following their clavicle fracture for 06/17/2024 without notifying anyone else. Legal Representative I reported Resident 10 was sent to their appointment in a taxicab alone. Legal Representative I stated s/he received a call from the medical provider explaining Resident 10 was sent to an appointment alone, they appeared confused, their depend was soiled, and they had a strong odor of urine. The medical provider reported Resident 10 did not know their name or date of birth, but after some time, Resident 10 was able to spell his/her last name, and his/her chart was located and Legal Representative I was called. Resident 10 was sent to the ER and diagnosed with a UTI. Legal Representative I stated when s/he asked the staff why Resident 10 was sent alone to an appointment, they stated they did not have enough staff to assist with transportation. Legal Representative I reiterated the ongoing challenges with the provider to	N 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 431	Continued From page 23	N 431		

communicate effectively about medical concerns or appointments.

On 02/13/2025 at 8:17 AM, Surveyor received an email from VP of Operations (VPO) B stating: "I feel the need to explain as upon reflection and getting more information from the leading staff at Biron - it seems that this survey process on our end did not go very smoothly. I apologize for any delays in information and or poor communication. I am not new to my role but new in the last week to providing more direct oversight to our CBRF's particularly Biron. In looking at the resident [Resident 10] you are requesting information on I can clearly see there were gaps in documentation particularly by our RN and the start of any type of investigation to this resident's new complaints of pain and subsequent findings. I know this resident's family was very difficult however we are still responsible for doing our due diligence."

On 02/13/2025 at 3:00 PM, Surveyor interviewed VPO B regarding the above concerns. VPO B reported when gathering documentation from Resident 10's closed record, it had been difficult with new management in place. VPO B stated s/he could not reach out to Former Administrator H since s/he left as a disgruntled employee. VPO B confirmed when looking over Resident 10's record like mentioned in previous email, s/he acknowledged the provider had gaps in documentation and did not look further into new complaints of pain. VPO B stated the provider will be addressing the health monitoring concerns with having an RN come to the building weekly rather than bi-monthly and working with Oak Medical services to provide monthly rounding by a medical provider.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 452	Continued From page 24	N 452		
N 452	83.41(3)(b) Food safety. Food safety. Whether food is prepared at the CBRF or off-site, the CBRF shall store, prepare, distribute and serve food under sanitary conditions for the prevention of food borne illnesses, including food prepared off-site, according to all of the following: 1. The CBRF shall refrigerate all foods requiring refrigeration at or below 40°F. Food shall be covered and stored in a sanitary manner. 2. The CBRF shall maintain freezing units at 0°F or below. Frozen foods shall be packaged, labeled and dated. 3. The CBRF shall hold hot foods at 140°F or above and shall hold cold foods at 40°F or below until serving. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure food was stored under sanitary conditions for the prevention of food borne illnesses. Surveyors observed 1 of the freezer units not holding a temperature of 0 degrees F or below. Findings include: On 01/31/2025 at 10:30 AM, Surveyor toured the provider's kitchen. Surveyor observed the main freezer unit was not holding a temperature at 0 degrees F or below. From 1:53 PM-2:03 PM, Surveyor rechecked the freezer unit with Maintenance Director C. The provider's freezer	N 452		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 452	Continued From page 25 unit had a thermometer gauge on the outside of the unit that read between 25 degrees F-35 degrees F. Surveyor observed many food items in the freezer were no longer frozen and some meat items were soft to the touch. Maintenance Director C stated s/he did not know how long the freezer was not working for and would call their contractor. On 02/13/2025 at 3:00 PM, Surveyor reviewed food safety concerns with VP of Operations (VPO) B. VPO B acknowledged the freezer unit was not holding a temperature per the requirement but noted a refrigeration company had fixed the issue. Surveyor asked for evidence of the freezer unit being fixed and sent by 12:00 PM on 02/14/2025. As of 02/15/2025, evidence was not provided to show freezer unit had been fixed.	N 452		
N 487	83.44(1)(b) Separate laundry storage areas or containers Storage and transport. The CBRF shall have separate clean and dirty laundry storage areas or containers. Storage containers shall be clean, leak-proof and have a tight fitting lid. The CBRF may not transport, wash or rinse soiled laundry in areas used for food preparation, serving or storage. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure resident laundry had separate clean and dirty storage areas. Findings include:	N 487		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 487	Continued From page 26 On 01/31/2025 at 9:42 AM, Surveyor toured the facility. Surveyor observed soiled clothing on bedrooms floors and in bathroom shower areas. Surveyor observed 6 laundry baskets filled with soiled clothing in the laundry room. The laundry baskets did not have lids and not lined with plastic. On 01/31/2025 at 9:43 AM, Surveyor interviewed Care Coordinator G regarding the laundry concerns observed during the tour. Care Coordinator G acknowledged soiled clothing had been observed on bedroom floors, bathroom shower areas, and laundry room. Care Coordinator G reported a staff member called in so housekeeping had to be pulled to work the floor. Care Coordinator G stated s/he did not know why soiled clothing was observed on the floor in many areas. On 01/31/2025 at 12:50 PM, Surveyor interviewed Resident 1. Resident 1 reported concerns with resident laundry not being completed timely. Resident 1 stated the provider's staffing pattern made it difficult to keep up with the laundry.	N 487		
N 489	83.44(2)(a) Rooms clean and free from odors. The CBRF shall keep all rooms clean and shall make reasonable attempts to keep all rooms free from odors. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure all rooms were clean and free from odors. Seven resident rooms had pungent odors consistent with urine.	N 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 489	Continued From page 27 Findings include: On 06/20/2024, the Department received a complaint alleging concerns with odors in the facility. On 01/31/2025, Surveyor toured the facility with Care Coordinator G and observed the following: During the tour of the facility the urine odor was pronounced in resident rooms, in Resident 2's, in Resident 3's, in Resident 5's, and in Resident 7's room. Other areas of concern observed. Resident 2's bedroom: -The carpet had many stains throughout the bedroom. The room had a pungent urine odor. Resident 3's bedroom: -The floor was 50 % covered in a mixture of what appeared to be shredded paper products and garbage. The carpet had many stains throughout the bedroom. Surveyor observed a laundry basket filled with soiled clothing and many articles of clothing hanging out of the basket onto the floor. The room had a pungent urine odor. Resident 4's bedroom: -The toilet bowel had a ring of black substance along the waterline. Resident 5's bedroom: -Surveyor observed a pillow on Resident 5's bed that had faded brown stains throughout the whole pillow. The mattress itself had a large brown faded stain in the center. There was a small kitchenette missing many drawers. The room had a pungent urine odor. Resident 6's bedroom:	N 489		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 489	Continued From page 28 -The toilet riser had brown matter consistent with fecal matter stuck to it. Resident 7's bedroom: -Surveyor observed soiled clothing piled up in the corner of the bathroom. The toilet seat had a large brown stain consistent with fecal matter.. Surveyor observed food crumbs and trash throughout the floor. Observed soiled bedding stripped from the bed next to Resident 5's recliner. There was a used incontinence pad sitting on a folding chair. The room had a pungent urine odor. Resident 8's bedroom: -The toilet riser had brown matter consistent with fecal matter stuck to it. Resident 9's bedroom: -The carpet had many stains throughout the bedroom. There was a small kitchenette missing many drawers. The room had a pungent urine odor. The shower room had chipped tile exposed. The white grout along walls was covered in a black tacky substance. On 02/13/2025 at 3:00 PM, Surveyor conducted an exit conference and shared findings with VP of Operations (VPO) B. VPO B acknowledged an understanding of the concerns. VPO B reported the provider had recently hired a full-time housekeeper. VPO B stated s/he was at the facility last week and odors were much better.	N 489		
N 498	83.45(2) Storage areas. Storage. The CBRF shall maintain storage areas	N 498		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 498	Continued From page 29 in a safe, dry and orderly condition. This Rule is not met as evidenced by: Based on observation and staff interview, the garage storage area was not in orderly condition. Findings include: On 01/31/2025 at 10:00 AM, Surveyor toured the garage of the facility with Maintenance Director C. Maintenance Director C reported staff use this area for housekeeping supplies and resident incontinence supplies. Upon entering the garage , observed one large pile of mattresses, recliners, hospital beds, hoyer lifts, sit to stand lifts, laundry baskets, fall mats, cardboard boxes, furniture, and clothing. These items were stored in a very disorderly fashion and made the garage difficult to access. The garage had an exit with a narrow path to the door. Surveyor asked Maintenance Director why the storage area was not orderly. Maintenance Director C stated the facility was having a dumpster delivered today and s/he would start to clear out the area. At 1:56 PM, Surveyor observed the food pantry area. Observed towards the back of the room, a circular approximately 1 foot by 1 foot section of a black mold-like substance in the ceiling tile. Dried brown water stains were observed near the mold-like substance. On 02/13/2025 at 3:00 PM, Surveyor interviewed VP of Operations (VPO) B and shared findings observed during the onsite portion of the survey. Surveyor asked for pictures to be sent by 02/14/2025 at 12:00 PM to ensure the garage storage area was cleaned out.	N 498		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 498	Continued From page 30 On 02/14/2025 at 9:39 AM, Surveyor received an email from VPO B stating: "In contacting the facility - the dumpster has been delivered however the garage is still being worked on so not to a standard that I would say it has been remediated. I have included pictures to show that the dumpster is in place and the process is underway."	N 498		
N 499	83.45(3) Toxic substances. Toxic substances. The CBRF shall ensure that cleaning compounds, polishes, insecticides and toxic substances are labeled and stored in a secure area. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure cleaning compounds and toxic substances were stored in a secured area. Findings include: On 09/23/2024 at 9:36 AM, Surveyor toured the facility with Maintenance Director C. The following was found: In the laundry room, Surveyor observed 18 bottles of laundry detergent and 1 bottle of bleach. The door was unlocked. In the garage, Surveyor observed a housekeeping cart filled with chemicals. Additionally, the facility had all their housekeeping supplies stored in cabinets within the garage. The door to the garage was unlocked. On 02/13/2025 at 3:00 PM, Surveyor interviewed	N 499		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 499	Continued From page 31 VP of Operations (VPO) B and shared findings observed during the onsite portion of the survey. VPO B acknowledged an understanding of the concern and stated toxic substances had been moved to a secured area.	N 499		
N 504	83.46(1)(c) Heating system maintenance. Heating. The CBRF shall maintain the heating system in a safe and properly functioning condition. The CBRF shall ensure that a heating contractor or local utility company completes all of the following maintenance and makes available to the facility documentation of the maintenance performed: 1. An oil furnace shall be serviced at least once each year. 2. A gas furnace shall be serviced at least once every 3 years. 3. The CBRF shall have a chimney inspected at intervals corresponding with the heating system service under subd. 1. or 2. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure the gas furnace was inspected at least every 3 years for 1 of 1 furnace. The facility was unable to provide documented evidence of a furnace inspection completed in the last 3 years. Findings include: On 01/31/2025, Surveyor conducted a review of safety records. There was no gas furnace inspection included. On 01/31/2025 at 9:55 AM, Surveyor interviewed	N 504		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 504	Continued From page 32 Maintenance Director C regarding the missing furnace inspection. Maintenance Director C confirmed s/he was unable to find a record of the furnace inspection but did place a call out to our contractor to schedule one as soon as possible.	N 504		
N 525	83.47(2)(d) Fire drills. Fire drills. 1. Fire evacuation drills shall be conducted at least quarterly with both employees and residents. Drills shall be limited to the employees scheduled to work at that time. Documentation shall include the date and time of the drill and the CBRF ' s total evacuation time. The CBRF shall record residents having an evacuation time greater than the time allowed under s. HFS 83.35(5) and the type of assistance needed for evacuation. Fire evacuation drills may be announced in advance. 2. At least one fire evacuation drill shall be held annually that simulates the conditions during usual sleeping hours. Fire evacuation drills may be announced in advance. Drills shall be limited to the employees scheduled to work during the residents ' normal sleeping hours. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure fire drills were conducted quarterly and at least one drill simulated the conditions during usual sleeping hours for 2 of 2 years reviewed (2023 and 2024). Findings include: This facility can serve up to 30 residents in the	N 525		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 525	Continued From page 33 client groups of advanced age, irreversible dementia/Alzheimer's, physically disabled, and advanced age. On 01/31/2025, Surveyor reviewed the provider's safety records and identified the following: -There was no record of quarterly fire drills completed for the 2nd, 3rd, and 4th quarters of 2023. Additionally, at least one drill did not simulate the conditions during usual sleeping hours in 2023. -There was no record of quarterly fire drills completed for the 1st and 4th quarters of 2024. Additionally, at least one drill did not simulate the conditions during usual sleeping hours in 2024. On 01/31/2025 at 9:55 AM, Surveyor interviewed Maintenance Director C regarding the above fire drills. Maintenance Director C confirmed what was provided to the Surveyor was what s/he had for documentation. Maintenance Director C reported s/he was newer to their role and could not speak to lack of fire drills not completed in 2023 and 2024. Maintenance Director C stated s/he will ensure compliance in 2025.	N 525		
N 526	83.47(2)(e) Other evacuation drills. Other evacuation drills. Tornado, flooding, or other emergency or disaster evacuation drills shall be conducted at least semi-annually. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure other emergency drills were conducted semi-annually for 2 of 2 years	N 526		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
N 526	Continued From page 34 reviewed (2023 and 2024). Findings include: On 01/312025, Surveyor reviewed the provider's safety records and identified the following: The records included 1 drill conducted in 2023 (03/07/2023) and 1 drill conducted in 2024 (08/15/2024). The provider did not conduct semi-annual drills for both years. On 01/31/2025 at 9:55 AM, Surveyor interviewed Maintenance Director C regarding the above evacuation drills. Maintenance Director C confirmed what was provided to the Surveyor was what s/he had for documentation. Maintenance Director C reported s/he was newer to their role and could not speak why other evacuation drills were not conducted semi-annually.	N 526		
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.	Z 012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	1661 BIRON DR BIRON, WI 54494

(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
Z 012	Continued From page 35 (am) 1. or (b) 1. The department or entity may require the person to be fingerprinted on 2 fingerprint cards, each 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 review and interview, the provider did not have evidence of making a good faith effort to obtain out of state background check information for 1 of 1 caregiver. Caregiver F indicated on the Background Information Disclosure (BID) form s/he had resided in the state of Kentucky within the previous 3 years. Findings include: On 01/31/2025, Surveyor reviewed Caregiver F's record. Caregiver F was hired 03/13/023. Caregiver F's completed BID form, dated 03/09/2023, indicated s/he resided in another state (Kentucky) in the previous 3 years. The employee record did not contain evidence the provider had made a good faith effort to obtain state of Kentucky background check. On 02/13/2025 at 3:00 PM, Surveyor conducted an exit conference and shared findings with VP of Operations (VPO) B. VPO B acknowledged an understanding of the concern. VPO B stated s/he would need to look into Caregiver F's record. Surveyor asked for evidence of Caregiver F's out	Z 012		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0017439	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WELLINGTON PLACE AT BIRON	**1661 BIRON DR BIRON, WI 54494**

(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
Z 012	Continued From page 36 of state background check be sent by 12:00 PM on 02/14/2025. As of 02/15/2025, evidence was not provided to show out of state background check was completed for Caregiver F.	Z 012		