STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	525602	A. Building B. Wing	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Glenhaven	612 E Oak St Glenwood City, WI 54013

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on record review and staff interviews, the facility did not ensure that an alleged violation involving abuse by a Resident (R1) was reported immediately to the Nursing Home Administrator (NHA) and to the State Survey and Certification Agency. An incident involving R1 and R2 occurred on 02/27/25. R1 hit R2 with a closed fist. The facility did not report the abuse to the State Survey and Certification Agency. Findings Include: Facility policy titled, Abuse Policy, shows a most recent review date of 10/04/16, stated, Law Enforcement: All reports of suspected crime and/or alleged sexual abuse must be immediately reported to local law enforcement to be investigated. Facility staff will fully cooperate with the local law enforcement designee. R1 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's, chronic kidney disease, dementia, difficulty in walking, unsteadiness on feet, and cognitive communication deficit. R1's most recent [NAME] Data Set (MDS) assessment dated [DATE] indicated that R1 was able to ambulate independently and has a Brief Interview for Mental Status (BIMS) score of 05/15, which indicates severe cognitive impairment. R2 was admitted to the facility on [DATE] with diagnoses that include dementia, major depressive disorder, and fibromyalgia. R2's most recent MDS assessment dated [DATE] indicated that R2 has a BIMS score of 1/15, which indicates severe cognitive impairment. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Facility reported incident submitted to state agency on 02/27/25 states, On 2/27/25, [R1] and [R2] were present in the E household living area. [R2] was walking past [R1] as she sat in the living room. [R1] commented to [R2] to wipe that look off your face. (resident [R2] had a flat look on her face). [R2] got closer to [R1] and stated: why don't you mind your own business?!. This upset [R1] and she struck [R2] in the upper right arm with a closed fist. [R2] became more upset after being struck and raised right hand as if to strike back. Staff was able to intervene before this happened. There were no other residents in the living area or dining area at the time of the incident in which to witness it. [staff] that did see the incident and was able to intervein [sp]. Both residents were agitated at that point. [Staff] assisted [R1] to her room to decompress as it was less stimulating. [R1] did kick [staff] during that process. [R2] remained in the dining room and drank some cocoa. The facility completed an investigation on 02/27/25 that included notification to both residents' power of attorney, notification to medical director, facility investigation, and notification to state agency. There was no evidence of notification to police regarding the potential crime of assault. On 04/01/25 at 11:05 AM, Surveyor interviewed Director of Nursing (DON) B regarding the lack of local law enforcement involvement. DON B said they felt this situation did not require it. On 04/02/25 at 1:10 PM, Surveyor asked DON B if they felt this incident could have been a potential crime. DON B said they did not think so. R1 hit R2 softly and they did not find any injury, so they felt it was not assault or some other crime.

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NAME OF PROVIDER OR SUPPLIER Glenhaven		STREET ADDRESS, CITY, STATE, ZIP CODE 612 E Oak St Glenwood City, WI 54013	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on interview and record review, the facility did not ensure, in response to resident-to-resident physical abuse, a thorough investigation was conducted to prevent further potential abuse for 1 of 2 (R1) residents reviewed for abuse. The facility did not conduct a thorough investigation of the resident-to-resident-altercation that occurred to R2 on 02/27/25. The facility did not conduct other resident interviews for potential abuse. Findings include: Facility policy titled, Abuse Policy, shows a most recent review date of 10/04/16, stated, Examine, assess and interview the resident and other residents potentially affected immediately to determine any injury and identity and immediate clinical interventions necessary. R1 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's, chronic kidney disease, dementia, difficulty in walking, unsteadiness on feet, and cognitive communication deficit. R1's most recent [NAME] Data Set (MDS) assessment dated [DATE] indicated that R1 was able to ambulate independently and has a Brief Interview for Mental Status (BIMS) score of 05/15, which indicates severe cognitive impairment. R2 was admitted to the facility on [DATE] with diagnoses that include dementia, major depressive disorder, and fibromyalgia. R2's most recent MDS assessment dated [DATE] indicated that R2 has a BIMS score of 01/15, which indicates severe cognitive impairment. Facility reported incident submitted to state agency on 02/27/25 On 2/27/25, [R1] and [R2] were present in the E household living area. [R2] was walking past [R1] as she sat in the living room. [R1] commented to [R2] to wipe that look off your face. (resident [R2] had a flat look on her face). [R2] got closer to [R1] and stated: why don't you mind your own business?!. This upset [R1] and she struck [R2] in the upper right arm with a closed fist. [R2] became more upset after being struck and raised right hand as if to strike back. Staff was able to intervene before this happened. There were no other residents in the living area or dining area at the time of the incident in which to witness it. [Staff] that did see the incident and was able to intervein [sp]. Both residents were agitated at that point. [staff] assisted [R1] to her room to decompress as it was less stimulating. [R1] did kick [staff] during that process. [R2] remained in the dining room and drank some cocoa. The facility completed an investigation on 02/27/25 that included notification to both residents' power of attorney, notification to medical director, facility investigation, and notification to state agency. There was no evidence of interviews with other residents to ensure they were also not targeted by R1 or R2. (continued on next page)

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 04/02/25 at 1:10 PM, Surveyor interviewed Director of Nursing (DON) B regarding the lack of interviews with other residents. DON B said they felt like this was an isolated event and they did not think other residents were affected. When asked if R1 or R2 had access to other residents DON B said yes, but they know their residents well and there were no changes. DON B also stated that after conversations with surveyor they did go and interview other residents to ensure they were not targeted.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47807 Based on interview and record review, the facility did not ensure the resident environment remained as free of accidents hazards as possible. The facility did not update resident's care plan after each event of a fall. This has the potential to affect 1 of 3 residents (R) (R1) reviewed for accidents. Facility did not update R1's care plan after R1's fall risk score increased from 12 to 16 on 02/16/25, and did not update care plan following a bruise noted on 03/05/25 from a fall. Findings include: The facility policy titled, Falls reviewed October 2023, states, 2. When notified a fall has occurred, the licensed nurse will: . R. fill out a care plan update sheet with new interventions for the MDS coordinator S. Make sure intervention and fall are reported through the 24 hr report sheet. t. [Director of Nursing] DON or designee will bring incident report to morning meeting where management team will review to make sure intervention is new, appropriate, documented and accessible to all staff. R1 was admitted to the facility on [DATE] with diagnoses that include Alzheimer's, chronic kidney disease, dementia, difficulty in walking, unsteadiness on feet, and cognitive communication deficit. R1's most recent [NAME] Data Set (MDS) assessment dated [DATE] indicated that R1 was able to ambulate independently and has a Brief Interview for Mental Status (BIMS) score of 05/15, which indicates severe cognitive impairment. On 01/17/25, facility performed a falls risk assessment for R1 where R1 scored a 12.0 indicating they were at risk for falls. On 02/16/25, facility performed a fall risk assessment for R1 where R1 scored a 16.0 indicating that fall risk was increasing. There was no change to resident's care plan as the risk of falls increased. On 03/05/25, progress notes indicated that R1 was discovered to have bruising and pain on left foot. R1 said they believe they fell in the restroom of their room. After fall IDT team reviewed and replaced intervention that previously worked. The facility added a pressure alarm to R1's bed. On 03/08/25 at 9:41 AM, progress note related to new fall stated, Residents bed alarm was alarming, CNA, went in to check the alarm at 6:38, Resident was kneeling on the floor mat next to the bed. Boot was on the left foot. No complaints of pain noted nonvisible bruising. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of incident revealed that R1's interventions on the care plan were not changed; there were no new care plan updates or strategies to insure R1's safety. Care plan only indicated that resident is likely to try and ambulate. On 04/02/25 at 1:10 PM, Surveyor interviewed DON B regarding the lack of interventions after R1's most recent fall. DON B said they felt the intervention that was already in place was ok and emphasizing that staff need to get to R1's room as they are prone to falling when they get out of bed due to forgetting they are wearing a walking boot for a broken foot. Surveyor then asked if there were any other interventions the facility could have implemented. DON B said they did not think so; staff need to get to the room when the bed alarm goes off. Facility failed to update R1's care with interventions to ensure no further incidents of falls.