Wisconsin Department of Health Services

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016473	A. BUILDING: _____ B. WING _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDEMERE BIRCH HOUSE	**2999 RIVERSIDE DR GREEN BAY, WI 54301**

(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 11/20/2023, with information gathered through 11/21/2023, Surveyor investigated 5 complaints at Wyndemere Birch House in Green Bay. One (1) of 5 complaints were substantiated. As a result of the survey, 1 deficiency will be issued. Census: 16	N 000		
N 326	83.31(4)(a) Notice of facility initiated discharges Discharge or transfer initiated by CBRF. Notice and discharge requirements. 1. Before a CBRF involuntarily discharges a resident, the licensee shall give the resident or legal representative a 30 day written advance notice. The notice shall explain to the resident or legal representative the need for and possible alternatives to the discharge. Termination of placement initiated by a government correctional agency does not constitute a discharge under this section. 2. The CBRF shall provide assistance in relocating the resident and shall ensure that a living arrangement suitable to meet the needs of the resident is available before discharging the resident. This Rule is not met as evidenced by: Based on record review and staff interview, the provider did not provide assistance in relocating a resident to ensure that a living arrangement suitable to meet the needs of the resident was available before discharging the resident when a 30 day involuntary discharge notice was given for 1 of 1 (Resident 1) resident reviewed.	N 326		

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
	0016473	A. BUILDING: _____ B. WING _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDEMERE BIRCH HOUSE	2999 RIVERSIDE DR GREEN BAY, WI 54301

(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 326	Continued From page 1	N 326		

Resident 1 was hospitalized on 09/27/2023. Resident 1 received a 30 day notice on 09/27/2023. On 09/27/2023 the hospital said Resident 1 was ready to return to the facility. The provider refused to take Resident 1 back into the facility. The provider did not ensure a suitable placement was found for Resident 1 before discharging Resident 1.

Findings include:

On 10/04/2023, the department received a complaint regarding involuntary discharges and suitable placement.

On 11/20/2023, Surveyor reviewed Resident 1's resident record. Resident 1 was admitted to the facility on 03/07/2023 with diagnoses to include type 2 diabetes mellitus, hyperlipidemia, hypomagnesemia, anemia and iron deficiency. On 09/27/2023, Resident 1 was issued a 30 day notice due to care needs that were inconsistent with the facility's program statement, Resident 1 was noted to not be following the facility's smoking policy; Resident 1 refusing to take medications resulting in increased behaviors (verbal outbursts, rage and diabetic hyperglycemia); Resident 1 self-neglecting through refusals of care and medications which resulted in infections, hospital visits and impaired skin integrity; and an imminent risk of serious harm to the health or safety of Resident 1, other residents and staff (physically abusive towards staff and fellow residents-kicking, hitting, punching, biting, threatening to kill self and staff.

On 09/27/2023, Resident 1 experienced a significant behavioral episode and was sent to the emergency room. Resident 1 was diagnosed with a UTI (urinary tract infection). Resident 1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016473	A. BUILDING: _____ B. WING _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDEMERE BIRCH HOUSE	2999 RIVERSIDE DR GREEN BAY, WI 54301

(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 326	Continued From page 2	N 326		

medically cleared and ready to be discharged from the hospital on 09/28/2023. Hospital staff called the provider and informed the provider Resident 1 was ready for discharge. The provider refused to take Resident 1 back. Resident 1 ended up staying in the hospital until 10/02/2023 (an additional 5 days) when s/he was discharged to another assisted living facility.

Resident 1's record did not indicate any discussions with hospital staff regarding Resident 1 returning to the facility.

On 11/20/2023 at approximately 11:00 A.M., Surveyor interviewed Interim Administrator A. Interim Administrator A indicated Resident 1 had several instances of refusing medications, not following the smoking rules of the facility, and behavioral disturbances. Interim Administrator A stated s/he had spoken with Resident 1's managed care organization case managers several times about not following the rules and the need for the facility to issue a 30 day discharge notice because of it. Interim Administrator A indicated during those conversations, s/he made it clear this facility was not a good fit for Resident 1 and the case managers should start to look for something more appropriate for Resident 1. Interim Administrator A verified Resident 1 had a significant change in behaviors which resulted in the need to send Resident 1 to the hospital on 09/27/2023. Interim Administrator A stated this was the same day as the 30 day discharge notice was issued. Interim Administrator A verified s/he did not accept Resident 1 back from the hospital because of the prior issues related to not following the smoking rules and behavioral disturbances affecting staff and other residents. Interim Administrator A stated Resident 1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0016473	A. BUILDING: _____ B. WING _____	C 11/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WYNDEMERE BIRCH HOUSE	**2999 RIVERSIDE DR GREEN BAY, WI 54301**

(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 326	Continued From page 3 only in the hospital for a few days and then got placed in another facility. Although the facility issued a 30 day notice on 09/27/2023, the provider did not allow Resident 1 to return after a brief hospitalization and assist Resident 1 with finding suitable placement to meet the needs of Resident 1.	N 326		