STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0015014	A. BUILDING: _____ B. WING _____	R-C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCH HAVEN SENIOR LIVING FALCONS CRE	218 22ND AVE W ASHLAND, WI 54806

(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 06/11/2024, Surveyor conducted standard licensure survey, verification visit, and 2 complaint investigations. Data was collected through 06/13/2024. One of 2 complaints was substantiated. Sixteen deficiencies were identified. Four of the 16 deficiencies were repeat deficiencies. See Statement of Deficiency (SOD) NDH011, dated 05/14/2019; SOD JFQV11, dated 09/17/2019, and SOD MFEW11, dated 04/10/2023. Census: 9 Under statutory provisions of Wis. Stat. ch. 50, a $200 revisit fee is being assessed.	{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 observation, record review, and interview, the licensee did not ensure that the provider and its operation were compliant with all laws governing a community based residential facility (CBRF). In the past 6 years, the Department has conducted 12 surveys, including the present survey. The Department issued enforcement with a Notice and Order letter for 5 of the previous 11 surveys. The Department investigated 11 complaints with 8 of the 11	N 196		

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

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N 196	Continued From page 1 complaints substantiated. This is a repeat violation. See Statement of Deficiency (SOD) JFQV11, dated 09/17/2019. Findings include: This provider is licensed as a class CNA (non-ambulatory) facility to serve up to 15 residents in the client groups of: physically disabled, traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced age, and emotionally disturbed/mental illness. On 06/11/2014 - 06/13/2014, Surveyor conducted a verification visit, 2 complaint investigations and a standard licensure survey. As a result, 16 deficiencies were identified. Four of the 16 deficiencies were repeat deficiencies. One of the 2 complaints were substantiated. The following deficiencies were identified (* - denotes a repeat deficiency): 83.14(2)(a) Licensee Ensures Facility Complies With Laws * 83.17(1) Licensee Conduct Caregiver Background Check * 83.28(4)(a) Resident Health Screening And Documentation 83.35(1)(b) Sources Used For Assessment Planning 83.35(2) Temporary Service Plan 83.35(3)(c) Implement, Follow The Individual Service Plan * 83.35 (3)(d) Service Plans Updated Annually Or On Changes 83.37(3)(c) Medication Storage: Locked Cabinets 83.38(1)(c) Leisure Time Activities 83.38(1)(g) Health Monitoring 83.41(2)(c) Nutrition Menus	N 196		

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N 196	Continued From page 2 83.44(1)(b) Separate Laundry Storage Areas Or Containers 83.44(2)(a) Rooms Clean And Free From Odors * 83.45(3) Toxic Substances 83.55(6)(b) Bath And Toilet Areas: Water Temperature 83.60(1) Total/Openable Window Area During this survey, Licensee B was also the administrator. Administrator in Training (AT) A was present during the survey but did not complete the course to become the administrator as of 06/13/2024. On 06/13/2024, AT A told Surveyor s/he just completed the prerequisites to take the administrator's course. Licensee B, as the administrator, was responsible for supervising the daily operations of the CBRF, including resident care and services and the physical plant. In the past 6 years, the provider has shown a pattern of non-compliance. In the last 6 years, the Department conducted 12 surveys (including this survey) and investigated 11 complaints. Eight of the 11 complaints were substantiated. In the last 6 years, the Department issued the following Statements of Deficiency: SOD Q5K311, dated 09/13/2018 - 1 complaint substantiated. SOD NDH011, dated 05/14/2019 - 3 of 3 complaints were substantiated, enforcement was issued. SOD JFQV11, dated 09/17/2019 - enforcement was issued. SOD QGQ911, dated 10/25/2021 - enforcement was issued. SOD QGQ912, dated 07/14/2022 - enforcement was issued. SOD MFEW11, dated 04/10/2023 - 3 of 3 complaints were substantiated, enforcement was	N 196		

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N 196	Continued From page 3 issued. Licensee B did not ensure the provider and its operation maintained compliance with all laws governing a CBRF.	N 196		
{N 219}	83.17(1) Licensee conduct caregiver background check Caregiver background check. At the time of hire, employment or contract and every 4 years after, the licensee shall conduct and document a caregiver background check following the procedures in s. 50.065, Stats., and ch. DHS 12. A licensee shall not employ, contract with or permit a person to reside at the CBRF if the person has been convicted of the crimes or offenses, or has a governmental finding of misconduct, found in s. 50.065, Stats., and ch. DHS 12, Appendix A, unless the person has been approved under the department ' s rehabilitation process as defined in ch. DHS 12. This Rule is not met as evidenced by: Based on record review and interview, the provider did not conduct and document caregiver background checks, following the procedures in s.50.065, Stats., for 1 of 3 caregivers reviewed. The provider did not obtain a copy of Caregiver C's criminal complaint and judgment of conviction related to Caregiver C's conviction of a violation of s. 947.01(1) (disorderly conduct). This is a repeat deficiency. See Statement of Deficiency MFEW11, dated 04/10/2023.	{N 219}		

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{N 219}	Continued From page 4 Findings include: 50.065(2)(bb) states, in part: "If information obtained under par. (am) or (b) indicates a charge of a serious crime, but does not completely and clearly indicate the final disposition of the charge, the department or entity shall make every reasonable effort to contact the clerk of courts to determine the final disposition of the charge... any other information indicates a conviction of a violation of s. 940.19 (1), 940.195, 940.20, 940.204, 941.30, 942.08, 947.01 (1), or 947.013 obtained not more than 5 years before the date on which that information was obtained, the department or entity shall make every reasonable effort to contact the clerk of courts to obtain a copy of the criminal complaint and judgment of conviction relating to that violation." On 06/11/2023, Surveyor reviewed 3 employee's caregiver background checks (CBC). Caregiver C's date of hire was 09/21/2023. His/her Department of Justice (DOJ) report, dated 09/21/2023, indicated Caregiver C was charged with disorderly conduct on 05/26/2023. The DOJ response did not conclude the final disposition of the charges. On 06/12/2024, Surveyor reviewed the WI Circuit Court Automation Program (CCAP) to review the summary report of Caregiver C's charges. This report indicated that on 11/21/2023, Caregiver C was found guilty due to a no contest plea of disorderly conduct. On 06/13/2024 at approximately 9:45 a.m., Surveyor interviewed Administrator in Training (AT) A and requested the criminal complaint and	{N 219}		

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{N 219}	Continued From page 5 judgement of conviction related to Caregiver C's conviction of disorderly conduct. On 06/13/2024 at approximately 1:00 p.m., Surveyor interviewed AT A. AT A told Surveyor the criminal complaint and judgement of conviction were not in Caregiver C's employee file. AT A said they called Caregiver C for it. Surveyor explained that the provider was required to obtain this information from the clerk of courts.	{N 219}		
N 302	83.28(4)(a) Resident health screening and documentation Resident health screening. 1. Within 90 days before or 7 days after admission, a physician, physician assistant, clinical nurse practitioner or a licensed registered nurse shall screen each person admitted to the CBRF for clinically apparent communicable disease, including tuberculosis, and document the results of the screening. 2. Screening for tuberculosis and all immunizations shall be conducted using centers for disease control and prevention standards. 3. The CBRF shall maintain the screening documentation in each resident ' s record. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 1 of 2 residents reviewed, who were recent admissions, were tested for tuberculosis (TB) prior to admission or within 7 days after admission.	N 302		

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N 302	Continued From page 6 Resident 4 did not have a documented TB test. Findings include: On 06/11/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 05/29/2024. A TB screen and assessment was completed on 05/29/2024. Surveyor could not locate documentation of a TB test. On 06/11/2024 at approximately 2:10 p.m., Surveyor interviewed Administrator in Training (AT) A. AT A told Surveyor the nurses missed doing Resident 4's TB test. AT A said they will do a TB test within the next day.	N 302		
N 382	83.35(1)(b) Sources used for assessment information. Information gathering. The CBRF shall base the assessment on the current diagnostic, medical and social history obtained from the person ' s health care providers, case manager and other service providers. Other service providers may include a psychiatrist, psychologist, licensed therapist, counselor, occupational therapist, physical therapist, pharmacist or registered nurse. The administrator or designee shall hold a face-to-face interview with the person and the person ' s legal representative, if any, and family members, as appropriate, to determine what the person views as his or her needs, abilities, interests, and expectations. This Rule is not met as evidenced by: Based on record review and interview, the provider did not gather all assessment	N 382		

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information prior to admitting 2 of 2 residents reviewed for admission requirements.

Resident 4 had pressure injuries requiring wound care. The provider did not obtain information related to Resident 4's wounds from his/her health care provider prior to admitting Resident 4.

The provider did not conduct a face to face assessment with Resident 1 and Resident 1's legal representative prior to admitting Resident 1.

Findings include:

RESIDENT 4
On 06/11/2024 at approximately 10:30 a.m., Surveyor interviewed Resident 4 and his/her spouse, Resident 5. Family Member (FM) G was present and told Surveyor s/he was a nurse. Resident 4 and Resident 5 told Surveyor they lived at the facility for approximately 2 weeks and were not satisfied. Resident 4 said s/he had wounds that required dressing changes and they thought a nurse would be available to provide these services. FM G said s/he had visited daily and continues to do wound care for Resident 4. FM G said a staff nurse has completed the wound care one time since Resident 4 was admitted.

On 06/11/2024 at approximately 11:30 a.m., Surveyor interviewed Registered Nurse (RN) H. RN H told Surveyor Resident 4 had a pressure injury on his/her sacrum/coccyx (tailbone) area that tunneled. S/he said Resident 4 also had a pressure injury to his/her right outer ankle. RN H said that prior to Resident 4's admission, FM G was doing the wound care at home. S/he said the plan would be to do wound care on Mondays and Fridays at the facility. Resident 4 would go to the

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N 382	Continued From page 8 wound care clinic on Wednesdays. On 06/11/2024 at approximately 2:00 p.m., Surveyor interviewed Administrator in Training (AT) A. AT A told Surveyor s/he was not aware of how extensive Resident 4's wounds were. S/he said s/he conducted a face to face assessment with Resident 4 prior to his/her admission, but did not receive the physician's plan of care (PPOC) until the day Resident 4 was admitted. S/he said that going forward, after s/he conducts a face to face assessment, s/he will have the nurses conduct a nurse to nurse assessment to determine if they can meet the residents' needs. AT A told Surveyor s/he did not obtain wound care notes for Resident 4. On 06/11/2024, Surveyor reviewed Resident 4's record. Resident 4 was admitted to the facility on 05/29/2024. The PPOC, signed 05/28/2024, contained the last physician's health and physical (H & P), dated 04/19/2024. The H & P read, in part: "Patient is an extremely pleasant [age] [fe/male] with a history of atrial fibrillation on anticoagulation, prediabetes, hypertension, chronic sacral and coccygeal ulcers followed by wound therapy, also ulcer of the right ankle followed by wound therapy ..." The problem list included: pressure injury of coccygeal region, stage 4; pressure injury of right ischium, stage 3; impaired sensation of sacral region with incontinence; Subacute osteomyelitis of right foot." The appointment list indicated Resident 4 was seen on 05/20/2024 for wound care. This appointment reason read: "Pressure injury of skin sacral region, unspecified injury stage (Primary Dx [diagnosis]); Non-healing ulcer	N 382		

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of right ankle, unspecified ulcer stage. (HCC [Hierarchical Condition Category]); Charcot ankle, right; Venous insufficiency of both lower extremities; Neuropathy of left lower extremity."

On 06/05/2024, RN H documented, in part: "Resident's wound care is involved and takes approx. (approximately) an hour to change. Resident is not happy with the cares here like [his/her] [spouse] and also expressed the fact that they will leave if no improvement. Concerns passed onto [sic] the administrator."

On 06/13/2024 at 9:30 a.m., Surveyor arrived at the facility. Resident 4, Resident 5, and FM G were packing Resident 4 and Resident 5's belongings. Surveyor asked FM G if they were discharging. FM G said they were.

On 06/13/2024 at 12:45 p.m., Surveyor interviewed RN H. Surveyor reviewed Resident 4's record with RN H. RN H told Surveyor s/he had watched FM G perform wound care on Resident 4 and completed the wound care once on 06/10/2024. RN H said FM G was completing the wound care on other days. Surveyor asked what stage the wounds were at. RN H said the pressure injury on Resident 4's bottom tunneled to the bone and was a stage 4. The pressure injury on Resident 4's ankle was a stage 2.

RESIDENT 1
On 06/13/2024, Surveyor reviewed Resident 1's record.

Resident 1 was admitted to the facility on 05/23/2024. A pre-admission assessment was completed and dated 05/14/2024.

On 06/13/2024 at approximately 11:55 p.m.,

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N 382	Continued From page 10 Surveyor interviewed AT A. AT A told Surveyor s/he did not conduct a face to face assessment with Resident 1 as s/he resided out of state prior to admission. On 06/13/2024, Surveyor reviewed the provider's waivers. The provider did not receive an approved waiver to conduct the pre-admission assessment without a face to face assessment.	N 382		
N 385	83.35(2) Temporary Service Plan. Temporary service plan. Upon admission, the CBRF shall prepare and implement a written temporary service plan to meet the immediate needs of the resident, including persons admitted for respite care, until the individual service plan under sub. (3) is developed and implemented. This Rule is not met as evidenced by: Based on record review and interview the provider did not prepare and implement a temporary service plan (TSP) to meet the immediate physical health needs for 1 of 2 residents reviewed for admission requirements. Resident 4 did not have a service plan to address his/her needs related to pressure injuries. Findings include: On 06/11/2024 at approximately 10:30 a.m., Surveyor interviewed Resident 4 and his/her spouse, Resident 5. Family Member (FM) G was present, who told Surveyor s/he was a nurse. Resident 4 and Resident 5 told Surveyor they lived at the facility for approximately 2 weeks and were not satisfied. Resident 4 said s/he had wounds that required dressing changes and they	N 385		

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thought a nurse would be available to provide these services. FM G said s/he has visited daily and has continued to do wound care for Resident 4. FM G said a staff nurse has completed the wound care once since Resident 4 was admitted.

On 06/11/2024, Surveyor reviewed Resident 4's record.

Resident 4 was admitted to the facility on 05/29/2024.

Resident 4's health and physical (H & P), dated 04/19/2024, indicated Resident 4 was seen on 05/20/2024 for wound care. This appointment reason read: "Pressure injury of skin sacral region, unspecified injury stage (Primary Dx (diagnosis)); Non-healing ulcer of right ankle, unspecified ulcer stage. (HCC (Hierarchical Condition Category)); Charcot ankle, right; Venous insufficiency of both lower extremities; Neuropathy of left lower extremity."

On 06/05/2024, RN H documented, in part: "Resident's wound care is involved and takes approx. (approximately) an hour to change ..."

Surveyor reviewed Resident 4's TSP, which was not dated. The TSP listed diagnoses which included: Pressure injury coccyx and non-healing ulcer right ankle. There was no documentation on how staff were to care for the wounds, no interventions to aid with healing and preventing infections to the wounds, and no instructions on how to complete the wound care.

On 06/13/2024 at 12:45 p.m., Surveyor interviewed Registered Nurse (RN) H. RN H told Surveyor s/he watched FM G complete wound care on Resident 4 to learn how to do the wound

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N 385	Continued From page 12 care. RN H said s/he completed the wound care once on 06/10/2024. RN H said FM G completed the wound care on other days. Surveyor asked what stage the wounds were at. RN H said the pressure injury on Resident 4's bottom tunneled to the bone and was a stage 4. The pressure injury on Resident 4's ankle was a stage 2. Surveyor asked where the instructions were for the wound care. RN H said s/he wrote out the instructions and they were kept in the box of wound care supplies. S/he said Administrator in Training (AT) A had a copy of the instructions. Surveyor asked if this information was put into Resident 4's TSP. RN H said s/he did not complete the service plans. S/he said that would be AT A. On 06/13/2024 at approximately 1:00 p.m., Surveyor interviewed AT A. Surveyor reviewed Resident 4's TSP with AT A. AT A confirmed the TSP did not include instructions to meet the needs for Resident 4's wounds.	N 385		
N 388	83.35(3)(c) Implement, follow the individual service plan Implementation. The CBRF shall implement and follow the individual service plan as written. This Rule is not met as evidenced by: Based on record review and interview, the provider did not ensure 2 of 2 residents that needed assistance with showers, received showers as identified in their individual service plan (ISP). Resident 1 and Resident 8 did not receive assistance with showers as identified in their ISPs.	N 388		

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(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 388	Continued From page 13 This is a repeat deficiency. See Statement of Deficiency NDH011, dated 05/14/2019. Findings include: On 06/11/2024, the Department received a complaint alleging residents were not receiving personal cares as needed. The provider is licensed to care for up to 15 residents in the client groups of: physically disabled, traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced age, and emotionally disturbed/mental illness. RESIDENT 1 On 06/13/2024, Surveyor reviewed Resident 1's record. Resident 1 was admitted to the facility on 05/23/2024, with a diagnosis of dementia. Resident 1's ISP, with a start date of 05/28/2024, indicated Resident 1 required total assist with bathing. The ISP read, in part, "Resident needs to be put on the weekly shower schedule." On 06/13/2024 at approximately 9:45 a.m., Surveyor interviewed Administrator in Training (AT) A. AT A told Surveyor staff document in the computer when they assist a resident with showers. Surveyor requested documentation of Resident 1's showers from the time s/he was admitted forward. At approximately 12:20 p.m., AT A told Surveyor there was no documentation of Resident 1's showers in the computer. AT A said they did have a shower schedule but someone took it down.	N 388		

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N 388	Continued From page 14 S/he explained s/he was working on developing a new shower schedule. Surveyor asked AT A:, "We don't know if [s/he] has had a shower since [s/he's] been here?" AT A replied, "Correct." At approximately 12:30 p.m., Surveyor interviewed Caregiver I who was working the floor that day. Caregiver I told Surveyor s/he had never given Resident 1 a shower. RESIDENT 8 On 06/13/2024, Surveyor reviewed Resident 8's record and shower schedule. Resident 8's ISP, with a start date of 04/24/2024, indicated Resident 8 required partial assist with showers on either Sunday or Friday. Resident 8's shower documentation from 01/01/2024 - 06/13/2024 indicated Resident 8 received assistance with showers on the following dates: 01/01/2024 01/05/2024 01/19/2024 01/20/2024 01/21/2024 02/17/2024 - This was almost a full month after Resident 8's last shower. 03/13/2024 - This was almost a full month after Resident 8's last shower. 03/20/2024 03/29/2024 04/14/2024 - This was 2 weeks after Resident 8's last shower. 04/18/2024 05/11/2024 - This was almost a full month after Resident 8's last shower. 05/22/2024 05/23/2024	N 388		

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N 388	Continued From page 15 05/24/2024 05/25/2024 06/02/2024 06/04/2024 - This was the last shower Resident 8 received prior to 06/13/2024. Resident 8 did not receive a shower at least weekly. Resident 8 went almost a full month between receiving showers multiple times. The provider did not assist Resident 1 and Resident 8 with showers as written in their ISPs.	N 388		
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 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 record review and interview, the provider did not review and revise Resident 8's individual service plan (ISP) when they assessed Resident 8 was no longer safe to use a motorized wheelchair.	N 389		

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N 389	Continued From page 16 Findings include: On 06/11/2024 at approximately 12:15 p.m., Surveyor observed Resident 8's room. His/her motorized wheelchair was in the room with laundry piled on top of it. On 06/11/2024, Surveyor reviewed Resident 8's record. Resident 8 was admitted to the facility on 11/28/2022. His/her diagnoses included abnormalities of gait and instability. A motorized wheelchair was listed as his/her durable medical equipment. Resident 8's ISP, dated 04/24/2024, read, in part: "[Resident 8] independently transfers self into motorized wc (wheelchair) and propels self in wc." On 06/13/2024 at approximately 10:15 a.m., Surveyor observed physical therapy working with Resident 8. Resident 8 was seated in a regular wheelchair. Surveyor interviewed the physical therapist. S/he told Surveyor Resident 8's family did not want Resident 8 using the motorized wheelchair anymore. S/he said they determined it was not safe for him/her due to Resident 8's increasing dementia. On 06/13/2024 at approximately 1:15 p.m., Surveyor interviewed Administrator in Training (AT) A. AT A told Surveyor Resident 8's family did not want him/her using his/her motorized wheelchair. They were concerned with his/her dementia and that s/he may try to leave and go into town. Surveyor told AT A Resident 8's ISP should be reviewed and revised to indicate the change.	N 389		

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N 419	83.37(3)(c) Medication storage: locked cabinet. Administered by facility. The CBRF shall keep medicine cabinets locked and the key available only to personnel identified by the CBRF. This Rule is not met as evidenced by: Based on observation and interview, the provider did not keep the medication cart locked. Findings include: The provider is licensed to care for up to 15 adults in the client groups of: physically disabled, traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced age, and emotionally disturbed/mental illness. On 06/11/2024 at 10:04 a.m., Surveyor toured the facility looking for staff. Surveyor observed the door to the kitchen was open. The medication cart was stored in the kitchen and was unlocked. The bottom drawer of the medication cart was opened. (Photo 1 and Photo 2). Caregiver C and Assistant Administrator (AA) D were outside and came in the back door. AA D told Surveyor Administrator in Training (AT) A was in his/her office. Surveyor found AT A in his/her office with the door closed. On 06/11/2024 at approximately 3:30 p.m., Surveyor observed the medication cart with AT A. Surveyor explained to AT A that when Surveyor entered the facility, the medication cart was unlocked and the door was open to the kitchen. AT A told Surveyor it should have been locked. The provider did not keep the medication cart secured at all times.	N 419		

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N 427	Continued From page 18	N 427		
N 427	83.38(1)(c) Leisure time activities. 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: Leisure time activities. The CBRF shall provide a daily activity program to meet the interests and capabilities of the residents. Employees shall encourage and promote resident participation in the activity program. The CBRF shall develop and post the activity schedule in an area available to residents. This Rule is not met as evidenced by: Based on record review and interview, the provider did not provide a daily activity program to meet the interests and capabilities of the residents. This had the potential to affect 9 of 9 residents. Findings include: The provider is licensed to care for up to 15 adults in the client groups of: physically disabled, traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced age, and emotionally disturbed/mental illness. On 06/11/2024 at approximately 10:30 a.m., Surveyor interviewed Resident 4 and Resident 5 in their rooms. Resident 4 told Surveyor they did not have an activity calendar given to them. S/he said they did play Bingo yesterday.	N 427		

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N 427	Continued From page 19 On 06/11/2024 at approximately 10:50 a.m., Surveyor interviewed Resident 3. Resident 3 was in a common space putting together a puzzle. Resident 3 told Surveyor they were his/her own puzzles. Surveyor asked about activities. Resident 3 told Surveyor s/he did not receive a schedule this month, but they do play Bingo, exercise, and go to Walmart. On 06/11/2024 at 10:58 a.m., Surveyor observed an activity white board in the dining room. The board indicated that there were independent activities that day. (Photo 4). On 06/11/2024 at approximately 11:00 a.m., Surveyor interviewed Caregiver C. Caregiver C said activities were a "hit and miss." S/he said it has been independent activities a lot lately. On 06/11/2024, Surveyor reviewed the activity calendar for June 2024. There were no activities planned on Thursdays in June 2024. On Fridays and Saturdays, the calendar read: independent activities, except for 06/22/2024 when the beauty shop would be open. On 06/13/2024 at 9:32 a.m., Surveyor observed the activity white board in the dining room. The board indicated it was for June 12, 2024, and there were independent activities that day. On 06/13/2024 at approximately 9:45 a.m., Surveyor interviewed Administrator in Training (AT) A. Surveyor asked which days Activity Director (AD) B worked. AT A told Surveyor AD B worked on Mondays, Wednesdays, and Fridays. AT A said they have independent activities when AD B was not present. Surveyor asked AT A for confirmation that there were no activities planned when AD B was not working. AT A told Surveyor,	N 427		

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N 427	Continued From page 20 "Correct." The provider did not ensure an activity was planned daily for the residents.	N 427		
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 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.	N 431		

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N 431	Continued From page 21	N 431		

This Rule is not met as evidenced by:
Based on record review and interview, the provider did not monitor the health of 2 of 2 residents reviewed, who resided at the provider for greater than a year.

The provider did not monitor the weight of Resident 6 and Resident 8.

Findings include:

On 06/13/2024 at approximately 9:45 a.m., Surveyor interviewed Administrator in Training (AT) A. Surveyor requested weights for the last 3 months for Resident 6, and Resident 8.

On 06/13/2024 at approximately 12:05 p.m., AT A told Surveyor Resident 6 and Resident 8 have not had any weights taken in the last 3 months. Surveyor asked the last time they were weighed. AT A showed Surveyor his/her computer. Resident 6 was last weighed 01/23/2024 (approximately 5 months prior) at 242 pounds. Resident 8 was last weighed 02/05/2024 (approximately 4 months ago) and weighed 155 pounds. AT A told Surveyor staff should be weighing the residents monthly. S/he said, "We're working on it." AT A said s/he would have staff weigh the residents that day after lunch. Surveyor requested AT A to email Surveyor their weights. Surveyor did not receive the current weights for Resident 1, Resident 6, and Resident 8.

On 06/13/2024, Surveyor reviewed Resident 8's record. Resident 8's face sheet, with a print date of 06/11/2014, indicated an alert that Resident 8 was at risk for weight loss. Resident 8's order

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N 431	Continued From page 22 sheet included the following: "12/01/22 MONTHLY VITALS AND WEIGHT - Monthly - Every 1st Thursday - Check blood pressure, pulse, temperature, O2 sat (oxygen saturation) and weight every month - PM - Indicated For Health." On 06/13/2024, Surveyor reviewed Resident 6's record. His/her order sheet included the following: "04/18/22 MONTHLY VITALS AND WEIGHT - Monthly - Every 4th Tuesday - Check B/P (blood pressure), Pulse, resp (respirations), temp (temperature), O2 sat and weight monthly AM - Indicated For Health Monitoring." The provider did not monitor the weight of Resident 6 and Resident 8.	N 431		
N 450	83.41(2)(c) Nutrition: menus. Menus. 1. The CBRF shall make reasonable adjustments to the menu for individual resident ' s food likes, habits, customs, conditions and appetites. 2. The CBRF shall prepare weekly written menus and shall make menus available to residents. Deviations from the planned menu shall be documented on the menu. This Rule is not met as evidenced by: Based on record review and interview, the provider did not document deviations from the planned menu and did not retain the daily menu for 60 days. Findings include: On 06/11/2024 at approximately 10:30 a.m., Surveyor interviewed Resident 4 and Resident 5.	N 450		

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N 450	Continued From page 23 They both voiced concerns related to the food and said they never had meat with their breakfast, there was seldom any fruit, and the juice was Kool-Aide. On 06/11/2024 at approximately 11:15 a.m., Surveyor observed the menu in the dining room, which had a note by it that it was subject to change. On 06/11/2024, Surveyor reviewed a laminated copy of the provider's weekly rotating menu. On 06/11/2024 at 2:10 p.m., Surveyor interviewed Administrator in Training (AT) A. AT A said the menu was a rotating menu. Surveyor asked if they document deviations from the menus. AT A said they did not. S/he did state they started to write down on a piece of paper when the menu was changed. S/he showed Surveyor a sheet of paper that said in April one of the days the menu was changed. Surveyor explained the requirement to retain 60 days of menus with deviations documented on the menu. On 06/11/2024 at approximately 3:20 p.m., Caregiver F was working. Caregiver F told AT A that s/he could not make spaghetti as the other shift did not thaw the meat and they were out of spaghetti sauce. Surveyor was unable to investigate Resident 4 and Resident 5's food complaints as Surveyor did not have the menus to review. The provider did not retain a daily menu with deviations from the planned menu documented on it.	N 450		

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N 487	Continued From page 24	N 487		
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 maintain the laundry in containers and did not keep clean and dirty areas separate. Findings include: On 06/11/2024 at 10:05 a.m., Surveyor observed the laundry room. There was a laundry basket overflowing with dirty linens on the floor. (Photo 3). On 06/11/2024 at approximately 11:00 a.m., Surveyor interviewed Caregiver C. Caregiver C said that with 1 staff working, they do get behind on laundry and cleaning. On 06/11/2024 at 3:34 p.m., Surveyor observed the laundry room with Administrator in Training (AT) A. There was laundry overflowing in the basket, laundry on the floor, and laundry on top of the dryer. (Photo 10). On 06/13/024 at 10:08 a.m., Surveyor observed the laundry room. There was laundry piled on the sink and laundry on top of the dryer. (Photo 12). On 06/13/2024 at 10:11 a.m., Surveyor observed Resident 8's room. There was laundry piled on	N 487		

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N 487	Continued From page 25 top of Resident 8's motorized wheelchair. (Photo 15).	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 keep all rooms clean and free from odors. This is a repeat deficiency. See Statement of Deficiency NDH011, dated 05/14/2019. Findings include: On 06/11/2024, the Department received a complaint that alleged resident rooms smelled of urine and were not kept clean. On 06/11/2024 at approximately 11:55 a.m., Surveyor interviewed Person J. Person J worked with Resident 2, providing activities and outings. S/he told Surveyor, in the past s/he has arrived at the facility at 1:00 p.m., and found Resident 2's bed soiled in urine. S/he said s/he would strip his/her bed and wash his/her laundry. On 06/11/2024 at approximately 12:15 p.m., Surveyor observed Resident 7 and Resident 8's rooms. Resident 7 and Resident 8 were married, and had their own room with an adjoining bathroom between their rooms. There was a strong odor of urine in Resident 8's room. There were 2 urinals on the carpet next to Resident 8's bed with urine in both urinals. (Photo 5). There was a cardboard box full of soiled incontinent	N 489		

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N 489	Continued From page 26	N 489		

briefs, along with a soiled brief on the carpet. (Photo 6). In the bathroom, the floor was yellow in front of their toilet. A commode basin was on the floor with soiled clothes inside of it. (Photo 7). The garbage under the sink was full and it contained soiled incontinent briefs. (Photo 8).

On 06/11/2024 at approximately 12:33 p.m., Surveyor observed Resident 2's room and bathroom. There was an odor of feces coming from his/her room. The toilet and the floor surrounding the toilet had feces smeared on it. (Photo 9).

On 06/11/2024 at approximately 3:30 p.m., Surveyor toured the facility with Administrator in Training (AT) A. Surveyor showed AT A Resident 7 and Resident 8's room. The room remained in the same condition as Surveyor observed at 12:15 p.m. Surveyor and AT A observed Resident 2's room and bathroom. There was still feces on the toilet and paper towels on the floor covering the feces on the floor.

On 06/13/2024 at approximately 10:11 a.m., Surveyor observed Resident 8's room. There were 2 urinals on the carpeted floor next to Resident 8's bed. Both urinals had urine in them. (Photo 14). There were clothes piled on top of Resident 8's motorized wheelchair. (Photo 15).

On 06/13/2024 at approximately 11:45 a.m., Surveyor interview Family Member (FM) E. FM E was Resident 8's activated healthcare power of attorney. FM E told Surveyor, "My biggest concern is keeping their room clean." FM E said s/he has talked to the owner (Licensee B), staff, and nurses about their room not being cleaned and it "smells like urine." FM E said one time "there was 36 dirty diapers" and their toilet was

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	0015014	A. BUILDING: _____ B. WING _____	R-C 06/13/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BIRCH HAVEN SENIOR LIVING FALCONS CRE	218 22ND AVE W ASHLAND, WI 54806

(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 dirty. S/he said, "If I ask, staff go clean it." FM E said this has been going on for over a year. FM E said, "As long as they have to be there, at least keep it clean." The provider did not keep all rooms clean and free from odors.	N 489		
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 all cleaning compounds were stored in a secure area on 2 of 2 survey dates. On 06/11/2024 and 06/13/2024, Surveyor made observations of cleaning compounds not stored in a secure area. Findings include: The provider is licensed to care for up to 15 residents in the client groups of: physically disabled, traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced age, and emotionally disturbed/mental illness. On 06/11/2024 at approximately 10:00 a.m., Surveyor toured the provider looking for a staff member and observed the door to the laundry room was open. There was a gallon bottle of floor cleaner sitting on top of the dryer. (Photo 3). Caregiver C and Assistant Administrator (AA) D	N 499		

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N 499	Continued From page 28 were outside and Administrator in Training (AT) A was in his/her office with the door closed. On 06/11/2024 at approximately 11:45 a.m., Surveyor checked the door to the laundry room and it was unlocked. The bottle of floor cleaner remained on the dryer. Resident 6 followed Surveyor into the laundry room. On 06/11/2024, Surveyor reviewed Resident 6's record. Resident 6 had a diagnosis of early onset Alzheimer's disease. His/her individual service plan identified Resident 6 as being a vulnerable adult. On 06/11/2024 at approximately 3:30 p.m., Surveyor toured the facility with AT A. The laundry room was unlocked. Surveyor told AT A that the laundry room had been open and unlocked throughout the day while Surveyor was present. There was a gallon of floor cleaner on the dryer and another gallon of cleaner on the floor in the laundry room. (Photo 10). AT A told Surveyor the cleaning chemicals should be placed in the locked closet in the laundry room. On 06/13/2024 at approximately 10:00 a.m., Surveyor toured the facility. The laundry room was open and the door in the laundry room to the cleaning closet was also opened. The cleaning closet contained multiple cleaning compounds. (Photo 12 and Photo 13).	N 499		
N 617	83.55(6)(b) Bath and toilet areas: water temperature The CBRF shall set the temperature of all water heaters connected to sinks, showers and tubs used by residents at a temperature of at least	N 617		

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N 617	Continued From page 29	N 617		

140°F. The temperature of water at fixtures used by residents shall be automatically regulated by valves and may not exceed 115°F, except for CBRFs serving residents recovering from alcohol or drug dependency or clients of a government correctional agency.

This Rule is not met as evidenced by:
Based on observation and interview, the provider did not ensure the temperature of all water heaters connected to sinks, showers, and tubs used by residents was set at a temperature of at least 140° Fahrenheit (F).

This had the potential to affect all 9 residents that resided in the facility.

Findings include:

The provider is licensed to care for up to 15 residents in the client groups of: physically disabled, traumatic brain injury, irreversible dementia/Alzheimer's disease, advanced age, and emotionally disturbed/mental illness.

On 06/11/2024 at approximately 10:30 a.m., Surveyor interviewed Resident 4 and Resident 5 in their room. Resident 5 told Surveyor s/he did not want to shower because the water was cold.

On 06/11/2024 at approximately 11:45 a.m., Surveyor tested the water temperature in the shower room. The water at the sink reached a temperature of 102.4°F. Surveyor tested the water temperature in the tub room. The water at the sink reached a temperature of 100.4°F.

On 06/11/2024 at approximately 3:20 p.m., Surveyor observed the boiler room with

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N 617	Continued From page 30 Administrator in Training (AT) A. The temperature gauges at the water heaters were reading approximately 110° F. On 06/12/2024, AT A emailed Surveyor. The email read, in part, "I was informed regarding the boil [sic] temp (temperature) was low was because the boilers were turned off. We have fixed this matter." On 06/13/2024 at approximately 9:45 a.m., Surveyor interviewed AT A. AT A told Surveyor s/he was unsure why the boilers were turned off. Surveyor asked if s/he received complaints that the showers were cold. AT A said s/he had not, until Resident 4 and Resident 5 arrived. AT A told Surveyor they rectified the problem. The provider did not ensure the temperature of all water heaters connected to sinks, showers, and tubs used by residents was set to at least 140° F.	N 617		
N 668	83.60(1) Total/openable window area Minimum size. Every habitable room shall have at least one outside window with a total window area of at least 8% of the floor area in the room. The window shall be openable from the inside without the use of tools or keys. The openable area of the window shall be not less than 4% of the floor area of the room. This Rule is not met as evidenced by: Based on observation and interview, the provider did not ensure every habitable room had at least	N 668		

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N 668	Continued From page 31 1 window to be openable from the inside without the use of tools or keys. The windows throughout the facility did not have handles to open them. Findings include: On 06/11/2024, from approximately 11:00 a.m. - 12:45 p.m., Surveyor toured the facility. Surveyor observed the windows in the common spaces did not have handles on them to open them. Surveyor observed Resident 1 and Resident 2's rooms. The windows did not have handles on them to allow a person to open the windows. At approximately 11:15 a.m., Surveyor interviewed Caregiver C. Caregiver C showed Surveyor that staff had a crank in the kitchen to open the windows. At approximately 3:30 p.m., Surveyor interviewed Administrator in Training (AT) A. AT A told Surveyor s/he was not sure why the handles were off of the windows. On 06/13/2024 at approximately 11:37 a.m., Surveyor observed Resident 3 putting a puzzle together in a common area by a large window. This window did not have handles on it to open the window. Surveyor interviewed Resident 3. Resident 3 told Surveyor there was only 1 crank to open the windows and you would have to ask staff for it. S/he laughed and said, "Half the time they can't find it." Surveyor asked if that was the same for his/her bedroom. Resident 3 told Surveyor it was. The provider did not ensure every habitable room had at least 1 window to be openable from the	N 668		

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N 668	Continued From page 32 inside without the use of tools or keys.	N 668		